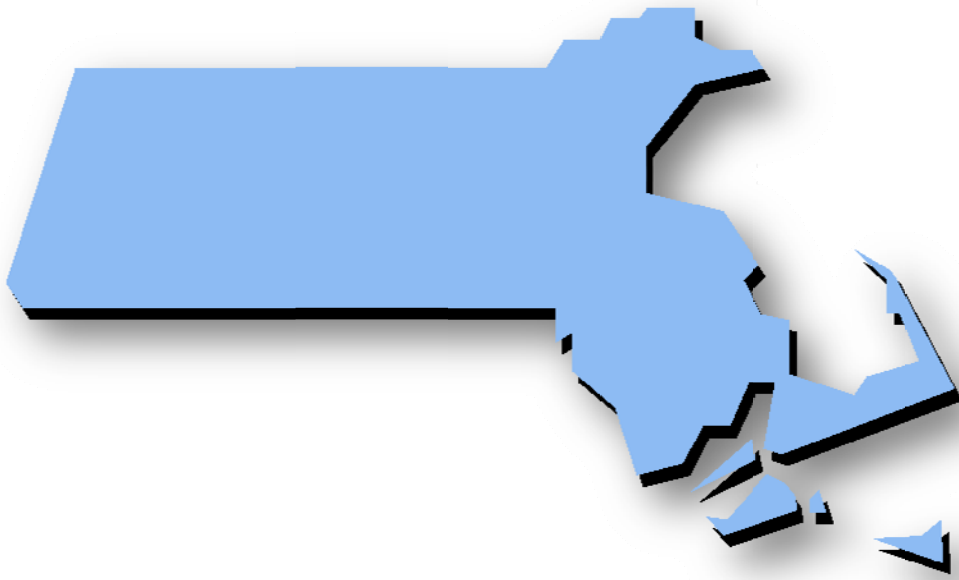


COMMONWEALTH OF MASSACHUSETTS

FISCAL YEAR 2009 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS
WORKERS' COMPENSATION SYSTEM



MASSACHUSETTS WORKERS' COMPENSATION
ADVISORY COUNCIL

JANUARY 2010



THE STATE OF THE MASSACHUSETTS WORKERS'
COMPENSATION SYSTEM

FISCAL YEAR 2009 ANNUAL REPORT

MASSACHUSETTS WORKERS' COMPENSATION
ADVISORY COUNCIL

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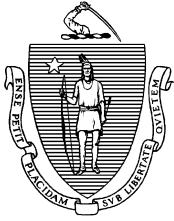
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Greg Bialecki (Secretary, Department of Business Development)

STAFF:

Andrew S. Burton (Executive Director)
Evelyn N. Flanagan (Chief Researcher)

* *Designates Voting Member*



DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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ANDREW S. BURTON
EXECUTIVE DIRECTOR

January 13, 2010

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

Dear Governor Patrick:

On behalf of the Massachusetts Workers' Compensation Advisory Council, I am pleased to present you with our Fiscal Year 2009 Annual Report: The State of the Massachusetts Workers' Compensation System.

The Advisory Council's Annual Report illustrates a detailed analysis of the workers' compensation system in Massachusetts. The report provides summaries in areas such as the workers' compensation insurance market, legislative initiatives, occupational illness and injury statistics, and the operations of the Division of Industrial Accidents (DIA). The Advisory Council also identifies six specific areas of concern and offers conclusive recommendations to enhance the workers' compensation system. Finally, the report recognizes significant achievements within the DIA and other related organizations that play a role in improving the system.

It is important to note that this report and its recommendations are a product of the commitment and contributions made by council members who volunteer their time to discuss a variety of workers' compensation issues with the ultimate goal of identifying problems and developing solutions. When the affirmative vote of at least seven members can be reached between business and labor, these positions are reflected in our recommendations.

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

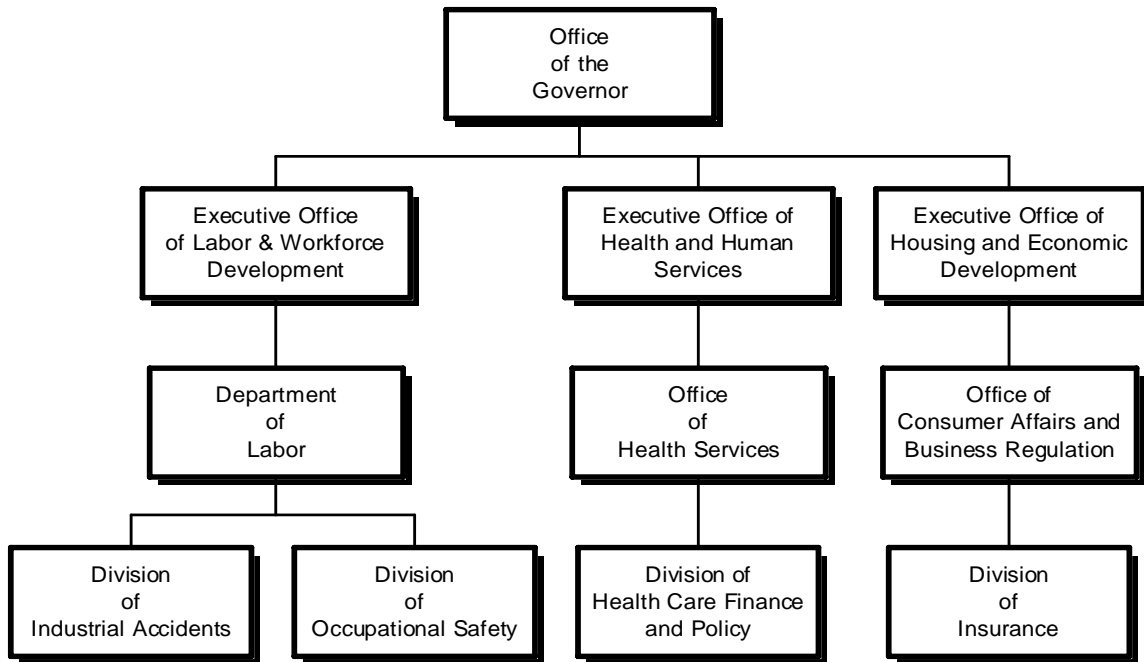
Very truly yours,

A handwritten signature in black ink, appearing to read 'A. S. Burton', with a stylized flourish at the end.

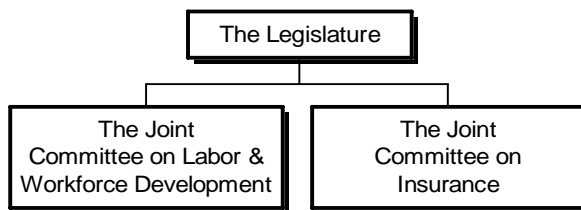
Andrew S. Burton
Executive Director

Government Regulation of Workers' Compensation

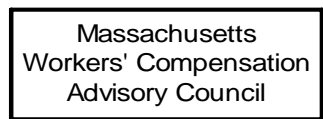
Executive Branch



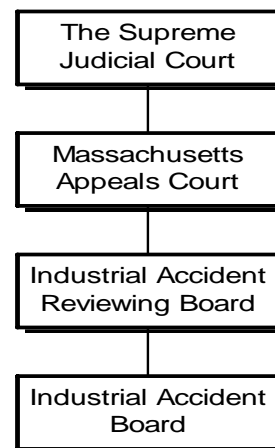
Legislative Branch



Oversight



Appeals Process



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

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ADVISORY COUNCIL

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

Pursuant to the Act, the Advisory Council is mandated to issue an annual report evaluating the operations of the Department of Industrial Accidents (DIA) and the state of the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the DIA and submit an independent recommendation when necessary. The Council also reviews the insurance rate filing and participates in insurance rate hearings (see Appendix B for a list of formal studies).

The Advisory Council is comprised of 16 members that are appointed by the Governor for five-year terms. The membership consists of: five employee representatives (each of whom is a member of a duly recognized and independent employee organization); five employer representatives (representing manufacturing classifications, small businesses, contracting classifications, and self-insured businesses); one representative of the workers' compensation claimant's bar; one representative of the insurance industry; one representative of the medical providers; and one representative of vocational rehabilitation providers. The Director of the Department of Labor and the Director of the Department of Economic Development serve as ex-officio members.

The voting members of the Council are comprised of the employee and employer representatives and cannot take action without at least seven affirmative votes. The Council's chair and vice-chair rotate between an employee representative and an employer representative.

The Advisory Council customarily meets on the second Wednesday of each month at 9:00 a.m. at the Department of Industrial Accidents, 600 Washington Street, 7th Floor Conference Room, Boston, Massachusetts. Meetings are open to the general public pursuant to the Commonwealth's open meeting laws (M.G.L. c.30A, §11(a)).

Advisory Council Studies

The Advisory Council's studies are available for review Monday through Friday, 9:00 a.m. - 5:00 p.m. at the Massachusetts State Library, State House, Room 341, Boston, Massachusetts, 02133, or by appointment at the office of the Advisory Council, 600 Washington Street, 6th Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

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

FISCAL YEAR 2009 IN REVIEW

During fiscal year 2009, the number of workers' compensation cases filed at the Department of Industrial Accidents (DIA) decreased by 5%. Since the enactment of the Workers' Compensation Reform Act of 1991, the number of cases filed at the DIA has decreased by 70%. The majority of cases filed at the DIA are employee claims. In fiscal year 2009, employee claims decreased by 3.5% from last fiscal year. Since 1991, employee claims have declined by 52%. The number of requests for a discontinuance or modification of benefits by insurers, which account for 16% of the total cases, decreased by 12% in fiscal year 2009 and have decreased by 80% since the 1991 Reform Act.

In August of 2008, the Advisory Council's Second Injury Fund (SIF) Subcommittee finalized their recommendations to be shared with the full Council. As a result of the subcommittee's work, the Advisory Council adopted the subcommittee's recommendation to support legislative efforts to phase out §37 SIF reimbursements for new and arising cases eligible for reimbursement for all injuries occurring before December 23, 1991 ("Mid Act" and "Old Act" claims). The Advisory Council also supported the subcommittee's recommendation to preserve the SIF for all claims arising on or after December 23, 1991 ("New Act" claims).

On September 10, 2008, the Advisory Council was presented with an overview of the operations of the DIA's Civil Litigation Unit. The Unit, which employs only one full time attorney solely working on civil litigation matters (nine other attorneys assist), currently has 200 civil litigation lawsuits pending. Although the Unit experienced a 16.4% increase in settlement amounts in fiscal year 2008, there continues to be numerous obstacles to the collections process. In many circumstances the employer may have limited or no assets, or will file for bankruptcy protection. Problems can also develop when claims are severe (death cases and brain/spinal cord injuries) and the compensation payout becomes disproportionate to the assets available for recovery.

Between September and December of 2008, the Advisory Council's Injury Reporting Subcommittee met on several occasions to discuss ways of improving injury reporting compliance in Massachusetts. The subcommittee learned that the DIA's computer system, which monitors First Report of Injury (FRI) violations, contained programmed algorithms that created "grace periods" stretching beyond the time limits provided in the statute. It was also discovered that annual FRI fines for individual employers were being arbitrarily capped at \$500. The DIA has since begun the process of reprogramming the parameters that are used to generate FRI violation notices and late payment demand notices in accordance to the mandated time periods. The subcommittee also drafted legislation to strengthen the penalties against employers who fail to timely report injuries. During the 2009-2010 Legislative Session, Representative David Torrisi filed House Bill 1838 on behalf of the Advisory Council to create an escalating fine structure (based on tardiness) for FRI violations.

On October 15, 2008, Governor Deval Patrick announced over \$1.4 billion in spending cuts, cost controls, and other budgetary solutions to bring the state's fiscal year 2009 operating budget in line with revised revenue estimates. Specifically, the Department of Industrial Accidents was required to reduce their fiscal year 2009 spending by \$92,184. The Advisory Council was informed that although the cuts would prevent some vacant positions from being filled, the core services of the DIA would not be negatively impacted in any manner. The fiscal year 2009 General Appropriations Act allotted the DIA an operating budget of \$21,196,452.

On December 19, 2008, the Massachusetts Supreme Judicial Court affirmed a DIA Reviewing Board decision in the Michael Seller's Case. At issue, was whether the Reviewing Board erred in finding that an employee is entitled to compensation based on their concurrent earnings when said employee is employed with two companies - one with workers' compensation insurance and one without coverage. The DIA's Trust Fund argued that because the employee had only one insured employer, the concurrent employer provision [M.G.L. c.152 §1(1)] should be inapplicable. In its decision, the SJC found this argument would be contrary to the purposes of the Workers' Compensation Act and ordered the Trust Fund to pay the concurrent wages.

During January and February of 2009, the Advisory Council's Information Exchange Subcommittee met to improve the flow of information shared between the DIA and the Workers' Compensation Rating & Inspection Bureau (WCRI) for the purpose of identifying uninsured employers and misclassification. Specifically, the subcommittee studied online Proof of Coverage (POC) applications used in other states that allow the general public to verify whether an employer is properly insured. In February, the WCRI's Governing Committee reached a consensus to support the co-development of an online POC application with the DIA. Both the subcommittee and the Advisory Council expressed support for this effort and further recommended that the DIA explore the benefits and feasibility of implementing a Compliance Statement Program similar to the one operating in New Hampshire. On September 15, 2009, the DIA and the WCRI launched the online Proof of Coverage application for public use.

On January 22, 2009, California Representative Joe Baca introduced H.R. 635 to establish a National Commission on State Workers' Compensation Laws. Under this federal legislation, a 14-member commission would be established to evaluate the adequacy of state workers' compensation laws and report back to Congress on its findings and recommendations. Workers' compensation in the United States is exclusively state-administered and is subject to the laws of each state's legislature. The Advisory Council continues to monitor the progress of this legislation to ensure that improvements made to the workers' compensation system in Massachusetts remain protected.

In February of 2009, the Division of Health Care Finance & Policy (DHCF) held two public hearings relative to the adoption of amendments to the Medical Fee Schedule that determines the rates of payment for hospitals and health care providers rendering services covered by insurers under the Workers' Compensation Act. For some of the services, the proposed increases would update the fee schedule to more closely reflect

the negotiated amounts already being paid by insurers and employers. At the public hearings, the Advisory Council testified that the DHCFP should work together with the DIA in establishing a Medical Fee Schedule Task Force that can promptly react when areas of the fee schedule become unrepresentative of system costs (see Appendix I for Advisory Council testimony). A total of fifteen organizations testified at the hearing showing overwhelming support for the proposed increases. The proposed amendments to the fee schedule regulations were adopted and became effective on April 1, 2009.

On February 11, 2009, the Advisory Council was presented with an overview of the revised calculation method for self insured bond requirements. Each year, the DIA's Office of Insurance evaluates employers to determine their eligibility for self insurance and to establish new bond amounts. The DIA contracted with Deloitte Consulting to develop a non-subjective method for determining bond amounts using the most up to date actuarial tools and analysis. Under the new calculation method, some companies may see an increased bond amount, while others may experience a decrease.

On February 19, 2009, Governor Deval Patrick signed Executive Order #510 mandating Information Technology (IT) consolidation in all Executive departments. The consolidation plan has several goals, which include, aligning each Secretariat's IT resources with their business priorities, creating management efficiencies, providing standardization, and ensuring that the Commonwealth's digital assets are secure. Under the plan, applications specific to the DIA (i.e. Case Management System) would continue to be managed at the agency level. However, the Executive Order will transfer the management of Help Desk Services, LAN, Desktop Support, and Website Application Support to the Secretariat level. All consolidated services at the Secretariat level will be offset by a chargeback to each respective agency for the amount of services received.

Also on February 19, 2009, the DIA's Office of Safety held their first annual Safety Grant Workshop for new applicants. The workshop was developed to educate and guide applicants through the safety grant process. The workshop was deemed a complete success with over 65 participants in attendance. Each year, the Office of Safety awards over \$800,000 in safety grants to Massachusetts' employers to help fund programs which provide workplace safety training. In fiscal year 2010, the Office of Safety will fund a total of 66 grants which will result in the training of 12,425 employees.

On March 5, 2009, the Advisory Council's Budget Subcommittee reviewed the DIA's line-item contained in the Governor's Fiscal Year 2010 Budget Recommendation (House 1). The subcommittee made a recommendation to the full Advisory Council to endorse the House 1 budget figure of \$20,758,502 for the DIA's operating expenses. In light of the Advisory Council's budgetary oversight responsibilities, the subcommittee also recommended that the DIA inform the Council of future Interdepartmental Service Agreements before the transfer of funds occur. In February of 2009, the DIA completed an Interdepartmental Service Agreement that transferred \$67,400 from the DIA's FY'09 employee payroll account to the Division of Occupational Safety to assist in underground economy fraud efforts. At the March 11, 2009 Advisory Council meeting, council members voted to adopt the subcommittee's recommendations.

On April 2, 2009, the DIA issued Circular Letter No. 329 announcing a new Pilot Program for the online payment of assessment fees. Initially, the pilot will include 10 of the largest writers of workers' compensation insurance in the Commonwealth. Payments are generated by the payer's bank and electronically transmitted to the DIA's bank account. This new free service is expected to save the insurance community both time and money while creating an exact audit trail of the money flow. All insurance companies in Massachusetts will be able to take advantage of online payment when the program officially launches on January 1, 2010.

On April 27, 2009, Governor Deval Patrick signed Executive Order #511 establishing a Massachusetts Employee Safety and Health Advisory Committee. In addition to the Advisory Committee, the Executive Order requires all Executive Branch agencies to keep detailed records concerning occupational injuries, illnesses, and death. Each agency will also be required to develop a joint labor-management health and safety committee to survey safety and health hazards and to make recommendations on improving workplace safety.

On April 28, 2009, Workers' Memorial Day was observed in Massachusetts 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 2008, 66 workers in Massachusetts died on the job.

On May 13, 2009, the Advisory Council met in Executive Session to review the qualifications of three judicial applicants seeking appointment or reappointment to the position of Administrative Judge. Upon the vote of at least seven voting members, the Advisory Council may rate any candidate as either "qualified," "highly qualified," or "unqualified." At the conclusion of the interviews, the Advisory Council forwarded all three judicial recommendations to the Governor's Chief Legal Counsel and to the members of the Governor's Council for review.

In June of 2009, the Workers' Compensation Research Institute (WCRI) released findings from their study, *"CompScope Benchmarks for Massachusetts, 9th Edition."* The study provides a comparison of the workers' compensation systems in Massachusetts and 13 other important states, covering injuries from 2001-2006, evaluated as of 2007. The study reported that employers in Massachusetts paid the lowest medical costs per claim among the 14 states in the study while achieving a very high rate of satisfaction with medical outcomes among those treated. However, the report noted that medical payments per claim in Massachusetts have been steadily increasing (9-12% per year) from 2001 to 2005 and at a slightly slower rate (7%) in 2006. The WCRI is an independent, not-for-profit research organization that studies the workers' compensation benefit delivery systems nationwide.

CONCERNS & RECOMMENDATIONS

The Advisory Council is mandated by M.G.L. c.23E, §17 to include in its annual report “an evaluation of the operations of the [DIA] along with recommendations for improving the workers’ compensation system.” In an effort to further improve the workers’ compensation system, the Council has identified the following areas of concern and offers these recommendations to address them.

1. Employer Fraud - Misclassification & Uninsured Employers

With the Massachusetts’ unemployment rate hovering around 9% and the uncertainty of the future economic climate, written workers’ compensation premium continues to decline in the Commonwealth. Although some of the reduction in premiums can be attributed to recent rate decreases and recession-related cuts in employment levels, Massachusetts regulators must make every effort to identify those employers who turn to illegal and insurance schemes as cost-saving alternatives to coverage. Studies have shown that in difficult economic times, some employers will fraudulently cut down on their workers’ compensation costs by operating without insurance, dishonestly misclassifying workers as independent contractors, or concealing payroll by the use of cash payments to employees.

Employers who misclassify their employees or forgo workers’ compensation insurance altogether, cost honest business owners and taxpayers millions of dollars annually and victimize hard working employees who go uninsured. The “underground economy” in the United States has by some estimates reached \$1 trillion annually, and contributes to over \$100 billion in lost revenue each year. Recent studies have estimated that there are between 126,000 to 248,000 misclassified workers in Massachusetts, with approximately 13% of the Commonwealth’s employers misclassifying some of their workers. A Harvard University study in 2004 revealed that the rate of misclassification of workers in Massachusetts increased from 8.2% during the late 1990s to 13.4% in 2001-2003.

Massachusetts has made great strides in the last year at curbing fraud to ensure a level playing field for all employers. In an effort to increase transparency and to include the business community and general public with anti-fraud efforts, the Department of Industrial Accidents (DIA) and the Workers’ Compensation Rating & Inspection Bureau of Massachusetts (WCRI) formed a public/private partnership to develop an online Proof of Coverage (POC) tool. Launched in September of 2009, the POC tool allows the public to verify whether a particular business has a current workers’ compensation insurance policy. In May of 2009, the multi-agency Joint Task Force on the Underground Economy completed its first year of work, generating over \$1.4 million in revenue from their anti-fraud efforts. The DIA’s Office of Investigations has also stepped up their enforcement efforts and reported a 200% increase in the number of stop work orders issued to uninsured companies in fiscal year 2009.

With the economic uncertainties that lay ahead, the Advisory Council believes that employer fraud is a significant threat to the health of the workers' compensation system in Massachusetts. Council members are pleased to see that the Patrick-Murray Administration has brought new focus and visibility to these deceptive business practices. Investing in anti-fraud efforts can have big payoffs. In 2007, the California Department of Insurance reported that for every dollar spent on workers' compensation fraud efforts, \$6.17 is returned to the workers' compensation system. The Advisory Council strongly believes that Massachusetts must continue its investment in combating employer fraud and proposes the following recommendations as a blueprint for success.

1.1 Create a Private Right of Action - Employee misclassification is a form of employer fraud. Classifications were created as a premium calculation tool based on the theory that the nature, extent and likelihood of certain injuries are common to any given industry (see page 108 for a more detailed description of the classification system). When employers misclassify their workers, they misrepresent the true nature or size of their business to their insurance carrier and various government agencies. Although employee misclassification can result from an honest misunderstanding of complex classification definitions, it frequently occurs when an employer is looking to cut costs.

While the practice of employee misclassification happens in all industries, it occurs most often in the construction industry, where employers are prone to deliberately misclassify their workers as "independent contractors," to avoid paying workers' compensation insurance and other state, federal or Social Security taxes. However, misclassification can be as simple as disguising the high-risk nature of the work being conducted, such as stating that a business employs clerical workers, when in fact they employ roofers. Or it can be as complex as defining certain workers as subcontractors to elude any premium payments and transfer liability to a third party.

Employee misclassification also creates a shortage in collected premiums needed by insurance carriers to pay the benefits of injured workers. When a business chooses to misclassify their workers, compliant employers end up paying millions of dollars in higher premium costs to cover this shortfall. Money spent subsidizing fraud takes away resources for worthy initiatives to improve workplace safety and provide job training.

During the 2009-2010 Legislative Session, the Advisory Council testified in support for the passage of **House Bill 1870**, filed by Representative Martin Walsh and **Senate Bill 682**, filed by Senator John Hart, Jr. These two identical bills would provide a vehicle for both private citizens and insurers to bring forth a civil action against employers who illegally fail to carry workers' compensation insurance or misclassify their workers for the purpose of avoiding premiums. On suits brought forth by private citizens, the majority of the damages would be deposited into the DIA's Trust Fund to help off-set payments made to injured workers of uninsured employers. In fiscal year 2009 alone, the Trust Fund paid approximately \$5.7 million in workers' compensation benefits to uninsured claimants.

In 2008, Illinois enacted a similar Private Right of Action Law that has already proven successful in helping curb misclassification fraud within the construction industry. The Advisory Council is recommending that the Legislature pass Private Right of Action legislation during the 2009-2010 Legislative Session. The passage of this legislation will help alleviate the competitive disadvantage faced by the vast majority of honest employers who purchase workers' compensation policies and properly classify their employees.

1.2 Increase Stop Work Order Fines & Expand DIA Investigative Powers - The DIA's Office of Investigations is responsible for ensuring that every employer in the Commonwealth with one or more employee(s) maintains a valid workers' compensation policy at all times. This can be a daunting challenge considering that at any given time, there are more than 200,000 businesses operating in Massachusetts, employing in excess of three million workers. With only twelve investigators responsible for covering 351 cities and towns, the DIA is placed at a severe disadvantage in the fight against employer fraud.

When a business chooses to operate without coverage, the result is an unfair and burdensome cost to compliant employers in the form of higher premiums to cover this shortfall. This shift in costs is especially detrimental to small businesses and construction companies where the margin of profit is already small. Beyond creating an unlevel playing field for competitors, uninsured employers unnecessarily jeopardize the health of the workers they employ. The central premise behind a workers' compensation insurance policy is that it will create incentives for an employer to provide a safer workplace. When an employer has a higher frequency of injuries, they are charged a higher premium to reflect future risk (see page 111 on "Premium Calculation"). Uninsured employers have fewer incentives to develop workplace safety programs because there is no tool in place to assess a financial penalty for poor injury experience.

During the 2009-2010 Legislative Session, **House Bill 17** was filed on behalf of the Executive Office of Labor & Workforce Development. This new legislation would increase the daily stop work order fines levied against uninsured employers to \$250 per day (presently \$100). In cases when a stop work order is appealed, the daily stop work order fines would increase to \$500 per day (presently \$250).

In addition to increasing the civil penalties, House Bill 17 would more clearly define the DIA investigative powers to ensure that business records can be inspected during compliance investigations for the purpose of uncovering misclassification. Although the Workers' Compensation Act refers to the penalties for workers' compensation misclassification in two sections of the law [c.152, §14(3) and §25C(10)], the statute is vague in regards to the DIA's enforcement powers. Under this legislation, the DIA would be required to share information with the agencies of the Joint Task Force on the Underground Economy when an investigator uncovers potential employee misclassification.

The Advisory Council believes that the current civil penalties for stop work orders, which have not been updated in 22 years, are grossly insufficient and no longer serve as a deterrent against uninsured employers. Furthermore, the Advisory Council recognizes the importance for allowing investigators to inspect employment records to ensure that employers who show proof of coverage are also properly classifying their workforce. The Advisory Council is recommending that the Legislature pass House Bill 17 during the 2009-2010 Legislative Session.

1.3 Increase Criminal Penalties - During the 2009-2010 Legislative Session, the Advisory Council testified in support for the passage of **Senate Bill 729**, filed by Senator Susan Tucker. This refiled legislation would significantly increase the severity of criminal penalties for employers who fail to provide mandatory workers' compensation insurance for their employees. On criminal convictions, this bill would allow a judge to impose sentencing for up to 5 years in state prison and/or fines up to \$10,000. In Massachusetts, criminal prosecutions against uninsured employers are reserved for the most extreme and flagrant cases.

Perhaps the most notable example of a case ripe for criminal prosecution comes from the 2003 Station Night Club Fire in Rhode Island that took the lives of 100 people, four of whom were club employees. Beyond not having the required workers' compensation insurance, a subsequent investigation found that club owners were engaged in a range of illegal business practices that included paying bartenders under the table, violating fire and building codes, and allowing overcrowding beyond the license capacity. Fortunately, Rhode Island's laws contained tough criminal penalties that fined the Night Club owners over a million dollars for failing to carry workers' compensation insurance. Had this tragedy occurred in Massachusetts, the criminal penalties for failing to carry workers' compensation insurance would be capped at \$1,500 or up to one year in prison.

Established in 1987, the present fine structure is outdated and insufficient. The Advisory Council is recommending that the Legislature pass Senate Bill 729 to toughen criminal penalties against uninsured employers. The Advisory Council believes this legislation sends a strong message to uninsured businesses in the Commonwealth that workers' compensation employer fraud is a serious violation of the law and will be met with serious consequences.

1.4 Provide an Online Classification Request Form - In September of 2009 the Advisory Council's Employee Misclassification Subcommittee met to address the problem of premium evasion fraud in Massachusetts. The subcommittee was comprised of a diverse representation of stakeholders in the workers' compensation system which included the business and labor community, the Workers' Compensation Rating & Inspection Bureau (WCRI), the Department of Labor, the Insurance Fraud Bureau of Massachusetts, and the DIA. One of the early goals of the subcommittee was to develop a non-legislative alternative to **House Bill 1838**, which would have required the

DIA to publish all classification codes for every insured employer within the recently launched Online Proof of Coverage Application.

As a result of the subcommittee's work, the Advisory Council unanimously supported the subcommittee's recommendation that the DIA implement an online Classification Request Form. Such a form would allow the public to request a specific employer's classification statement detailing all of the classification codes listed on their workers' compensation insurance policy as well as the percentage of payroll by classification code for the current and prior two policy years. The WCRIB has already agreed to provide this information to the DIA on a case-by-case basis to assist the agency with uncovering misclassification in accordance to M.G.L. c.152, §14(3) and §25C(10).

The Advisory Council strongly believes that providing public access to classification codes and their respective percentage of payroll could assist state investigators with uncovering misclassification. A classification request form will also benefit general contractors in the construction industry with ensuring that all subcontractors are properly classifying their employees. The Advisory Council is recommending that the DIA work closely with the WCRIB in developing an online Classification Request Form for the public.

2. Employee Benefits

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

2.1 Restore Scar-Based Disfigurement Benefits - In September of 2009, the Advisory Council testified before the Joint Committee on Labor & Workforce Development advocating for the passage of **Senate Bill 681**, filed by Senator John Hart, Jr. This bill would provide compensation for scar-based disfigurement appearing on any part of the body, subject to a \$15,000 maximum benefit. The eligibility criteria for this benefit was last modified 18 years ago by the 1991 Reform Act, which limited compensation for disfigurement to the face, neck or hands.

During fiscal year 2007, the Advisory Council contracted with Deloitte Consulting to investigate the cost implications of expanding workers' compensation scar-based disfigurement benefits. Specifically, the Advisory Council directed the actuary to measure the cost impact for six proposed amendment scenarios accounting for historical claim trends and changes in claim frequency and severity. Unfortunately, after conducting interviews with representatives from both the DIA and the WCRIB, it was

determined that the available statistical data was not refined to the required level of detail in either organization's databases.

In June of 2000, the Advisory Council attempted to conduct a similar scar-based disfigurement study with the actuarial firm Tillinghast - Towers Perrin to estimate the cost-impact of restoring scarring awards to their pre-chapter 398 levels. Again, our contracted actuaries were unable to quantify the impact of such a proposed revision due to incomplete data, though it was suggested that such a change would have a "relatively minimal impact on system costs."

Although scar-based disfigurement legislation has failed to become a law during the three legislative sessions, the Advisory Council remains committed with its support of restoring this benefit to the injured worker. The Advisory Council is recommending that the Legislature pass Senate Bill 681 during the 2009-2010 Legislative Session. Advisory Council members strongly believe that the location of scarring on the body is irrelevant and that compensation, with a \$15,000 maximum benefit, should be provided to workers who suffer these traumatic, and at times, horrific injuries.

2.2 Increase the Maximum Burial Allowance - Although the majority of workers' compensation benefits are indexed to the Average Weekly Wage, there remains to be certain benefits that are not tied to an index, and therefore, not adjusted on an annual basis. One such benefit is the maximum burial allowance for the dependents of deceased workers. In Massachusetts, when an employee has been killed on the job, the workers' compensation statute requires the insurer to "pay the reasonable expenses of burial, not exceeding four thousand dollars" [M.G.L. c.152, §33]. This amount has not been adjusted in 18 years.

On June 2, 2008, the National Funeral Directors Association released the results from their biennial Member General Price List Survey. In 2006, the average adult casketed funeral cost (with vault) in New England was \$7,407. It is important to note that these costs do not include cemetery monument or marker costs or miscellaneous cash advance charges such as flowers or obituaries.

State mandated burial allowances vary considerably in the U.S., ranging from a high of \$15,000 in Rhode Island to a low of \$2,000 in Mississippi. The Advisory Council is recommending that the Legislature pass **House Bill 1865**, filed by Representative David Torrisi. This bill would increase the maximum amount an insurer is obligated to pay for burial expenses from \$4,000 to \$8,000. Council members believe that the passage of such legislation will ensure there is sufficient compensation available to the families of those workers killed on the job so that they may be honored with a respectful burial.

3. Employer Responsibilities

In addition to providing indemnity and medical benefits to injured employees, workers' compensation insurance also protects employers from personal injury lawsuits. With

these protections come a wide range of employer responsibilities. Although the penalties for the violations of these responsibilities are often negligible, their effect can have great implications on the speed in which a claim is processed. The Advisory Council believes that there is a need to legislatively address two basic employer responsibilities that are far too often disregarded.

3.1 Create Civil Fines for Employers who fail to Notify Employees of Coverage - In

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

The Advisory Council supports the passage of **House Bill 1839**, filed by Representative Pam Richardson. This new bill would create civil fines for employers who fail to properly notify their employees under §22 of the Workers' Compensation Act. Under the provisions of this bill, employers would be fined not less than \$50, nor more than \$100 per day, for failing to provide written notice of coverage or cancellation.

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

The DIA's First Report Compliance Office, within the Office of Claims, is responsible for ensuring that employers are timely reporting workplace injuries. Failure to file, or timely file, a FRI three or more times within any year is punishable by a fine of \$100 for each violation. Each failure to pay a fine within 30 days is considered a separate violation. Massachusetts is the only state in the nation that allows an employer to have two violations in any year before fines are assessed. In fiscal year 2009, the First Report Compliance Office collected \$235,450 in fines stemming from late or unreported injuries, representing a 5% increase from last fiscal year. From the 31,216 FRIs processed in the fiscal year, only 29% were filed online.

In September of 2008, the Advisory Council formed an Injury Reporting Subcommittee to investigate ways of increasing employer compliance and promoting the online filing of the FRI. The subcommittee worked closely with the First Report Compliance Office,

the Office of Revenue, and the Information Technology Department to review the current procedures in place that trigger the issuance of FRI fines. During this review, the subcommittee learned that the computer system that monitors FRI violations had programmed algorithms that created "grace periods" stretching beyond the time limits provided in the statute. It was also discovered that annual FRI fines for individual employers were being capped at \$500, although the statute provides no such cap. As a result of the subcommittee's work, the DIA has begun the process of reprogramming the parameters that are used to generate FRI violation notices and late payment demand notices in accordance to the mandated time periods. The \$500 annual cap has also been removed.

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

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

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

4. Second Injury Fund

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

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

In May of 2008, the Advisory Council formed a Second Injury Fund Subcommittee to better understand how SIFs operate both nationally and within Massachusetts. The subcommittee also evaluated the effectiveness of SIFs in promoting the employment and retention of employees with prior disabilities. The subcommittee met throughout the summer to examine the SIF caseload within Massachusetts, the Americans with Disabilities Act, experience rating, recent SIF case law, and national trends.

SIF Caseload within Massachusetts - The DIA's Trust Fund administers SIF reimbursements in Massachusetts. The Trust Fund has an annual budget of approximately \$61 million, in which nearly half of the expenditures are primarily attributed to SIF expenses. Just ten years ago, SIF expenses only accounted for 25% of the Trust Fund's annual budget. Although the number of SIF settlements has decreased over the last decade, the average cost per claim has steadily increased by nearly 50% due to rising medical costs in Massachusetts. In fiscal year 2009, the Trust Fund disbursed \$26,419,935 for SIF reimbursements and received 284 claims. The administration of SIF claims is complicated by the fact that the Trust Fund continues to receive claims from three distinct statutory time periods, known as the "Old Act," "Mid Act," and "New Act" (see page 79 for a complete description of the three statutory time periods).

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

Experience Rating - SIF reimbursements are specifically designed to help employers bear the additional cost associated with hiring workers with prior disabilities. In order for this financial assistance to work, the reimbursements collected by insurance carriers must be timely reported to the designated rating bureau so that the employer can have their experience modification factor revised to reflect the lower claim costs. Unfortunately, many SIF claims are processed too late (not within the 3-year experience period) to have any effect on an employer's experience modification factor. This is the

case with "Mid-Act" (1985-1991) and "Old-Act" (1973-1985) claims which represent approximately 25% of all the claims received by the Trust Fund. To be eligible for experience rating in Massachusetts, an employer must have a premium of at least \$11,000 during the last two years. Although only 20% of Massachusetts employers are experience rated, this accounts for approximately 80% of the total premium volume.

Recent SIF Case Law - On April 16, 2008, the Massachusetts Supreme Judicial Court (SJC) issued a decision on the Kim Oakes's Case/Steven Alves's Case. The issue before the SJC was whether the lower courts erred in finding that the "Mid Act" Section 37 claims (filed between 12/10/85 thru 12/23/91) were not subject to any statute of limitations. In both cases, the SJC affirmed the decision of the lower courts that "Mid-Act" Second Injury Fund petitions are not subject to a statute of limitations. The Advisory Council has been informed that this decision could jeopardize the Trust Fund's ability to make accurate predictions regarding the level of future assessments that will be necessary to keep the SIF solvent. From FY'04 through FY'07, there were over 500 pre-1991 cases filed with the Trust Fund.

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

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

The Advisory Council is recommending that during the 2009-2010 Legislative Session, lawmakers file and pass legislation to phase out Section 37 Second Injury Fund reimbursements for new and arising cases eligible for reimbursement for all injuries occurring before December 23, 1991, so called "Mid Act" and "Old Act" claims. Council members believe that such legislation should become effective 180 days after enactment to allow insurers adequate time to review and submit remaining caseloads. The Advisory Council is further recommending the preservation of the Second Injury Fund in Massachusetts for all claims arising on or after December 23, 1991, so called "New Act" claims.

5. Medical Fee Schedule Task Force

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

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

The Rhode Island Model - In September of 2007, the Advisory Council was presented with an overview of Rhode Island's Fee Schedule Task Force. The Task Force was created in 1992 and consists of a diverse group of representatives from that state's Department of Labor & Training, Beacon Mutual Insurance, self insured employers, the Medical Advisory Board, Blue Cross/Blue Shield, third party administrators, the Rhode Island Medical Society, and the Hospital Association of Rhode Island. As a representative body of the Rhode Island workers' compensation system, the Task Force provides all parties with a forum to continually fine-tune the fee schedule and expand codes when necessary.

Recent Amendments to the Fee Schedule - In February of 2009, the DHCFP held two public hearings relative to proposed increases to the fee schedule to more closely reflect the negotiated amounts already being paid by insurers and employers. At the public hearings, the Advisory Council recommended that the DIA and the DHCFP work together to form a Massachusetts Medical Fee Schedule Task Force, similar to Rhode Islands. A total of fifteen organizations testified at the hearing showing overwhelming support for the proposed increases. The Advisory Council applauds the DHCFP for addressing the workers' compensation medical fee schedule in 2009. The fee schedule, which had not been adjusted in nearly five years, is now closer to the actual costs of healthcare services rendered in certain fields. However, the recent amendments to the fee schedule only serve as a "band-aid" to the much larger problem of maintaining updated and accurate rates.

The Advisory Council was impressed with how various interests were able to come together in Rhode Island to produce a fee schedule that accurately reflects the costs

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

6. DIA Funding

Leading up to the 1985 Reform Act, the DIA had consistently experienced funding shortfalls which led to costly delays in the Dispute Resolution System. At one point in 1983, the DIA ran out of money for stamps which required insurers and law firms to pick up their own mail - mail which contained judicial orders with 10-day appeal deadlines! Between 1974 and 1984, the DIA's administrative budget declined and staffing levels plunged, further slowing the administration of justice. One practicing attorney dubbed the DIA, "the most neglected orphan in the judicial system in the Commonwealth."

In November of 1983, Governor Michael Dukakis appointed industry experts to a Governor's Task Force on Workers' Compensation to identify systematic problems and determine where reform was necessary. Amongst their findings, the Task Force identified funding shortfalls as one of the root causes for delays to the workers' compensation system and recommended independent funding for the DIA.

To ensure the DIA had adequate funding, the Legislature in 1985 adopted the recommendation of the Task Force and transferred the agency's cost burden from the state's General Fund to the Commonwealth's employer community via assessments collected by workers' compensation insurance carriers. In addition to assessments, the DIA also derives revenue from the collection of fees (for various filing costs) and fines (for violations of the Act). The statute requires all revenue received from assessments, be kept in accounts, "separate and apart" from all other monies received by the Commonwealth [M.G.L. c.152, §65(6)].

All income received by the DIA is deposited into one of three funds: the Special Fund, the Private Trust Fund, or the Public Trust Fund. 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 injured employees and those denied vocational 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.

Upon signing the 2010 General Appropriations Act, Governor Patrick reduced the DIA's Special Fund line-item by \$202,534 from all previous proposed amounts (House 1, House-Passed Budget, Senate-Passed Budget, and Conference Committee Budget). The Governor stated in his Veto Explanation that he reduced this line-item, "by an amount not recommended in light of available revenues." In October of 2009, the Governor used his Section 9C powers and proposed further reductions which decreased the DIA's fiscal year 2010 line-item by \$789,719. The Governor explained that the reductions were necessary due to a \$600 million statewide shortfall in projected General Fund revenues. As a result of the combined decreases of nearly a million dollars, the DIA will have to institute furloughs and consider staffing reductions in fiscal year 2010.

The Advisory Council would like all parties involved in the state budget process to recognize that the DIA is funded by an assessment on employers which is based on an amount to adequately fund the DIA. There are no tax dollars used to fund this agency or any of its activities, as the DIA's Special Fund is used to reimburse the Commonwealth's General Fund for 100% of its budgeted appropriation. Due to this unique, self-sustaining, employer-funded mechanism, General Fund revenues should have no impact on the agency's budget. No system can function if it is not adequately funded, staffed and managed. Since neither budget reduction resulted in a lower assessment for Massachusetts employers, reducing DIA expenditures without reducing assessments is an unfair way to balance the state budget. The Advisory Council remains committed to monitoring the budget process to ensure the DIA can provide effective services to injured workers and employers.

LEGISLATION

During the 2009-2010 Legislative Session, approximately 48 bills were filed by the House and Senate seeking to amend 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 & Workforce Development (JCLWD). For a complete list of JCLWD members, see Appendix C.

Legislation Endorsed by the Advisory Council

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

House Bill 1870 (Walsh) & **Senate Bill 682** (Hart) - Private Right of Action
House Bill 17 (EOLWD) - Stop Work Order Fines/DIA Investigative Powers
Senate Bill 729 (Tucker) - Increasing Criminal Penalties
Senate Bill 681 (Hart) - Scar-Based Disfigurement
House Bill 1865 (Torrise) - Maximum Burial Allowance
House Bill 1863 (Torrise) - Penalties for Failing to Timely Report Injuries
House Bill 1839 (Richardson) - Civil Fines for Failing to Notify Employees of Coverage

Public Hearing on Workers' Compensation Legislation

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

The next step for the JCLWD is to convene in Executive Session to review public testimony and discuss the merits of each bill before making their recommendations to the full membership of the House or Senate. When a committee deems a bill to be favorably rated, it is the first essential step for a bill to become a law. Bills that are reported out favorably are then sent on to various relevant committees for review. At the halfway point of the 2009-2010 Legislative Session, the JCLWD has not met in Executive Session to report on workers' compensation legislation.

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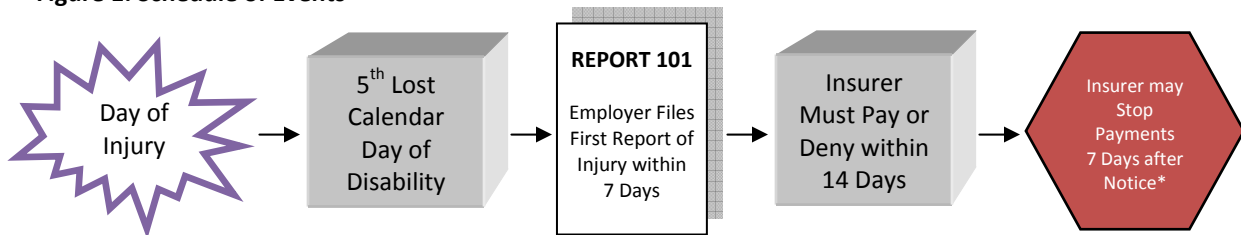
PROVISIONS TO RESOLVE DISPUTES

Workers' Compensation Claims

When an employee is disabled or incapable of earning full wages for five or more calendar days, or dies, as the result of a work-related injury or disease, the employer must file a First Report of Injury. This form must be sent to the Office of Claims Administration at the DIA, the insurer, and the employee within seven days of notice of the injury.¹ Failure to file, or timely file, a First Report of Injury three or more times within any year is punishable by a fine of \$100 for each violation. In addition to state mandated reporting guidelines, employers must also comply with federal injury recordkeeping and reporting requirements administered by the Occupational Safety and Health Administration (OSHA).

The insurer then has 14 days upon receipt of the employer's First Report of Injury to either pay the claim or to notify the DIA, the employer, and the employee of their refusal to pay.² When the insurer pays a claim, they may do so without accepting liability for a period of 180 days. This is known as the "pay without prejudice period." This period establishes a window where the insurer may refuse a claim and stop payments at will. Up to 180 days, the insurer can unilaterally terminate or modify any claim, as long as it specifies the grounds and factual basis for so doing.³ The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.

Figure 1: Schedule of Events



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

¹ The First Report of Injury can be submitted to the DIA by mail or through online submission.

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

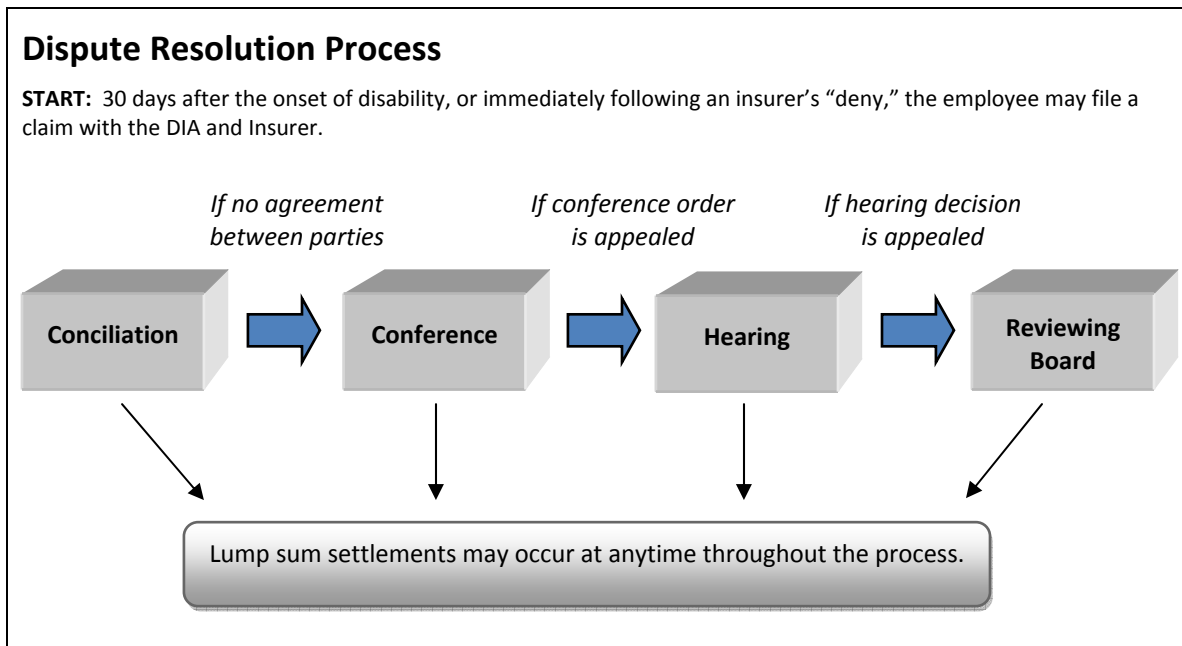
³ The insurer does not need permission from the DIA to terminate or reduce benefits during the 180 day "pay without prejudice" period if said change is based on actual income of the employee or if it gives the employee and the DIA at least seven days written notice of its intent to stop or modify benefits and contest any claim filed. The employee can contest discontinuance by filing a claim with the DIA. The pay without prejudice period may be extended up to one year under special circumstances.

After a conference order is issued or the pay without prejudice period expires, the insurer may not stop payment without an order from an Administrative Judge (AJ). The insurer must request a modification or termination of benefits, based on an impartial medical exam and other statutory requirements. A discontinuance or modification of benefits may take place no sooner than 60 days following a referral to the division of dispute resolution.

Dispute Resolution Process

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

Figure 2: Dispute Resolution Process



Dispute resolution begins at conciliation, where a conciliator will attempt to resolve a dispute by informal means. Disputes should go to conciliation within 15 days of receipt of the case from the Division of Administration.

A dispute not resolved at conciliation will then be referred to a conference, where it is assigned to an AJ who retains the case throughout the process if possible. The insurer must pay an appeal fee of 65% of the state average weekly wage (SAWW) or 130% of the SAWW if the insurer fails to appear at conciliation. The purpose of the conference is to compile the evidence and to identify the issues in dispute. The AJ may require both injury and hospital records. A conference order may be appealed to a hearing within 14 days from the filing date of such order.

At hearing, the AJ reviews the dispute according to oral and written documentation. The procedure at a hearing is formal and a verbatim transcript of the proceeding is

recorded by a stenographer. Witnesses are examined and cross-examined according to the Massachusetts Rules of Evidence. The AJ may grant a continuance for reasons beyond the control of any party. Any party may appeal a hearing decision within 30 days.

This time limit for appeals may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then proceed to the reviewing board, where a panel of Administrative Law Judge's (ALJ's) will hear the case.

At the reviewing board, a panel of three ALJ's review the evidence presented at the hearing. The ALJ's may request oral arguments from both sides. They can reverse the AJ's decision only if they determine that the decision was beyond the scope of authority, arbitrary, capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an AJ for further findings of fact.

All orders from the dispute resolution process may be enforced by the Superior Court of the Commonwealth. Reviewing Board cases may also be appealed to the Appeals Court. The costs of appeals are reimbursed to the claimant (in addition to the award of the judgment), if the claimant prevails.

Lump Sum Settlements

A case can be resolved at any point during the DIA's three-step dispute resolution process by either a voluntary settlement agreed to by the parties or by the decision of an AJ or ALJ.

Conciliators may "review and approve as complete" lump sum settlements, a standard that allows the conciliator to review a completed lump sum settlement. Conciliators or the parties at conciliation may also refer a case to a lump sum conference, where an ALJ will decide if a lump sum settlement is in the best interest of the parties.

At the conference or hearing level of dispute resolution, the AJ may approve lump sum settlements in the same manner that an ALJ approves a settlement at the lump sum conference. AJ's and ALJ's must determine whether settlements are in the best interest of the employee, and they may reject a settlement offer if it appears to be inadequate.

Alternative Dispute Resolution Measures

Arbitration & Mediation - At any time prior to five days before a conference, a case may be referred to an independent arbitrator. The arbitrator must make a decision whether to vacate or modify the compensation pursuant to M.G.L. c.251, §12 and §13. The parties involved may agree to bring the matter before an independent mediator at any stage of the proceeding. Mediation shall in no way disrupt the dispute resolution process, and any party may continue with the process at the DIA if they decide to do so.

Collective Bargaining - An employer and a recognized representative of its employees may engage in collective bargaining to establish certain binding obligations and procedures related to workers' compensation. Agreements are limited to the following topics: supplemental benefits under §34, §34A, §35, and §36; alternative dispute resolution (arbitration, mediation, conciliation); limited list of medical providers; limited list of impartial physicians; modified light duty return to work program; adoption of a 24-hour coverage plan; establishing safety committees and safety procedures; and establishing vocational rehabilitation or retraining programs.

SUMMARY OF BENEFITS

An employee, who is injured during the course of employment or suffers from work-related mental or emotional disabilities, as well as occupational diseases, is eligible for workers' compensation benefits. These benefits include weekly compensation for lost income during the period the employee cannot work.

Indemnity payments vary, depending on the average weekly wage of the employee (AWW) and the degree of incapacitation. The statute dictates that the maximum benefit be set at 100% of the State Average Weekly Wage (SAWW) and that a minimum benefit of at least 20% of the SAWW.⁴ In addition, the insurer is required to furnish medical and hospital services, as well as any medicines if needed. The insurer must also pay for vocational rehabilitation services if the employee is determined to be suitable for such services by the DIA.

Below is a list of the SAWW since 1995 along with the maximum (SAWW) and minimum benefit levels for §34 and §34A claims. In October of 2009, the SAWW increased by .1% (\$1.43) from the previous year.

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

<u>Effective Date</u> (Effective Oct 1st)	<u>Maximum Benefit</u> (100% of SAWW)	<u>Minimum Benefit</u> (20% of SAWW)
10/1/95	\$604.03	\$120.81
10/1/96	\$631.03	\$126.21
10/1/97	\$665.55	\$131.11
10/1/98	\$699.91	\$131.98
10/1/99	\$749.69	\$149.93
10/1/00	\$830.89	\$166.18
10/1/01	\$890.94	\$178.19
10/1/02	\$882.57	\$176.51
10/1/03	\$884.46	\$176.89
10/1/04	\$918.78	\$183.76
10/1/05	\$958.58	\$191.72
10/1/06	\$1,000.43	\$200.09
10/1/07	\$1,043.54	\$208.71
10/1/08	\$1,093.27	\$218.65
10/1/09	\$1,094.70	\$218.94

Source: DIA Circular Letter No. 332 - Table I (October 1, 2009)

⁴ The Statewide Average Weekly Wage (SAWW) is determined under M.G.L. c.151A, §29(2) & promulgated by the Director the Division of Employment and Training. As of October 1, 2009, the SAWW is \$1,094.70.

Indemnity and Supplemental Benefits

The following are the various forms of indemnity and supplemental benefits employees may receive depending on their average weekly wage, state average weekly wage, and their degree of disability.

Temporary Total Disability (§34) - Compensation will be 60% of the employee's average weekly wage (AWW) before injury, while remaining above the minimum and below the maximum payments that are set for each form of compensation. The maximum weekly compensation rate is 100% of the state average weekly wage (\$\$1,094.70), while the minimum is 20% of the SAWW (\$218.94), if claims involve injuries occurring on or after October 1, 2009. The limit for temporary benefits is 156 weeks.

Partial Disability (§35) - Compensation is 60% of the difference between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits. The maximum benefit period is 260 weeks for partial disability, but may be extended to 520 weeks.

Permanent and Total Incapacity (§34A) - Payments will equal 66.67% of the AWW following the exhaustion of temporary (§34) and partial (§35) payments. The maximum weekly compensation rate is 100% of the state average weekly wage (\$1,094.70), while the minimum is 20% of the SAWW (\$218.94), if claims involve injuries that occurred on or after October 1, 2009. The payments must be adjusted each year for cost of living allowances (COLA benefits).

Death Benefits for Dependents (§31) - The widow or widower that remains unmarried shall receive 2/3 of the worker's AWW, but not more than the state's AWW or less than \$110 per week. They shall also receive \$6 per week for each child (not to exceed \$150 in additional compensation). There are also benefits for other dependents. Benefits paid to all dependents cannot exceed 250 times the state AWW plus any cost of living increases (COLA). However, children under 18 years old may continue to receive payments even if the maximum has been reached. Burial expenses may not exceed \$4,000.

Subsequent Injury (§35B) - An employee who has been receiving compensation, has returned to work for two months or more and is subsequently re-injured, will receive compensation at the rate in effect at the time of the new injury (unless the old injury was paid in a lump sum). If the old injury was settled with a lump sum, then the employee will be compensated only if the new claim can be determined to be a new injury.

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

Attorney's Fees

The dollar amounts specified for attorney's fees are listed in M.G.L. c.152, §13A(10). As of October 1, 2009, subsections 1 through 6 were updated to reflect adjustments to the State Average Weekly Wage. Below is a summary of the attorney's fee schedule:

(1) When an insurer refuses to pay compensation within 21 days of an initial liability claim but prior to a conference agrees to pay the claim (with or without prejudice), the insurer must pay an attorney's fee of **\$1,048.11** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **\$524.04**.

(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 **\$1,497.28**. The Administrative Judge can increase or decrease this fee based on the complexity of a case and the amount of work an attorney puts in. If the employee's attorney fails to appear at a scheduled conciliation, the fee may be reduced to **\$747.75**.

(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 **\$747.66** plus necessary expenses. This fee can be reduced to **\$373.89** if the employee's attorney fails to appear at a scheduled conciliation.

(4) When an insurer contests a claim for benefits or files a complaint to reduce or discontinue benefits by refusing to pay compensation within 21 days, and the order of the Administrative Judge after a conference reflects the written offer submitted by the claimant (or conciliator on the claimant's behalf), the insurer must pay the employee's attorney a fee of **\$1,048.11** 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 **\$524.04** 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 **\$5,240.44** plus necessary expenses. An Administrative Judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

(6) When the insurer appeals the decision of an Administrative Judge and the employee prevails in the decision of the Reviewing Board, the insurer must pay a fee to the employee's attorney in the amount of **\$1,497.28**. An Administrative Judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

SECTION
- 3 -

***WORKPLACE INJURY AND
FATALITY STATISTICS***

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Occupational Fatalities.....38

OCCUPATIONAL INJURIES AND ILLNESSES

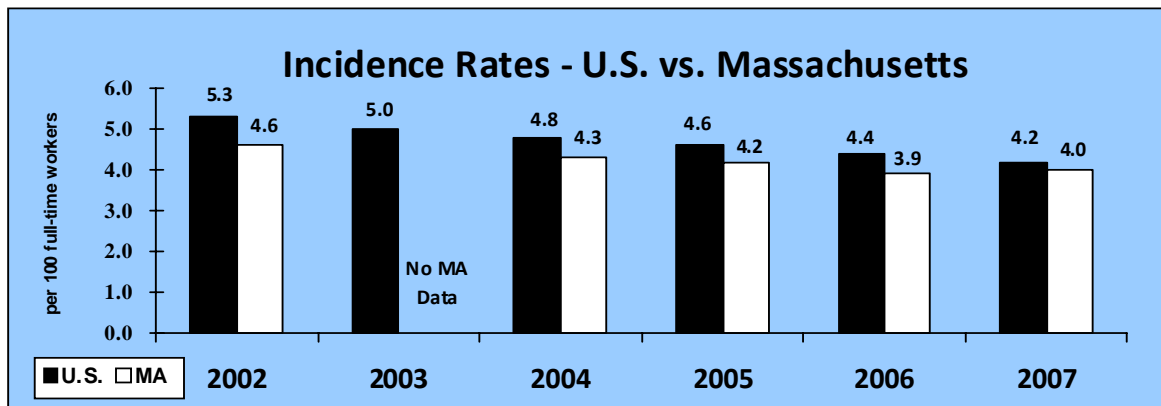
Since 1992, the Massachusetts Division of Occupational Safety (DOS) has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys are collected from a sample of private industry establishments in an effort to represent the total private economy. Each year these statistics are published in a document known as the *Annual Survey of Occupational Injuries and Illnesses*. Funding for the annual survey is split 50/50 between state (DOS) and federal (BLS) government.

Injury and Illness Incidence Rates

Incidence rates are calculated to measure the frequency of injuries. Specifically, the study examines the frequency of non-fatal injuries and illnesses that occurred in the private sector workforce for every 100 full-time workers. Each year the level of incidence rates can be influenced by changes in the economic climate, working conditions, an employer's emphasis on safety, and the number of hours that employees work. In 2007, Massachusetts had a population of 6,467,967 people with an estimated private sector workforce of 2,824,300 workers.

During 2007, the private sector workforce in the U.S. experienced approximately 4.0 million non-fatal injuries and illnesses, resulting in an incidence rate of 4.2 cases per 100 full-time workers. In Massachusetts alone, there were 89,600 non-fatal occupational injuries and illnesses, resulting in an incidence rate of 4.0 cases per 100 full time workers. Of the 89,600 workplace injuries and illnesses in Massachusetts during 2007, roughly 42,400 (47%) did not result in lost workdays, while approximately 47,200 (53%) involved days away from work, job transfer, or restrictions. The graph below shows how occupational injury and illness rates have steadily declined at both the national level and within Massachusetts from 2002 to 2007. The graph also displays how incidence rates in Massachusetts have consistently remained lower than national rates.

Figure 3: Incidence Rates - U.S. vs. Massachusetts, 2002 - 2007



Source: Bureau of Labor Statistics - Boston Office.

Incidence Rates by Region

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

Table 2: Injury and Illness Incidence Rates - U.S. and New England 2002-2007 (Private Industry)

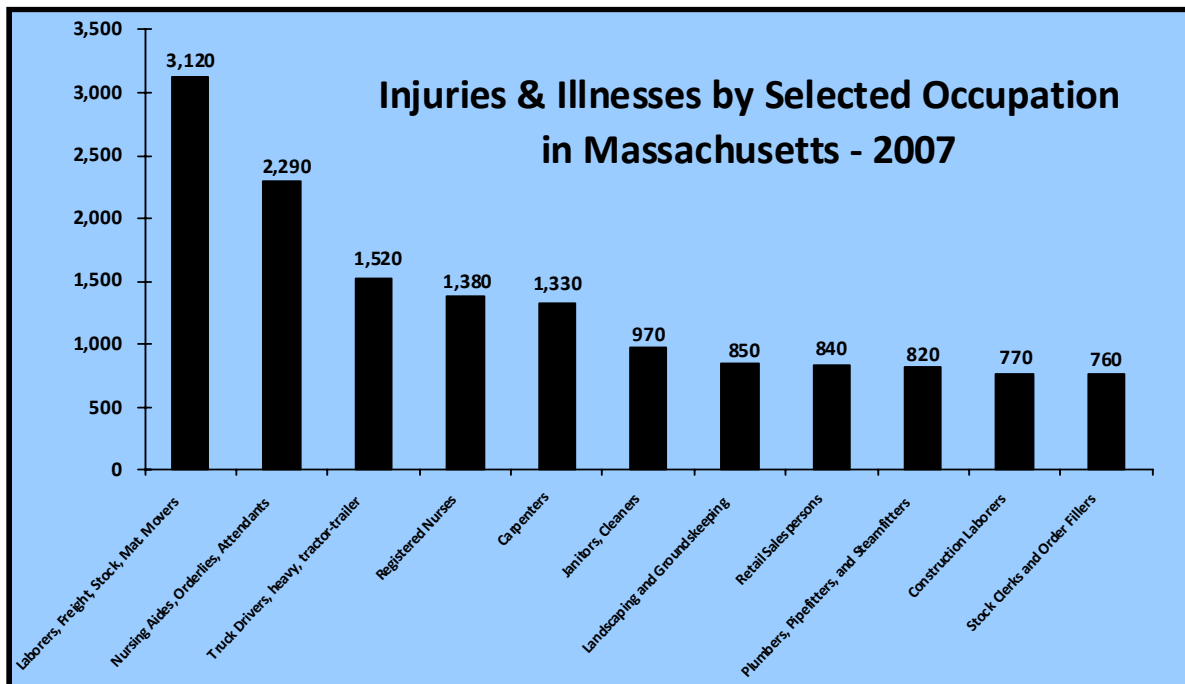
<i>Region</i>	<i>2007</i>	<i>2006</i>	<i>2005</i>	<i>2004</i>	<i>2003</i>	<i>2002</i>
United States.....	4.2	4.4	4.6	4.8	5.0	5.3
Massachusetts.....	4.0	3.9	4.2	4.3	no data	4.6
Connecticut.....	4.8	4.8	5.0	4.8	5.1	5.4
Maine.....	6.4	7.0	7.2	6.9	7.7	8.1
Rhode Island.....	5.1	5.2	5.5	5.2	5.4	5.3
Vermont.....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

Source: Bureau of Labor Statistics - Boston Office.

Injuries & Illnesses by Occupation

The survey also has the ability to categorize the number of injuries and illnesses by occupation in Massachusetts. In 2007, laborers (non-construction) and nursing aides, orderlies and attendants had the highest number of injuries and illnesses involving days away from work in Massachusetts.

Figure 4: Injuries & Illnesses by Selected Occupation in Massachusetts - 2007



Source: Bureau of Labor Statistics - Boston Office.

Incidence Rates by Industry

The survey also has the ability to categorize incidence rates by industry. In Massachusetts, the construction industry had the highest overall incidence rate in 2007, with 6.1 injuries for every 100 full-time workers. Approximately 140,900 workers or 5% of the Massachusetts private sector employees worked in construction. Finance, insurance and real estate had the lowest incidence rates, with 1.3 injuries per 100 workers, which employed 8% of the private sector workforce. As a whole, the goods-producing industries in Massachusetts, which employed about 16% of the private sector workforce, had a higher incidence rate (4.5) than service-producing industries (3.9), which employed the remaining 84% of the private sector workforce in 2007.

Table 3: Nonfatal Injury & Illness Incidence Rates by Industry - Massachusetts 2002-2007

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

Source: Bureau of Labor Statistics - Boston Office.

OCCUPATIONAL FATALITIES

Fatal work injuries are calculated nationally each year by the U.S. Department of Labor, Bureau of Labor Statistics. The program, known as the *National Census of Fatal Occupational Injuries*, tracks data from various states and federal administrative sources including death certificates, workers' compensation reports and claims, reports to various regulatory agencies, and medical examiner reports. Much like the *Annual Survey of Occupational Injuries and Illnesses*, this census is a federal/state cooperative venture.

In 2008, a total of 5,071 work-related fatalities were recorded nationally by the program, representing a 10% decrease from the revised total of 5,657 fatalities in 2007. The national rate of fatal work injuries in 2008 was 3.6 per 100,000 workers, down from the rate of 4.0 per 100,000 workers in 2007. The overall fatal work injury rate for the U.S. in 2008 was at its lowest level since the fatality census was first conducted in 1992.

Workplace Fatalities in Massachusetts

In 2008, Massachusetts experienced 61 workplace fatalities, 14 fewer fatalities than 2007. The leading cause of workplace death in Massachusetts came from transportation incidents (18) and falls (15) in which 33 workers were killed. Nationally, transportation incidents were the leading cause of on-the-job fatalities, accounting for 40% of the fatal work injuries in 2008. Following transportation incidents and falls, Massachusetts workers were killed by exposure to harmful substances and equipment (10), assaults and violent acts (8), and contact with objects and equipment (8).

Figure 5: Fatal Occupational Injuries by State and Event or Exposure, 2008 (Northeast Region)

State of Fatality	Total Fatalities		Event or Exposure (state total for 2008)					
	2007	2008	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total.....	5,657	5,071	2,053	794	923	680	432	173
Massachusetts....	75	61	18	8	8	15	10	--
Connecticut.....	38	28	9	6	6	4	3	--
Maine.....	21	24	16	--	4	--	--	--
New Hampshire..	14	7	3	--	--	--	--	--
Rhode Island.....	5	6	--	--	--	--	--	--
Vermont.....	10	10	3	--	4	--	--	--

Source: Bureau of Labor Statistics, News-USDL-09-0979

SECTION

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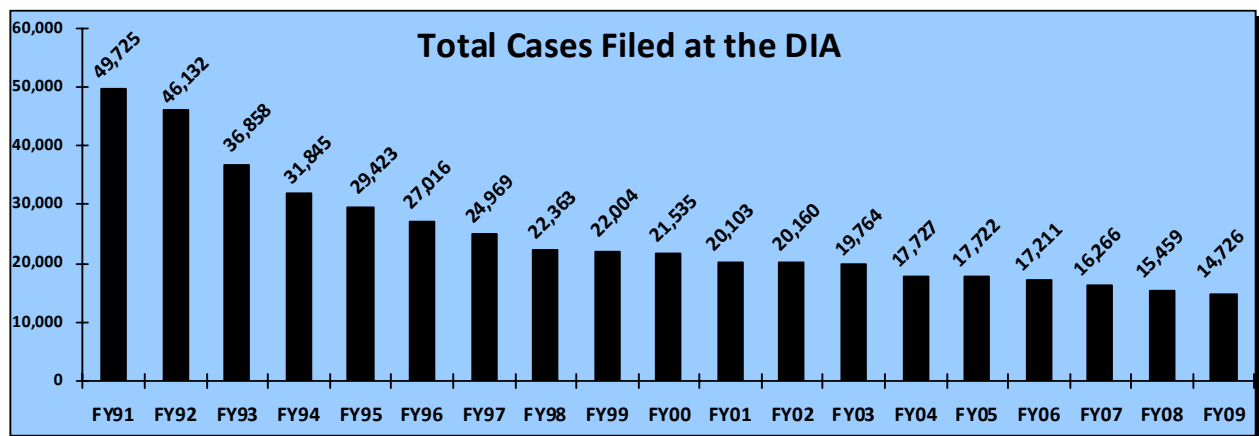
DISPUTE RESOLUTION

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Administrative Judges.....	60

CASES FILED AT THE DIA

Cases originate at the DIA when any of the following are filed: an employee's claim for benefits, an insurer's complaint for termination or modification of benefits, a third party claim, a request for approval of a lump sum settlement, or a Section 37/37A request. As demonstrated in Figure 6, there has been a significant decline (-70%) in the DIA caseload since the implementation of the 1991 Reform Act. In FY'09, the total number of cases filed at the DIA was 14,726, a decrease of 5% from the previous fiscal year.

Figure 6: Total Cases Filed at the DIA, FY'91 - FY'09



Source: CMS Report 28

Employee claims, which account for 76% of the total cases filed at the DIA, decreased by 411 cases (-3.5%) in FY'09. In 1991, employee claims reached an all time high of 23,240 cases filed. Employee claims have decreased by 52% since 1991. Insurers request for discontinuance or modification of benefits account for 16% of the total cases and decreased by 307 cases in FY'09. Since the 1991 Reform Act, these insurer requests for discontinuance have decreased by 80%.

Table 4: Breakdown of Total Cases Filed at the DIA, Fiscal Year 2009 and Fiscal Year 2008

Total Cases Filed at the DIA FY'09 and FY'08	Number of Cases		Percentage	
	FY'09	FY'08	FY'09	FY'08
Employee Claims	11,211	11,622	76.1%	75.2%
Insurer's Request for Discontinuance	2,324	2,631	15.8%	17.0%
Lump Sum Conference Request	594	667	4.0%	4.3%
Third Party Claims	283	211	1.9%	1.4%
Section 37/37A Request	314	328	2.1%	2.1%
TOTALS:	14,726	15,459	100%	100%

Source: CMS Report 28

CONCILIATION

The first stage of the dispute resolution process is known as the conciliation. The main objective of the conciliation is to remove cases that can be resolved without formal adjudication from the dispute resolution system. At this stage, cases are reviewed for documentation substantiating the positions of both sides of the dispute. Conciliators are empowered to withdraw or reschedule a case until adequate documentation is presented. Although conciliators may encourage the parties to work out a settlement, they have no authority to order the parties to resolve their differences. Approximately 45% of the cases that are scheduled for conciliation are “resolved” as a result of this process and exit the dispute resolution system. Such resolved cases take on a broad range of dispositions including withdrawals, lump sum settlements, and conciliated cases. The remaining 55% of cases are referred from conciliation to a conference to be heard before an Administrative Judge.

The Conciliation Process

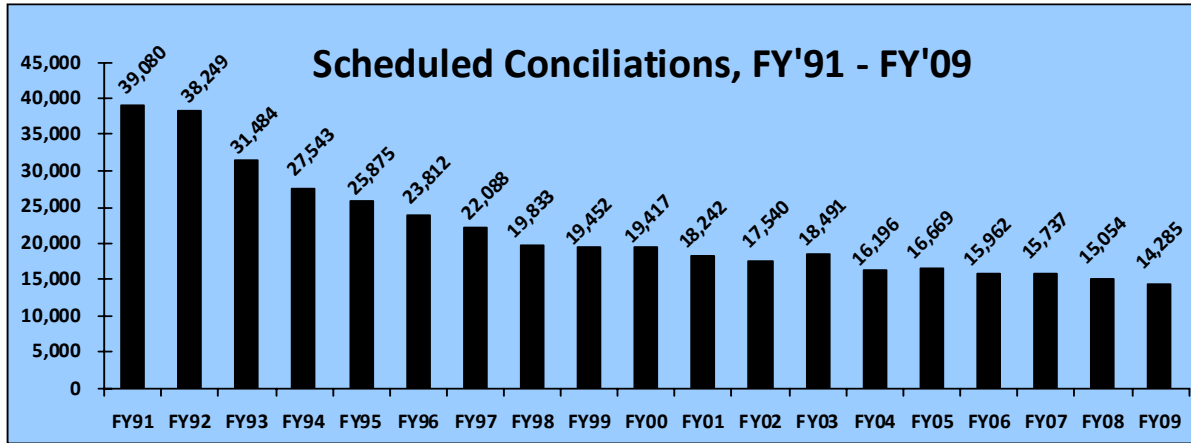
Conciliations are scheduled automatically by computer through the Data Processing Unit. Attendance of both the insurer and the employee is required. The employer may attend, as well as other interested parties, with the permission of all parties. All relevant issues (including causal relationship, disability,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

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

Volume of Scheduled Conciliations

The number of cases reviewed at conciliation is indicative of the total volume of disputed claims, as nearly every case to be adjudicated must first go through conciliation. The caseload of scheduled conciliations peaked in 1991 at 39,080 cases. In FY'09, there were 14,285 cases scheduled for conciliation, which represents a 63% decrease since the Workers' Compensation Reform Act of 1991.

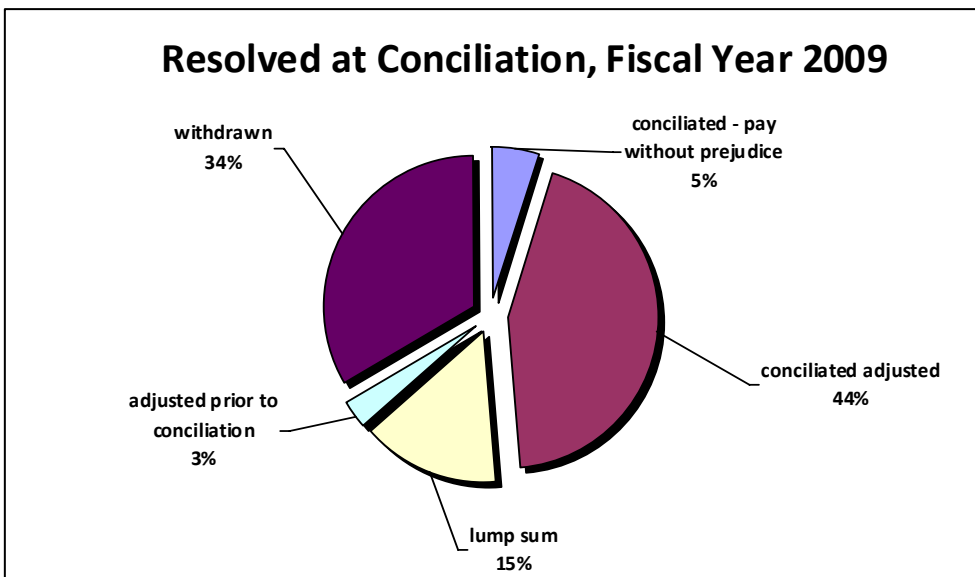
Figure 7 displays the number of cases scheduled for conciliation at the DIA beginning in fiscal year 1991. In fiscal year 2009, the volume of cases scheduled for conciliation decreased by 5% (769 cases) from the previous year. It is important to note that many cases scheduled for conciliation may never actually appear before a conciliator as cases can be withdrawn or adjusted prior to the scheduled meeting.

Figure 7: Volume of Cases Scheduled for Conciliation, FY'91-FY'09

Source: CMS Report 17

Resolved at Conciliation

Disputed cases that are scheduled for conciliation can be divided into two distinct outcomes: “referred to conference,” or “resolved.” In FY’09, 6,465 cases were resolved (they were not referred on to a conference) and exited the dispute resolution system. Approximately 45% of cases that are scheduled for conciliation are resolved while the remaining 55% of cases are referred to conference, the next stage of dispute resolution. As in previous years, a small percentage of the cases scheduled for conciliation are referred to conference without a conciliation taking place. This occurs when the respondent (the party not putting forth the case) does not appear for the conciliation.

Figure 8: Pie-Chart Detailing Cases Resolved at Conciliation, Fiscal Year 2009

Source: CMS Report 17

Table 5: Resolved at Conciliation, Fiscal Year 2009 and Fiscal Year 2008

<i>Resolved at Conciliation FY'09 and FY'08</i>	<i>Number of Cases</i>		<i>Percentage</i>	
	FY'09	FY'08	FY'09	FY'08
Conciliated - Pay Without Prejudice	343	336	5.3%	4.8%
Conciliated Adjusted	2,818	2,953	43.6%	42.4%
Lump Sum	937	1,022	14.5%	14.7%
Adjusted Prior to Conciliation	171	199	2.6%	2.9%
Withdrawn	2,196	2,461	34.0%	35.3%
TOTALS:	6,465	6,971	100%	100%

Source: CMS Report 17

As displayed in *Table 5*, cases may be conciliated by two methods. Approximately 44% of the resolved cases were “conciliated-adjusted,” meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. Secondly, cases may be “conciliated - pay without prejudice” (5% of resolved cases in FY'09), meaning the pay without prejudice period has been extended and the insurer may discontinue compensation without DIA or claimant approval.

The table also indicates that the second most prevalent method a case can exit the dispute resolution system at conciliation is through a withdrawal (2,196 cases in FY'09). A case can be withdrawn under various methods. Either before or during the conciliation, the moving party may choose to withdraw the case. A case can also be withdrawn by the agency if the parties either fail to show up for conciliation or provide the required information.

A case may also be resolved at conciliation utilizing a lump sum settlement. Conciliators are empowered by law to approve lump sum agreements "as complete" but cannot make a determination that the lump sum is in the claimants "best interest." At conciliation, lump sum settlements only account for 15% of the resolved cases at this level of dispute resolution. The percentage of resolved cases that result in a lump sum, increase dramatically at both the conference stage and the hearing stage.

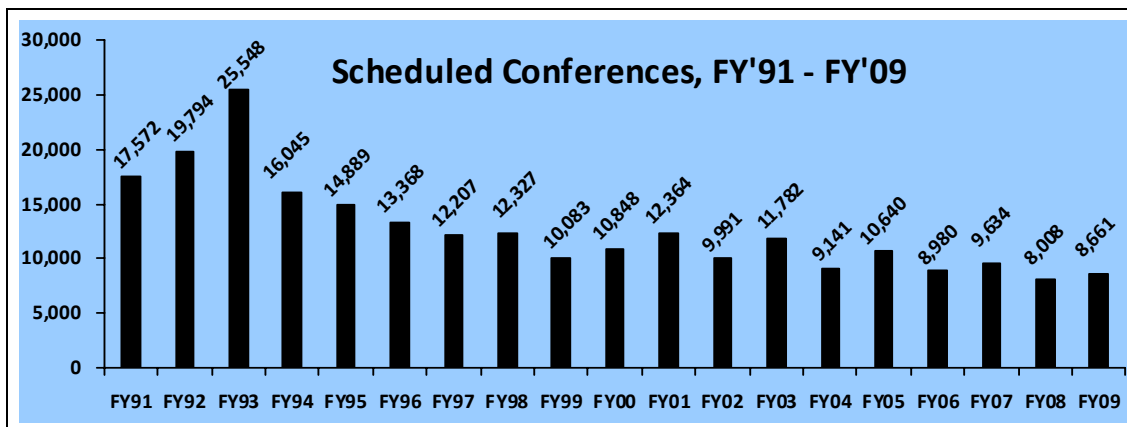
CONFERENCE

The second stage of the dispute resolution process is known as the conference. Each case referred to a conference is assigned to an Administrative Judge (AJ) who must retain the case throughout the entire process if possible. The intent of the conference is to compile the evidence and to identify the issues in dispute. The AJ may require injury and medical records as well as statements from witnesses. Although the conference is an informal proceeding, the AJ will issue a binding order (subject to appeal) shortly after the conference has concluded. The conference order is a short, written document requiring an AJ's initial impression of compensability, based upon a summary presentation of facts and legal issues. Conference orders give the parties an understanding as to how the judge might find at a full evidentiary hearing thus providing incentives to pursue settlements or devise return to work arrangements. Approximately 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 Central Scheduling Unit at the DIA. This occurs after a conciliation has taken place and was unsuccessful at bringing the parties together to reach an agreement on the disputed issues. The number of conferences scheduled in FY'09 increased by 8% (8,008 in FY'08 to 8,661 in FY'09) from last fiscal year.⁵ Each year, the number of conferences scheduled is greater than the number of conferences that will actually take place before an Administrative Judge since many cases are withdrawn or resolved before ever reaching a conference.

Figure 9: Scheduled Conferences, FY'91 - FY'09



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

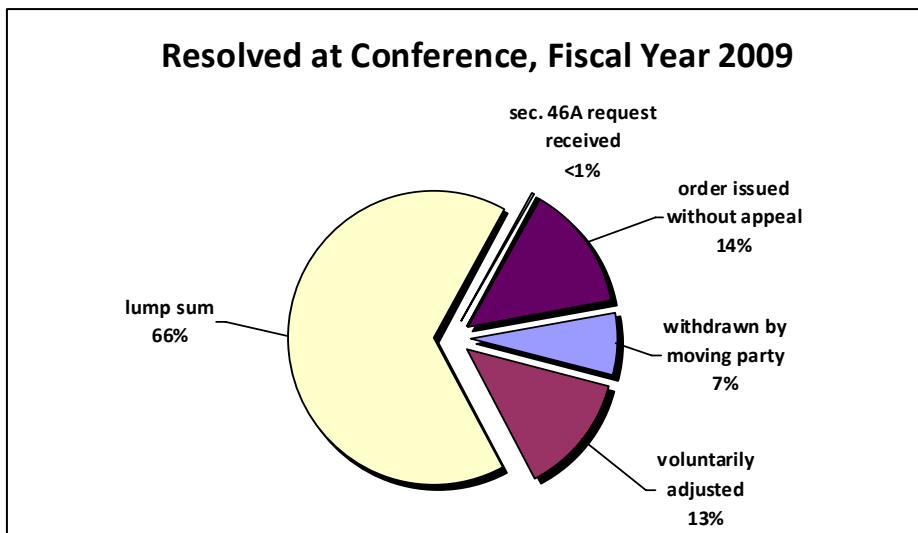
⁵ In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'09, 1,731 cases were "rescheduled for a conference."

Cases Resolved at Conference

Each year, thousands of disputed cases are resolved at the conference level of the dispute resolution process and will not be forwarded to a hearing. In fiscal year 2009, 6,041 cases were resolved at the conference level and exited the dispute resolution system. Although a case may be resolved at the conference level, this does not necessarily mean that the parties appeared before an Administrative Judge. Often a case may be withdrawn before a scheduled conference takes place either by the moving party or by the Administrative Judge. Furthermore, when a case is directed to a lump sum conference or is voluntarily adjusted, it may never actually reach the scheduled conference.

Figure 10 and Table 6 display the various methods a disputed case can be resolved at conference.

Figure 10: Pie-Chart Detailing Cases Resolved at Conference, Fiscal Year 2009



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

Table 6: Cases Resolved at Conference, Fiscal Year 2009 and Fiscal Year 2008

Resolved at Conference FY'09 and FY'08	Number of Cases		Percentage	
	FY'09	FY'08	FY'09	FY'08
Withdrawn by Moving Party	401	380	6.6%	6.4%
Voluntarily Adjusted	789	709	13.1%	11.9%
Lump Sum	4,008	4,122	66.3%	69.1%
Section 46A Request Received	7	3	<1%	<1%
Order Issued Without Appeal	836	754	13.8%	12.6%
Total	6,041	5,968	100%	100%

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

As displayed in *Table 6* there are various methods by which a disputed case can be resolved at the conference level. First, the moving party may decide to withdraw the case completely from the system. In fiscal year 2009, 401 cases (7% of resolved cases at conference) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the conference when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In fiscal year 2009, 789 cases (13% of resolved cases at conference) were voluntarily adjusted.

The most prevalent method in which a case exits the system at the conference level is through a lump sum settlement. Lump sum settlements may be approved either at a conference or a separate lump sum conference. The procedure is the same for both meetings. In some instances, the presiding AJ will hear the lump sum, while in others, an assigned ALJ will hear the case on a lump sum list. Most lump sum settlements are approved directly at the conference or the hearing level by the presiding AJ, rather than scheduling a separate meeting. In fiscal year 2009, 4,008 cases (66% of resolved cases at conference) exited the system through a lump sum.

Another method in which a case could exit the system is if a "Section 46A Request" is filed when there is an outstanding lien on a case that has been deemed compensable. A "Section 46A Request" occurs in conjunction with a lump sum settlement. The case is required to appear before an Administrative Law Judge (ALJ) to determine if reimbursement is owed out of the proceeds of the award. In fiscal year 2009, only 7 of these requests have been documented.

Finally, a case can exit the system at the conference level when the presiding AJ issues a conference order and it is not appealed by any of the parties to the hearing level. In fiscal year 2009, 836 conference orders (14% of resolved cases at conference) were issued by AJs, not resulting in an appeal. However, the vast majority of conference orders are appealed to the hearing stage of dispute resolution. In fiscal year 2009, 5,245 conference orders (86% of all conference orders) were appealed to a hearing.

Table 7: Conference Orders, FY'09 - FY'01

<i>Conference Orders FY'09 - FY'01</i>	Total Orders	Appealed	Without Appeal
Fiscal Year 2009	6,081	5,245 (86.3%)	836 (13.7%)
Fiscal Year 2008	5,695	4,941 (86.8%)	754 (13.2%)
Fiscal Year 2007	7,048	6,149 (87.2%)	899 (12.8%)
Fiscal Year 2006	6,591	5,768 (87.5%)	823 (12.5%)
Fiscal Year 2005	7,494	6,457 (86.2%)	1,037 (13.8%)
Fiscal Year 2004	6,448	5,609 (87.0%)	839 (13.0%)
Fiscal Year 2003	7,899	6,680 (84.6%)	1,219 (15.4%)
Fiscal Year 2002	6,802	5,841 (85.9%)	961 (14.1%)
Fiscal Year 2001	8,486	7,361 (86.7%)	1,125 (13.2%)

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

Conference Queue

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

As presented in *Figure 12*, the conference queue during fiscal year 2009 remained well below the benchmark of 1,500 cases, thereby allowing cases to be efficiently scheduled. In FY'09 the conference queue ended 264 cases higher than the start of the year (534 on 7/2/08 and 270 on 6/24/09). The conference queue reached a high of 695 on 8/6/08 and a low of 87 on 4/1/09.

Figure 11: Conference and Hearing Queues; Fiscal Years 1991 – 2009

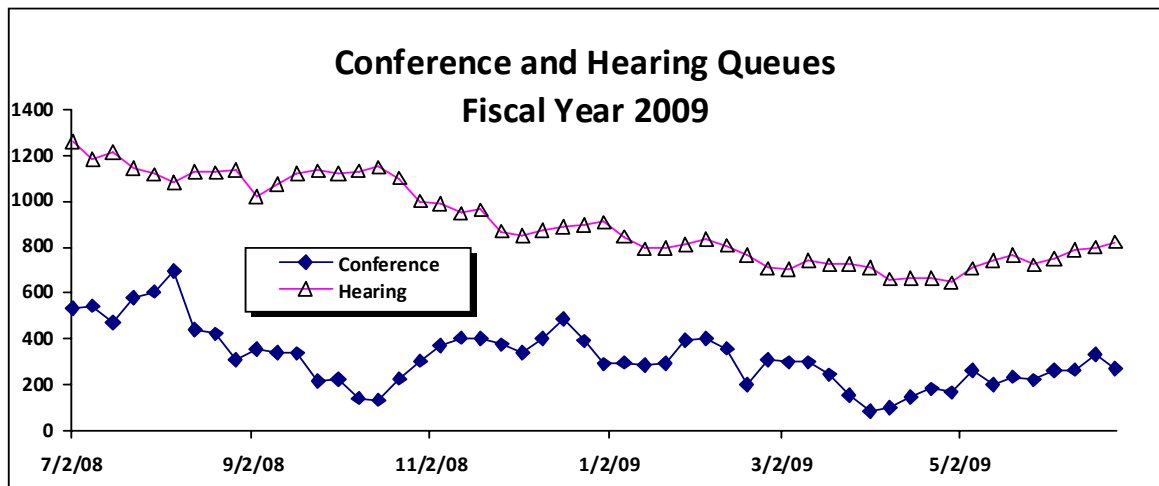
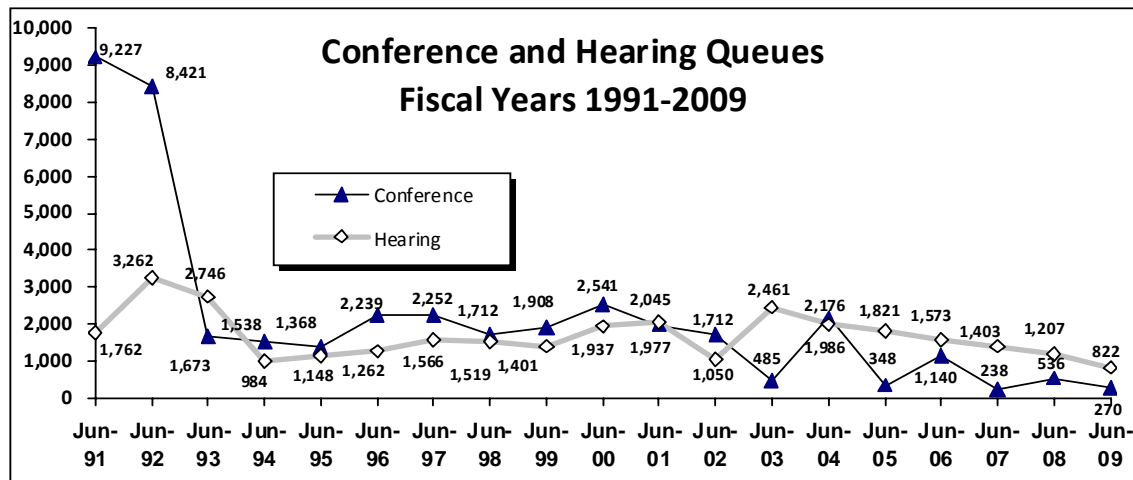


Figure 12: Conference and Hearing Queue; Fiscal Year 2009



Source: CMS Report 404

HEARINGS

The third stage of the dispute resolution process is known as the hearing. According to the Workers' Compensation Act, an Administrative Judge (AJ) that presides over a conference must review the dispute at the hearing level, unless scheduling becomes "impractical." The procedure is formal and a verbatim transcript of the proceedings is recorded. Written documents are presented and witnesses are examined and cross-examined, in accordance with the Massachusetts Rules of Evidence. If the parties are disputing medical issues, an impartial physician will be selected from a DIA roster before the hearing takes place so that an Impartial Medical Examination (IME) of the injured employee can occur. At the hearing, the IME report is the only medical evidence that can be presented unless the AJ determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed in the report. Any party may appeal a hearing decision within 30 days. This time may be extended up to 1-year for reasonable cause. Appealing parties must pay a fee of 30% of the state average weekly wage. The claim is then forwarded to the Reviewing Board.

Hearing Queue

Much like conferences, hearings are scheduled by the Central Scheduling Unit at the DIA. This occurs after a conference has taken place and the judge's order has been appealed by any party. The scheduling of hearings is more difficult than conferences because the hearing must be assigned to the judge who heard the case at the conference level. This is especially problematic since judges have different conference appeal rates. A judge with a high appeal rate will generate more hearings than a judge with a low rate of appeal. This can create difficulty in evenly distributing cases because hearing queues may occur for individual judges with high appeal rates.

It is difficult to compare the hearing queue with the conference queue because of the differences in the two proceedings. Hearings must be scheduled with the same judge who presided over the conference, whereas conferences are scheduled according to availability (when "judge ownership" is not yet a factor). Since hearings are also more time consuming than conferences, it takes more time to handle a hearing queue than a conference queue. Fiscal year 2009 began with a hearing queue of 1,260 cases and decreased to 822 cases by the end of the fiscal year. In the last eighteen years, the hearing queue has been as low as 409 cases (Sept. '89) and as high as 4,046 (Nov. '92).

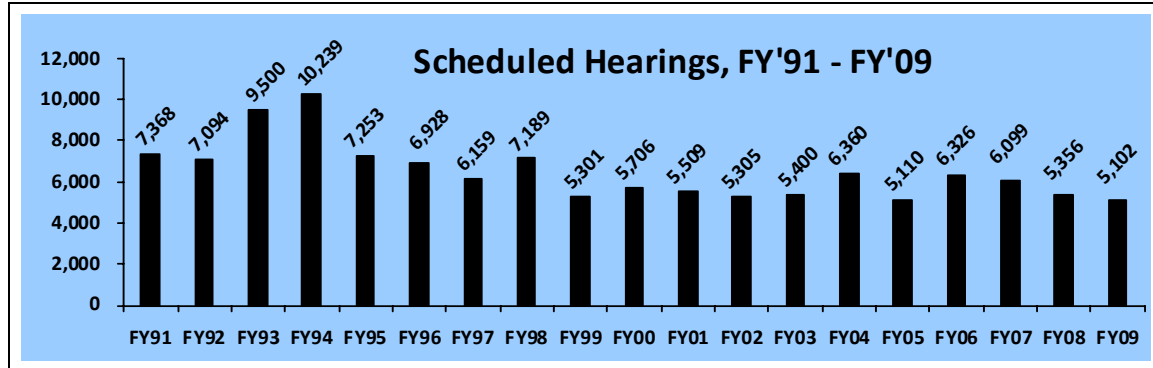
Volume of Scheduled Hearings

The number of hearings scheduled in FY'09 decreased by 254 cases (5,356 in FY'08 to 5,102 in FY'09) from last fiscal year.⁶ Each year, the number of hearings scheduled is greater than the number of hearings that will actually take place before an

⁶ In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'09, 2,769 cases were "rescheduled for a hearing."

Administrative Judge since many cases are withdrawn or resolved before ever reaching a hearing. The figure below shows that the number of "scheduled hearings" in fiscal year 2009 decreased by 5% from the previous fiscal year.

Figure 13: Scheduled Hearings, FY'91 - FY'09



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

Cases Resolved at Hearing

In fiscal year 2009, 4,923 cases were resolved at the hearing level. It is important to note that a case resolved at the hearing level does not necessarily exit the system as the parties have 30 days from the decision date to appeal a case to the reviewing board. Much like conferences, a case resolved at the hearing level does not mean that the case made it to the actual hearing as it may be withdrawn, voluntarily adjusted or a lump sum could occur prior to the proceeding. The following pie-chart and statistical table shows the various methods by which a disputed case can be resolved at hearing.

Figure 14: Pie-Chart Detailing Cases Resolved at Hearing, Fiscal Year 2009

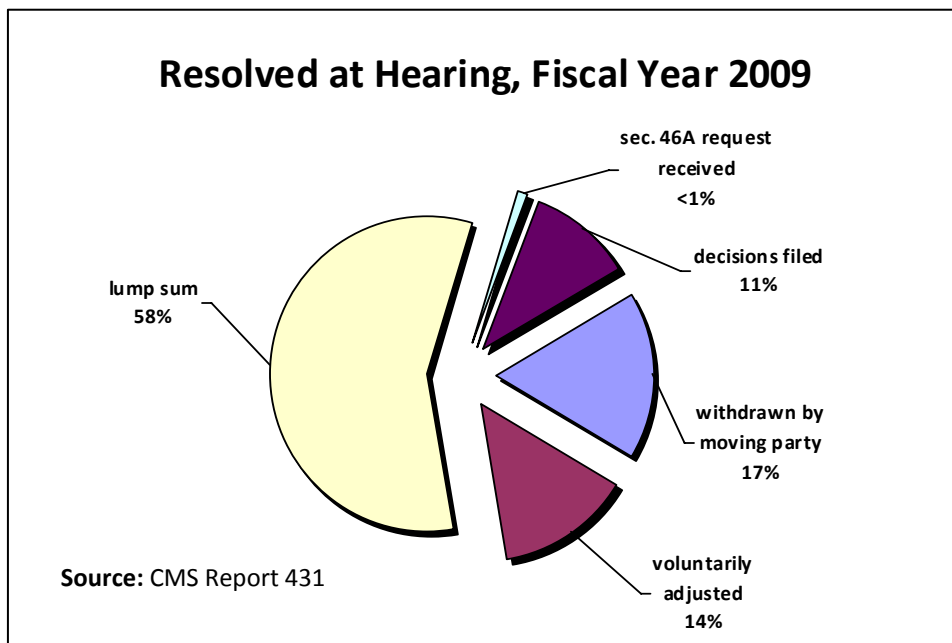


Table 8: Cases Resolved at Hearing, Fiscal Year 2008 and Fiscal Year 2009

<i>Resolved at Hearing FY'09 and FY'08</i>	<i>Number of Cases</i>		<i>Percentage</i>	
	FY'09	FY'08	FY'09	FY'08
Withdrawn by Moving Party	849	875	17.2%	17.2%
Voluntarily Adjusted	665	635	13.5%	12.5%
Lump Sum	2,838	2,873	57.6%	56.5%
Section 46A Request Received	11	11	<1%	<1%
Decisions Filed	560	693	11.4%	13.6%
Total	4,923	5,087	100%	100%

Source: CMS Report 431

As displayed in Table 8 there are various methods by which a disputed case can be resolved at the hearing level. First, the moving party may decide to withdraw the case completely from the system. In fiscal year 2009, 849 cases (17% of resolved cases at hearing) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the hearing when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In fiscal year 2009, 665 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 fiscal year 2009, 2,838 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 (ALJ) to determine if reimbursement is owed out of the proceeds of the award. In fiscal year 2009, only 11 of these requests have been documented at the hearing level.

Finally, a case can exit the system at the hearing level when the presiding Administrative Judge issues a hearing decision. In fiscal year 2009, 560 hearing decisions (11% of resolved cases at hearing) were filed by Administrative Judges.

REVIEWING BOARD

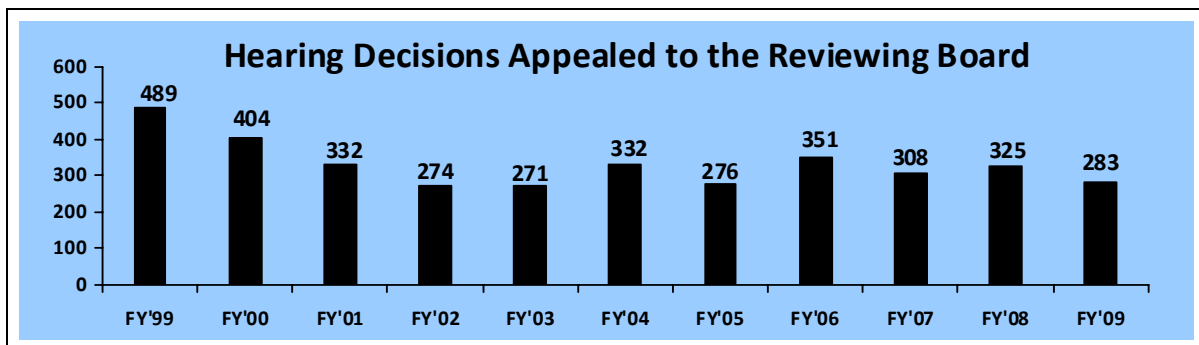
The fourth and final stage of dispute resolution at the DIA is known as the reviewing board. The reviewing board consists of six Administrative Law Judges (ALJ's) whose primary function is to review the appeals from hearing decisions. While appeals are heard by a panel of three ALJ's, initial pre-transcript conferences are held by individual ALJ's. The Administrative Law Judges also work independently to perform three other statutory duties: preside at lump sum conferences, review third party settlements (§15), and discharge and modify liens against an employee's lump sum settlement (§46A).

Volume of Hearing Decisions Appealed to the Reviewing Board

An appeal of a hearing decision must be filed with the Reviewing Board no later than 30 days from the decision date. A filing fee of 30% of the state's average weekly wage, or a request for waiver of the fee, based on indigence, must accompany any appeal. Pre-transcript conferences are held before a single ALJ to identify and narrow the issues, to determine if oral argument is required and to decide if producing a transcript is necessary. This is an important step that can clarify the issues in dispute and encourage some parties to settle or withdraw the case. Approximately 25% to 30% of the cases are withdrawn or settled following this first meeting. After the pre-transcript conference takes place, the parties are entitled to a verbatim transcript from the appealed hearing.

Ultimately, cases that are not withdrawn or settled proceed to a panel of three ALJ's. The panel reviews the evidence presented at the hearing, as well as any findings of law made by the AJ. The appellant must file a brief in accordance with the board's regulations and the appellee must also file a response brief. An oral argument may be scheduled. The vast majority of cases are remanded for further findings of fact and/or review of conclusions of law. However, the panel may reverse the Administrative Judge's decision only when it determines that the decision was beyond the AJ's scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an AJ for further findings of fact. The number of hearing decisions appealed to the Reviewing Board in fiscal year 2009 was 283.

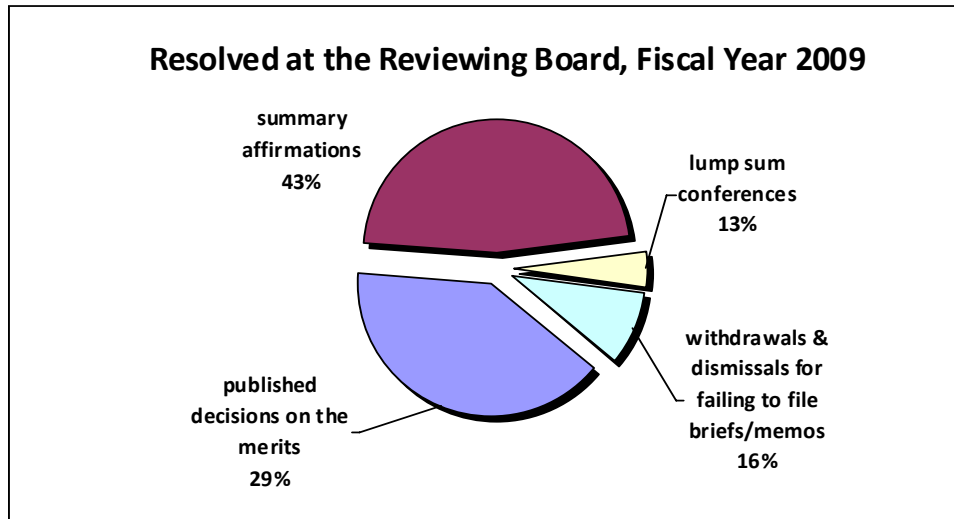
Figure 15: Hearing Decisions Appealed to the Reviewing Board, FY'99 - FY'09



Source: DIA Reviewing Board

In fiscal year 2009, the Reviewing Board resolved 281 cases (some from the prior year), representing a 17% increase from cases resolved in fiscal year 2008 (240 cases).

Figure 16: Appeals Resolved at the Reviewing Board, Fiscal Year 2009



Source: DIA Reviewing Board

Table 9: Appeals Resolved at the Reviewing Board, Fiscal Year 2009

<i>Appeals Resolved at the Reviewing Board, FY'09</i>	<i>Number of Cases</i>
Published Decision on the Merits (Full Panel):	112 (39.9%)
Summary Affirmations (After Full Panel Deliberation):	131 (46.6%)
Lump Sum Conferences:	12 (4.3%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	26 (9.3%)
Total Number of Appeals Resolved by the Reviewing Board:	281 (100%)

Source: DIA Reviewing Board

Lump Sum Conferences

The purpose of the lump sum conference is to determine if a settlement is in the best interest of the employee. A lump sum conference may be requested at any point during the dispute resolution process upon agreement of both the employee and insurer. Lump sum conferences are identical to the approval of settlements by Administrative Judges at the conference and hearing. Conciliators may refer cases to a lump sum conference at the request of the parties or the parties may request a lump sum conference directly. The number of lump sum conferences scheduled in 2009 was 952.

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'09, Administrative Law Judges heard 1,234 Section 15 petitions on a rotating basis.

Compromise and Discharge of Liens (§46A)

Administrative Law Judges are also responsible for determining the fair and reasonable amount to be paid out of lump sum settlements to discharge liens under M.G.L. c.152, §46A.

A health insurer or hospital providing treatment may seek reimbursement under this Section for the cost of services rendered when it is determined that the treatment provided arose from a work related injury. The Commonwealth's Department of Transitional Assistance (DTA) can make a similar claim for reimbursement after providing assistance to an employee whose claim has subsequently been determined to be compensable under the workers' compensation laws.

In those instances, the health insurer, hospital, or DTA may file a lien against either the award for benefits or the lump sum settlement. When a settlement is proposed and the employee and the lien-holder are unable to reach an agreement, the ALJ must determine the fair and reasonable amount to be paid out of the settlement to discharge the lien.

The number of Section 46A conferences that were heard in fiscal year 2009 was 30.

LUMP SUM SETTLEMENTS

A lump sum settlement is an agreement between the employee and the employer's workers' compensation insurer, whereby the employee will receive a one-time payment in place of weekly compensation benefits. In most instances, the employer must ratify the lump sum settlement before it can be implemented. While settlements close out indemnity payments for lost income, medical and vocational rehabilitation benefits must remain open and available to the employee if needed.

Lump sum settlements can occur at any point in the dispute resolution process, whether it is before the conciliation or after the hearing. Conciliators have the power to "review and approve as complete" lump sum settlements that have already been negotiated. Administrative Judges may approve lump sum settlements at conference or hearing just as an ALJ does at a lump sum conference. At the request of the parties, conciliators and Administrative Judges may also refer the case to a separate lump sum conference whereby an Administrative Law Judge will decide if it is in the best interest of the employee to settle.

Table 10: Lump Sum Conference Statistics, FY'09-FY'91

<i>Fiscal Year</i>	<i>Total lump sum conferences scheduled</i>	<i>Lump sum settlements approved</i>
FY'09	6,897	6,480 (94.0%)
FY'08	7,093	6,484 (91.4%)
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 65% since FY'91. In FY'09, only 7 lump sum settlements were disapproved. The remainder of the scheduled lump sum conferences without an "approved" disposition were either withdrawn or rescheduled.

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

Lump Sum Reviewed - Approved as Complete - Pursuant to §48 of chapter 152, conciliators have the power to "review and approve as complete" lump sum settlements when both parties arrive at conciliation with a settlement already negotiated.

Lump Sum Approved - Administrative Judges at the conference and hearing may approve lump sum settlements, however, just as an ALJ at a lump sum conference, they must determine if the settlement is in the best interest of the employee.

Referred to Lump Sum - Lump sums settlements may also be reviewed at a lump sum conference conducted by an assigned ALJ. Conciliators and Administrative Judges may refer cases to lump sum conferences to determine if settlement is in the best interest of the employee. Many lawyers prefer to have a case referred to a lump sum conference rather than have a conciliator approve a settlement. An ALJ renders a judgment regarding the adequacy and appropriateness of the settlement amount, whereas a conciliator merely approves the agreement "as complete." Most attorneys want their client's settlement reviewed and determined by a judge to be in their "best interest."

Lump Sum Request Received - A lump sum conference may also be requested after a case has been scheduled for a conciliation, conference, or hearing. In this situation, the parties would fill out a form to request a lump sum conference and the disposition would then be recorded as "lump sum request received." Lump sum conferences may also be requested without scheduling a meeting.

Lump sum settlements have historically become increasingly prevalent at the later stages of the dispute resolution process.

Table 11: Lump Sum Settlements Pursued at Each Level of Dispute Resolution - FY'09

Fiscal Year 2009	<i>Lump Sum Pursued⁷</i>	<i>% Total Cases Resolved (at each level of dispute)</i>
Conciliation	937	14.5%
Conference	4,008	66.3%
Hearing	2,838	57.6%

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

IMPARTIAL MEDICAL EXAMINATIONS

The impartial medical examination has become a significant component of the dispute resolution process since it was created by the Reform Act of 1991. During the conciliation and conference stages, a disputed case is guided by the opinions of the employee's treating physician and the independent medical report of the insurer. Once a case is brought before an Administrative Judge at a hearing, however, the impartial physician's report is the only medical evidence that can be presented. Any additional medical testimony is inadmissible, unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed by the report.

The 1991 reforms were designed to solve the problem of "dueling doctors," which frequently resulted in the submission of conflicting evidence by employees and insurers. Prior to 1991, judges were forced to make medical judgments by weighing the report of an examining physician, retained by the insurer, against the report of the employee's treating physician.

Section 11A of the Workers' Compensation Act now requires that the Senior Judge periodically review and update a roster of impartial medical examiners from a variety of specialized medical fields. When a case involving disputed medical issues is appealed to hearing, the parties must agree on the selection of an impartial physician. If the parties cannot agree, the AJ must appoint one. An insurer may also request an impartial examination if there is a delay in the conference order.⁸ 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.⁹

Under Section 11A, the impartial medical examiner must determine whether a disability exists, whether such disability is total, partial, temporary or permanent, and whether such disability has as its "major or predominant contributing cause" a work-related personal injury. The examination should be conducted within 30 to 45 calendar days from assignment. Each party must receive the impartial report at least 7 days prior to the start of a hearing.

Impartial Unit

The Impartial Unit, within the DIA's Division of Dispute Resolution, will choose a physician from the impartial physician roster when parties have not selected one or when the AJ has not appointed one. While it is rare that the Impartial Unit chooses the

⁷ 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.

⁸ M.G.L. c.152, §8(4).

⁹ M.G.L. c.152, §45.

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 Commissioner and set by regulation through the Commonwealth's Executive Office of Administration & Finance.

The following table details the DIA's fee schedule:

Table 12: Fee Schedule - Impartial Medical Examinations

\$450	Impartial medical examination and report
\$500	For deposition lasting up to 2 hours
\$100	Additional fee when deposition exceeds 2 hours
\$225	Review of medical records only
\$125	Supplemental medical report
\$100	When worker fails to keep appointment (maximum of 2)
\$100	For cancellation less than 24 hours before exam

Source: DIA Medical Unit

Note: Fee Schedule is subject to increase.

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'09, approximately \$1,792,626 was collected in filing fees.

As of 6/30/09, there were 263 physicians on the roster consisting of 33 specialties. ¹⁰ The impartial unit is responsible for scheduling appointments with the physicians. Scheduling depends upon the availability of physicians, which varies by geographic region and the specialty sought. A queue for scheduling may arise according to certain specialties and regions in the state.

In FY'09 the impartial unit scheduled 5,239 examinations. Of these, 3,971 exams were actually conducted in the fiscal year (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or took place in the next year). ¹¹ Medical reports are required to be submitted to the DIA and to each party within 21 calendar days after completion of the examination. Last year (FY'08), the impartial unit scheduled 5,187 examinations. Of these, 3,828 exams were actually conducted in the fiscal year.

¹⁰ Including contracts pending renewal.

¹¹ Additional reports may be entered upon FY'09 closure.

Impartial Exam Fee Waiver for Indigent Claimants

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

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

It is within the discretion of the DIA Commissioner to accept or deny a claimant's request for a waiver, based on documentation supporting the claimant's assertion of indigency as established in 452 CMR 1.02. If the Commissioner denies a waiver request, it must be supported by findings and reasons in a Notice of Denial report. Within ten days of receipt of the Notice of Denial report, a party can request a reconsideration. The Commissioner can deny this request without a hearing if past documentation does not support the definition of "indigent" set out in 452 CMR 1.02, or if the request is inconsistent or incomplete. If a claimant is granted a waiver and prevails at a hearing, the insurer must reimburse the DIA for any fees waived.

An indigent party is defined as:

- a) one who receives one of the following types of public assistance: Aid to Families with Dependent Children (AFDC), Emergency Aid to Elderly Disabled and Children (EAEDC), poverty related veteran benefits, food stamps, refugee resettlement benefits, Medicaid, or Supplemental Security Income (SSI) or;
- b) one whose annual income after taxes is 125% of the current federal poverty threshold (established by the U.S. Department of Health and Human Services) as referred to in M.G.L. c.261, §27A(b). Furthermore, a party may be determined indigent based on the consideration of available funds relative to the party's basic living costs.

Table 13: DIA Indigency Requirements, 2009

2009 HHS Poverty Guidelines	
Size of Family Unit	Amount*
1	\$10,800
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010

For family units with more than eight members, add \$3,740 for each additional member in the family. The poverty guidelines are updated annually by the U.S. Department of Health and Human Services.

Source: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201.

*48 Contiguous States and the District of Columbia.

ADMINISTRATIVE JUDGES

DIA Administrative Judges (AJs) and Administrative Law Judges (ALJs) are appointed by the Governor, with the advice and consent of the Governor's Council (see Appendix E for a list of Governor's Council members). Candidates for the positions are first screened by the Industrial Accidents Nominating Panel and then rated by the Advisory Council. M.G.L. c.23E allows for the appointment of 21 Administrative Judges, 6 Administrative Law Judges, and as many former judges to be recalled as the Governor deems necessary (see Appendix G for a roster of judicial expiration dates).

As one management tool to maintain a productive staff, the Senior Judge may stop assigning new cases to any judge with an inordinate number of hearing decisions unwritten. This provides a judge who has fallen behind with the opportunity to catch up. The administrative practice of taking a judge off-line is relatively rare and occurs for a limited time period. However, the Senior Judge may take an AJ off-line near the end of a term until reappointment or a replacement is made. This enables the off-line judges to complete their assigned hearings, thereby, minimizing the number of cases that must be re-assigned to other judges after their term expires.

Appointment Process

Nominating Panel - The Nominating Panel is comprised of thirteen members as designated by statute (see Appendix D for a list of Industrial Accident Nominating Panel members). When a judicial position becomes available, the Nominating Panel convenes to review applications for appointment and reappointment. The panel considers an applicant's skills in fact finding and the understanding of anatomy and physiology. In addition, an AJ must have a minimum of a college degree or four years of writing experience and an ALJ must be a Massachusetts attorney (or formerly served as an AJ). Consideration for reappointment includes review of a judge's written decisions, as well as the Senior Judge's evaluation of the applicant's judicial demeanor, average time for disposition of cases, total number of cases heard and decided, and appellate record.

Advisory Council Review - Upon the completion of the Nominating Panel's review, recommended applicants are forwarded to the Advisory Council. The Advisory Council will review these candidates either through a formal interview or by a "paper review." On the affirmative vote of at least seven voting members, the Advisory Council may rate any candidate as either "qualified," "highly qualified," or "unqualified." This rating must then be forwarded to the Governor's Chief Legal Counsel within one week from the time a candidate's name was transmitted to the Council from the Nominating Panel (see Appendix K for Advisory Council guidelines for reviewing judicial candidates).

SECTION

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DIA ADMINISTRATION

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OFFICE OF CLAIMS ADMINISTRATION

The Office of Claims Administration (OCA) is the “starting point” for all documents within the Department of Industrial Accidents (DIA). A 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. The OCA has various roles of responsibility that are significant within the DIA and to the public sector. Quality control is a priority of the office and it is essential to ensure that each case is recorded in a systematic and uniform method.

The OCA consists of the Claims Processing Unit, the Record Room, the Keeper of Records, and the First Report Compliance Office. The Manager of Claims Administration is responsible for overseeing the operations of each unit within the OCA.

Claims Processing Unit

The Claims Processing Unit has two primary functions. The first being the recipient of lost time reports, insurance forms, claims, and liens. The second function is to enter information (including online filings) into the Case Management System (CMS) database. If submitted information is not complete or accurate, the Claims Processing Unit will return the filings with the proper instructions.

While quality control measures may slow down the process, they are necessary for accurate and complete record keeping. Forms are entered 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 generates violation notices, scheduling of conciliations and judicial proceedings, and statistical reports. The DIA and other agencies use this data to facilitate various administrative and law enforcement functions.

In FY’09, the OCA received 31,216 First Report of Injury Forms, a decrease of 5% from FY’08 (32,794). The number of First Report of Injury Forms filed online during FY’09 was 8,934, (29% of the total received) and 265 less than FY’08 (9,199). In FY’09, the number of claims, discontinuances and third party claims received by the office increased slightly to 15,873 from 15,084 received in FY’08 (prior to review and CMS processing). The total number of referrals to conciliation for the FY’09 was 13,806, (including 1,516 filed online) which represents a decrease of 658 from FY’08 (14,464).

Record Room

The record room serves as the “central repository” for all files pertaining to the Department of Industrial Accidents. All incoming transactions, when forwarded to the Record Room, are referenced with a board number which is generated when a case is created and attached to its file. All contents in the file correlate to the DIA case management database, which tracks the activities and status of the workers’

compensation case. The DIA files have a retention cycle of 40 years, 28 at the state archive and 12 years within the DIA's jurisdiction. Due to limited space within the state archives, the DIA's main Record Room serves as a mini-archive area containing approximately 2,000 boxes of files. Complex file management procedures, in accordance with State Record Center (SRC) regulations, are the key to maintaining information that is accessible and easy to transfer upon request.

Keeper of Records Office

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

The KOR processes subpoenas, conducts in-house depositions, and answers investigative services 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, retirement, etc. A fee is charged to all requestors for copies, labor and research. The Office also assists the Insurance Fraud Bureau, the Attorney General's Office and other governmental agencies in related matters.

First Report Compliance Office

All Employers must file an *Employer's First Report of Injury or Fatality – Form 101*, within seven calendar days of receiving notice of any injury alleged to have arisen out of and in the course of employment that incapacitates an employee from earning full wages for a period of five calendar days. Failure to file this report or filing of the report late is a violation under M.G.L. c.152, §6. If this violation occurs three or more times within any year, a fine of \$100 for each such violation will be sent to the employer. Each failure to pay a fine within thirty calendar days of receipt of a bill from the DIA is considered a separate violation.

In fiscal year 2009, the First Report Compliance Office collected \$235,450 in fines, an increase of \$10,976 from the \$224,474 collected in FY'08. The office is also responsible for maintaining a database on cases discovered by the DIA, where there may be suspicion of fraud. In fiscal year 2009, the OCA received 23 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 files on suspected fraudulent cases. A total of 25 such inquiries were processed during FY'09.

OFFICE OF EDUCATION & VOCATIONAL REHABILITATION

The Office of Education and Vocational Rehabilitation (OEVR) oversees the rehabilitation of disabled workers' compensation recipients with the ultimate goal of successfully returning them to employment.

While OEVR seeks to encourage the voluntary development of rehabilitation services, it has the authority to mandate services for injured workers determined to be suitable for rehabilitation. Vocational rehabilitation (VR) is defined by the Workers' Compensation Act as:

“non-medical services reasonably necessary at a reasonable cost to restore a disabled employee to suitable employment as near as possible to pre-injury earnings. Such services may include vocational evaluation, counseling, education, workplace modification, and retraining, including on-the-job training for alternative employment with the same employer, and job placement assistance. It shall also mean reasonably necessary related expenses.”¹²

A claimant is eligible for vocational rehabilitation services when an injury results in a functional limitation prohibiting a return to previous employment, or when the limitation is permanent or will last an indefinite period of time. Liability must be established in every case and the claimant must be receiving benefits.

Vocational Rehabilitation Specialist

Each year, OEVR approves vocational rehabilitation specialists to develop and implement the individual written rehabilitation plans (IWRP). The standards and qualifications for a certified provider are found in the regulations, 452 C.M.R. §4.03. Any state vocational rehabilitation agency, employment agency, insurer, self-insurer, or private vocational rehabilitation agency may qualify to perform these services. All Request for Response (RFR) information, including application forms, are now available through the DIA website [www.mass.gov/dia/].

Credentials for a vocational rehabilitation specialist must include at least a master's degree, rehabilitation certification, or a minimum of ten years of experience. A list of certified providers can be obtained directly from OEVR or from the department's website. In FY'09, OEVR approved 49 VR providers. It is the responsibility of each provider to submit progress reports on a regular basis so that OEVR's Rehabilitation Review Officers (RROs) can have a clear understanding of each case's progress. Progress reports must include the following:

¹² M.G.L. c.152, §1(12)

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

Determination of Suitability

It is the responsibility of OEVR to identify those disabled workers' who may benefit from rehabilitation services. OEVR identifies rehabilitation candidates according to injury type after liability has been established, and through referrals from internal DIA sources (including the Office of Claims Administration and the Division of Dispute Resolution), insurers, certified providers, attorneys, hospitals, doctors, employers and injured employees themselves.¹³ Through the use of new technology, such as the automatic scheduling system, OEVR has made significant progress in identifying disabled workers for mandatory meetings early on in the claims process.

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

Once a "mandatory meeting" has concluded, it is the duty of the RRO to issue a decision on the appropriateness of the client for vocational rehabilitation services. This is done through a Determination of Suitability (DOS) Form. Suitability is determined by a number of factors including: medical stability, substantial functional limitations, feasibility and cost-effectiveness of services, and liability must be established. If a client is deemed "suitable," the RRO will write to the insurer and request VR services for the injured worker. The insurer must then choose an OEVR-approved provider so that an 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

¹³ M.G.L. c.152, §30 (E-H); 452 C.M.R. §4.00

still in disagreement, the RRO can refer the matter back to the parties with recommendations and an action plan. All team meetings are summarized in writing.

Individual Written Rehabilitation Program (IWRP)

After an employment goal and vocational goal has been established for the injured worker, an IWRP can be written. The IWRP is written by the vocational provider and includes the client's vocational goal, the services the client will receive to obtain that goal, an explanation of why the specific goal and services were selected, and the signatures necessary to implement it. A vocational rehabilitation program funded voluntarily by the insurer has no limit of time. However, OEVR-mandated IWRP's are limited to 52 calendar weeks for pre-12/23/91 injuries and 104 calendar weeks for post-12/23/91 injuries.¹⁴ The IWRP should follow OEVR's priority of employment goals:

1. Return to work with same employer, same job modified;
2. Return to work with same employer, different job;
3. Return to work with different employer, similar job;
4. Return to work with different employer, different job;
5. Retraining; and
6. Any recommendation for a workplace accommodation or a mechanical appliance to support the employee's return to work.

In order for an IWRP to be successful, it needs to be developed jointly with the client and the employer. An IWRP with the specific employment goal of permanent, modified work must include:

1. a complete job description of the modified position (including the physical requirements of the position);
2. a letter from the employer that the job is being offered on a permanently modified basis; and
3. a statement that the client's treating physician has had the opportunity to review and comment on the job description for the proposed modified job.

Before any vocational rehabilitation activity begins, the IWRP must be approved by OEVR. Vocational Rehabilitation is successful when the injured worker completes a VR program and is employed for 60 days. A "Closure Form" must then be signed by the provider and sent to the appropriate RRO. Closures should meet the following criteria:

1. all parties should understand the reasons for case closure;
2. the client is told of the possible impact on future VR rights;

¹⁴ M.G.L. c.152, §19.

3. the case is discussed with the RRO;
4. a complete closure form is submitted by the provider to OEVR; and
5. the form should contain new job title, DOT code, employer name and address, client wage, and the other required information if successfully rehabilitated.

Lump Sum Settlements

An employee obtaining vocational rehabilitation services must seek the consent of OEVR before a lump sum settlement can be approved. In the past, disabled and unemployed workers have settled for lump sum payments without receiving adequate job training or education on how to find employment. As a result, settlement money would run out quickly and employees would be left with no means of finding suitable work. OEVR tries to have disabled employees initiate, if not complete, rehabilitation before the lump sum settlement is approved. Nevertheless, OEVR will consent to a lump sum settlement if the insurer agrees to continue to provide rehabilitation benefits.

Utilization of Vocational Rehabilitation

In fiscal year 2009, OEVR was headed by a Director and staffed by 9 Rehabilitation Review Officers, 1 Disability Analyst, 1 Program Coordinator, and 3 Clerks. Out of the 2,611 cases referred to OEVR in FY'09, 82% (2,150) proceeded to a "mandatory meeting" for a determination of suitability for vocational rehabilitation services. The remaining 18% exited the system for reasons that include the non-establishment of liability or the employee was not on compensation. Of those cases that received a "mandatory meeting," 30% (642) were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR certified provider. In FY'09, there was a 30% success ratio of injured workers who completed plans and returned to work.

Table 14: Utilization of Vocational Rehabilitation Services, FY'05 - FY'09

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

Source: DIA - OEVR

Trust Fund Payment of Vocational Rehabilitation

If an insurer refuses to pay for vocational rehabilitation services while OEVR determines that the employee is suitable for services, the office may utilize monies from the Workers' Compensation Trust Fund to finance the rehabilitation services. In fiscal year 2009, the Trust Fund paid \$12,951.97 for vocational rehabilitation services. OEVR is required to seek reimbursement from the insurer when the Trust Fund pays for the rehabilitation and the services are deemed successful (e.g., the employee returns to work). The DIA may assess the insurer a minimum of two times the cost of the services.

OFFICE OF SAFETY

The Office of Safety is responsible for establishing and supervising the Safety Grant Program for the education and training of employees and employers in the recognition, avoidance and prevention of unsafe or unhealthy working conditions. On an annual basis, safety training grants are awarded to qualified applicants based upon a competitive selection process initiated by a grant application. The Office of Safety also advises employees and employers of safety issues surrounding the work environment and maintains a comprehensive safety library containing numerous safety manuals and videos at its main headquarters in Boston.

Since 1991, the Office of Safety has annually issued a grant application for the "Occupational Safety and Health Education and Training Program." To date, the DIA has funded a total of 805 preventive training programs which have trained approximately a half-million workers in the Commonwealth.

The Safety Grant Program

Each fiscal year the DIA's Office of Safety awards over \$800,000 in safety grants to pay for programs which provide workplace safety training for employees and/or employers of industries operating within the Commonwealth and whose entire staff is covered under the Massachusetts Workers' Compensation Law (M.G.L. c.152).

The overall objective of the education and training program is to reduce work related injuries and illnesses by:

- Targeting preventive educational programs for specifically identified audiences with significant occupational health and/or safety problems;
- Fostering activities by employees/employers to prevent workplace accidents, injuries, and illnesses;
- Identifying, evaluating, and controlling safety and health hazards in the workplace;
- Making employees/employers aware of all federal and state health and safety standards, statutes, rules and regulations that apply, including those that mandate training and education in the workplace;
- Encouraging awareness and compliance with federal and/or state occupational safety and health standards and regulations;
- Encouraging labor/management cooperation in the area of occupational safety and health prevention programs; and,
- Encouraging collaborations between various groups, organizations, educational or health institutions to devise innovative preventive methods for addressing safety.

Grant Applications

Each fiscal year the Office of Safety publishes a grant application to notify the general public that safety grants are available for funding in the upcoming fiscal year. Language contained in the DIA's line-item in the FY'10 General Appropriations Act did not indicate a specific allocation amount for the agency to make available for the Safety Grant Program. However, the agency has set aside \$800,000 in funding for Fiscal Year 2010 safety grants. In an effort to maximize the number of grants that can be awarded, the Office of Safety restricted the maximum amount for each proposal to \$25,000. During the fiscal year, 2,500 announcement letters were mailed to various industries throughout the state. As a result of these mailings and advertisements published in regional newspapers, the Office of Safety issued more than 66 grant applications in FY'09 for FY'10 funding.

A uniform criteria to competitively evaluate all proposals received is developed by a Proposal Selection Committee, appointed by the Commissioner. Following review, the Committee recommends a list of qualified applicants for funding. Upon approval of this list by the Commissioner, contracts are then awarded. In fiscal year 2010, the Office of Safety will expend \$800,000 to fund a total of 66 grants which will result in the training of 12,425 employees (see Appendix L for a list of safety grant proposals recommended for funding in FY'10).

Changes to the Grant Application Process

During the last several years, the Office of Safety has reconfigured the Safety Grant Program in an effort to simplify the application process and to expand the number of employees who could benefit from the program. After reviewing the application process, it was discovered that the grant application was redundant and that a large amount of money was being spent on administrative costs. To address these issues, the Office of Safety significantly revised the grant application and no longer funds administrative costs without justification. The Office of Safety believes that these changes to the grant application process will help expand the number of grants that can be awarded, thereby, increasing the number of employees who will benefit from the training.

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.¹⁵ To be self insured, employers must have enough capital to cover the expenses associated with self insurance (i.e. bond, reinsurance, and a TPA). However, many smaller and medium-sized companies have also been approved to self insure. The Office of Insurance evaluates employers annually to determine their eligibility for self insurance and to establish new bond amounts.

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

For an employer to qualify to self insure, it must post a surety bond or negotiable securities to cover any losses that may occur. The amount of deposit varies for every company depending on their previous reported losses and predicted future losses. The average bond or security deposit is usually over \$1 million and depends on many factors including loss experience, the financial state of the company, the hazard of the occupation, the number of years as a self insured company, and the attaching point of reinsurance.

Employers who are self insured must purchase catastrophe reinsurance of at least \$500,000. Smaller self insured companies are required to purchase aggregate excess insurance to cover multiple claims that exceed a set amount. Many self insured employers engage the services of a law firm or a third party administrator (TPA) to handle claims administration. Each self insurance license provides approval for a parent company and its subsidiaries to self insure.

The Commonwealth of Massachusetts does not fall under the category of self insurance, although its situation is analogous to self insured employers. It is not required to have a license to self insure because of its special status as a public employer and it therefore funds workers' compensation claims directly from the treasury as a budgetary expense. The agency responsible for claims management, the Human Resources Division (HRD), has similar responsibilities to an insurer, however, the state does not pay insurance premiums or post bond for its liabilities.

¹⁵ C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers. These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover for all incurred losses.

Four semi-autonomous public employers are also licensed to self insure including the Massachusetts Bay Transportation Authority (MBTA), the Massachusetts Turnpike Authority (MTA), the Massachusetts Port Authority, and the Massachusetts Water Resource Authority (MWRA).

In FY'09, no new licenses were issued, keeping the total number of "parent-licensed" companies at 112, covering a total of 373 subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. This amounts to approximately \$276,125,233 in equivalent premium dollars. A complete list of self insured employers and their subsidiaries is available for public viewing on the DIA's website.

Insurance Unit

The Insurance Unit maintains a record of the workers' compensation insurer for every employer in the state. This record, known as the insurer register, dates back to the 1930's and facilitates the filing and investigation of claims after many years. Any injured worker may contact this office directly to obtain the insurance information of an employer.¹⁶

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'09, an estimated 4,422 inquiries were made to the Insurance Register.

¹⁶ The Insurance Unit can be contacted directly at 617-727-4900 x408. The Unit also maintains a website that is accessible through the DIA's homepage at: www.mass.gov/dia/.

OFFICE OF INVESTIGATIONS

In Massachusetts, every employer with one or more employees is required to have a valid workers' compensation policy at all times.¹⁷ Employers can meet this statutory requirement by purchasing a commercial insurance policy, gaining membership in a self-insurance group, or licensing as a self insurer (M.G.L. c.152, §25A). The Office of Investigations is charged with enforcing this mandate by investigating whether employers are maintaining insurance policies and by imposing penalties when violations are uncovered. When an employer fails to carry an insurance policy and an injury occurs at their workplace, the claim is paid from the DIA's Workers' Compensation Trust Fund (funded entirely by the employers who purchase workers' compensation policies).

Referrals to the Office of Investigations

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

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

Another type of referral the Office of Investigations receives is through anonymous calls (1-877-MASSAFE) and letters received from the general public. In May 2008, the Office of Investigations also began managing a new fraud hotline developed by the Joint Task Force on the Underground Economy and Employee Misclassification (1-877-96-LABOR). Anonymous phone tips have historically played a crucial role in identifying which companies may be without insurance.

Referrals can also come to the Office of Investigations internally within the DIA. Whenever a Section 65 claim (an injury occurs at an uninsured business) is entered into the system, the Office of Investigations is immediately notified by the Office of Insurance that a particular company is without insurance.

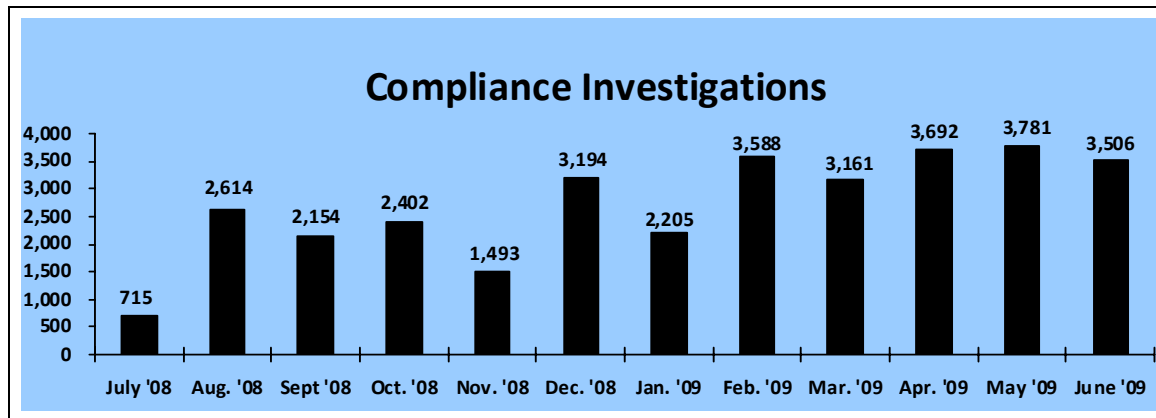
Compliance Investigations

Referrals received by the Office of Investigations are assigned to an individual investigator who conducts comprehensive "in-house" research utilizing all available

¹⁷ A law passed in 2002 allows officers of corporations who own at least 25% of the stock of the corporation to exempt themselves from coverage. If a corporation has non-exempt employees, the corporation does not need workers' compensation insurance.

databases. This initial research, known as a “compliance investigation,” allows the investigator to close cases where an insurance policy has been discovered or when there is substantial evidence that a company has ceased operations. In FY’09, the Office of Investigations conducted a total of 32,505 “compliance investigations.” Once a referral has been thoroughly reviewed “in-house” and it is demonstrated that an employer is in violation of the statute, the DIA will conduct a “field investigation” at the worksite.

Figure 17: MA Compliance Investigations, Fiscal Year 2009

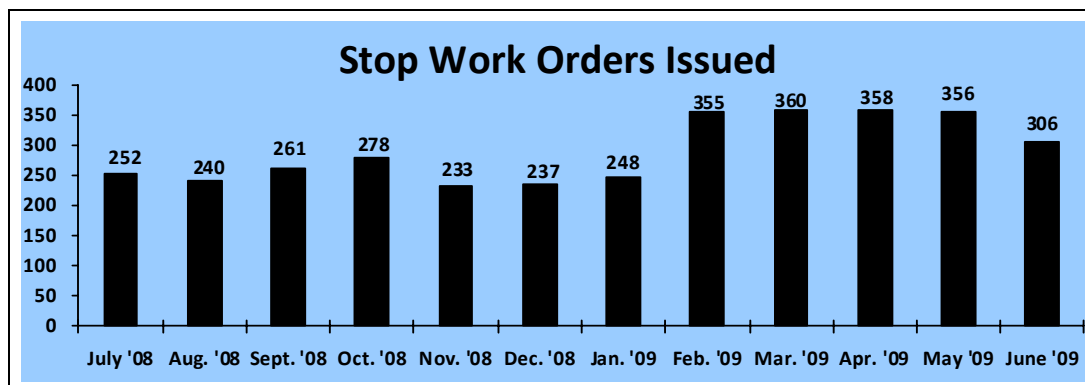


Source: Office of Investigations

Field Investigations & Stop Work Orders

During a “field investigation” to a worksite, an investigator will request that the business provide proof of workers' compensation insurance coverage. In FY’09, the Office of Investigations conducted 8,171 “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 resolved. In FY’09, the DIA issued a total of 3,484 SWOs. Of the 3,484 SWOs issued, 98% (3,383) were issued to “small” companies with ten or less employees.

Figure 18: MA SWO's Issued, Fiscal Year 2009



Source: Office of Investigations

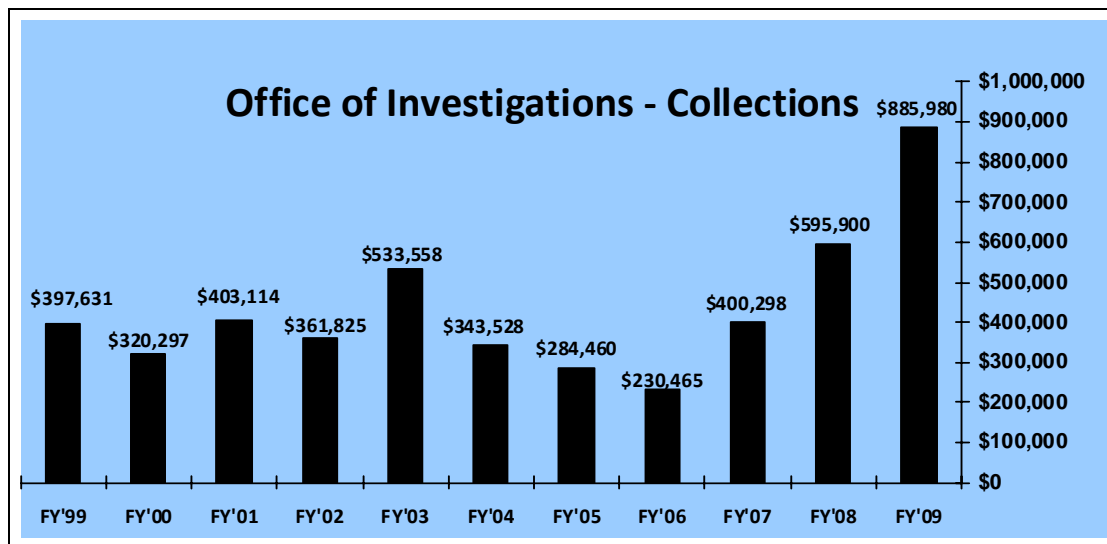
Stop Work Order Fines

Fines resulting from a SWO begin at \$100 per day, starting the day the stop work order is issued, and continuing until proof of coverage and payment of the fine is received by the DIA. An employer, who believes the issuance of the SWO was unwarranted, has ten days to file an appeal. A hearing must take place within 14 days, during which time the SWO will not be in effect. The SWO and penalty will be rescinded if the employer can prove it had workers' compensation insurance during the disputed time. If at the conclusion of the hearing the DIA hearing officer finds the employer had not obtained adequate insurance coverage, the employer must pay a fine of \$250 a day. Any employee affected by a SWO must be paid for the first ten days lost and that period shall be considered "time worked."

In addition to established fines, an employer lacking insurance coverage may be subject to a criminal court proceeding with a possible fine not to exceed \$1,500, or by imprisonment for up to one year, or both. If the employer continues to fail to provide insurance, additional fines and imprisonment may be imposed. The Commissioner or designee can file criminal complaints against employers (including the President and Treasurer of a corporation) that violate any aspect of Section 25C.

In fiscal year 2009, the Office of Investigations collected \$885,980 in fines from employers who violated the workers' compensation insurance mandate. In an effort to make paying SWO fines much easier, the DIA is now allowing the payment of fines online with debit cards, credit cards or checks.

Figure 19: Office of Investigations - Collections, FY'99 - FY'09



Source: Office of Investigations

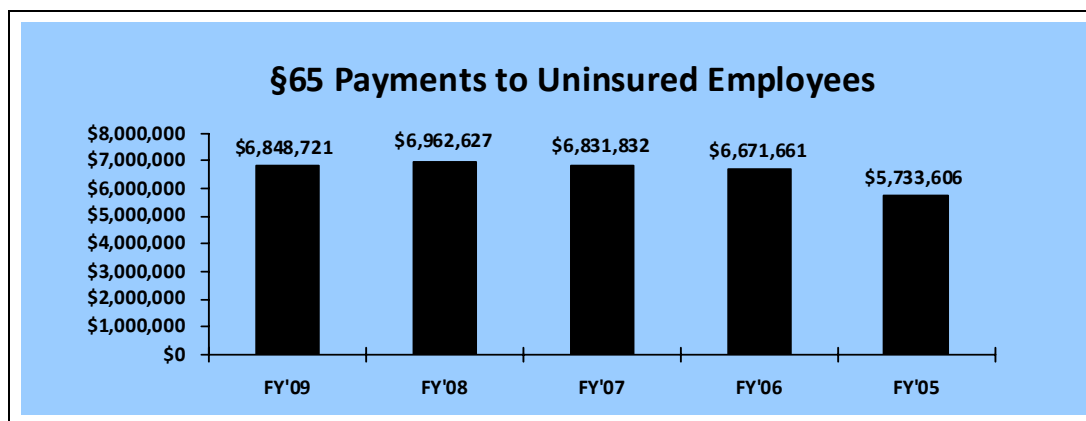
WORKERS' COMPENSATION TRUST FUND

Section 65 of the Workers' Compensation Act establishes a Trust Fund in the State Treasury to make payments to injured employees whose employers did not obtain insurance, and to reimburse insurers for certain payments under Sections 26, 34B, 35C, 37, 37A, and 30H. The DIA has established a department, known as the Workers' Compensation Trust Fund (WCTF), to process requests for benefits, administer claims, and respond to claims filed before the Division of Dispute Resolution.

Uninsured Employers (Section 65)

Section 65 of the Workers' Compensation Act directs the Trust Fund to pay benefits resulting from approved claims against Massachusetts' employers who are uninsured in violation of the law. The Trust Fund must either accept the claim or proceed to Dispute Resolution over the matter. Every claim against the fund under this provision must be accompanied by a written certification from the DIA's Office of Insurance, stating that the employer was not covered by a workers' compensation insurance policy on the date of the alleged injury, according to the agency's records.¹⁸ In FY'09, \$6,848,721 was paid to uninsured claimants, 167 claims were filed, and 593 claims for benefits paid. The DIA aggressively goes after uninsured employers to recoup monies paid out from the Trust Fund. During fiscal year 2008, the DIA collected \$1,404,666 from recovery efforts.

Figure 20: §65 Payments to Uninsured Employees



Source: Collections & Expenditures Reports, FY'09 - FY'05

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

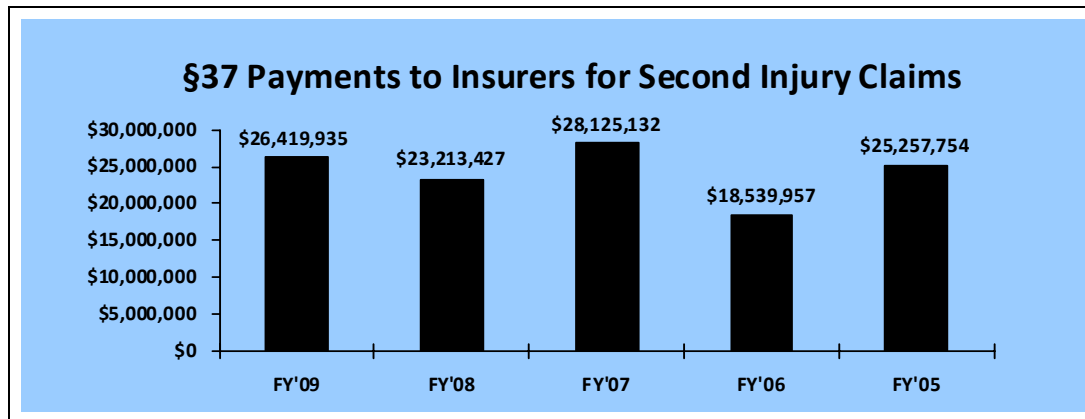
In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund to offset any financial disincentives associated with the employment of injured workers. Section 37 requires insurers to pay benefits at the current rate of compensation to all claimants, whether or not their injury was

¹⁸ 452 C.M.R. 3.00

exacerbated by a prior injury. When the injury is determined to be a "second injury," insurers become eligible to receive reimbursement from the DIA's WCTF for up to 75% of compensation paid after the first 104 weeks of payment.¹⁹ Employers are entitled to an adjustment to their experience modification factors as a result of these reimbursements.

At the close of fiscal year 2009, 284 §37 claims were received and 284 §37 claims were settled. The total amount of §37 payments in FY'09 was \$26,419,935 (includes quarterly payments under §37 and interest).

Figure 21: §37 Payments to Insurers for Second Injury Claims



Source: Collections & Expenditures Reports, FY'09 - FY'05

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

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

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

¹⁹ An employee is considered to suffer a second injury when an on the job accident or illness occurs that exacerbates a pre-existing disability. How the preexisting condition was incurred is immaterial; the impairment may derive from any previous accident, disease, or congenital condition. The disability, however, must be "substantially greater" due to the combined effects of the preexisting impairment and the subsequent injury than the disability as a result of the subsequent injury by itself.

"Old Act" - 1973 thru 1985

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

"Mid Act" - 1985 thru 1991

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

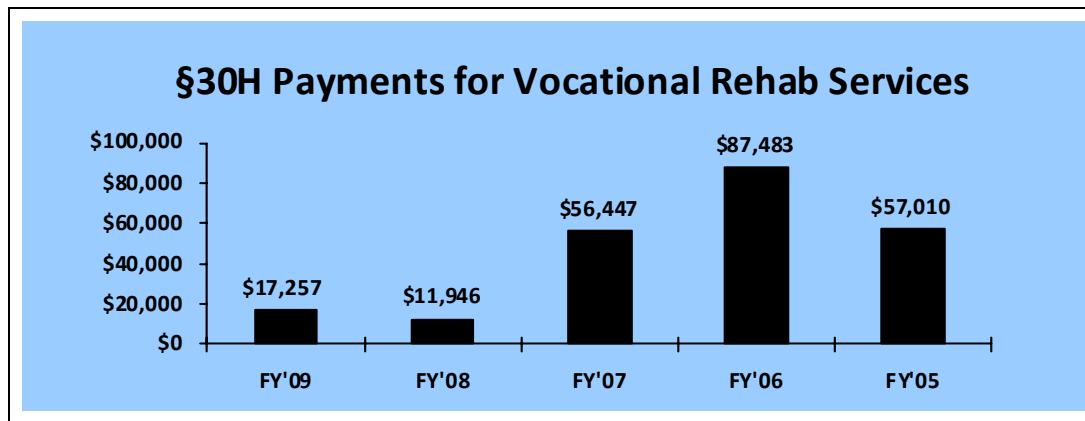
"New Act" - 1991 thru Present

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

Vocational Rehabilitation (Section 30H)

Section 30H provides that if an insurer and an employee fail to agree on a vocational rehabilitation program, the Office of Education and Vocational Rehabilitation (OEVR) must determine if vocational rehabilitation is necessary and feasible to return the employee to suitable employment. If OEVR determines that vocational rehabilitation is necessary and feasible, it will develop a rehabilitation program for the employee for a maximum of 104 weeks. If the insurer refuses to provide the program to the employee, the cost of the program will be paid out of the Section 65 Trust Funds. If upon completion of the program OEVR determines that the program was successful, it will assess the insurer no less than twice the cost incurred by the office, with that assessment paid into the Trust Fund. In FY'09, two (2) new cases were accepted for §30H benefits and the Trust Fund paid \$17,257 for vocational rehabilitation services.

Figure 22: §30H Payments for Vocational Rehabilitation Services



Source: Collections & Expenditures Reports, FY'09 - FY'05

Latency Claims (Section 35C)

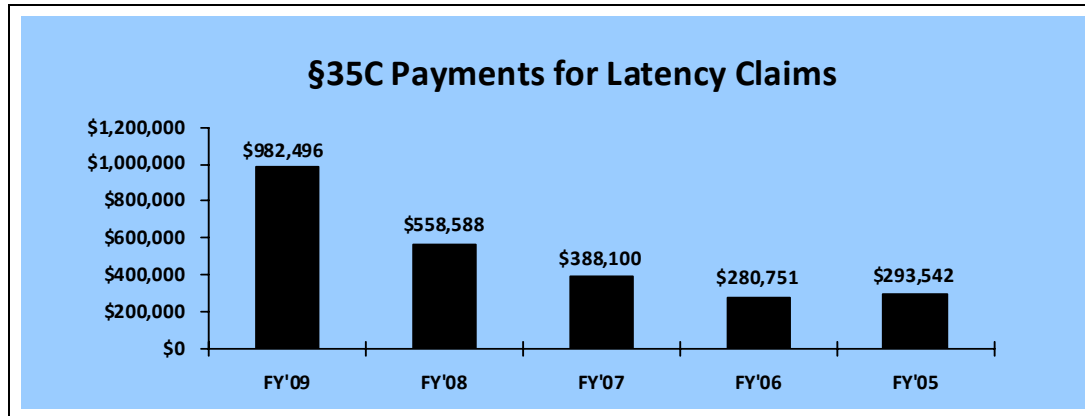
Because some occupational diseases and illnesses might not show up until many years after initial exposure, the Legislature added §35C to the Workers' Compensation Act in 1985:

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

Some examples of latent medical conditions are asbestosis, hepatitis C and chemical exposures causing certain forms of cancer. The purpose of §35C is to make an employee or surviving spouse whole by adjusting the compensation to what would be presumed to be the higher wages at the date of disability or death rather than the likelihood of a lower wage at the date of exposure. The Trust Fund is required to pay

the difference when the wages at death or disability are higher than the wages at the time of exposure. In FY'09, the Trust Fund paid out \$982,496 for latency claims.

Figure 23: §35C Payments for Latency Claims

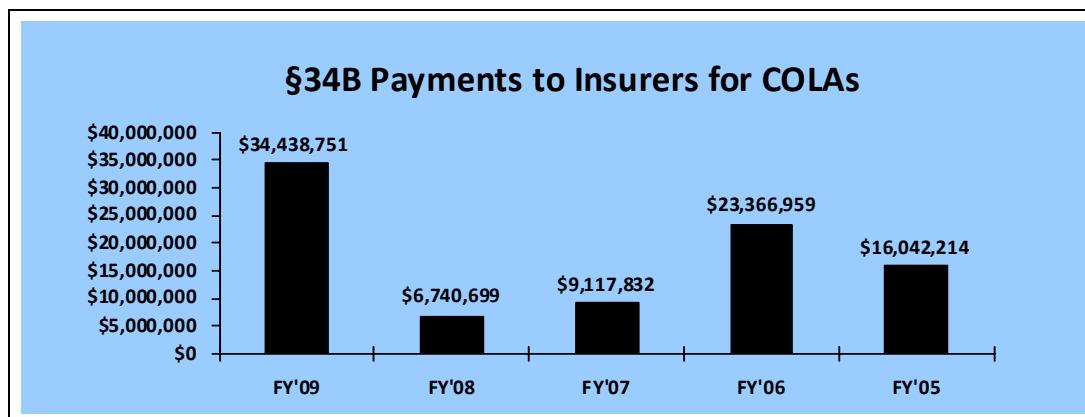


Source: Collections & Expenditures Reports, FY'09 - FY'05

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 current benefits and his/her benefit after an adjustment for the change in the statewide average weekly wage between the review date and the date of injury. Insurers pay the supplemental benefit concurrently with the base benefit. They are then entitled to quarterly reimbursements for the supplemental benefits paid on all claims with dates of injury occurring prior to 10/1/86. For injury dates after 10/1/86, insurers will be reimbursed for any increase that exceeds 5%. COLA payments for FY'09 totaled \$34,438,751 for the Private Trust Fund.

Figure 24: §34B Payments to Insurers for Cost of Living Adjustments



Source: Collections & Expenditures Reports, FY'09 - FY'05

OFFICE OF HEALTH POLICY

The Office of Health Policy (OHP) was created in July of 1993 by the Commissioner pursuant to the promulgation of M.G.L. c.152, §5, §13, and §30. The statute authorizes the Office of Health Policy to approve and monitor workers' compensation utilization review (UR) programs in the Commonwealth to ensure compliance with the requirements of 452 CMR 6.00 et seq.

During fiscal year 2009, the Office of Health Policy was staffed by four employees: an Executive Director (Nurse/Attorney), a UR Coordinator (Registered Nurse), a Program Analyst, and a Research Analyst.

Utilization Review

Utilization review is a system for reviewing proposed medical treatment/procedures in order to determine whether or not the services are appropriate, reasonable, and necessary. This review of medical care is conducted before, during, or following treatment to an injured worker. The utilization review and quality assessment regulations mandate that all insurers conduct UR on all health care services provided to injured workers that have been delivered on or after October 1, 1993, regardless of the date the employee is injured. 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 guidelines and review criteria.

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 or registered nurse using established guidelines and review criteria. Care that cannot be approved must be reviewed by a licensed health care practitioner in the same school as the provider prescribing the care or treatment for the injured employee. All decisions regarding care and treatment (and the basis for the decision) must be disclosed in writing to the injured employee and the ordering practitioner within specific timeframes. Any decision, by any licensed reviewer cannot be arbitrary and will 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 the exhaustion of this process, the injured worker and practitioner have additional rights to appeal the determination of the UR Agent to the DIA or file a claim for payment to the DIA in accordance with 452 CMR 1.07.

The OHP conducts investigations on all complaints received. During fiscal year 2009, 22 complaints were received and responded to by the Executive Director of the OHP. The OHP tracks the nature and pattern of these complaints and takes this information into account when reviewing policy and procedures of UR Agents.

To ensure the regulatory compliance with UR regulations, the OHP:

- Reviews new applications from UR Agents seeking approval to conduct UR for workers' compensation in Massachusetts. The OHP UR Coordinator provides consultation as requested throughout the application process to ensure all systems, policies and procedures comply with the DIA's rules, regulations and standards.
- Conducts system wide Quality Assessment Audits annually for UR Agents. The OHP UR Coordinator supports and assists the UR Agent throughout the following alternating process to remain in compliance with the DIA's regulations and requirements:

Application Review - Conducted every two years, the Application Review examines demographic information, changes in operations, and policy procedures.

Case Record Audits - A sample of the agent's case records are reviewed to monitor the quality of care provided to injured workers and to ensure the agent's compliance with the DIA's rules and regulations.

On-Site Reviews - Upon a mutually agreed date, this review is conducted for the purpose of confirming that the organization is operating in a manner consistent with 452 CMR 6.00 *et seq.* and in accordance with the policies and procedures set forth in the UR application.

- Ensures that applications of Preferred Provide Arrangements identify the approved UR Agent who will conduct the utilization reviews. Pursuant to 452 CMR 6.03, the OHP may require the PPA to survey affected employees to determine the employees' understanding of their rights when participating in the PPA arrangement.

Outreach and Support to UR Agents

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

Health Care Services Board

Pursuant to M.G.L. c.152 §13, the Health Care Services Board ("HCSB") is a medical advisory body consisting of 14 members specified by statute and appointed by the Commissioner (see Appendix F for a list of HCSB members). The HCSB met throughout fiscal year 2009, discharged its statutory responsibilities with regularity, and continued to assist the Commissioner and the DIA with the implementation of multiple medical initiatives stemming from the Workers' Compensation Reform Act of 1991.

The HCSB managed its affairs with its Chair appointed by the Commissioner, Legal Counsel and administrative staff.

Complaints Against Providers - The HCSB is required to accept and investigate complaints from employees, employers and insurers regarding the provision of health

care services. Such complaints include provider's discrimination against compensation claimants, over-utilization of procedures, unnecessary surgery or other procedures, and inappropriate treatment of workers' compensation patients. Upon a finding of a pattern of abuse by a particular provider, the HCSB is required to refer its findings to the appropriate board of registration. The HCSB continues to receive, investigate and resolve complaints against health care practitioners providing medical services to injured workers under the workers' compensation statute.

IME Roster Criteria - The HCSB is also required to develop eligibility criteria for the DIA to select and maintain a roster of qualified impartial physicians to conduct medical examinations pursuant to M.G.L. c.152, §8(4) and §11A. The HCSB continued to work with the Senior Judge in the recruitment of physicians and health care practitioners throughout fiscal year 2009.

Treatment Guidelines - Under §13 of c.152, the Commissioner is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, including appropriate parameters for treating injured workers. In fiscal year 2009, the HCSB revised one guideline – *"Guideline Number 14 – Knee Injury: Conservative Care."* In addition to an annual review and endorsement of the existing 28 medical treatment guidelines adopted by the DIA, the HCSB continues to work on a medical guideline for pain management.

Compensation Review System (CRS)

As part of the 1991 Workers' Compensation Reform Act, the statute mandated that the DIA "monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment" (M.G.L. c.152, §13).

In order to fulfill this legislative mandate, the OHP set out to create a Compensation Review System (CRS). The goals of CRS are to provide standardized, comparable data for the improvement of programs, policies, and services relative to injured workers in Massachusetts, as well as review compliance with HCSB Treatment Guidelines, review patterns of care, and review utilization of medical services and trends in medical care. In addition, CRS was designed to aid in controlling costs by detecting over-utilization and improper utilization of treatments. The OHP originally collected medical billing data from insurers, self-insurers and third party administrators. In fiscal year 2009, the OHP suspended the collection of all CRS data. The OHP continues to review prior collected data to assist the HCSB in developing treatment guidelines and updating existing guidelines.

OFFICE OF ASSESSMENTS & COMPLIANCE

In 2005, the DIA created the Office of Assessments & Compliance to verify the accuracy of the assessments that are collected by the agency. Each year, the DIA determines an assessment rate that will yield revenues sufficient to pay the obligations of the Workers' Compensation Trust Fund as well as the operating costs for the DIA.²⁰ 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.²¹ Prior to the creation of the Office of Assessments & Compliance, the DIA had completely relied upon insurance carriers to self-report and pay the appropriate amounts collected from employers.

Definition of "Standard Premium"

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

Assessment Audit - Phase I

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

²⁰ Regulated by M.G.L. c.152, §65(4).

²¹ Quarterly assessment reports are due no later than 40 days after the end of the calendar quarter being reported. The quarterly assessment forms are mailed to each insurance company the first week in January, April, July and October.

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

Assessment Audit - Phase II

Phase II of the assessment reviews was initiated in FY'06 and continued through FY'08. In Phase II, the focus was on assessments calculated and remitted during the review period from January 1, 1999 to December 31, 2003. The insurance companies reviewed as part of Phase II include both companies currently licensed to write workers' compensation insurance in Massachusetts as well as companies that no longer write new business in Massachusetts but did so during the applicable review time period. Phase II encompassed a selection of companies that range from single insurance carriers to multi-company insurance groups. The DIA's clarification of the definition of standard premium has effectively decreased confusion in the insurance industry regarding assessment calculation, thus resulting in the increased accuracy of assessment payment by insurance companies on a quarterly basis.

In FY'09, the DIA collected \$44,421 from companies under assessment review from Phase II audits. The audit expense associated with the reviews in FY'09 was 18%, thereby representing a DIA retention rate of 82%. The Office of Assessments & Compliance has explained that Phase II reviews have taken longer than expected due to the size and complexity of the few remaining insurers selected for review. The anticipated completion date for Phase II assessment reviews will be December 2009.

Assessment Audit - Phase III

In FY'08, Phase III of the assessment reviews was initiated and continued through FY'09. Phase III originally focused on assessments calculated and remitted during a 3-year review period between January 1, 2004 and December 31, 2006. This review began with the selection of five major insurers (and their subsidiaries) licensed to write workers' compensation insurance in Massachusetts.

In FY'09, the DIA engaged two CPA firms to assist with the audit reviews of insurance companies. These two additional firms have allowed the DIA to expand Phase III audit reviews to include an additional 10 companies. The review period which was originally set from January 1, 2004 to December 31, 2006 has now been expanded to December 31, 2007. Currently there are 44 companies being reviewed by 3 CPA firms.

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

Table 15: Assessment Recovery Project - Collections by Fiscal Year

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

Source: DIA Office of Assessments & Compliance

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

Online Payment of Assessments

On January 1, 2010 all insurers will be able to securely file and pay assessments online, moving the DIA towards a paperless environment. Currently, the 10 largest writers of workers' compensation insurance in the Commonwealth are testing the online payment system. The payments will be generated by the payer's bank and electronically transmitted to the DIA's bank account. This new service will save insurers both time and money while creating an exact audit trail of the money flow.

DIA REGIONAL OFFICES

The Department of Industrial Accidents has offices in Boston, Lawrence, Worcester, Fall River, and Springfield. The main headquarters are located in Boston where all DIA case records are permanently stored.

The Senior Judge and the managers of the conciliation, stenography, judicial support and vocational rehabilitation units are located in Boston, but each has managerial responsibility for the operations of their respective divisions at the regional offices.

Each regional office has a regional manager, a staff of conciliators, stenographers, vocational rehabilitation counselors, disability managers, administrative secretaries, clerks, and data entry operators. In addition, Administrative Judges make a particular office the base of their operations, with an assigned administrative secretary.

Administration and Management of the Offices

Each regional manager is responsible for the administration of his or her regional office. The offices are equipped with conference and hearing rooms in which conciliations, conferences, hearings and other meetings are held. A principle clerk and a data processing operator manage the scheduling of these proceedings and the assignment of meeting rooms through the Case Management System (CMS).

Cases are assigned to Administrative Judges by CMS in coordination with the Senior Judge. Conciliators are assigned cases according to availability on the day of the meeting, and report to the conciliation manager located at the Boston office. Likewise, stenographers are assigned when needed, but report to the stenographer manager at the Boston office. The vocational rehabilitation personnel report directly to the OEVR manager in the Boston office, and take assignments as delegated from Boston.

When an employee or insurer files a workers' compensation claim or complaint with the DIA, the case is assigned to the office geographically closest to the home of the claimant. Assignments are based on zip codes, with each regional office accounting for a fixed set of zip codes.

Each regional office occupies space rented from a private realtor with the exception of the Springfield office, which is located in a building owned by the Commonwealth. The managers are responsible for working with building management to ensure the building is accessible and that the terms of the lease are met. Moreover, each regional manager is responsible for maintenance of utilities, including the payment of telephone, electricity, and other monthly services. Therefore, the cost of operating each office is managed by each regional manager.

Resources of the Offices

Three of the four regional offices have moved to more expanded and enhanced office space within the last ten years; Fall River, Lawrence and Worcester.

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 regional offices:

Fall River

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

Lawrence

160 Winthrop Avenue
Lawrence, MA 01840
(978) 683-6420
Nancy Stolberg, Manager

Worcester

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

Springfield

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

SECTION
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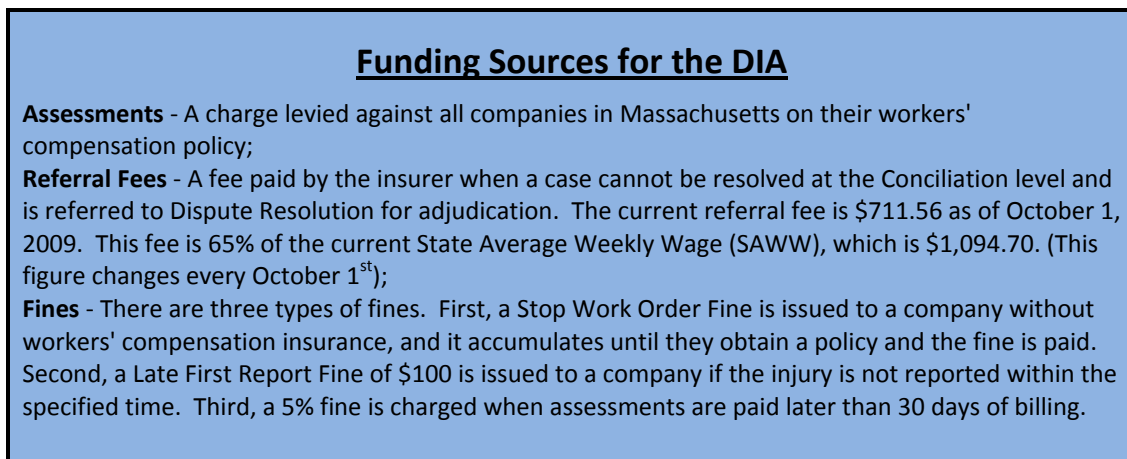
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DIA FUNDING

Leading up to the 1985 Reform Act, the Department of Industrial Accidents had been experiencing funding shortfalls which led to costly delays in the Dispute Resolution System. To ensure the DIA had adequate funding, the Legislature in 1985 transferred the agency's cost burden from the State's General Fund to the Commonwealth's employer community via assessments collected by workers' compensation insurance carriers. In addition to these assessments, the DIA also derives revenue from the collection of fees (for various filing costs) and fines (for violations of the Act). There are no tax dollars used to fund the Department of Industrial Accidents or any of its activities.

Figure 25: Funding Sources for the Department of Industrial Accidents



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

The Assessment Rate

Each year, the DIA determines an assessment rate that will yield revenues sufficient to pay the obligations of the Workers' Compensation Trust Fund and the operating costs for the DIA. This assessment rate, multiplied by the employer's standard premium, is the DIA assessment and is paid as part of an employer's insurance premium.²² The assessment rate for private sector employers in FY'10 is 7.222% of standard premium. This represents a 15.3% increase from the FY'09 assessment rate of 6.262%.

The Special Fund - The DIA's operating expenses are paid from a Special Fund, which is funded entirely by assessments charged to private sector employers. Although the Special Fund budget is subject to the general appropriations process, the DIA reimburses the General Fund the full amount of its budget appropriations plus fringe benefits and indirect costs from the assessments, fines, and fees collected. These

²² For employers that are self insured or are members of self insured groups, an "imputed" premium is determined, whereby the WCRI will estimate what their premium would have been had they obtained insurance in the traditional indemnity market. Some employers are entitled to "opt out" from paying a full assessment. By opting out, the employer agrees that it cannot seek reimbursement for benefits paid under sections 34B, 35C, 37, 30H, 26, and 37A. Separate opt out assessment rates are determined.

payments are made quarterly to the State Treasurer's Office. Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the DIA's operating budget as well as the Workers' Compensation Trust Fund budgets. With the affirmative vote of seven members, the Council may submit an alternative budget to the Director of Labor.

The Trust Fund - The Trust Fund was established so the DIA can make payments to uninsured injured employees and employees denied vocational rehabilitation services by their insurers. In addition, the Trust Fund must reimburse insurers for benefits for second and latent injuries, injuries involving veterans, and for specified cost of living adjustments.²³ One account is reserved for payments to private sector employers (Private Trust Fund); the other is for payments to public sector employers (Public Trust Fund).

The Funding Process

At the beginning of each fiscal year, the DIA estimates the amount of money needed to maintain its operations in the next fiscal year. This amount is refined by December, when it is submitted to the Governor's Office for inclusion in the Governor's budget (House 1), and submitted for legislative action.

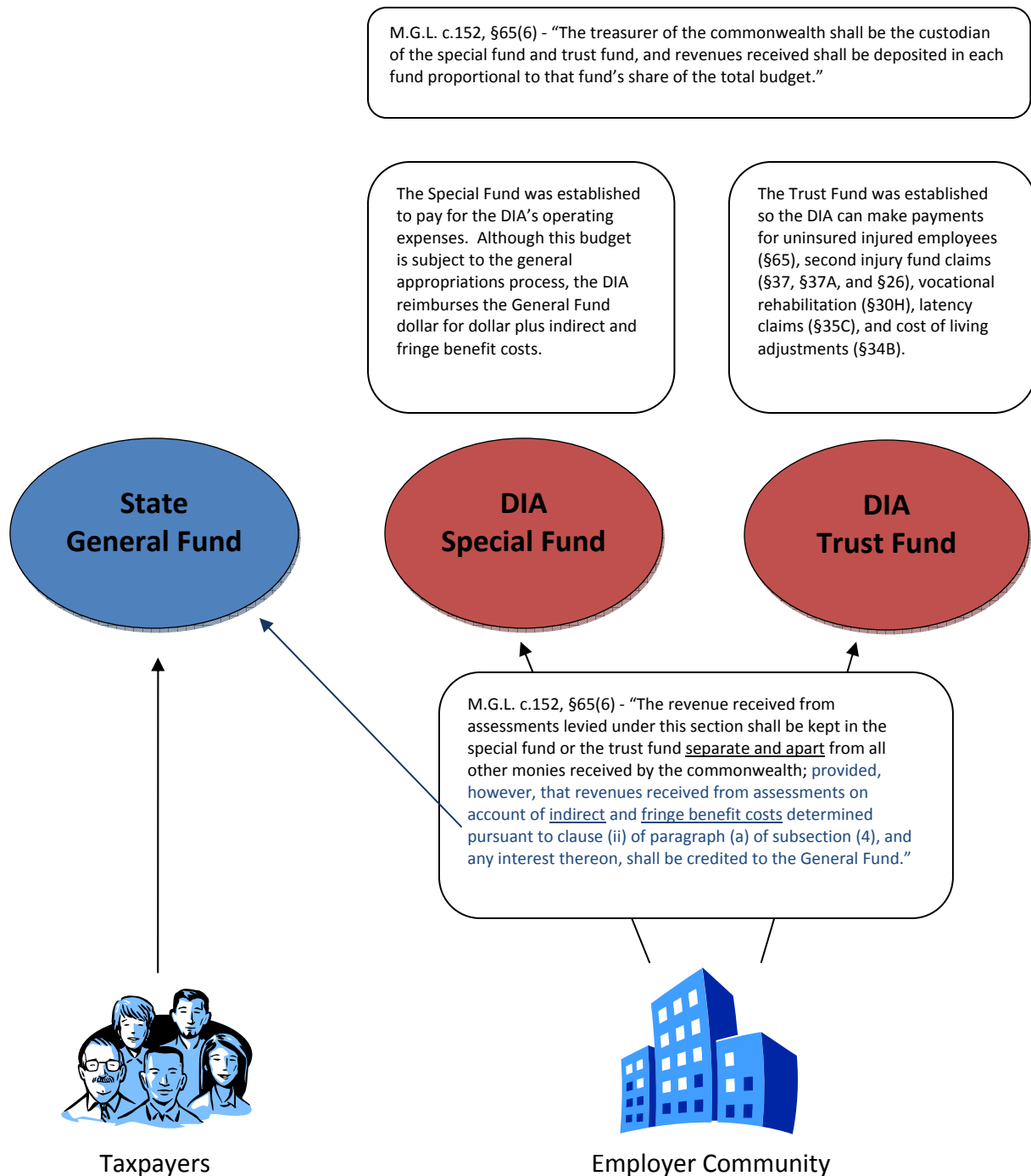
In May and June, the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the Special Fund and the Trust Fund. The budgets and the corresponding assessments must be submitted to the Director of Labor by July 1st annually. Historically, the Legislature appropriates the DIA's operating expenses before July 1st. At that time, insurance carriers are notified of the assessment rates paid quarterly directly to the DIA. Collected assessments are deposited into the DIA's accounts, which are managed by the Commonwealth's Treasurer.

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

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

²³ M.G.L. c.152, §65(2).

Figure 26: The DIA's Unique Funding Process

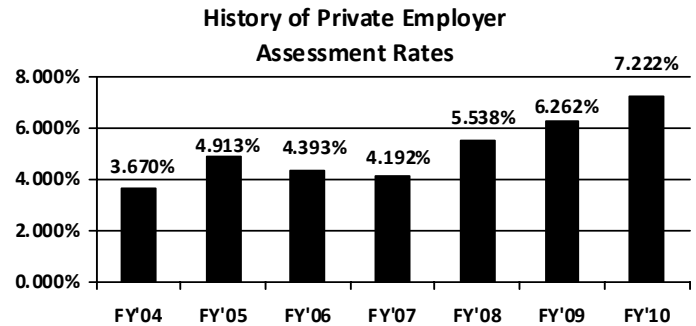


IMPORTANT: Year End Balances within the Special Fund and Trust Fund **DO NOT** revert to the State's General Fund. These balances remain within their respective accounts and are only used to offset future assessments when the balance of a particular fund exceeds 35% of the previous year's disbursements.

PRIVATE EMPLOYER ASSESSMENTS

On June 24, 2009, Deloitte Consulting released an analysis of the DIA's FY'10 assessment rates as mandated under M.G.L. c.152, sections 65 (4) & (5). Specifically, the report details the estimated amount required by the Special Fund and Trust Funds for FY'10, beginning July 1, 2009. Included in the report are the assessment rates to be applied to public and private employer insurance premiums. The private assessment rate has been calculated to be **7.222%** of standard premium, an increase of 15.3% from last year's assessment (6.262%).

Figure 27: History of Private Employer Assessment Rates



The increase to the assessment rate is a result of several factors. First, there has been a significant reduction to the workers' compensation base as a result of the severe economic downturn which has forced many of the Commonwealth's employers to reduce the size of their payroll. Second, there has been a continued rise in Trust Fund expenses, especially payouts to insurance carriers for COLA and Second Injury Fund reimbursements. Finally, insurance rate reductions for the prior two years (-18%) has helped influence the increase to the assessment rate.

Overview of Assessment Rate Calculations

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

1. Project the Fiscal Year 2010 Expenditures;
2. Project the Fiscal Year 2010 Income (excluding assessments);
3. Estimate Fiscal Year 2010 Balance Adjustments, if any;
4. Convert Above Items to Ratios by comparing them to the Assessment Base ('08 Paid Losses);
5. Calculate the Assessment Ratio by Subtracting the Projected Income and Balance Adjustment Ratios from the Projected Expenditure Ratio; and
6. Calculate the Assessment Rate by multiplying the Assessment Ratio by the Assessment Base Factor.

1. FISCAL YEAR 2010 PROJECTED EXPENDITURES: \$86.5M

The first step in the assessment process is the calculation of the expected FY'10 expenditures. Private employers are assessed for the sum of the Private Trust Fund budget and the Special Fund budgets.

<u>PRIVATE TRUST FUND BUDGET</u>	<u>Projected FY'10 Expenditures (06/09)</u>
Section 37 (2nd Injuries)	\$27,748,617
Uninsured Employers	\$ 8,951,321
Section 30H (Rehabilitation)	\$ 26,392
Section 35C (Latency)	\$ 1,728,971
Section 34B (COLA's)	\$17,571,313
Defense of the Fund	\$ 5,000,000
Total:	<u>\$61,026,614</u>

<u>SPECIAL FUND BUDGET</u>	<u>Projected FY'10 Expenditures (06/09)</u>
Total:	<u>\$25,558,502</u>

<u>PRIV. EMPLOY. EXPENDITURES</u>	<u>Projected FY'10 Expenditures (06/09)</u>
Total:	<u>\$86,585,116</u>

2. PROJECTED FISCAL YEAR 2010 INCOME: \$7.3M

Any income derived by the funds is used to offset assessments. An amount is projected for the collection of fees and fines for deposit in the Special Fund, reimbursements from uninsured employers for deposit in the Private Trust Fund, and an amount estimated for interest earned on the Private Fund and the Special Fund balances.

<i>FY'10 Fines and Fees (Special Fund)</i> =	\$5,774,679	
<i>FY'10 Income Due to Reimbursements</i> =	\$1,444,059	
<i>Estimated Investment Income (FY'09)</i> =	\$ 100,962	(Private Fund: \$63,702/Special Fund: \$37,260)

Total Projected FY'10 Income: **\$7,319,700**

3. ADJUSTMENTS TO FUND BUDGETS: \$0

According to M.G.L. c.152, §65(4)(c), the amount assessed employers for any fund must be reduced by a certain percentage of moneys held over from the previous year. Any amount greater than 35% of the previous year's expenditures in a particular fund must be used to reduce amounts assessed for that fund. The balances of both the Special Fund and Private Trust Fund at the end of FY'09 do not have surpluses exceeding 35% of FY'08 disbursements. Therefore, the assessment was calculated without a reduction to either budget.

<i>SPECIAL FUND:</i>	<u>FY'09 Estimated Year End Balance</u>	<u>35% of FY'08 Expenditures</u>	<u>Amount of Reduction Required</u>
	\$4,019,745	\$8,815,851	\$0
<i>PRIVATE TRUST FUND:</i>	<u>FY'09 Estimated Year End Balance</u>	<u>35% of FY'08 Expenditures</u>	<u>Amount of Reduction Required</u>
	\$6,872,490	\$14,410,900	\$0

4. CONVERSION TO RATIO:

Expenditures, income, and any balance adjustment, must be converted to a ratio. This is calculated by dividing each of the first three steps by the assessment base, which represents losses paid during Calendar Year 2008. For the Private Fund, the assessment base is \$703.8M.

<i>Private Expenditure Ratio:</i>	12.303%	(\$86.5 million/\$703.8 million)
<i>Projected Income Ratio:</i>	1.040%	(\$7.3 million/\$703.8 million)
<i>Balance Adjustment Ratio:</i>	0%	(\$0/\$703.8 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 11.2637%

After the projected expenditures, income and balance adjustments are converted to ratios, the last two items are subtracted from the expected expenditure ratio to calculate an assessment ratio.

Projected expenditures - Projected income - Balance adjustment = Assessment Ratio			
12.303%	1.040%	0%	11.263%

6. CALCULATION OF THE ASSESSMENT RATE: 7.222%

Since the assessment ratio is relative to paid losses, the ratio must be converted into a rate that is relative to projected premiums. This is done by multiplying the assessment ratio by an assessment base factor which represents a ratio of losses to premiums (based on information provided by the WCRI). The 2010 assessment base factor is .641.

Assessment Ratio x Assessment Base Factor = Assessment Rate		
11.263%	.641	7.222%

DIA OPERATING BUDGET

Legislative Appropriations, Fiscal Year 2010

The Department of Industrial Accidents initially submitted a request to the Executive Office for Administration & Finance for a budget of \$21,196,452 for fiscal year 2010. On January 28, 2009, Governor Deval Patrick released his Fiscal Year 2010 Budget Recommendations (House 1) and appropriated \$20,758,502 to the DIA's line-item. After extensive review by the Advisory Council's Budget Subcommittee, the Advisory Council endorsed the Governor's House 1 Budget Recommendation, stating that it "would fairly and adequately fund the operations of the DIA." Both branches of the Legislature agreed with the Governor and the Advisory Council and appropriated \$20,758,502 in their respective budgets for the DIA.

Fiscal Year 2010 General Appropriations Act

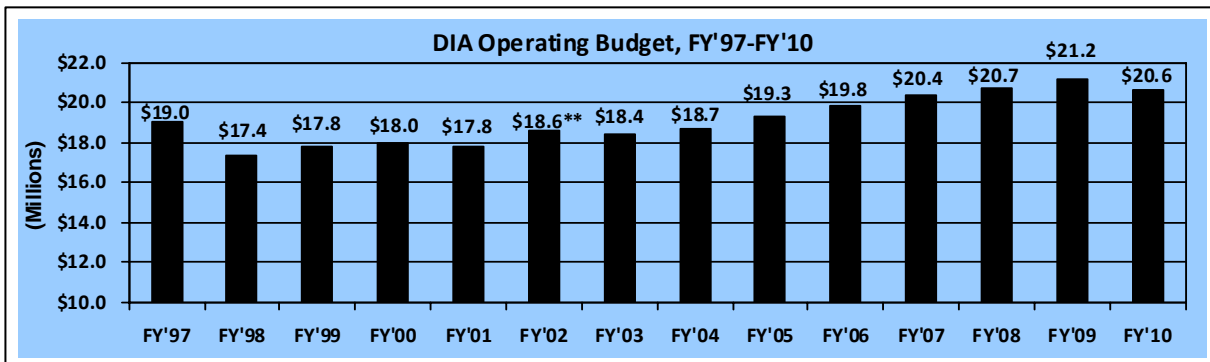
On June 29, 2009, Governor Patrick signed the FY'10 General Appropriations Act, which allocated the DIA a **\$20,555,968** operating budget. This final appropriation represents a \$202,534 decrease from the Conference Committee's Budget. The Governor stated in the Veto Explanation that he reduced this line-item, "by an amount not recommended in light of available revenues." The FY'10 appropriation for the DIA represents a 3% decrease from last year's final appropriation. The line-item contained a provision that allows for the Advisory Council to release sufficient funds from the Special Reserve Account to pay for the continued expansion of the agency's Oracle conversion project.

Fiscal Year 2010 Spending Cuts (Section 9C)

On October 29, 2009, Governor Patrick outlined his plans to close a \$600 million budget shortfall due to lower than expected revenues. The Governor plans to cut \$352 million in state spending for fiscal year 2010 and add \$82 million in new "departmental revenues," and \$62 million in federal stimulus aid. Specifically, the DIA was required to reduce their fiscal year 2010 spending by \$789,719.

Table 16: Legislative Budget Process for DIA Line-Item, Fiscal Year 2009 - Fiscal Year 2010

Fiscal Year 2009 Budget Process		Fiscal Year 2010 Budget Process	
DIA Request	\$21,328,387	DIA Request	\$21,196,452
Governor's Rec.	\$21,196,452	Governor's Rec.	\$20,758,502*
Full House	\$21,196,452	Full House	\$20,758,502
Full Senate	\$21,196,452	Full Senate	\$20,758,502
Conference Committee	\$21,196,452	Conference Committee	\$20,758,502
Gen. Appropriations Act	\$21,196,452	Gen. Appropriations Act	\$20,555,968
9C Spending Cuts	(- \$92,184)	9C Spending Cuts	(- \$789,719)

Figure 28: DIA Operating Budget, FY'97 - FY'10

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

The Budget Process

The operating budget of the DIA is appropriated by the Legislature even though employer assessments fund the agency. The Division, therefore, must abide by the budget process in the same manner as most other tax funded government agencies. It is helpful to view this process in nine distinct phases.²⁴

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

Figure 29: Overview of the Massachusetts' Budget Process

STAGE #1: Department Request

Time Frame: Between July and October

Each agency prepares a budget for the next fiscal year and a spending plan for the current fiscal year. Agency requests are submitted to the Executive Office for Administration & Finance (A&F).

STAGE #2: Governor's Recommendation (House 1)

Time Frame: November, December, and first weeks of January

The Governor's recommendation must be the first bill submitted to the House of Representatives each calendar year. On the fourth Wednesday in January, copies of House 1 are distributed to members of the House and Senate, the Executive Secretaries and department heads, the media, and to any other interested parties. The Governor's recommended budget must be balanced and include all revenue accounts and all expenditure accounts.

²⁴ Making and Managing the Budget in the Commonwealth of Massachusetts, Donahue Institute for Government Services, University of Massachusetts.

STAGE #3: House Ways and Means Committee Recommendations

Time Frame: February, March, and April

House 1 is referred to the House Ways and Means Committee where each line item is analyzed. Public hearings are held in which testimony is taken from the Governor's staff, executive secretariats, departments, and any other interested parties. In April, a new version of the budget replaces House 1 and is traditionally given the label of House 5600.

STAGE #4: The House "Passed" Version

Time Frame: Early May

The members of the House of Representatives take over by subjecting each line item in the budget to debate and amendments. The full House votes to pass a new version of the budget.

STAGE #5: Senate Ways and Means Committee Recommendations

Time Frame: Early June

The House version of the budget is referred to the Senate Ways and Means Committee where hearings and testimony are held. Typically by early June, a recommendation will be published and given to members of the Senate and interested parties. The Chairperson and members of the Committee will hold a press conference to address concerns with this new version of the budget.

STAGE #6: The Senate "Passed" Version

Time Frame: Middle of June

The full Senate reviews each line item and section and subjects them to debate and amendment. Members of the Senate will then vote to pass the new, updated budget.

STAGE #7: Conference Committee**Time Frame:** By June 30th

A Conference Committee is created in an effort to resolve differences between the House passed version of the budget and the Senate version. Members of this committee include the chair of both Ways and Means Committees and ranking minority party members from both committees. The only budget information the Conference Committee can analyze is what survived from the House and Senate debates. Compromises are made on each line item by selecting either the budget amount from the House version, the Senate version, or a number in between the two versions. Finally, a new draft is created that both the House and Senate must ratify. If one branch does not ratify the budget, it is sent back to Conference Committee for more work. Once the budget is ratified, it is signed by the Speaker of the House and the President of the Senate. (An interim budget can be enacted by the Legislature if the budget is late to allow the government to continue spending while the General Appropriation Act is being finished.)

STAGE #8: General Appropriations Act**Time Frame:** Within ten days of receipt

The Governor has ten calendar days to decide their position on the budget. During this period, the Governor may both sign the budget and approve as complete; veto selected line items (reduce to zero) but approve and sign the rest; or partially veto (reduce to a lower number) selected line items and approve and sign the rest. The Legislature has the power to override a Governor's veto by a 2/3 vote in both chambers.

STAGE #9: Section 9C Spending Cuts**Time Frame:** At any time during a Fiscal Year

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

SECTION
- 7 -

INSURANCE COVERAGE

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MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.²⁵ Coverage may consist of purchasing a commercial insurance policy, membership in a self-insurance group, participation in a reciprocal insurance exchange, or maintaining a license as a self-insured employer.²⁶

All Commonwealth of Massachusetts employees are covered under the Workers' Compensation Act, with claims paid directly from the General Fund. The Human Resources Division within the Executive Office of Administration & Finance administers workers' compensation claims for state agencies. On an annual basis, each individual agency pays a yearly "charge-back" based on losses paid in the prior year. This charge-back comes directly from each agency's operating budget.

When enacted in 1911, the Workers' Compensation Act was elective for counties, cities, towns, and school districts. The majority of municipal employees are covered, with only a few communities having never adopted coverage for certain employee groups. Municipalities attain insurance coverage in a manner identical to private employers (commercial insurance, self-insurance, or membership in a self-insurance group).

The Office of Investigations at the DIA monitors employers in the state to ensure no employer operates without insurance. The office may issue fines and close any business operating without coverage.²⁷ If an employee is injured while working for a company without coverage, a claim may be filed with the DIA's Trust Fund.²⁸

Exemption of Corporate Officers

In 2002, a new law was passed that made the requirement of obtaining workers' compensation insurance elective for corporate officers (or the director of a corporation) who own at least 25% of the issued and outstanding stock of that corporation. A corporate officer must provide the DIA with a written waiver of their rights should they choose to opt-out from the workers' compensation system.²⁹ The policies and procedures surrounding the exemption of a corporate officer or director are governed by 452 CMR 8.06 et. seq. The new law also amended the definition of an employee by giving a sole-proprietor or a partnership the ability to be considered an "employee" so they can obtain coverage under a workers' compensation insurance policy.

²⁵ 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.

²⁶ A reciprocal exchange is a group of employers from diverse industries who pool their funds to insure themselves. An exchange is not self insurance or a self insurance group, but a way to provide commercial insurance to small and medium sized companies without resorting to the residual market.

²⁷ See page 74 covering the Office of Investigations.

²⁸ See page 77 covering the Workers' Compensation Trust Fund.

²⁹ Form 153 - "Affidavit of Exemption for Certain Corporate Officers."

COMMERCIAL INSURANCE

Purchasing a commercial insurance policy is the most common method of complying with the workers' compensation mandate. These policies are governed by the provisions of M.G.L. c.152, and are regulated by the Division of Insurance (DOI). The Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRI) 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 WCRI's Massachusetts Workers' Compensation and Employers Liability Insurance Manual sets forth the methods to determine the classification of insureds as well as terms of policies, premium calculations, credits and deductibles.

The Insurance Market

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

Commercial insurance carriers are regulated by the DOI, which provides licensing, monitors solvency, determines rates, approves the terms of policies, and adjudicates unfair claims handling practices. In FY'09, the DOI approved a total of seven new licenses to carriers to write workers' compensation insurance in Massachusetts. During the fiscal year, one insurance carrier gave up their license to write workers' compensation insurance.

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.³⁰ Insurance rates are proposed by the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRI) on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRI submits to

³⁰ In the United States, workers' compensation insurance rates are regulated one of three ways: through administered pricing, competitive rating, or a monopolistic state fund. Administered pricing involves strict regulation of rates by the state. Competitive rating allows carriers to set rates individually, usually based on market-wide losses developed by a rating organization and approved by the state. Monopolistic state funds require that workers' compensation insurance be purchased exclusively through a program run by the state. Some states have competitive state funds that allow employers to purchase insurance from either a private carrier or the state.

the Commissioner a classification of risks and premiums, referred to as the rate filing, which is reviewed by the State Rating Bureau. By law, a rate filing must be submitted at least every two years, and no classifications or premiums may take effect until approved by the Commissioner.³¹

According to the Workers' Compensation Act, the Commissioner of Insurance must conduct a hearing within 60 days of receiving the rate filing, to determine whether the classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that "they fall within a range of reasonableness" (see Appendix J for Advisory Council testimony).³²

On Thursday, April 17, 2008, Insurance Commissioner Nonnie S. Burnes issued a rate decision, which reduced average rates for workers' compensation insurance by 1.0% from 2007 rate levels, resulting in the savings of \$11 million in workers' compensation premiums for Massachusetts employers. The Commissioner's decision was based on an agreement reached between the State Rating Bureau, the Workers' Compensation Rating & Inspection Bureau (WCRIB), and the Attorney General's Office. In February 2008, the WCRIB had originally proposed a 2.3% rate increase to average workers' compensation rates. The rate reduction became effective for policies taking effect on or after September 1, 2008. This rate decrease marks the ninth time since workers' compensation rates have decreased since 1991.

The table to the right illustrates the fluctuations in workers' compensation insurance rates since 1991 and how each year's rate would effect a company's premium, assuming their premium was \$100 in 1987 (with all other factors remaining the same - experience rating, discounts, etc.).

Table 17: Impact of Rate Changes, 1991-2009

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

Source: Division of Insurance WC Rate Decisions

³¹ 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.

³² M.G.L. c.152, §53A(2).

Deviations & Scheduled Credits

The Workers' Compensation Act allows individual carriers to seek permission from the Commissioner to use a percentage decrease from approved rates within certain classifications.³³ These percentage decreases are called "downward deviations." Scheduled credits are also used in Massachusetts as a tool for competitive pricing, by allowing insurers to reward policyholders for good experience. These discounting techniques have become an important part of the Massachusetts insurance market. While open competition is not permitted, the use of deviations (and other alternatively priced policies) has encouraged carriers to compete for business on the basis of pricing.

In calendar year 2008, approximately 60 insurers were offering deviations or scheduled credits to their customers in Massachusetts. These discounts (some as high as -25% on certain classes) will remain in effect until the next rate filing.

Table 18: Workers' Compensation Rate Deviations, 2004-2008

Five Year Trends - State Rating Bureau	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Workers' Compensation Rate Deviations:	53	60	61	60	60

Source: Division of Insurance 2008 Annual Report.

The Classification System

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

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

Regulation of Classifications - Classifications in Massachusetts are established by the Workers' Compensation Rating & Inspection Bureau (WCRIB) subject to approval by the Commissioner of Insurance. Hearings are conducted at the Division of Insurance to determine whether classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that they fall within a "range of reasonableness."³⁴

³³ M.G.L. c.152, §53A(9).

³⁴ M.G.L. c.152, §53A.

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

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

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

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

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

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

Class Code	Governing Classification	Manual Rate	Payroll	Base Rate
5188	Automatic Sprinkler Installation & Drivers	\$2.50	\$200,000	\$5,000

Class Code	Standard Exception	Manual Rate	Payroll	Base Rate
8810	Clerical Employees	\$.25	\$50,000	\$125

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

Construction Industry - In the construction industry alone, there are over 67 different classifications for the various types of construction or erection operations. Often, multiple classifications must be assigned to large general contractors who use different trades during the many phases of construction projects. Separate payrolls must be maintained for separate classifications or else a construction company can be assigned to the highest rated classification that applies to the job or location where the operation is performed. The Massachusetts Construction Classification Premium Adjustment Program is a program that provides for a manual premium credit ranging from 5% to 25%, depending on average hourly wages paid to employees. Because a disparity exists between high and low wage construction employers (largely determined by the existence of a collective bargaining agreement), this program is designed to offset the higher premiums associated with larger payrolls and equalize workers' compensation costs.

Premium Calculation

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

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

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

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

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

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

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

Experience rating is a system of comparing the claims history of each employer against the average claims experience of all employers within the same classification. An

experience modification factor is calculated, which provides either a premium reduction (credit) or a premium increase (debit) to an insured's premium. For example, a modification of .75 results in a 25% credit or savings to the premium, while a modification of 1.10 produces a 10% debit or additional charge to the premium. When a modification of 1.00 (unity) is applied, no change to premium results.

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

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

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

Premium Discounting

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

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

TYPE "A" COMPANIES			TYPE "B" COMPANIES		
Layer of Standard Premium		Percent of Premium Discount	Layer of Standard Premium		Percent of Premium Discount
First	\$10,000	0.0%	First	\$10,000	0.0%
Next	\$190,000	9.1%	Next	\$190,000	5.1%
Next	\$1,550,000	11.3%	Next	\$1,550,000	6.5%
Over	\$1,750,000	12.3%	Over	\$1,750,000	7.5%

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

Deductible Policies

Since 1991, deductible policies can provide the advantages of a retrospective policy and self-insurance. Employers are responsible for paying from the first dollar incurred up to the deductible limit, either on a per claim basis or on an aggregate basis for claims in the policy year. The insurer pays all benefits and then seeks reimbursement from the employer up to the amount of the deductible.

Table 20: Premium Reduction % per Claim Deductible

PER CLAIM DEDUCTIBLE ³⁵ <i>Effective September 1, 2005</i>	
Medical and Indemnity Deductible Amount	Premium Reduction Percentage
\$ 500	3.0%
\$1,000	4.2%
\$2,000	6.2%
\$2,500	7.1%
\$5,000	10.6%

Source: WCRI

Table 21: Massachusetts Benefits Claim and Aggregate Deductible Program

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM ³⁶ <i>Effective September 1, 2005</i>			
Estimated Annual Standard Premium	Claim Deductible Amount	Aggregate Deductible Amount	Premium Reduction Percentage
0 to \$75,000	\$2,500	\$10,000	7.0%
\$75,001 to \$100,000	\$2,500	\$10,000	6.5%
\$100,001 to \$125,000	\$2,500	\$10,000	5.9%
\$125,001 to \$150,000	\$2,500	\$10,000	5.4%
\$150,001 to \$200,000	\$2,500	\$10,000	4.5%
over \$200,000	\$2,500	5% of Estimated Annual Standard Premium	4.3%

Source: WCRI

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

³⁵ Massachusetts Workers' Compensation and Employer's Liability Insurance Manual.

³⁶ Massachusetts Workers' Compensation and Employer's Liability Insurance Manual.

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.³⁷ 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 \$75,000.³⁸ Although these eligibility standards exclude many small businesses, one of the biggest misconceptions is that retrospective plans are only for large employers and high-risk groups. In Massachusetts, more smaller employers are purchasing retrospective plans to lower premiums by controlling company losses.

Benefits and Disadvantages - Under the right circumstances, retrospective rating can benefit both the insurer and the policyholder. The policyholder benefits by paying a smaller premium at the beginning of the policy year. Because premium is determined by losses, retrospective plans reward those businesses that maintain effective loss control programs. If losses are low, the insured will pay less than standard premium. However, there is a significant uncertainty regarding the final premium amount, since it is impossible to be precise in predicting the volume or severity of workplace accidents. An unexpected claim towards the end of a policy period can be detrimental to a company, if funds have not been set aside for the retro-premium. Furthermore, there is little incentive for the insurance company to limit settlement costs, when they are able to recover payments made on claims brought against the policyholder.

³⁷ “Retrospective Rating,” *Risk Financing*, Supplement No. 46, May 1995: III.D.7.

³⁸ *Workers’ Compensation: Exposures, Coverage, Claims*, Levick, Dwight E. Standard Publishing Corp., page 11-4.

Dividend Plans

Offered as another means of reducing an employers insurance costs, dividend plans can provide the policy-owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year. The dividend is usually paid to the insured directly or by applying it to future premiums due. Regardless of how the payment is issued, dividends are non-taxable, since they are considered a return of premium.³⁹ Dividend plans may seem attractive to policy holders, but sometimes promise more than can be delivered. Insurer's are not legally bound to pay what they may have estimated a policy holder's return to be. Moreover, many insurers strategically calculate a dividend only once between 18 and 24 months after a policy's inception, and not always to the advantage of the insured.⁴⁰

³⁹ "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.

⁴⁰ "Thinking About the Work Comp Crisis," Merrit Risk Management Review, December 1991: 3.

ASSIGNED RISK POOL

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

The estimated ultimate residual market share for the 12-months ending June, 2009 is 11.7%.⁴¹ During the last five years this percentage has trended downward from 18.4%. Today the residual market remains far below the 1992 policy year level of 64.7%.

Employers insured through the pool pay standard premium and are not offered premium discounts, dividend plans, etc. The Commissioner of Insurance chooses the carriers that will administer the policies, called "servicing carriers." The servicing carriers are paid a commission for servicing these policies, and are subject to performance standards and a paid loss incentive program. These programs are designed to provide servicing carriers with incentives to provide loss control services to those insured.

Residual Market Loads - Every insurance carrier licensed to write workers' compensation policies is required to be a member of the Assigned Risk Pool. Members are collectively responsible for underwriting pool policies, for bearing the risk of all losses, and are entitled to any profits generated. When the pool operates at a deficit, the members are subject to an assessment. Assessments are calculated in direct proportion to the amount of premium written in the voluntary market. This is called the Residual Market Load.

The Residual Market Load is incorporated into rates and can be a significant factor for employers to search out alternative risk financing options. Self insurance and self-insurance groups are not subject to residual market assessments. The Residual Market Load is incorporated into manual rates. The residual market loss ratio measures the amount of losses and expenses to the premiums written (roughly money out divided by money in). A loss ratio greater than 100% indicates that losses are greater than revenues (premiums). The estimated (as of the first quarter of 2009) residual market loss ratio for Policy Year 2008 is 65.0% with a resulting residual market burden of -0.66%.⁴²

⁴¹ WCRIB Special Bulletin No. 09-09 (August 15, 2009).

⁴² WCRIB Special Bulletin No. 10-09 (September 8, 2009).

ALTERNATIVE RISK FINANCING METHODS

Self insurance and self insurance groups (SIGs) became an extremely popular device to control rising workers' compensation costs when insurance rates rose dramatically in the late 1980's and early 1990's. Much of the cost savings derived from avoidance of residual market loads incorporated into commercial insurance premiums to pay for the large assigned risk pool. Since 1993, insurance rates have decreased dramatically, making alternative risk financing measures less attractive. Many employers now turn to traditional commercial insurance plans, most noticeably large deductible policies and retrospective rating plans.

Self Insurance

The DIA strictly regulates self insured employers through its annual licensing procedures. For an employer to qualify to self insure, it must post a surety bond or negotiable securities to cover any losses that may occur (452 C.M.R. 5:00). This amount varies for every company depending on their previous reported losses and predicted future losses. The average bond or security deposit is usually over \$1 million. Self insurance is generally available to larger employers with at least 300 employees and \$750,000 in annual standard premium.⁴³ These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover incurred losses. In addition, employers who are self insured must purchase reinsurance of at least \$500,000. Each self-insured employer may administer its own claims or engage the services of a law firm or a third party administrator (TPA) to handle claims administration. The Office of Insurance evaluates employers every year to determine their continued eligibility and to set bond amounts.

Table 22: Total Self Insured Licenses in Massachusetts, FY'99 - FY'09

<u>Fiscal Year</u>	<u>New Licenses</u>	<u>Total Licenses</u>	<u>Companies Covered</u>	<u>Equivalent Premium Dollars</u>
FY'09	0	112	373	\$276M
FY'08	1	108	401	\$264M
FY'07	2	116	400	\$292M
FY'06	2	114	434	\$277M
FY'05	2	129	409	\$262M
FY'04	1	129	380	\$245M
FY'03	2	143	445	\$225M
FY'02	2	139	478	\$221M
FY'01	3	151	419	\$219M
FY'00	5	173	437	\$221M
FY'99	6	174	464	\$240M

⁴³ 452 C.M.R. 5:00: Code of Massachusetts Regulations concerning insurers and self insurers.

Self Insurance Groups

Companies in related industries may join forces to form a self insurance group (SIG). Regulated by the Division of Insurance, SIGs may include public employers, non-profit groups, and private employers in the same industry or trade association.⁴⁴

As part of the workers' compensation reform package of 1985, SIGs were permitted in Massachusetts to provide an alternative to coverage in the assigned risk pool. Since that time, membership has been a popular alternative to commercial insurance because of the ability for members to manage their own claims. In addition, SIGs are generally able to reduce administrative costs from a fully insured plan. These savings result from reduced or eliminated commissions, premium taxes, etc.

Members of a self insurance group are assigned a classification and are charged manual rates approved by the Commissioner of Insurance for commercial insurance policies. Premium is calculated in the same manner, with manual rates adjusted by an experience modification factor and the All Risk Adjustment Program (ARAP).⁴⁵ Cost savings arise through dividends returned to members and deviated rates.

Companies who join self insurance groups rely heavily on the solvency and safety records of fellow members, since the insurance risks are spread amongst the group. If one of the employers in a group declares bankruptcy or suffers a catastrophic accident, the whole group must absorb the losses. In addition, all members share joint and several liability for losses incurred.

The first group was approved in 1987. After a few years of modest interest, eight SIGs were formed in 1991 and 21 in 1992. As of January 1, 2009, Massachusetts had 24 SIGs with 5,553 members.

Table 23: Membership in W/C SIGs as of Jan. 1st

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

Source: Division of Insurance

⁴⁴ According to Division of Insurance regulations, a SIG must have "five or more employers who are engaged in the same or similar type of business, who are members of the same bona fide industry, trade or professional association which has been in existence for not less than two years, or who are parties to the same or related collective bargaining agreements. (Div. of Insurance Regulations, 211 CMR 67.02).

⁴⁵ 211 CMR 67.09.

INSURANCE FRAUD BUREAU

The Insurance Fraud Bureau (IFB) is an insurance industry supported agency authorized by the Commonwealth to detect, prevent and refer for criminal prosecution suspected fraudulent insurance transactions involving all lines of insurance.⁴⁶ The IFB was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.⁴⁷ While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance.

The IFB's Workers' Compensation Fraud Team has grown from one investigator to its current make-up of a Deputy Chief and seven investigators. The unit exclusively focuses on workers' compensation fraud with an emphasis on premium fraud matters.

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 2008, each of these bureaus separately contributed a total of \$4,020,209 to fund the IFB. The 2008 operating expenses for the IFB totaled \$8,446,385, representing a \$640,458 increase (+8.2%) over 2007 expense levels.

The Investigative Process

The types of workers' compensation cases that are investigated vary greatly. Fraud can be perpetrated by the employee, employer, medical provider, attorney, and in some cases the insurance agent. The majority of IFB investigations, however, involve employee misconduct. IFB personnel primarily investigate the following types of workers' compensation fraud:

- *Claimants with duplicate identities who worked while receiving workers' compensation benefits or who earned income from one or more employers and failed to disclose it;*
- *Cases in which the subject staged an on-the-job accident;*
- *Cases where subjects participated in physical activities wholly inconsistent with the disability claimed or whose injuries were fraudulently attributed to the workplace;*
- *Premium evasion fraud and phony death claims.*

Referrals - Cases of suspected fraud for all types of insurance are generally referred to the IFB, either through an insurance carrier or through a toll-free hotline, which can be

⁴⁶ The Insurance Fraud Bureau has its own Internet web site which can be found at <http://www.ifb.org>. The site is designed to inform the public on the activities and accomplishments of the IFB. The site also allows the general public to submit anonymous tips on suspected insurance fraud.

⁴⁷ M.G.L. St. 1990, c.338 as amended by St. 1991, c.398, §9

reached at: 800-32-FRAUD. In calendar year 2008, the IFB received 326 referrals regarding workers' compensation fraud. Workers' compensation fraud referrals only represent 9% of all IFB referrals. The vast majority of referrals (83%) received by IFB are for automobile insurance fraud (3,043 in calendar year 2008). Workers' compensation cases are fewer in count because automobile policies vastly outnumber workers' compensation policies. However, the dollar amounts for workers' compensation fraud perpetrated is significantly higher per case, particularly for premium evasion cases which can be in the millions of dollars in losses.

Evaluation - Once a referral is received by the IFB, an investigative staff must evaluate each case within 20 working days. During this time, status letters are sent to the insurance companies indicating whether the case was referred to another agency or accepted for further investigation. A backlog has historically existed in investigations at this initial stage.

Assigned Cases - Once resources become available, a referral is assigned to an investigator and officially becomes a "case." In calendar year 2008, a total of 109 workers' compensation cases were investigated and completed. Although there were 90 newly-created workers' compensation cases, not all of these were assigned to an investigator by the end of the calendar year. After an investigator has completed their work on a case, it is referred to a prosecutor (primarily the Massachusetts Attorney General's Office), transferred to another agency, or closed due to lack of evidence.

Indictments & Convictions

In 2008, there were 9 individuals charged (either through indictments or complaints issued) involving workers' compensation fraud as a result of the work of the Insurance Fraud Bureau. Much like the cases referred to the Insurance Fraud Bureau, the vast majority of indictments or complaints issued are for cases involving automobile insurance fraud (338 individuals charged in 2008).

In calendar year 2008 there were 9 convictions for workers' compensation fraud and 41 convictions involving automobile insurance fraud.

JOINT TASK FORCE ON THE UNDERGROUND ECONOMY

Established in March, 2008 through Executive Order #499 signed by Governor Deval Patrick, the Joint Enforcement Task Force on the Underground Economy and Employee Misclassification ("Task Force") is charged with coordinating the efforts among multiple state agencies to increase employer and individual compliance with existing labor, licensing and tax laws.

Chaired by the Director of Labor, the Task Force accomplishes this through collaboration, sharing data and exchanging information as well as leveraging resources to enhance enforcement and investigation activity. As the Task Force nears the end of its second year of operation, continued progress is being made in creating a fairer, more balanced economy in which all employers can compete.

Central to the Task Force mission is helping Massachusetts businesses, by increasing fair competition, Massachusetts workers, by ensuring that they receive all benefits and protections due to them under the law; Massachusetts consumers, by ensuring that they can purchase licensed and regulated goods and services and Massachusetts taxpayers, by working to increase employer compliance with the Commonwealth's tax laws in order to recover lost revenue.

Since its inception, members of the Task Force have expanded to 17 partners, with more expected to join in the next year.

- Executive Office of Labor and Workforce Development
 - Department of Labor
 - Department of Industrial Accidents
 - Division of Apprentice Training
 - Division of Career Services
 - Division of Occupational Safety
 - Division of Unemployment Assistance
- Executive Office of Administration and Finance
 - Division of Capital Asset Management
 - Department of Revenue
- Executive Office of Health and Human Services
 - Massachusetts Office of Refugees and Immigrants
- Executive Office of Housing and Economic Development
 - Department of Housing and Community Development
 - Division of Professional Licensure
 - Office of Small Business & Entrepreneurship
 - State Office of Women and Minority Owned Businesses

- Executive Office of Public Safety and Security
 - Department of Public Safety
- Office of the Attorney General
 - Fair Labor Division
- Office of the Treasurer
 - Alcoholic Beverages Control Commission
- Insurance Fraud Bureau

First Year Accomplishments

In June of 2009, the Task Force released an Annual Report detailing the accomplishments of the Task Force since its inception in May of 2008. In its first year of operation, the Task Force reported that it recovered in excess of \$1 million through the cooperative efforts of the 17-member agencies. As of March 21, 2009, the Task Force has received 515 complaints. The vast majority of these complaints (453) are received through the telephone referral line (1-877-96-LABOR). The remainder of the complaints were received through either regular mail (33) or email (28). Among the telephone line complaints, 29% of complaints were launched against businesses in the Services sector, 21% in the Retail Trade sector, while 21% were in the Construction sector.

Table 24: Revenue Generated Directly Through Task Force Efforts

REVENUE GENERATED DIRECTLY THROUGH TASK FORCE EFFORTS	
<i>Task Force Annual Report, June 2009</i>	
Division of Unemployment Assistance	\$737,439 - Collection of new UI taxes from newly-registered employers
Fair Share Contributions (DLWD)	\$239,742 - New Contributions collected through JTF collaborations
Department of Revenue	\$233,468 - Assessments for overdue tax collections
Attorney General's Office	\$200,425 - Civil citations issued and fines imposed
Department of Industrial Accidents	\$24,750 - Fines collected through stop work orders issued
Division of Professional Licensure	\$1,700 - Fines collected from unlicensed individuals/businesses
Division of Occupational Safety	\$1,500 - New application fees collected from unlicensed agencies
Total Revenue Generated	\$1,439,024

Expanding Outreach

Massachusetts has been playing a leadership role throughout the region in its efforts to combat workplace fraud through the Task Force. Over the past year, the Director of Labor and senior staff met with labor officials and members of newly formed misclassification commissions/task forces throughout the region, offering advice and technical assistance as to structuring and managing task force operations.

In October, 2009, the Massachusetts Task Force, and the New York State Department of Labor, Joint Enforcement Task Force on Employee Misclassification, co-sponsored the first Northeastern States Regional Summit on the Underground Economy and Employee

Misclassification. This summit convened nearly 80 state labor directors and senior officials representing nine states, from Maryland to Maine and points in between, to discuss best practices, potential pitfalls and successful strategies central to investigating/enforcing state labor, licensing and tax laws, as well as an array of state perspectives around successful data sharing to strengthen enforcement.

This regional initiative attracted federal recognition through a video presentation created especially for regional summit attendees by US Secretary of Labor Hilda L. Solis, who spoke about the importance of finding ways to grow regional partnerships in an effort to reduce workplace fraud and restore fairness to our economy. Throughout the conference, participants discovered that states share common challenges, such as industries operating across state lines which tend to commit fraud and employee misclassification more often. This in turn led to a call for finding vehicles in which to improve communication between states. The Massachusetts Department of Labor is working with partners to develop a forum to foster inter-state communications regarding workplace fraud fighting activities. While compliance is cornerstone of the work of the Task Force, additional attention is being paid to conducting education and outreach all across the Commonwealth. Forums where Department of Labor and Task Force staff have participated include the national International Labor Standards Association (ILSA) conference in Albany, NY, the 16th Annual IRS Town Meeting, the Massachusetts Association of Public Accountants, the South Eastern Massachusetts Building Officials Association as well as at several Town Business Day events sponsored by the Greater Lowell Chamber of Commerce.

Task Force partner agencies make a point to mention their involvement in the Task Force and refer citizens to the Task Force to lodge a complaint when necessary when conducting information sessions or public forums.

Leveraging and Information Sharing

Increasing compliance has been possible through the strategic leveraging of state resources, expanding Task Force partnerships to bolster compliance across industry lines. One prime example is the sharing of information between the Division of Unemployment Assistance (DUA) and the Alcoholic Beverage Control Commission (ABCC). Applicants seeking to obtain or renew their liquor licenses must now be in or come into compliance with their unemployment insurance taxes, including the state's Fair Share requirement under the health care law before any such license is issued.

Additionally, the Division of Capital Asset Management has cross-referenced contractor debarments and citations from the 25 press releases on contractor debarments and citations issued by the Attorney General's Office relating to prevailing wage and wage and hour laws violations between April-2009 to November-2009.

Examples of the Task Force at work for Massachusetts include:

- **Recovery of \$1M in unpaid unemployment insurance contributions through collaborative efforts of the state Division of Capital Asset Management (DCAM) and the Division of Unemployment Assistance (DUA).** Since January 2009, DCAM has assisted in bringing 40 DCAM contractors into compliance with the Division of Unemployment Assistance.
- **Recovery of nearly \$385,000 in liquor license related unemployment insurance receivables from April to October 2009.** This money stems from coordinated efforts between the Division of Unemployment Assistance and the Alcoholic Beverage Control Commission and is the result of agency compliance checks.
- **As a result of referrals from the Joint Task Force, the Department of Revenue has assessed approximately \$1 million against non-compliant businesses.** An additional \$450,000 in taxes, interest and penalties should be assessed shortly. Through the JTF the DOR has closed 146 cases to date.
- **More than \$1.1M has been collected by the Division of Unemployment Assistance (DUA)** as a result of cross-checking Division of Capital Asset Management contractor listings between March 25, 2009 and November 18, 2009.
- **The Attorney General's Office has issued six civil citations against corporations and/or individuals,** which included orders of fines totaling \$21,650 and \$550 in restitutions from Task Force referrals. Since the end of FY 2009.
- **Issuing of 66 criminal indictments against a Worcester company, Labor Solutions and its owner Tam Vuong, for violations of the Massachusetts wage and hour laws, and for committing insurance and tax fraud.** Authorities began an investigation into Vuong and his company in April 2008, after Task Force members received complaints alleging that Labor Solutions was violation the wage and hour law, including failure to pay the mandatory minimum wage. Investigators discovered that a substantial number of employees, all of whom were paid in cash, received \$6.25 or \$6.50 an hour.
- **The Division of Occupational Safety has conducted 10 Inspections of employment or staffing agencies for which the Task Force had received a complaint or referral.** Through the Task Force, DOS also recovered \$1,560 in license fees for referred employment or staffing agencies that were not licensed or registered with DOS and are required to be. The DOS is further investigating activities of suspect firms as a result of JTF referral. DOS has made 78 compliance checks on license applications for Lead and Asbestos related licenses with the Division of Unemployment Assistance and the Fair Share Contribution program to ensure compliance with employer unemployment insurance coverage and required Fair Share contributions. Additionally, DOS conducted 481 compliance checks on license applications for employment and staffing agency-related licenses and registrations to ensure compliance with employer unemployment insurance coverage and Fair Share compliance.

Task Force Coordination in Action

Task Force partners including the Department of Industrial Accidents (DIA) and Division of Professional Licensure (DPL) teamed up to investigate businesses involved in the workplace fatality in which a worker, a native of Brazil, named Romulo Santos, was electrocuted at a renovation project at a Wal-Mart site in Walpole. This collaborative effort led to the Division of Professional Licensure issuing of a cease and desist order to the company due to its discovery that an unlicensed electrician and two laborers from out-of-state were performing electrical work. The company had a Massachusetts-licensed electrician sign for the electrical permit with the Town of Walpole, yet there was no Massachusetts-licensed electrician onsite performing this work. The DPL is in the process of taking licensure action against the licensee and his company for aiding the work of unlicensed electricians.

Additionally, the DIA issued two Stop Work Orders to two of the companies at the site for lack of workers' compensation insurance. Moreover, the employer for whom Mr. Santos worked did not have workers' compensation insurance.

The US Occupational Safety and Health Administration (OSHA) has since cited and fined Santos' employer, Italo Masonry, for seven serious violations, and the electrical company, M and T Electric for six serious OSHA violations, with combined fines totaling just over \$15,000. Another Task Force partner, the Office of the Attorney General, cited Italo Masonry \$10,000 in March, 2009 for failure to provide payroll records. The company subsequently failed to pay or appeal the citation and a lien was placed upon real estate owned by the company's owner.

To date, the Task Force has received more than 800 referrals from workers and businesses reporting suspected cases of workplace fraud. A number of these referrals are in the pipeline for further enforcement and other action.

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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APPENDIX A – Advisory Council Members, FY'09

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APPENDIX B – Advisory Council Studies, 1989-2009

- 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, FY'09

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State House - Room 26
Boston, MA 02133-1053
(617) 722-2263

Representative Karyn E. Polito

State House - Room 167
Boston, MA 02133-1053
(617) 722-2080

Senator Karen E. Spilka

State House - Room 511-C
Boston, MA 02133-1053
(617) 722-1120

Senator Robert O'Leary

State House - Room 511-B
Boston, MA 02133-1053
(617) 722-1485

Senator Robert L. Hedland

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

Representative Robert L. Rice, Jr.

State House - Room 39
Boston, MA 02133-1053
(617) 722-2425

Representative John P. Fresolo

State House - Room 156
Boston, MA 02133-1053
(617) 722-2380

Representative Paul McMurtry

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

Representative James Arciero

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

Representative Todd M. Smola

State House - Room 156
Boston, MA 02133-1053
(617) 722-2220

APPENDIX D – Industrial Accident Nominating Panel

Paul V. Buckley, Commissioner (Chair)
Division of Industrial Accidents
600 Washington Street
Boston, MA 02111
Tel: 617-727-4900 x356
Email: pbuckley@dia.state.ma.us

Joseph Bonfiglio, Bus. Mgr. & Sec. Treasurer
Laborer's International Union - Local 151
298 Main Street
Cambridge, MA 02141
Tel: 617-876-8081
Email: joebonfiglio@hotmail.com

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

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

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

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

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

Martine Carroll, Senior Judge
Division of Industrial Accidents
600 Washington Street
Boston, MA 02111
Tel: 617-727-4900 x340
Email: martinec@dia.state.ma.us

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

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

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

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

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

APPENDIX E – The Governor’s Council

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

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

The Council generally meets at noon on Wednesdays in the State House Chamber, next to the Governor’s Office, to act on such issues as payments from the state treasury, criminal pardons and commutations, and approval of gubernatorial appointments; such as judges, notaries, and justices of the peace. The Governor’s Council is responsible for approving all Administrative Judges and Administrative Law Judges at the Department of Industrial Accidents.

Carol A. Fiola - District 1

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

Mary-Ellen Manning - District 5

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

Kelly A. Timilty - District 2

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

Michael J. Callahan - District 6

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

Marilyn M. Petitto Devaney - District 3

98 Westminster Avenue
Watertown, MA 02472
GC: (617) 725-4015 x 3
Res: (617) 923-0778
Fax: (617) 727-6610

Thomas J. Foley - District 7

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

Christopher A. Iannella - District 4

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

Thomas T. Merrigan - District 8

23 Plum Tree Lane
Greenfield, MA 01301-9687
GC: (617) 725-4015 x 8
Bus: (413) 774-5300
Fax: (413) 773-3388

APPENDIX F – Health Care Services Board, 2009

600 Washington Street, 7th Floor
Boston, MA 02111
(617) 727-4900 x 310

Current Members (2009):

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

Staff:

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

APPENDIX G – Roster of Judicial Expiration Dates

INDUSTRIAL ACCIDENT REVIEWING BOARD - SIX YEAR TERMS

1.	Martine Carroll	Unenrolled	05/28/10
2.	Bernard Fabricant	Unenrolled	05/28/10
3.	Mark Horan	Democrat	06/10/10
4.	William McCarthy	Democrat	05/21/10
5.	Patricia Costigan	Unenrolled	06/03/10
6.	Catherine W. Koziol	Democrat	08/18/14

INDUSTRIAL ACCIDENT BOARD - SIX YEAR TERMS

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

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

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

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

The Advisory Council is a Governor-appointed board comprised of leaders from business and labor, as well as representatives from the legal, medical, insurance and vocational rehabilitation communities. Each month, Council Members volunteer their time to discuss a variety of workers' compensation issues with the ultimate goal of identifying problems and developing solutions. When the affirmative vote of at least seven members can be reached between business and labor, these positions are reflected in our recommendations. The Advisory Council has reviewed the proposed workers' compensation legislation before your committee and has identified employer fraud, employee benefits, and employer responsibilities, as the three most important areas in the system in need of improvements.

Employer Fraud

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

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

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

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

Employee Benefits

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

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

Employer Responsibilities

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

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

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

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

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

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

APPENDIX I – WCAC Testimony: DHCFP Fee Schedule Hearing, 2/10/09

February 10, 2009

**Re: Amendments to 114.3 CMR 40.00: Rates for Services under M.G.L. c.152,
Workers' Compensation Act**

STATEMENT OF THE WORKERS' COMPENSATION ADVISORY COUNCIL

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

It has been nearly five years since the last adjustment to the medical fee schedule. While studies by the Workers' Compensation Research Institute have shown injured workers in Massachusetts have an 85% satisfaction level with their health care coverage, Council members have been apprised of accounts where injured workers were limited in their access to quality medical care due to rate inadequacy. Although the law allows for rate negotiation amongst the parties, it seems this practice has become the rule for many services, instead of the exception.

The Advisory Council is aware of the past difficulties this Division has encountered with obtaining reliable medical data, largely because many insurance companies have been reluctant to share their medical claim information. Furthermore, there is evidence that many of the rates that physicians charge can vary substantially for the same procedure. This inconsistency in fees, combined with a lack of medical data, represents many of the challenges this agency confronts when attempting to set an equitable rate.

In September of 2007, the Advisory Council was presented with an overview of Rhode Island's Fee Schedule Task Force. The Task Force was created in 1992 and consists of a diverse group of representatives that include the state's Department of Labor & Training, Beacon Mutual Insurance, self insured employers, the Medical Advisory Board, Blue Cross/Blue Shield, third party administrators, the Rhode Island Medical Society, and the Hospital Association of Rhode Island. As a representative body of the Rhode Island workers' compensation system, the Task Force provides all parties with a forum to continually fine-tune the fee schedule and expand codes when necessary.

The Advisory Council is impressed with how various interests were able to come together in Rhode Island to produce a fee schedule that accurately reflects the costs incurred by health care providers. In Massachusetts, where medical providers receive the lowest payments in the nation, yet face the second highest practice expenses associated with providing medical care to injured workers, an effective vehicle is needed to better coordinate dialogue between the medical community, insurance companies, and the Division of Health Care Finance & Policy. The Advisory Council is recommending that this agency work together with the Department of Industrial Accidents in establishing a Massachusetts Medical Fee Schedule Task Force to provide a permanent mechanism that can promptly react when areas of the fee schedule become unrepresentative of system costs.

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

APPENDIX J – WCAC Testimony: DOI Insurance Rate Hearing, 4/3/08

APRIL 3, 2008

**WORKERS' COMPENSATION RATE HEARING
DOCKET NO. R2008-01**

STATEMENT OF THE MA WORKERS' COMPENSATION ADVISORY COUNCIL

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

Although the Advisory Council's involvement in the rate hearing process is limited by statute, we are empowered to gather loss data from "any insurance company or rating organization" and to "present a written statement and oral testimony relating to any issues which may arise during the course of the hearing" [M.G.L. c.152, §53A(6)].

At our last meeting, members discussed the Council's role in the rate setting process and how we could increase our value to the Commissioner of Insurance with ensuring that rates are not excessive, inadequate or unfairly discriminatory and fall within a range of reasonableness. Because the Council's greatest asset stems from our diverse membership, which reflects the various participants in the workers' compensation system, the Council is respectfully offering you our assistance in resolving any issue pertaining to the filing.

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

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

APPENDIX 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 Grant Proposals Recommended for Funding, FY'10

RECOMMENDED FOR FUNDING

Eastern MA Carpenters
350 Fordham Road
Wilmington, MA 01887
cmfaro@neccarpenters.org

Category of Applicant: Trade Association

Geographic Target: Metro North

Program Administrator: Connie Faro

Total Funds Approved: \$24,998.00

Mabbett & Associates
5 Alfred Circle
Bedford, MA 01730
781-275-6050
info@mabbett.com

Category of Applicant: Private Employer

Geographic Target: Statewide

Program Administrator: Jennifer Burrill

Total Funds Approved: \$24,995.20

Boston Carpenters
385 Market Street
Brighton, MA 02135
617-782-4314

Category of Applicant: Trade Association

Geographic Target: Boston Region

Program Administrator: Ben Tilton

Total Funds Approved: \$24,994.00

Medical Training Associates
P.O. Box 4
Rockport, MA 01966
800-822-0550

Category of Applicant: Private Employer

Geographic Target: Northeastern MA

Program Administrator: Craig Morrill

Total Funds Approved: \$24,975.00

Middlesex Sheriff's Office
400 Mystic Avenue
Medford, MA 02155
781-960-2834
jgriffin@sdm.state.ma.us

Category of Applicant: Public Employer

Geographic Target: Northeastern MA

Program Administrator: John Griffin

Total Funds Approved: \$12,433.40

Laboratory Safety Institute (LSI)
192 Worcester Road
Natick, MA 01760
508-647-1900
info@labsafety.org

Category of Applicant: Private Employer

Geographic Target: Metro West

Program Administrator: Jim Kaufman

Total Funds Approved: \$24,931.00

EOHHS Wellness
600 Washington Street
Boston, MA 02111

Category of Applicant: Public Employer

Geographic Target: Boston Region

Program Administrator: Denise Atwood

Total Funds Approved: \$12,438.75

Boston Education Hotel Workers
33 Harrison Avenue
Boston, MA 02111
617-542-1177
mdowney@best-corp.org

Category of Applicant: Labor Organization

Geographic Target: Boston Region

Program Administrator: Marie Downey

Total Funds Approved: \$24,760.87

Tenable Defense Contract
53 Webster Street
Needham, MA 02494
ericanderson@rcn.com
Category of Applicant: Private Employer
Geographic Target: Metro West
Program Administrator: Eric Anderson
Total Funds Approved: \$24,476.25

MassCOSH
42 Charles Street
Dorchester, MA 02122
Marcy.gelb@masscosh.org
Category of Applicant: Non-profit Org.
Geographic Target: Boston Region
Program Administrator: Marcy Gelb
Total Funds Approved: \$24,224.80

Southcoast Hospital
101 Page Street
New Bedford, MA 02740
508-910-3404
Category of Applicant: Non-profit Org.
Geographic Target: Southeastern MA
Program Administrator: Kathleen Nelson
Total Funds Approved: \$24,034.87

Mass Trial Court Security Department
200 Trade Place
Woburn, MA 01801
Category of Applicant: Public Employer
Geographic Target: Metro North
Program Administrator: Michael McPherson
Total Funds Approved: \$11,588.10

City of Boston
City Hall Plaza
Boston, MA
617-635-3193
Category of Applicant: Public Employer
Geographic Target: Boston Region
Program Administrator: John Walsh
Total Funds Approved: \$20,423.62

Sheet Metal Workers Local 17
1181 Adams Street
Dorchester, MA 02124
617-298-0850
jhealy@lu17jatc.org
Category of Applicant: Labor Organization
Geographic Target: Boston Region
Program Administrator: John Healy
Total Funds Approved: \$24,343.64

UMass Medical School
55 Lake Avenue
North Worcester, MA 01655
debra.campbell@umassmed.edu
Category of Applicant: Public Employer
Geographic Target: Western Massachusetts
Program Administrator: Debra Campbell
Total Funds Approved: \$24,075.00

Carney Hospital
2100 Dorchester Avenue
Dorchester, MA 02124
617-296-4000 x4466
Category of Applicant: Public Employer
Geographic Target: Metro Boston
Program Administrator: Jane Metzger
Total Funds Approved: \$23,593.50

Education Cooperative
P.O. Box 1112
High Street
Dedham, MA 02027
gail@tec-coop.org
Category of Applicant: Public Employer
Geographic Target: Metro South
Program Administrator: Gail Ross McBride
Total Funds Approved: \$22,251.72

Boston Medical Center
1 Medical Center Place
Boston, MA 02118
617-638-4935
cpack@bu.edu
Category of Applicant: Non-profit Org.
Geographic Target: Boston Region
Program Administrator: Constance L. Packard
Total Funds Approved: \$20,062.50

Flexcon Company
1 Flexcon Industrial Park
Spencer, MA 01562
bburgess@flexcon.com
Category of Applicant: Private Employer
Geographic Target: Central Massachusetts
Program Administrator: Brian Burgess
Total Funds Approved: \$19,064.19

R.H. White
41 Central Street
Auburn, MA 01501
hwhitney@rhwhite.com
Category of Applicant: Private Employer
Geographic Target: Statewide
Program Administrator: Heather Whitney
Total Funds Approved: \$15,445.45

Mercy Hospital
271 Carew Street, P.O. 9315
Springfield, MA 01102
Lewis.rudolph@sphs.com
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: Joan Erwin
Total Funds Approved: \$14,204.25

Boys & Girls Club Woburn
Charles Gardner Lane
Woburn, MA 01801
781-935-3777
Category of Applicant: Non-profit Org.
Geographic Target: Metro North
Program Administrator: Rick Metters
Total Funds Approved: \$13,785.34

Crane & Company
30 South Street
Dalton, MA 01226
rrdionne@crane.com
Category of Applicant: Private Employer
Geographic Target: Berkshire/Western MA
Program Administrator: Robert Dionne
Total Funds Approved: \$13,235.00

Massachusetts Port Authority
One Harborside Drive
East Boston, MA 01789
bдинneen@massport.com
Category of Applicant: Public Employer
Geographic Target: Boston Region
Program Administrator: Brian Dinneen
Total Funds Approved: \$17,044.56

Hasbro
443 Shaker Road
E. Longmeadow, MA 01028
413-526-2598
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: Elaine Eldridge
Total Funds Approved: \$14,332.38

Webco Chemical Company
420 West Main Street
Dudley, MA 01517
markr@webco-chemical.com
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: Mark Ruggeri
Total Funds Approved: \$13,962.43

Whittier Health Center
1125 Tremont Street
Roxbury, MA 02120
timothy.potsaid@wshc.org
Category of Applicant: Public Employer
Geographic Target: Boston Region
Program Administrator: Timothy Potsaid
Total Funds Approved: \$13,634.00

N East Retail Lumber Association
585 Greenbush Road
Rensselaer, NY 12144
800-292-6752
aisha@nria.org
Category of Applicant: Non-profit Org.
Geographic Target: Statewide
Program Administrator: Aisha Tator
Total Funds Approved: \$12,840.00

North Shore Arc
64 Holten Street
Danvers, MA 01923
srbrown@nsarc.org
Category of Applicant: Non-profit Org.
Geographic Target: Northeastern MA
Program Administrator: Susan Ring Brown
Total Funds Approved: \$11,769.93

Old Colony Elder Services
144 Main Street
Brockton, MA 02301
dwitkus@oldcolonyelderservices.org
Category of Applicant: Non-profit Org.
Geographic Target: Southeastern MA
Program Administrator: Diane Witkus
Total Funds Approved: \$11,652.00

Tewksbury Public Schools
139 Pleasant Street
Tewksbury, MA 01876
lbradley@tewksbury.k12.ma.us
Category of Applicant: Public Employer
Geographic Target: Northeastern MA
Program Administrator: Loreen Bradley
Total Funds Approved: \$10,531.74

Lewcott Corporation
86 Providence Road
Millbury, MA 01527
hwing@lewcott.com
Category of Applicant: Private Employer
Geographic Target: Central Massachusetts
Program Administrator: Herb Wing
Total Funds Approved: \$10,133.54

Mass Pile Drivers
22 Drydock Avenue
Boston, MA 02210
617-443-1991
Category of Applicant: Trade Association
Geographic Target: Boston Region
Program Administrator: David Borrus
Total Funds Approved: \$9,922.11

Raytheon Integrated Air Defense Center
350 Lowell Street
Andover, MA 01810
George_I_chretien@raytheon.com
Category of Applicant: Private Employer
Geographic Target: Northeastern MA
Program Administrator: George Chretien
Total Funds Approved: \$11,689.75

Cook Professional Resources
PO Box 3488
Worcester, MA 01613
darcy@safetytrainers.com
Category of Applicant: Private Employer
Geographic Target: Central Massachusetts
Program Administrator: Darcey Cook
Total Funds Approved: \$10,572.59

UMass Memorial Health Care
291 Lincoln Street
Worcester, MA 01605
Margo.mello@umassmemorial.org
Category of Applicant: Non-profit Org.
Geographic Target: Central Massachusetts
Program Administrator: Margo Mello
Total Funds Approved: \$10,327.64

Winchester Hospital
41 Highland Avenue
Winchester, MA 01890
salspau@winhosp.org
Category of Applicant: Non-profit Org.
Geographic Target: North Shore
Program Administrator: Sharlene Alsbaugh
Total Funds Approved: \$10,031.25

Worcester Electrical JATC
51 Union Street
Worcester, MA 01608
508-753-8653
david@ibewlocal96.org
Category of Applicant: Trade Association
Geographic Target: Central Massachusetts
Program Administrator: David de la Gorgendiere
Total Funds Approved: \$9,533.91

City of Somerville
93 Highland Avenue
Somerville, MA 02143
617-625-6600 ext 2411
mello@somervillema.gov
Category of Applicant: Public Employer
Geographic Target: Metro North
Program Administrator: Renee Mello
Total Funds Approved: \$9,148.50

Berkshire Healthcare Systems Inc.
75 North Street, Suite 210
Pittsfield, MA 01201
dwenger@bhs1.org
Category of Applicant: Non-profit Org.
Geographic Target: Western Massachusetts
Program Administrator: Donna Wenger
Total Funds Approved: \$8,901.33

Brockton Day Nursery
243 Crescent Street
Brockton, MA 02302
aplamer@brockondaynursery.org
Category of Applicant: Public Employer
Geographic Target: Southeastern MA
Program Administrator: Patricia Plummer-Wilson
Total Funds Approved: \$7,155.03

Kids Terrain, Inc.
34 Salem Street, P.O. Box 560
Wilmington, MA 01887
978-988-8832
rhannaford@kidsterrain.com
Category of Applicant: Private Employer
Geographic Target: Metro North
Program Administrator: R. Hannaford
Total Funds Approved: \$6,420.00

Prospect Hill Academy
15 Webster Avenue
Somerville, MA 02143
scamposano@prospecthillacademy.org
Category of Applicant: Private Employer
Geographic Target: Metro Boston
Program Administrator: Stacy Camposano
Total Funds Approved: \$5,623.85

Construction Institute
256 Freeport Street
Boston, MA 02122
maryvogel@theconstructioninstitute.net
Category of Applicant: Non-profit Org.
Geographic Target: Boston Region
Program Administrator: Mary Vogel
Total Funds Approved: \$9,022.77

Brockway Smith Company
125 Chestnut Street
Hatfield, MA 02038
413-247-9674
lguillette@broscow.com
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: Louis Guillette
Total Funds Approved: \$7,435.60

John R. Lyman Company
60 Depot Street
Chicopee, MA 01013
mburzynski@lymtech.com
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: Michael Burzynski
Total Funds Approved: \$7,149.74

City of Waltham
19 School Street
Waltham, MA 02451
781-314-3355
Category of Applicant: Public Employer
Geographic Target: Metro North
Program Administrator: Brenda Capello
Total Funds Approved: \$6,019.00

Mass College of Liberal Arts
375 Church Street
North Adams, MA 01247
t.bernard@mcla.edu
Category of Applicant: Public Employer
Geographic Target: Western Massachusetts
Program Administrator: Thomas Bernard
Total Funds Approved: \$5,015.62

NEADS
P.O. Box 213
West Boylston, MA 01583
978-422-9064 ext. 15
Category of Applicant: Non-profit Org.
Geographic Target: Central Massachusetts
Program Administrator: Candi Hitchcock
Total Funds Approved: \$4,732.99

Town of West Springfield
26 Central Street
West Springfield, MA 01089
413-263-3232
Category of Applicant: Public Employer
Geographic Target: Western Massachusetts
Program Administrator: Sandra MacFayden
Total Funds Approved: \$4,686.60

Sheet Metal Workers
32 Stevens Street
Springfield, MA 01104
413-733-8332
Category of Applicant: Non-profit Org.
Geographic Target: Western Massachusetts
Program Administrator: Michael LaFleur
Total Funds Approved: \$4,248.00

Reading Municipal Lighting Department
230 Ash Street
Reading, MA 01867
bantonio@rmlld.com
Category of Applicant: Public Employer
Geographic Target: Metro North
Program Administrator: Beth Allen Antonio
Total Funds Approved: \$3,571.12

Westfield State College
577 Western Avenue
Westfield, MA 01086
msullivan@wsc.ma.edu
Category of Applicant: Public Employer
Geographic Target: Western Massachusetts
Program Administrator: Mindy Sullivan
Total Funds Approved: \$3,049.50

Springfield Partners for Community Action
619 State Street
Springfield, MA 01109
spfca@springfieldpartnersinc.com
Category of Applicant: Public Employer
Geographic Target: Western Massachusetts
Program Administrator: Heather Rose
Total Funds Approved: \$374.50

Henry Lee Willis Community Center
119 Forest Street
Worcester, MA 01609
508-799-0702
carlton@williscenter.org
Category of Applicant: Non-profit Org.
Geographic Target: Central Massachusetts
Program Administrator: Beth Mather-Noonan
Total Funds Approved: \$4,494.00

Branford Hall Career Institute
189 Brookdale Drive
Springfield, MA 01104
mpatton@branfordhall.com
Category of Applicant: Public Employer
Geographic Target: Western Massachusetts
Program Administrator: Michael Patton
Total Funds Approved: \$3,948.30

Merrimac Valley YMCA
101 Amesbury Street
Lawrence, MA 01840
jgreus@mvyymca.org
Category of Applicant: Non-profit Org.
Geographic Target: Northeastern MA
Program Administrator: Jessica Greus
Total Funds Approved: \$3,241.03

City of Newton
100 Commonwealth Avenue
Newton Centre, MA 02459
lburke@newtonma.gov
Category of Applicant: Public Employer
Geographic Target: Metro West
Program Administrator: Lois Burke
Total Funds Approved: \$2,889.00

IBEW 223 JATC
P.O. Box 1238
Lakeville, MA 02347
tclayton@ibew223.org
Geographic Target: Southeastern MA
Program Administrator: Timothy Clayton
Total Funds Approved: \$2,380.21

Faulkner Hospital
1153 Centre Street
Boston, MA 02130
617-983-7432
dcorbin1@partners.org
Category of Applicant: Non-profit Org.
Geographic Target: Boston Region
Program Administrator: David Corbin
Total Funds Approved: \$2,367.37

Massachusetts Division Finance Agency
33 Andrews Parkway
Devens, MA
apierce@massdevelopment.com
Category of Applicant: Public Employer
Geographic Target: Central Massachusetts
Program Administrator: Anne Pierce
Total Funds Approved: \$481.50

City of Cambridge DPW
147 Hampshire Street
Cambridge, MA 02139
617-349-4800
Category of Applicant: Public Employer
Geographic Target: Metro North
Program Administrator: Lisa Peterson
Total Funds Approved: \$2,375.40

Sanford & Hawley
253 Baldwin Street
West Springfield, MA 01089
jdubrowin@sanfordandhawley.com
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: John Dubrowin
Total Funds Approved: \$905.22

APPENDIX M – Collections & Expenditures Report, FY'05 - FY'09

COLLECTIONS AND EXPENDITURES REPORT - FISCAL YEAR 2009

<i>SPECIAL FUND</i>	<i>FY'09</i>	<i>FY'08</i>	<i>FY'07</i>	<i>FY'06</i>	<i>FY'05</i>
<u>COLLECTIONS</u>					
INTEREST	107,609	432,041	785,884	670,515	350,529
ASSESSMENTS	20,458,701	17,245,272	15,301,449	18,005,869	16,404,375
LESS RET. CHECKS	(94,125)	(4,615)	0	(10,806)	0
LESS REFUNDS	(336,026)	(119,948)	(457)	0	(8,658)
SUB-TOTAL	20,028,550	17,120,709	15,300,992	17,995,063	16,395,717
REFERRAL FEES	4,786,125	4,068,091	4,362,429	4,162,760	4,336,826
COLLECTION FEE	0	(422)	(15,534)	(17,889)	(36,577)
LESS RET. CHECKS	(3,998)	(10,134)	(10,536)	(4,497)	(6,908)
LESS REFUNDS	(654,402)	(10,422)	(3,094)	(7,129)	(7,119)
SUB-TOTAL	4,127,725	4,047,093	4,333,265	4,133,245	4,286,222
1ST REPORT FINES	243,050	225,474	206,904	198,008	315,125
LESS COLLECTION FEE	0	0	(7,368)	(11,077)	(10,318)
LESS RET. CHECKS	(1,200)	(500)	(2,700)	0	(2,100)
LESS REFUNDS	(6,780)	(500)	(700)	0	0
SUB-TOTAL	235,070	224,474	196,136	186,931	302,707
STOP WORK ORDERS	1,381,180	535,396	391,328	250,299	303,030
LESS REFUNDS	0	(200)	0	(3,537)	0
EDS FEE	(21)	0	(71)	(105)	0
LESS BAD CHECKS	(11,200)	0	(300)	0	(1,300)
MERCHANT FEE	(5)	(1,224)	(1,091)	0	(17,270)
SUB-TOTAL	1,369,954	533,972	389,867	246,657	284,460
LATE ASSESS. FINES	74,673	26,942	20,400	28,050	14,074
SEC. 7 & 14 FINES	0	0	0	0	2,000
MISCELLANEOUS	29,848	29,817	37,044	32,945	37,823
ADJUSTMENT	6,939				
SUB-TOTAL	111,460	56,759	57,444	60,995	53,897
TOTAL COLLECTIONS	25,980,368	22,415,048	21,063,588	23,293,406	21,673,532
BALANCE BRGT FWD	2,470,245	5,634,120	9,201,123	9,148,914	10,090,768
TOTAL	28,450,613	28,049,168	30,264,710	32,442,320	31,764,300
LESS EXPENDITURES	(23,572,008)	(25,602,577)	(24,630,590)	(23,250,818)	(22,615,386)
ADJUSTMENT	0	0		9,621	
BALANCE	4,878,605	2,446,591	5,634,121	9,201,123	9,148,914
<u>EXPENDITURES</u>					
TOTAL COMPUTER	37	414,431	1,020,176	438,890	0
<u>REPAYMENT</u>					
REPAYMENT - SALARIES	14,298,709	14,284,592	13,698,054	13,535,090	13,552,369
FRINGE BENEFITS	3,490,000	5,161,232	4,227,282	3,614,974	3,606,371
INDIRECT COSTS	365,987	265,292	255,506	230,155	232,262
NON-PERSONNEL COSTS	5,385,628	5,176,399	5,418,795	5,428,939	5,200,563
OTHER INDIRECT COSTS	0	3,312	9,534	0	
IP INDIRECT-EXPENSE	31,647	0	1,243	0	23,821
ADJUSTMENT FRINGE Q.1	0	297,319	0	2,770	
TOTAL SF EXPENDITURES	23,572,008	25,602,577	24,630,590	23,250,818	22,615,386

COLLECTIONS AND EXPENDITURES REPORT - FISCAL YEAR 2009

PUBLIC TRUST FUND	FY'09	FY'08	FY'07	FY'06	FY'05
<u>COLLECTIONS</u>					
INTEREST	4,039	8,466	9,718	7,324	3,604
ASSESSMENTS	457	142,598	39,415	62,936	173,786
LESS FUNDS TRANSFERRED	(45)	(109,108)			
TOTAL ASSESSMENTS	412	33,490	39,415	62,936	173,786
TOTAL COLLECTIONS	4,451	41,956	49,133	70,260	177,390
BALANCE BRGT FWD	841,852	799,896	750,763	680,503	503,112
TOTAL	846,303	841,852	799,896	750,763	680,502
LESS EXPENDITURES	0	0	0	0	0
BALANCE	846,303	841,852	799,896	750,763	680,502
<u>EXPENDITURES</u>					
RR COLAS	0	0	0	0	0
RR SEC. 37	0	0	0	0	0
RR SEC. 19 COLA	0	0	0	0	0
TOTAL EXPENDITURES	0	0	0	0	0

PRIVATE TRUST FUND	FY09	FY'08	FY'07	FY'06	FY'05
<u>COLLECTIONS</u>					
INTEREST	128,052	268,411	308,118	232,217	126,512
ASSESSMENTS	55,002,085	50,338,430	53,365,665	46,686,859	50,919,285
LESS RET. CHECKS	(282,474)	0	(2,500)	(2,584)	0
LESS REFUNDS	(980,934)	(87,852)	(196)	0	(26,906)
SUB-TOTAL	53,738,678	50,250,578	53,362,969	46,684,275	50,892,379
REIMBURSEMENTS	1,401,891	1,289,675	1,205,800	1,444,681	885,811
RET. CHECK	(11,496)	(1,569)	(28,053)	(1,161)	(2,225)
REFUNDS	(1,877)	(1,070)	(10,282)	0	0
SUB-TOTAL	1,388,518	1,287,036	1,167,465	1,443,520	883,586
SEC. 30 H	25,924	0	3,393	728	0
OTHER TRUST FUND	87,378	238,385			
TOTAL COLLECTIONS	55,368,550	52,044,410	54,841,945	48,360,740	51,902,477
BALANCE BRGT FWD	26,153,119	15,282,709	8,934,528	13,618,318	11,685,006
TOTAL	81,521,669	67,327,119	63,776,473	61,979,058	63,587,483
LESS EXPENDITURES	(73,853,717)	(41,174,001)	(48,493,764)	(53,044,529)	(49,969,164)
ADJUSTMENT	0	0		1,500	
BALANCE	7,667,952	26,153,118	15,282,709	8,936,029	13,618,319

COLLECTION AND EXPENDITURE REPORT - FISCAL YEAR 2009

PRIVATE TRUST FUND	FY'09	FY'08	FY'07	FY'06	FY'05
<u>EXPENDITURES</u>					
RR SEC. 34	1,209,059	1,320,000	1,248,883	1,183,723	1,078,481
RR SEC. 35	428,448	449,319	474,278	465,122	301,736
RR LUMP SUM	1,345,645	1,570,455	1,242,755	1,635,402	1,651,369
RR SEC. 36	220,957	502,719	176,065	119,966	247,314
RR SEC. 31	163,090	131,075	78,508	91,434	100,386
RR SEC. 34, PERM. TOTAL	436,661	376,980	356,338	306,009	290,558
RR COLA ADJ	269,725	331,026	275,751	154,612	152,639
RR EE MEDICAL	22,527	56,400	75,111	98,387	104,327
RR EE TRAVEL	3,500	2,059	6,045	3,500	3,920
RR EE MISC. EXPENSE	632	15,726	0	637	0
RR BURIAL BENEFITS	4,000	0	4,575	0	0
RR LEGAL FEES	618,683	672,952	606,698	643,260	471,698
RR VOC. REHAB SERVICES	10,666	11,874	9,956	6,236	1,400
RR REHAB (PRIOR YEAR)	0	504	63	397	1,768
RR MEDICAL	2,108,479	1,515,100	2,272,265	1,941,114	1,328,010
SUB-TOTAL CLAIMANT PAYM.	6,842,072	6,956,189	6,827,291	6,649,799	5,733,606
MM TUITION	6,649	6,438	4,541	21,862	0
TOTAL CLAIMANTS	6,848,721	6,962,627	6,831,832	6,671,661	5,733,606
<u>INSURERS - EXP.</u>					
RR COLAS	33,566,021	5,751,523	8,032,750	21,914,829	14,948,170
RR SEC. 19 COLA LUMP SUM	872,730	989,176	1,085,082	1,452,130	1,094,044
RR LATENCY SEC. 35C	982,496	558,588	388,100	280,751	293,542
RR SEC. 37	20,116,257	16,990,276	19,389,653	7,543,763	19,836,350
RR SEC. 37 QUARTERLY	5,998,937	6,138,343	8,537,194	10,996,194	5,421,404
RR SEC. 37 INTEREST	304,741	84,808	198,285	0	
TOTAL PAY TO INSURERS	61,841,182	30,512,714	37,631,064	42,187,667	41,593,510
TOTAL LEGAL EXP.	68,689,903	37,475,341	44,462,896	48,859,328	47,327,116
<u>OEVR - EXPENDITURES</u>					
MM TUITION	7,427	3,893	40,070	63,834	36,694
RR PRIOR YEAR REHAB	0	0	0	0	1,645
RR REHAB-30H	3,814	4,189	7,708	12,022	13,173
RR HEALTHSOUTH HLDS	0	0	0	780	
RR FCE REIMBURSEMENT	0	0	0	625	
RR CRAWFORD & CO.	0	0	0	462	
EE OTHER	463	182	896		
RR EE TRAVEL	4,000	1,942	2,282	2,886	2,015
RR EE BOOKS & SUPPLIES	1,553	1,740	5,491	6,874	3,483
SUB-TOTAL OEVR EXP.	17,257	11,946	56,447	87,483	57,010
TOTAL PRIVATE TRUST EXP.	68,707,160	37,487,287	44,519,343	48,946,811	47,384,520

COLLECTION AND EXPENDITURE REPORT - FISCAL YEAR 2009

EXPENDITURES DEFENSE OF THE FUND	FY'09	FY'08	FY'07	FY'06	FY'05
AA PAYROLL - SALARY	2,837,630	1,611,214	1,661,496	1,833,394	1,018,958
AA OVERTIME COSTS	0	362	26,798	11,803	4,067
AA SICK LEAVE BUY BACK	0	0	293	0	0
SUB-TOTAL	2,837,630	1,611,576	1,688,587	1,845,197	1,023,025
BB TRAVEL	0	18,877	23,291	18,578	5,504
BB CONFERENCE TRAINING	2,015	81	1,074	437	0
BB EE REIMBURSEMENT	47,071	0	23	448	
BB EMPLOYEE REIMBURS	5,976	5,265	1,774	1,696	341
SUB-TOTAL	55,062	24,223	26,162	21,159	5,845
CONT STUDENT INTERNS	9,010	5,803			
SUB-TOTAL	9,010	5,803			
DD FRINGE	732,511	632,427	542,343	493,193	273,755
DD UNIVERSAL HEALTH INS.	0	0	0	269	269
DD MEDICARE TAX	0	0	0	9,653	10,144
DD UNEMPLOYMENT INS.	0	0	0	1,914	3,118
DD BOND	0	445	0	356	
DD WC CHARGEBACK	16,556	57,571	18,842	39,141	23,411
DD HEALTH SERVICES CORP	2,092	1,935			
SUB-TOTAL	751,159	692,378	561,185	544,526	310,697
EE RENTAL/MV CHRGE-BACK	3,402	3,629	3,629	3,629	681
EE DEST. OLD RECORDS	7,052	6,912	5,875	5,786	0
EE ADVERTISING	713	365	990	474	
EE BOOKS/SUPPLIES	27,241	20,138	29,220	28,400	19,678
EE IMPARTIAL APPEALS	17,188	13,050	13,950	20,375	13,175
EE CENTRAL REPRO.	2,686	2,821	1,170	0	0
EE POSTAGE	12,796	0	3,317	14,101	21,334
EE WATER	1,251	1,087		0	0
EE TRAINING / TUITION	0	0	(50)	12,190	3,654
EE JUDGEMENT (E54)	0	0	0	0	43,836
EE TEMP USE SPACE	0	4,415	0	815	
EE PRINTING	4,635	149	83		
EE CONFERENCE, INCIDEN.	2,820	0	3,795		
EE MCKENZIE	0	0	93,983		
EE INDIRECT COSTS	82,829	35,696	44,578	39,875	25,952
EE POSTAGE CHRGE-BACK	2,742	3,177			
EE FIA CREDIT CARDS	0	1,852			
EE MEMBERSHIPS	0	1,350			
SUB-TOTAL	165,355	94,641	200,540	125,645	128,310
GG BOSTON LEASE	620,826	647,011	507,823	495,209	470,156
GG ELECTRICITY - BOSTON	26,792	33,994	13,409	9,084	10,268
GG FUEL FOR VEHICLES	63				
SUB-TOTAL	647,681	681,005	521,232	504,293	480,424

(CONTINUED ON NEXT PAGE)

COLLECTION AND EXPENDITURE REPORT - FISCAL YEAR 2009

EXPENDITURES DEFENSE OF THE FUND	FY'09	FY'08	FY'07	FY'06	FY'05
HH CONSULTANTS	197,310	150,143	422,850	412,422	276,713
SUB-TOTAL	197,310	150,143	422,850	412,422	276,713
JJ OPERATIONAL SERV.	144,383	186,493	391,137	438,802	292,525
SUB-TOTAL	144,383	186,493	391,137	438,802	292,525
KK EQUIPMENT	6,649	18,914	1,650	1,225	5,580
SUB-TOTAL	6,649	18,914	1,650	1,225	5,580
LL CBE HOLDINGS	35,791	12,711	4,536	29,017	
LL XEROX	424	1,113	0	1,685	7,187
LL ORACLE	17,607	23,583	13,692	16,538	13,335
LL ASAP SOFTWARE EXPRS	22,963	18,489	0	10,593	
LL SIMPLEX	424	245	0	0	245
LL SHARED TECHNOLOGY	0	0	0	1,883	2,138
LL PITNEY BOWES	1,439	1,419	1,272	1,331	1,272
LL IKON	608	784	0	0	0
LL SUN MICROSYSTEMS	4,982	4,467	3,601	4,748	0
LL RETROFIT	6,086	3,829	2,527	2,837	903
LL MILLENNIUM MECHAN	1,395	992	0	191	742
LL FIRE EQUIPMENT	225	183	0	168	
LL JEWEL PROTECTIVE SYS.	0	0	0	125	
LL ENTERPR. RENT-A-CAR	27,113	4,979	3,808	3,639	
LL OFFICE EQUIPMENT	0	0	0	204	
LL CAM OFFICE SVCS	222	222			
LL NTIRETY	0	0	3,371	11,556	
LL RONCO COMM & ELEC	0	0	21,233	6,865	
LL MMARS ACCT SYST	2,672	2,652	1,872	1,499	
LL KEANE	0	2,603	0	874	
LL KFORCE	0	0	0	2,340	
LL COMPUTER EQUIPMENT	0	0	0	1,239	
LL TSG HEALTHCARE RESR	0	0	0	18,763	
LL DELL MARKETING	85,670	32,865	43,038	35,996	
LL QWEST COMM.	356	332	376	27	0
LL ITT COMPUTER SERV.	22,439	23,460	16,327	17,918	14,004
LL VERIZON SERVICES	37,964	23,296	17,918	18,808	17,110
LL AMS IMAGINING	30,692	0	116	0	
LL TELEPHONE LEASE	1,188	4,754	4,753	3,692	0
LL NEXTELL	0	2,500	2,702	6,353	4,983
LL EGI BUSINESS TRUST	0	17,434	18,826		
LL EMC CORP.	0	1,500			
LL PEOPLESERVE	0	6,306			
LL PAUL DAUBITZ	0	1,648			
LL OVERTURE PARTNERS	0	3,900			
LL LANTEL COM	1,276	3,494			
LL CITY LIGHTS ELEC	0	2,543			
LL GATEWAY COMPANIES	0	1,825			
LL STENOGRAPHER CORP	0	434			

(CONTINUED ON NEXT PAGE)

COLLECTION AND EXPENDITURE REPORT - FISCAL YEAR 2009

EXPENDITURES DEFENSE OF THE FUND	FY'09	FY'08	FY'07	FY'06	FY'05
LL EOS APPROACH	1,439	1,523			
LL ULTRAGUARD PROTECT	156	156			
LL EASTON CONSULTING	4,000				
LL ATLANTIC ASSOCIATES	7,963				
LL COMM-TRACT	440				
LL PAETEC COMM	7,500				
LL GRAYBAR ELECTRIC	600				
LL GOVCONNECTION	1,430				
LL INTEGRATED PARTNERS	6,944	2,450			
SUB-TOTAL	332,008	208,691	159,968	198,889	61,919
NN NON-MAJOR INFRA MAIN	0	0	725	0	0
NN DOC DESTRUCTION	0	2,847	385	0	0
NN PASEK EQUIPMENT	43				
NN ACCENT BANNER	117				
NN KILLEN ELECTRIC SVC	150				
SUB-TOTAL	310	2,847	1,110	0	0
RR PENALTIES SEC. 8	0	10,000	0	5,560	0
SUB-TOTAL	0	10,000	0	5,560	0
TOTAL DEF. OF FUND EXP.	5,146,557	3,686,714	3,974,421	4,097,718	2,585,038
TOTAL EXPENDITURES	73,853,717	41,174,001	48,493,764	53,044,529	49,969,164

DIA - INCOME SUMMARY

INCOME SUMMARY	FY'09	FY'08	FY'07	FY'06	FY'05
Total Assessments (All 3 Funds)	73,767,640	67,404,777	68,703,376	64,742,274	67,461,882
Total Filing Fees	4,127,725	4,047,093	4,333,265	4,133,245	4,286,222
Total First Report Fines	235,070	224,474	196,136	186,931	302,707
Total SWOs	1,369,954	533,972	389,867	246,657	284,460
Total Misc. Fines	29,848	29,817	37,044	32,945	37,823
Total 5% Fines (Late Assess.)	74,673	26,942	20,400	28,050	14,074
Section 7 and 14 Fines	0	0	0	0	2,000
Total Reimbursements	1,388,518	1,287,036	1,167,465	1,443,520	883,586
Total 30H	25,924	0	3,393	728	0
Total Other Trust Fund	87,378				
Yr. Adj. for Refunds to TF	6,939	238,385	0	0	0
Total Interest	239,700	708,918	1,103,720	910,056	480,645
TOTAL INCOME	81,353,369	74,501,414	75,954,666	71,724,406	73,753,399

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

Workers' Compensation Legislation Before the Joint Committee on Labor & Workforce Development

H.17*	NEW	Stop Work Orders - Strengthening Enforcement
H.1796	<i>Refile</i>	Election to Receive WC Benefits or Pension - MBTA
H.1800	<i>Refile</i>	Workers' Compensation Dependency Benefits - Increase
H.1801	<i>Refile</i>	Extension of Temporary Total Benefits
H.1805	<i>Refile</i>	Workers' Compensation - Comprehensive
H.1811	<i>Refile</i>	Serious and Willful Misconduct – Intoxication
H.1812	<i>Refile</i>	Safe Workplaces for Employees of the Commonwealth
H.1821	<i>Refile</i>	Widow's Benefits
H.1822	NEW	Waiver of Right of Action for Injuries
H.1825	<i>Refile</i>	Attorney Fees - Agreements to Pay Benefits - Temp. Total - Perm. Total
H.1826	<i>Refile</i>	Appointment of Impartial Physicians - Impartial Exams
H.1827	<i>Refile</i>	Average Weekly Wage - Attorney Fees - Last Best Offer
H.1828	<i>Refile</i>	Average Weekly Wage - Attorney Fees - Last Best Offer
H.1834	NEW	Permanent and Partial Incapacity
H.1835	<i>Refile</i>	Partial Incapacity - Removes Ability to Extend Benefit
H.1836	NEW	Referral at Conciliation - Conference Heard on Same Date
H.1838	NEW	Online Proof of Coverage Tool
H.1839*	NEW	Notice by Insured to New Employees – Fines
H.1843	<i>Refile</i>	Third Party Lawsuits - Protecting Employee Leasing Companies
H.1846	<i>Refile</i>	Workers' Compensation Payroll Audits - Requirements & Penalties
H.1853	<i>Refile</i>	Insurance Rates - Loss Cost – Competition
H.1863*	NEW	Penalties for Failing to Timely Report Injuries
H.1864	<i>Refile</i>	Insurance Rates - Loss Cost – Competition
H.1865*	<i>Refile</i>	Burial Expenses
H.1866	NEW	Invalid Workers' Compensation Certificate - Criminal Offense
H.1868	<i>Refile</i>	Scar-Based Disfigurement - Burial Expenses - Extension of Partial Disability
H.1870*	<i>Similar</i>	Private Right of Action to Recover WC Un-Paid Premiums
H.1871	<i>Refile</i>	Safe Workplaces for Employees of the Commonwealth
H.1872	<i>Refile</i>	Termination or Modification of Payments - Impartial Medical Exams
H.1873	<i>Refile</i>	Rate of Payment by Insurers for Health Care Services
H.1877	<i>Refile</i>	Private Right of Action to Recover WC Coverage Payments
H.2549	<i>Refile</i>	Benefits for State Social Workers Resulting from Acts of Violence
H.2989	<i>Similar</i>	Public Records Exemption - Information within First Report of Injury
H.3693	NEW	Impartial Medical Examinations - Recording/Videotaping
H.3694	<i>Refile</i>	Workers' Compensation Insurance Premiums – Placeholder
S.681*	<i>Refile</i>	Scar-Based Disfigurement
S.682*	<i>Similar</i>	Private Right of Action to Recover WC Un-Paid Premiums
S.686	<i>Refile</i>	Widow's Benefits
S.694	<i>Refile</i>	Workers' Compensation – Comprehensive
S.695	<i>Refile</i>	Benefits for Members of the Armed Services or National Guard
S.703	<i>Refile</i>	Authority for AJs to Determine Fraudulent Acts by Parties
S.704	<i>Refile</i>	Definition of "Proceeding" for the Purpose of Fraudulent Acts
S.705	<i>Refile</i>	Definition of "Proceeding" for the Purposes of Chapter 152
S.716	NEW	Workers' Compensation – Comprehensive
S.718	<i>Refile</i>	Workers' Compensation – Comprehensive
S.728	<i>Refile</i>	Falsifying or Forging WC Certificates and Declarations
S.729*	<i>Refile</i>	Increasing Criminal Penalties for Failing to Provide WC Insurance
S.2011	<i>Refile</i>	Benefits for Members of the Armed Services or National Guard

* Endorsed by the Workers' Compensation Advisory Council

HOUSE BILLS:

HOUSE BILL 17

Filed By: Executive Office of Labor and Workforce Development

Type of Bill: NEW

Endorsed by Advisory Council: YES

Laws Affected: Stop Work Orders - Strengthening Enforcement (c.152, §25C)

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

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

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

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

HOUSE BILL 1796

Filed By: Representative Brian S. Dempsey

Type of Bill: Refile (H.3460)

Endorsed by Advisory Council: No

Laws Affected: Election to Receive WC Benefits or Pension - MBTA (c.152, §73)

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

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

This refiled bill would amend §35A, which provides additional compensation to injured workers who have dependents. Currently, §35A provides additional compensation of \$6 per/week to injured workers who have persons dependent upon them for injuries occurring under §34, §34A, and §35. No weekly payments under this section can be greater than \$150 per week when combined with the compensation due under §34, §34A, and §35. House 1800 would provide injured workers additional compensation of \$15 per/week for each person wholly dependent upon them. This bill would also cap weekly payments at \$300 when combined with the compensation due under §34, §34A, and §35.

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

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

This refiled bill would extend the benefits for injuries compensable under section 34 (temporary total) assuming there has been no discontinuance or modification order of an administrative judge. Currently, §34 benefits are equal to 60% of the injured worker's average weekly wage and are limited in duration to 156 weeks. House 1801 would allow an injured worker to receive additional benefits upon the exhaustion of their §34 benefits. This additional compensation would be equal to 45% of their average weekly wage "pursuant to section 35." The maximum benefits period for §35 injuries is 260 weeks, but may be extended to 520 weeks.

HOUSE BILL 1805**Filed By:** Representative Sean Garballey**Type of Bill:** Refile (H.1861)**Endorsed by Advisory Council:** No**Laws Affected:** Comprehensive Bill (c.152, §1(7A), §13, §14, §30, §34, §35, §36, §46A)

Section 1 of this refiled bill would amend Section 1(7A) by allowing administrative judges to consider the employee's pre-injury employment when determining predominant cause of disability.

Section 2 would amend Section 13 setting the medical payment rate at no less than 80% of the usual and customary fee for any such health care service.

Section 3 would clarify Section 14(1) providing penalties against an insurer who refuses to pay medical benefits without reasonable grounds.

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HOUSE BILL 1805 CONTINUED

Section 4 would amend Section 30 allowing an emergency conference before an administrative judge to determine if an injured worker is entitled to medical treatment.

Sections 5 and 6 would amend Section 30 by limiting utilization review to five of "the most common industrial injury or illnesses." This change would limit the utilization review process to the most frequent care given to injured workers. Failure for an insurance company to comply with utilization review time guidelines would result in said treatments to "be deemed approved."

Section 7 would increase wage benefits for injured workers under §34 by restoring the amount to 2/3 of an employee's average weekly wage (AWW).

Section 8 would amend Section 35 by adding additional circumstances under which an administrative judge may extend the number of weeks under §35 (partial disability) benefits. These additional conditions are that the injured worker has returned to employment pursuant to an Individual Written Rehabilitation Plan under Section 30(H), has been found unsuitable for vocational rehabilitation by the OEVR, has returned to work at less than their pre-injury AWW, or has a permanent partial incapacity.

Section 9 would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. This bill would require compensation for all disfigurement, whether or not scar-based, regardless of its location on the body. Section 36(k) was amended by the 1991 Reform Act to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

Section 10 would amend Section 46A by requiring an injured worker's general health insurance carrier (if they have one) to cover all medical expenses of the injured worker until the workers' compensation insurer is ordered to pay a disputed claim. Currently, there is no language requiring a health insurance provider to cover these costs.

HOUSE BILL 1811

Filed By: Representative Bradley H. Jones and Representative George N. Peterson, Jr.

Type of Bill: Refile (H.1796)

Endorsed by Advisory Council: No

Laws Affected: Serious and Willful Misconduct (c.152, §27) - Intoxication, Unlawful Use of a Controlled Substance

This refiled bill would amend §27 and deny workers' compensation benefits to employees who are injured while intoxicated or unlawfully using a controlled substance as defined in §1 of Chapter 94C. Currently, §27 bars workers' compensation benefits to employees injured as a result of "serious and willful misconduct," but does not elaborate specifically what constitutes "serious and willful misconduct." This bill would not bar compensation to dependents if the injury resulted in death.

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

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

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

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

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

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

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

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HOUSE BILL 1822 CONTINUED

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

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

HOUSE BILL 1825

Filed By: Representative Eugene L. O'Flaherty

Type of Bill: Refile (H.1825)

Endorsed by Advisory Council: No

Laws Affected: Attorney's Fees (c.152, §13A(10)), Agreements to Pay Benefits (§19), Temporary Total Disability (§34), Permanent and Total Incapacity (§34A)

Section 1 of this refiled bill would allow attorneys to collect fees for advancing an employee's rights under §75A (preferential hiring of injured workers) and §75B (protections against handicap discrimination), in addition to any attorney's fees owed under §13A. In Massachusetts, the attorney fees specified in §13A are the only fees payable for any services provided to employees.

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

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

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

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

Section 1 of this refiled bill would create a new section (§9C) to allow an AJ or ALJ to appoint an impartial physician to examine and report on a claimant's condition prior to a conference or hearing. [Currently, under §8(4), an impartial physician can be requested at the conference stage only at the request of the insurer after the 180-day pay without prejudice period has expired.]

Section 2 of this bill replaces language for §11A on impartial exams. It would remove the c.398 requirement that an impartial exam be conducted whenever "a dispute over medical issues is the subject of a conference order." Under this bill, appointment of an impartial physician would be at the discretion of the AJ or ALJ. It also requires that the report indicate whether employment is the predominant contributing cause for mental or emotional disability.

This bill would also expand the role of the impartial physician by requiring that the physician make a determination about causation, whether or not the determination can be made with a reasonable degree of medical certainty. Moreover, the causation standard would change from whether the work-related injury was the "major or predominant contributing cause" of the disability, to whether the work-related injury was "probably caused or was contributing cause" of the disability. The standard would therefore be eased.

The report from §9C must be entered into evidence at the hearing, and the current requirement that it be treated as prima facie evidence is eliminated. This means that the impartial report must not be the only medical evidence presented to the AJ, but that medical evidence from the employee's treating physician and insurer reports may be entered as well. The deposing party would pay the fee for any deposition. However, if the decision of the AJ is in favor of the employee, the cost of the deposition would be added to the amount awarded to the employee.

HOUSE BILL 1827**Filed By:** Representative Eugene L. O'Flaherty**Type of Bill:** Refile (H.1827) / Identical to H.1828 (this session)**Endorsed by Advisory Council:** No**Laws Affected:** Definition of Average Weekly Wage (c.152, §1(1)), Return to Work - Attorney Fees (§13A(4)), Eliminate Consideration of Offers at Conciliation (§13A(4))

Section 1 of this refiled bill addresses injured employees who return to work (without a lump sum settlement) and receive wages that are less than the pre-injury wages. This bill would apply the prior average weekly wage to any subsequent period of incapacity, whether or not such incapacity was the result of a new injury, or subsequent injury as set forth in §35B.

Section 2 of this bill would eliminate consideration of the last best offer in awarding attorney's fees when the insurer files for discontinuance of benefits or refuses initial payment. Currently, the claimant's attorney is only entitled to payment if the administrative judge accepts the offer of the claimant or the amount submitted by the conciliator.

HOUSE BILL 1828**Filed By:** Representative Eugene L. O'Flaherty**Type of Bill:** Refile (H.1827) / Identical to H.1827 (this session)**Endorsed by Advisory Council:** No**Laws Affected:** Definition of Average Weekly Wage (c.152, §1(1)), Return to Work - Attorney Fees (§13A(4)), Eliminate Consideration of Offers at Conciliation (§13A(4))

Section 1 of this refiled bill addresses injured employees who return to work (without a lump sum settlement) and receive wages that are less than the pre-injury wages. This bill would apply the prior average weekly wage to any subsequent period of incapacity, whether or not such incapacity was the result of a new injury, or subsequent injury as set forth in §35B.

Section 2 of this bill would eliminate consideration of the last best offer in awarding attorney's fees when the insurer files for discontinuance of benefits or refuses initial payment. Currently, the claimant's attorney is only entitled to payment if the administrative judge accepts the offer of the claimant or the amount submitted by the conciliator.

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

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

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

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

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

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

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

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

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

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

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

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

- whether or not coverage is in effect;

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HOUSE BILL 1838 CONTINUED

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

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

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

HOUSE BILL 1839

Filed By: Representative Pam Richardson

Type of Bill: NEW

Endorsed by Advisory Council: YES

Laws Affected: Notice by Insured to New Employees - Fines (c.152, §22)

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

HOUSE BILL 1843

Filed By: Representative Michael J. Rodrigues

Type of Bill: Refile (H.1069)

Endorsed by Advisory Council: No

Laws Affected: Third Party Lawsuits (§15) - Protecting Employee Leasing Companies (§14A)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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HOUSE BILL 1863 CONTINUED

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

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

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

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

HOUSE BILL 1864

Filed By: Rep. David M. Torrisi

Type of Bill: Refile (H.4590) / Identical to H.1853 (this session)

Endorsed by Advisory Council: No

Laws Affected: Insurance Rates – Loss Cost - Competition (c.152, §53A)

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

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

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

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HOUSE BILL 1864 CONTINUED

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

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

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

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

HOUSE BILL 1865

Filed By: Representative David M. Torrissi

Type of Bill: Refile (H.4170)

Endorsed by Advisory Council: YES

Laws Affected: Burial Expenses (§33)

This refiled bill would require an insurer to pay for burial expenses when a worker has died, not to exceed eight thousand dollars. Currently, the statute requires the insurer to pay reasonable expenses of burial, not to exceed four thousand dollars. In 2006, the average adult casketed funeral cost (with vault) in New England was \$7,407. It is important to note that these costs do not include cemetery monument or marker costs or miscellaneous cash advance charges such as flowers or obituaries.

HOUSE BILL 1866

Filed By: Representative Cleon H. Turner

Type of Bill: NEW

Endorsed by Advisory Council: No

Laws Affected: Invalid Workers' Compensation Certificate - Criminal Offense

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

HOUSE BILL 1868**Filed By:** Representative Martin J. Walsh**Type of Bill:** Refile (H.1862)**Endorsed by Advisory Council:** No**Laws Affected:** Scar-Based Disfigurement (c.152, §36(k)), Burial Expenses (§33), Extension of Partial Incapacity Benefits (§35).

Section 1 of this refiled bill would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. This would require compensation for all disfigurement, whether or not scar-based, regardless of its location on the body. Section 36(k) was amended by the 1991 Reform Act to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands. Under this bill, compensation could not exceed the average weekly wage in the Commonwealth (at time of injury) multiplied by 29 (\$1,093.27 x 29 = \$31,704.83). Currently, the statute states that scar-based disfigurement compensation cannot exceed \$15,000.

Section 2 would require an insurer to pay for burial expenses when a worker has died, not to exceed eight thousand dollars. Currently, the statute requires the insurer to pay reasonable expenses of burial, not to exceed four thousand dollars.

Section 3 would amend Section 35 by adding additional select circumstances under which an administrative judge may extend the number of weeks under §35 (partial disability) benefits from 260 weeks to 520 weeks. These additional conditions are that the injured worker has returned to employment pursuant to an Individual Written Rehabilitation Plan, has been found unsuitable for vocational rehabilitation, has returned to employment at less than his pre-injury average weekly wage, or has a permanent partial incapacity.

HOUSE BILL 1870**Filed By:** Representative Martin J. Walsh**Type of Bill:** Similar (S.1066) / Identical to S.682 (this session)**Endorsed by Advisory Council:** YES**Laws Affected:** Private Right of Action to Recover WC Un-Paid Premiums (c.152, §25C)

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

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

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

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HOUSE BILL 1870 CONTINUED

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

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

HOUSE BILL 1871

Filed By: Representative Martin J. Walsh

Type of Bill: Refile (H.1866)

Endorsed by Advisory Council: No

Laws Affected: Safe Workplaces for Employees of the Commonwealth (c.149, §40)

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

HOUSE BILL 1872

Filed By: Representative Martin J. Walsh

Type of Bill: Refile (H.1865)

Endorsed by Advisory Council: No

Laws Affected: Termination or Modification of Payments (c.152, §8) - Impartial Medical Exams (c.152, §11A)

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

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HOUSE BILL 1872 CONTINUED

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

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

Section 3 of this bill would amend §11A involving the necessity to obtain an IME when a conference order is appealed. Under current law, the parties may agree upon an impartial physician, or the Senior Judge will assign one. This bill requires the Administrative Judge to appoint the impartial physician. This section of the bill would also diminish the weight given to the IME report thereby allowing the parties to submit other medical evidence at a hearing. Under current law, once a case is brought before an Administrative Judge at a hearing, the impartial physician's report and deposition are the only medical evidence that can be presented. Any additional medical testimony is inadmissible, unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed by the report. The 1991 Reform Act was designed to solve the problem of "dueling doctors," which frequently resulted in the submission of conflicting evidence by employees and insurers.

HOUSE BILL 1873

Filed By: Representative Martin J. Walsh

Type of Bill: Refile (H.1864)

Endorsed by Advisory Council: No

Laws Affected: Rate of Payment by Insurers for Health Care Services (c.152, §13)

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

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

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

House Bill 1877 would allow "any 10 persons" to bring a civil action, on behalf and in the name of the "Workers' Compensation Trust Fund," against an employer to recover amounts which should have been paid in securing proper workers' compensation insurance. Such persons seeking a civil action must first petition either the Commissioner of Insurance, the Attorney General's Office or a superior court to hold a "probable cause hearing." At the hearing, it shall be *prima facie* evidence that such probable cause exists if it is shown that:

- An employee was paid any portion of wages in cash with no deductions or taxes withheld;
- No accompanying pay slip showing the wage payment and deductions as required by law;
- An individual was misclassified as an independent contractor when actually an employee;
- Wages were not timely paid;
- The employer failed to withhold from the employee's wages all related state taxes; or
- The employees have not been properly reported on certified payroll records as required by law.

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

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

This refiled bill would compensate state employees who receive bodily injuries resulting from acts of violence by children in their caseload or parents of said children. If eligible for workers' compensation benefits, these injured state employees would receive the difference between the weekly cash benefits entitled under Chapter 152 and their regular salary. The affected employee's absence would not be charged against their available sick leave credits. Current law allows this benefit to state employees who receive bodily injuries resulting from acts of violence from patients or prisoners only.

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

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

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

This new legislation would provide the claimant with the right to record or videotape the Impartial Medical Examination at their own expense. Such recording could be introduced as evidence at the hearing. The DIA would be required to advise claimants of these rights. Under current law, the impartial physician's report and deposition are the only medical evidence that can be presented, unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed by the report.

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

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

SENATE BILLS:

SENATE BILL 681

Filed By: Senator John A. Hart

Type of Bill: Refile (S.1060)

Endorsed by Advisory Council: YES

Laws Affected: Scar-Based Disfigurement (c.152, §36(k))

This refiled bill would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. Compensation would be required for all disfigurement, whether or not scar-based, regardless of its location on the body. This bill would not affect the \$15,000 maximum benefit for scar-based disfigurement currently in the statute. In 1991, section 36(k) was amended by the 1991 Reform Act to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

SENATE BILL 682

Filed By: Senator John A. Hart, Jr.

Type of Bill: Similar (S.1066) / Identical to H.1870 (this session)

Endorsed by Advisory Council: YES

Laws Affected: Private Right of Action to Recover WC Un-Paid Premiums (c.152, §25C)

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

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

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

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SENATE BILL 682 CONTINUED

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

SENATE BILL 686

Filed By: Senator John A. Hart

Type of Bill: Refile (H.1816 and S.1061) / Identical to H.1821 (this session)

Endorsed by Advisory Council: No, Unable to Reach a Consensus in 2008

Laws Affected: Widow's Benefits (c.152, §35C, §32, §31)

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

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

SENATE BILL 694

Filed By: Senator Thomas M. McGee

Type of Bill: Refile (S.1076)

Endorsed by Advisory Council: No

Laws Affected: Comprehensive Bill (c.152, §1, §6, §7, §8, §13A, §28, §29, §30, §31, §33, §34, §34A, §34B, §35, §35D, §35E, §36, §50)

This refiled bill seeks to amend many aspects of Chapter 152.

Section 1 of this bill would amend the definition of "Average Weekly Wage" by specifying that if an injured employee is employed by more than one *employer*, the total earnings from the several *employers* should be considered in determining average weekly wage. Currently, the law is more specific in stating that if the injured employee is employed by more than one *insured*

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SENATE BILL 694 CONTINUED

employer or self-insurer rather than "employer" as proposed by this legislation. Section 1 of this bill also states that weeks in which an employee received less than *four hours* in wages is considered lost time for determining average weekly wage. Currently, the law considers lost time as weeks when an employee receives *less than five dollars in wages*.

Section 2 of this bill would amend §1(7A) regarding the definition of "Personal Injury" in dealing with mental or emotional disabilities. Currently, "Personal Injuries" include mental or emotional disabilities only where the *predominant contributing cause* of such disability is an event or series of events occurring within any employment. This bill would replace "the predominant contributing cause" with "a significant contributing cause."

Section 3 of this bill would substantially increase the fines for employers who violate the provisions of §6 with regard to the reporting of the notice of injury to the DIA, the employee, or insurer. Currently, if an employer violates this provision three or more times they are required to pay a fine of \$100 for each violation. This bill would eliminate the necessity that a violation occurs three or more times before a penalty is issued. Fines would be issued as follows: \$100 for first violation; Subsequent violations within a year are increased \$100 for each subsequent violation; If employer fails to make notice to the DIA, employee, and insurer, it must pay an additional penalty to the DIA of \$1,000 into the Special Fund and \$1,000 to the employee;

If employer fails to make notice to the DIA, employee, and insurer, within 90 days, an additional penalty of \$10,000 will be assessed.

Section 4 would amend §7(2) by increasing the penalty placed on insurers who fail to begin payment of weekly benefits or notify parties of refusal to pay benefits within 14 days of receipt of the employer's First Report of Injury. This bill would require the insurer to pay the employee an amount of \$200 or their compensation rate (whichever is higher). If the insurer still fails to begin payments or make such notification within 60 days, they must pay a penalty of \$1,000 to both the Special Fund and to the employee.

Section 5 and 6 of this bill would amend §8 by decreasing the "pay without prejudice" period to 90 days. Currently, when an insurer pays a claim, it may do so without accepting liability for period of 180 days. This pay without prejudice period establishes a window where the insurer may refuse a claim and stop payments at its will. Up to 180 days, the insurer can unilaterally terminate or modify any claim as long as it specifies the grounds and factual basis for so doing. The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.

Section 7 of this bill would allow the pay without prejudice period to be extended upon agreement by the parties in 90-day increments not to exceed one year. Currently, pay without prejudice extensions are not required to be set at 90-day increments.

Section 8 of this bill would amend §13A(5). This section assesses an insurer a penalty of \$3,500 (plus necessary expenses) whenever an insurer files a complaint or contests a claim for benefits

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SENATE BILL 694 CONTINUED

and then later accepts the claim or withdraws the complaint within 5 days. This section of the proposed legislation would increase the number to 10 days.

Section 9 of this bill would amend §28, paragraph 1, which addresses injuries caused by serious and willful misconduct of the employer. This section of the proposed legislation would further define "willful misconduct" as a "knowing and willful violation of the Federal and/or State O.S.H.A. standards." Currently, if an employee is injured by serious and willful misconduct by the employer, they will receive double compensation for their injuries.

Section 10 of this bill would amend §29 dealing with the required period of incapacitation. Current law states that no compensation pursuant to §34 and §35 shall be paid for any injury which does not incapacitate the employee from earning full wages for a period of 5 or more calendar days. If incapacity extends for a period of 21 days or more, compensation is paid from the date of the onset of the incapacity. This bill decreases the 21-day period to *5 days or more*.

Section 11 of this bill would amend §30, which requires the insurer to furnish medical and hospital services, and medicines if needed. Except for the first appointment, the injured worker may select a treating physician and may switch to another such professional *once*. This bill would allow the injured worker the option of switching physicians *twice*.

Section 12 would amend §31 covering death benefits for dependents. Current law provides the widow or widower, that remains unmarried, 2/3 of the average weekly wage (AWW), but not more than the state's AWW or less than \$110 per week. They shall also receive \$6 per week for each child (this is not to exceed \$150 in additional compensation) of the deceased employee. This bill would increase the minimum amount a widower is entitled, to \$200 per week and \$12 more a week for each child of the deceased employee.

Section 13 would amend §33 regarding burial expenses for deceased employees. Currently, the insurer is required to pay reasonable expenses of burial, not exceeding \$4,000. This bill would increase the amount the insurer is required to pay for burial expenses to not exceed \$6,000.

Section 14 would increase the weekly compensation for total incapacity (§34) benefits. Compensation would increase from the current 60% to 2/3 of their average weekly wage. The duration would increase from the current 156 weeks to 208 weeks.

Section 15 would amend §34A pertaining to permanent and total incapacity. When the incapacity for work resulting from the injury is both permanent and total, an insurer is required to pay an injured employee a weekly compensation equal to 2/3 of their average weekly wage before injury, but not more than the maximum weekly compensation rate nor less than the minimum compensation rate. Current law requires that this payment be made "following payment of compensation in §34 and §35." This section of S.694 would delete this requirement.

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

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SENATE BILL 694 CONTINUED

This bill would expand supplemental benefits to include both §34 and §35.

Section 18 would amend §35 pertaining to partial incapacity benefits, by raising the wage benefits for injured workers to 2/3 AWW of the difference between their AWW before the injury and the weekly wage they are capable of earning after the injury, *but not more than the maximum weekly compensation rate*. Currently, under §35, compensation is 60% of the difference between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits.

Section 19 would amend the durations allowed for §35 benefits. Currently, the maximum benefit period for partial disability is 260 weeks, but may be extended to 520 weeks. This bill increases the maximum benefit period to 442 weeks and could be extended at "the discretion of an AJ."

Section 20 would amend §35A, which provides additional compensation to injured workers who have dependents. Currently, §35A provides additional compensation of \$6 per/week to injured workers who have persons dependent upon them for injuries occurring under §34, §34A, and §35.

No weekly payments under this section can be greater than \$150 per week when combined with the compensation due under §34, §34A, and §35. This section of Senate 694 would provide injured workers additional compensation of \$12 per/week to injured workers who had persons dependent upon them. This bill would also cap weekly payments at \$250 when combined with the compensation due under §34, §34A, and §35.

Section 21 of this bill would amend §35D(5) regarding the computation of a weekly wage. This section would disallow an employee's compensation rate to be decreased in any proceeding on the fact that an employee had enrolled or is participating in a vocational rehabilitation program, whether or not it is paid for by the insurer or the department.

Section 22 of this bill would amend §35E. It would require that any person receiving old age benefits pursuant to federal social security law or receiving pension benefits paid by an employer should not be entitled to benefits under §35. This is unless the employee can establish that they would have remained active in the labor market.

Section 23 of this bill would amend §36(k). It would require that for bodily disfigurement, compensation will not exceed \$20,000 and will be payable in addition to other sums outlined in this legislation.

Section 24 of this bill would amend §50. Payments required by order that are not made within 60 days of being claimed by employee, dependent or other party would accrue interest at a rate of 12% per year. If sums include weekly payments, then interest will accrue on each unpaid weekly payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SENATE BILL 718 CONTINUED

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

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

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

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

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

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

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

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

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

This refiled bill would increase the severity of criminal penalties for employers who fail to provide workers' compensation coverage for their employees. Under this bill, employers convicted of criminal offenses, would be subject to minimum mandatory fines, imprisonment, or both. The maximum imprisonment sentence would be 5 years in state prison with a minimum imprisonment in the house of correction for not less than 6 months nor more than 2.5 years. The maximum criminal fine would increase to \$10,000 with a minimum fine of \$1,000. Current law limits criminal penalties at no more than \$1,500 or by imprisonment for not more than 1 year, or both.

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

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

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