

Maine Revised Statutes
Title 39-A: WORKERS' COMPENSATION
Enacted by PL 1991, c. 885, Pt. A, §8

Table of Contents

Part 1. MAINE WORKERS' COMPENSATION ACT OF 1992 ENACTED BY PL 1991, C. 885, PT. A, §8.....	3
Chapter 1. GENERAL PROVISIONS ENACTED BY PL 1991, C. 885, PT. A, §8.....	3
Chapter 3. WORKERS' COMPENSATION BOARD ENACTED BY PL 1991, C. 885, PT. A, §8.....	21
Chapter 5. COMPENSATION AND SERVICES ENACTED BY PL 1991, C. 885, PT. A, §8.....	33
Chapter 7. PROCEDURES ENACTED BY PL 1991, C. 885, PT. A, §8.....	63
Subchapter 1. BOARD PROCEEDINGS ENACTED BY PL 1991, C. 885, PT. A, §8.....	63
Subchapter 2. MISCELLANEOUS ENACTED BY PL 1991, C. 885, PT. A, §8.....	87
Chapter 9. INSURANCE AND SELF-INSURANCE ENACTED BY PL 1991, C. 885, PT. A, §8.....	105
Part 2. OCCUPATIONAL DISEASE LAW ENACTED BY PL 1991, C. 885, PT.A, §8.....	143
Chapter 15. OCCUPATIONAL DISEASE LAW ENACTED BY PL 1991, C. 885, PT. A, §8.....	143
Part 3. EMPLOYER'S LIABILITY ENACTED BY PL 1991, C. 885, PT. A, §8.....	151
Chapter 19. EMPLOYER'S LIABILITY ENACTED BY PL 1991, C. 885, PT. A, §8.....	151

**Title 39-A: WORKERS' COMPENSATION
ENACTED BY PL 1991, C. 885, PT. A, §8**

**Part 1: MAINE WORKERS' COMPENSATION ACT
OF 1992 ENACTED BY PL 1991, C. 885, PT. A, §8**

Chapter 1: GENERAL PROVISIONS

§101. SHORT TITLE

This Part may be known and cited and referred to in proceedings and agreements under this Part as the "Maine Workers' Compensation Act of 1992." [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§102. DEFINITIONS

As used in this Part, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. After-tax average weekly wage. "After-tax average weekly wage" means average weekly wage, as defined in subsection 4, reduced by the prorated weekly amount that would have been paid under the Federal Insurance Contributions Act, 26 United States Code, Sections 3101 to 3126, state income tax and federal income tax calculated on an annual basis, using as the number of exemptions the disabled employee's dependents plus the employee, and without excess itemized deductions. Effective January 1, 1993 and each January 1st until and including January 1, 2012, the applicable federal and state laws in effect on the preceding July 1st are used in determining the after-tax weekly wage. Each December 1st until and including December 1, 2011, the board shall publish tables of the average weekly wage and 80% of after-tax average weekly wage that will take effect on the following January 1st. These tables are conclusive for the purpose of converting an average weekly wage into 80% of after-tax average weekly wage.

[2013, c. 63, §1 (AMD) .]

2. Agriculture. "Agriculture" means the operation of farm premises, including:

A. The planting, cultivating, producing, growing and harvesting of agricultural or horticultural commodities on those premises; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The raising of livestock and poultry on those premises; [2013, c. 111, §1 (AMD); 2013, c. 111, §2 (AFF).]

C. Any work performed as an incident to or in conjunction with these farm operations, including the packing, drying and storing of these commodities for market, if these operations:

- (1) Are incident to or in conjunction with growing and harvesting farm operations of the same employer; and
- (2) Are not provided as a service for other farm operations or employers; or [2013, c. 111, §1 (AMD); 2013, c. 111, §2 (AFF).]

D. Equine activity, as defined in Title 7, section 4101, subsection 5. [2013, c. 111, §1 (NEW); 2013, c. 111, §2 (AFF).]

[2013, c. 111, §1 (AMD); 2013, c. 111, §2 (AFF) .]

3. Aquaculture. "Aquaculture" means the commercial production of cultured fish, shellfish, seaweed or other marine plants for human and animal consumption, including:

A. All cultivating activities occurring at hatcheries or nurseries, from the egg, larval or spore stages to the transfer of the product to a growing site; and [1993, c. 209, §1 (NEW).]

B. All cultivating activities occurring on water, from the receipt of fish, shellfish, seaweed or other marine plants from onshore facilities to the delivery of harvested products to onshore facilities for processing. [1993, c. 209, §1 (NEW).]

[1993, c. 209, §1 (AMD) .]

4. Average weekly wages or average weekly wages, earnings or salary. The term "average weekly wages" or "average weekly wages, earnings or salary" is defined as follows.

A. "Average weekly wages, earnings or salary" of an injured employee means the amount that the employee was receiving at the time of the injury for the hours and days constituting a regular full working week in the employment or occupation in which the employee was engaged when injured; except that this does not include any reasonable and customary allowance given to the employee by the employer for the purchase, maintenance or use of any chainsaws or skidders used in the employee's occupation if that employment or occupation had continued on the part of the employer for at least 200 full working days during the year immediately preceding that injury. For purposes of this paragraph, "reasonable and customary allowance" is the allowance provided in a negotiated contract between the employee and the employer or, if not provided for by a negotiated contract, an allowance determined by the Department of Labor. In the case of piece workers and other employees whose wages during that year have generally varied from week to week, wages are averaged in accordance with the method provided under paragraph B. [1995, c. 560, Pt. G, §21 (AMD); 1995, c. 560, Pt. G, §29 (AFF).]

B. When the employment or occupation did not continue pursuant to paragraph A for 200 full working days, "average weekly wages, earnings or salary" is determined by dividing the entire amount of wages or salary earned by the injured employee during the immediately preceding year by the total number of weeks, any part of which the employee worked during the same period. The week in which employment began, if it began during the year immediately preceding the injury, and the week in which the injury occurred, together with the amounts earned in those weeks, may not be considered in computations under this paragraph if their inclusion would reduce the average weekly wages, earnings or salary. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Notwithstanding paragraphs A and B, the average weekly wage of a seasonal worker is determined by dividing the employee's total wages, earnings or salary for the prior calendar year by 52.

(1) For the purposes of this paragraph, the term "seasonal worker" does not include any employee who is customarily employed, full time or part time, for more than 26 weeks in a calendar year. The employee need not be employed by the same employer during this period to fall within this exclusion.

(2) Notwithstanding subparagraph (1), the term "seasonal worker" includes, but is not limited to, any employee who is employed directly in agriculture or in the harvesting or initial hauling of forest products. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. When the methods set out in paragraph A, B or C of arriving at the average weekly wages, earnings or salary of the injured employee can not reasonably and fairly be applied, "average weekly wages" means the sum, having regard to the previous wages, earnings or salary of the injured employee and of other

employees of the same or most similar class working in the same or most similar employment in the same or a neighboring locality, that reasonably represents the weekly earning capacity of the injured employee in the employment in which the employee at the time of the injury was working. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. When the employee is employed regularly in any week concurrently by 2 or more employers, for one of whom the employee works at one time and for another of whom the employee works at another time, the employee's average weekly wages are computed as if the wages, earnings or salary received by the employee from all such employers were wages, earnings or salary earned in the employment of the employer for whom the employee was working at the time of the injury. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. When the employer has paid the employee a sum to cover any special expense incurred by the employee by the nature of the employee's employment, the sum paid is not reckoned as part of the employee's wages, earnings or salary. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

G. The fact that an employee has suffered a previous injury or received compensation for a previous injury does not preclude compensation for a later injury or for death; but, in determining the compensation for a later injury or death, the employee's average weekly wages are the sum that will reasonably represent the employee's weekly earning capacity at the time of the later injury in the employment in which the employee was working at that time, and are computed according to and subject to the limitations of this subsection. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

H. "Average weekly wages, earnings or salary" does not include any fringe or other benefits paid by the employer that continue during the disability. Any fringe or other benefit paid by the employer that does not continue during the disability must be included for purposes of determining an employee's average weekly wage to the extent that the inclusion of the fringe or other benefit will not result in a weekly benefit amount that is greater than 2/3 of the state average weekly wage at the time of injury. The limitation on including discontinued fringe or other benefits only to the extent that such inclusion does not result in a weekly benefit amount greater than 2/3 of the state average weekly wage at the time of injury does not apply if the injury results in the employee's death. [2003, c. 437, §1 (AMD).]

[2003, c. 437, §1 (AMD) .]

5. Board; board member. "Board" means the Workers' Compensation Board created by section 151 and includes a designee of the board. "Board member" means any member of the board, including the executive director.

[2003, c. 608, §4 (AMD) .]

6. Community. "Community" means the area within a 75-mile radius of an employee's residence or the actual distance from an employee's normal work location to the employee's residence at the time of an employee's injury, whichever is greater.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Compensation payment scheme. "Compensation payment scheme" means the procedure whereby an employer is required to provide compensation or other benefits under this Act to an employee. "Compensation payment scheme" includes a decree of the board, payment under the early-pay system provided in former Title 39, section 51-B and, in case of injuries prior to January 1, 1984, an approved agreement.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Dependent. "Dependent" means a member of an employee's family or that employee's next of kin who is wholly or partly dependent upon the earnings of the employee for support at the time of the injury. The following persons are conclusively presumed to be wholly dependent for support upon a deceased employee:

A. A spouse of the deceased employee who was living with the employee at the time of the employee's death, who was living apart from the employee for a justifiable cause or because the spouse had been deserted by the employee or who was actually dependent in any way upon the employee at the time of the injury. A spouse living apart from the employee must produce a court order or other competent evidence as to separation and actual dependency; and [2013, c. 63, §2 (RPR).]

B. [2013, c. 63, §3 (RP).]

C. A child, including an adopted child or a stepchild, under the age of 18 years, or under the age of 23 years if a student or over the age of 18 years but physically or mentally incapacitated from earning, who is dependent upon the parent with whom the dependent is living or upon whom the dependent is actually dependent in any way at the time of the injury to the parent, there being no surviving dependent parent. For the purposes of this paragraph, "child" includes any dependent posthumous child whose mother is not living. If there is more than one child dependent, the compensation must be divided equally among them.

For the purposes of this paragraph, the term "student" means a person regularly pursuing a full-time course of study or training at an institution that is:

- (1) A school, college or university operated or directly supported by the United States or by any state or local government or political subdivision thereof;
- (2) A school, college or university that has been accredited by a state or by a state-recognized or nationally recognized accrediting agency or body;
- (3) A school, college or university not accredited pursuant to subparagraph (2) but whose credits are accepted, on transfer, for credit on the same basis as if transferred from an accredited institution by not fewer than 3 institutions accredited pursuant to subparagraph (2); or
- (4) An additional type of educational or training institution as defined by the board, but not after the dependent reaches the age of 23 or has completed 4 years of education beyond the high school level, except that, when the dependent's 23rd birthday occurs during a semester or other enrollment period, the dependent continues to be considered a student until the end of the semester or other enrollment period. A child is not deemed to have ceased to be a student during any interim between school years if the interim does not exceed 5 months and if the dependent shows to the satisfaction of the board that the dependent has a bona fide intention of continuing to pursue a full-time course of education or training during the semester or other enrollment period immediately following the interim or during periods of reasonable duration during which, in the judgment of the board, the dependent is prevented by factors beyond the dependent's control from pursuing the dependent's education. A child is not deemed to be a student under this Act during a period of service in the Armed Forces of the United States. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

In all other cases, questions of total or partial dependency must be determined in accordance with the fact as the fact was at the time of the injury. If there is more than one person wholly dependent, the compensation must be divided equally among them and persons partly dependent, if any, are not entitled to a part of the compensation during the period in which compensation is paid to persons wholly dependent. If there is no one wholly dependent and more than one person who is partly dependent, the compensation must be divided among them according to the relative extent of their dependency.

[2013, c. 63, §§2, 3 (AMD).]

9. Dependent of another person. For purposes of the payment or the termination of compensation under section 215, "dependent of another person" means a widow or widower of a deceased employee that over 1/2 of that person's support during a calendar year was provided by the other person.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Design professional. "Design professional" means:

A. An architect, professional engineer, landscape architect, land surveyor, geologist or soil scientist licensed to practice that profession in the State in accordance with Title 32; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Any corporation or partnership, professional or general, that employs one or more of any of the professionals described in paragraph A and whose sole purpose is the rendering of professional services practiced by any professional described in paragraph A. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

11. Employee. The term "employee" is defined as follows.

A. "Employee" includes officials of the State and officials of counties, cities, towns, water districts and all other quasi-public corporations of a similar character, every duly elected or appointed executive officer of a private corporation other than a charitable, religious, educational or other nonprofit corporation, and every person in the service of another under any contract of hire, express or implied, oral or written, except:

(1) Persons engaged in maritime employment or in interstate or foreign commerce who are within the exclusive jurisdiction of admiralty law or the laws of the United States, except that this section may not be construed to exempt from the definition of "employee" a person who is employed by the State and is thereby barred by the State's sovereign immunity from bringing a claim against that person's employer under admiralty law or other laws of the United States for claims that are otherwise cognizable under this Act;

(2) Firefighters, including volunteer firefighters who are active members of a volunteer fire association as defined in Title 30-A, section 3151; volunteer emergency medical services persons as defined in Title 32, section 83, subsection 12; and police officers are employees within the meaning of this Act. In computing the average weekly wage of an injured volunteer firefighter or volunteer emergency services person, the average weekly wage must be taken to be the earning capacity of the injured employee in the occupation in which the employee is regularly engaged. Employers who hire workers within this State to work outside the State may agree with these workers that the remedies under this Act are exclusive as regards injuries received outside this State arising out of and in the course of that employment; and all contracts of hiring in this State, unless otherwise specified, are presumed to include such an agreement. Any reference to an employee who has been injured must, when the employee is dead, include the employee's legal representatives, dependents and other persons to whom compensation may be payable;

(3) Notwithstanding any other provisions of this Act, any charitable, religious, educational or other nonprofit corporation that may be or may become an assenting employer under this Act may cause any duly elected or appointed executive officer to be an employee of the corporation by specifically including the executive officer among those to whom the corporation secures payment of compensation in conformity with chapter 5; and the executive officer must remain an employee of the corporation under this Act while such payment is so secured. With respect to any corporation that secures compensation by making a contract of workers' compensation insurance, specific inclusion of the executive officer in the contract causes the officer to be an employee of the corporation under this Act;

(4) Except for persons engaged in harvesting of forest products, any person who, in a written statement to the board, waives all the benefits and privileges provided by the workers' compensation laws, provided that the board has found that person to be a bona fide owner of at least 20% of the outstanding voting stock of the corporation by which that person is employed or a shareholder of the professional corporation by which that person is employed and that this waiver was not a prerequisite condition to employment. For the purposes of this subparagraph, the term "professional corporation" means a domestic or foreign professional corporation as defined in Title 13, section 723.

Any person may revoke or rescind that person's waiver upon 30 days' written notice to the board and that person's employer. The parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child of a person who has made a waiver under the previous sentence may state, in writing, that the parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child waives all the benefits and privileges provided by the workers' compensation laws if the board finds that the waiver is not a prerequisite condition to employment and if the parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child is employed by the same corporation that employs the person who has made the first waiver;

(5) Except for persons engaged in harvesting of forest products, the parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child of a sole proprietor who is employed by that sole proprietor or the parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child of a partner who is employed by the partnership of that partner or the parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child of a member of a limited liability company who is employed by that limited liability company may state, in writing, that the parent, spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1 or child waives all the benefits and privileges provided by the workers' compensation laws if the board finds that the waiver is not a prerequisite condition to employment;

(6) Employees of an agricultural employer when harvesting 150 cords of wood or less each year from farm wood lots, provided that the employer is covered under an employer's liability insurance policy as required in subsection 17;

(7) An independent contractor;

(8) Except as otherwise provided in sections 105-A and 401, if a person employs an independent contractor, any employee of the independent contractor is not considered an employee of that person for the purposes of this Act. The person who employs an independent contractor is not responsible for providing workers' compensation insurance covering the payment of compensation and benefits to the employees of the independent contractor. An insurance company may not charge a premium to any person for any employee excluded by this subparagraph; or

(9) A state or municipal employee while the employee is on assignment as a certified disaster service volunteer for the American Red Cross pursuant to Title 5, section 19-B or Title 30-A, section 2705. Duties performed while on a volunteer disaster relief assignment for the American Red Cross may not be considered a work assignment by a state agency or municipality. [2009 , c. 452 , §3 (AMD) .]

B. "Employee" includes, if the person elects to be personally covered by this Title, any person who regularly operates a business or practices a trade, profession or occupation, whether individually or in partnership or association with other persons or as a member of a limited liability company, whether or not the person hires employees. Such a person shall elect personal coverage by insuring and keeping insured the payment of compensation and other benefits under a workers' compensation insurance policy. The insurance policy must clearly indicate the intention of the parties to provide coverage for the person electing to be personally covered. The insurance company shall file with the board notice, in such form as the board approves, of the issuance of any workers' compensation policy to a person electing personal coverage. That insurance may not be cancelled within the time limited in that policy for its expiration until at least 30 days after mailing a notice of the cancellation of that insurance to the board and the person electing personal coverage. In the event that the person electing personal coverage has

obtained a workers' compensation insurance policy from another insurance company, and that insurance becomes effective prior to the expiration of the 30 days, cancellation is effective as of the effective date of the other insurance. The Superintendent of Insurance is authorized to review for approval, at the superintendent's discretion, an appropriate classification for this class of persons and a reasonable rate. [2001, c. 518, §2 (AMD).]

B-1. "Employee" includes any person engaged in harvesting forest products, except the following persons:

- (1) A person who contracts directly with the landowner if the person meets the criteria for obtaining a certificate of independent status or a predetermination of independent contractor status and:
 - (a) Performs all of the wood harvesting alone;
 - (b) Performs all of the wood harvesting alone or with the assistance of one or more of the following persons whose relationship with the person is that of spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1, parent, sibling, child, niece or nephew;
 - (c) Performs all of the wood harvesting alone or with the assistance of one or more other persons all covered by workers' compensation insurance; or
 - (d) Performs all of the wood harvesting alone or with the assistance of a partner when a legal partnership exists and neither partner acts as a supervisor of the other;
- (2) A spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1, parent, sibling, child, niece or nephew of a person who contracts directly with the landowner to perform all of the wood harvesting alone or with the assistance of one or more of the following: the person's spouse, domestic partner as defined in Title 24, section 2319-A, subsection 1, parent, sibling, child, niece or nephew; or
- (3) A partner of a person who contracts directly with the landowner to perform all of the wood harvesting alone or with the assistance of a partner when a legal partnership exists and neither partner acts as a supervisor of the other.

Unless employed by a private employer, a person considered an employee under this paragraph shall obtain personal coverage in the same manner and under the same provisions as a person described in paragraph B who elects to be covered by this Title. [2007, c. 350, §2 (AMD).]

C. "Employee" does not include any person who is otherwise an employee, if the person is injured as a result of the person's voluntary participation in an employer-sponsored athletic event or an employer-sponsored athletic team. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. "Employee" does not include a real estate broker or salesperson whose services are performed for remuneration solely by way of commission if the broker or salesperson has signed a contract with the agency indicating the existence of an independent contractor relationship. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. "Employee" does not include any person who is a sentenced prisoner in actual execution of a term of incarceration imposed in this State or any other jurisdiction for a criminal offense, except in relation to compensable injuries suffered by the prisoner during incarceration and while the prisoner is:

- (1) A prisoner in a county jail under final sentence of 72 hours or less and is assigned to work outside of the county jail;
- (2) Employed by a private employer;
- (3) Participating in a work release program;
- (5) Employed in a program established under a certification issued by the United States Department of Justice under 18 United States Code, Section 1761;
- (6) Employed while in a supervised community confinement program pursuant to Title 34-A, section 3036-A; or

(7) Employed while in a community confinement monitoring program pursuant to Title 30-A, section 1659-A. [2013, c. 133, §35 (AMD).]

F. A person certified by the Director of the Maine Emergency Management Agency within the Department of Defense, Veterans and Emergency Management as a qualified search and rescue worker is an employee of the State within the meaning of this Act while that person is performing search and rescue activity at the request of a state, county or local government entity. In computing the average weekly wage of a certified search and rescue worker injured while performing such activity, the average weekly wage must be taken to be the earning capacity of the injured employee in the occupation in which the employee is regularly engaged. [2003, c. 489, §2 (NEW).]

[2013, c. 133, §35 (AMD) .]

12. Employer. The term "employer" includes:

A. Private employers; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The State; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Counties; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. Cities; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Towns; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. Water districts and all other quasi-public corporations of a similar nature; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

G. Municipal school committees; and [2011, c. 678, Pt. C, §9 (AMD).]

H. [2011, c. 678, Pt. C, §10 (RP).]

I. Design professionals. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If the employer is insured, "employer" includes the insurer, self-insurer or group self-insurer unless the contrary intent is apparent from the context or is inconsistent with the purposes of this Act.

[2011, c. 678, Pt. C, §§9, 10 (AMD) .]

12-A. Harvesting forest products. "Harvesting forest products" means to sever and remove standing trees from a forest as a raw material for commercial purposes. "Forest products" has the same meaning as in Title 12, section 8881, subsection 3.

[1999, c. 364, §3 (NEW) .]

13. Independent contractor.

[2011, c. 643, §14 (AFF); 2011, c. 643, §7 (RP) .]

13-A. Independent contractor. A person who performs services for remuneration is presumed to be an employee unless the employing unit proves that the person is free from the essential direction and control of the employing unit, both under the person's contract of service and in fact and the person meets specific criteria. In order for a person to be an independent contractor:

A. The following criteria must be met:

- (1) The person has the essential right to control the means and progress of the work except as to final results;
- (2) The person is customarily engaged in an independently established trade, occupation, profession or business;
- (3) The person has the opportunity for profit and loss as a result of the services being performed for the other individual or entity;
- (4) The person hires and pays the person's assistants, if any, and, to the extent such assistants are employees, supervises the details of the assistants' work; and
- (5) The person makes the person's services available to some client or customer community even if the person's right to do so is voluntarily not exercised or is temporarily restricted; and [2011, c. 643, §8 (NEW); 2011, c. 643, §14 (AFF).]

B. At least 3 of the following criteria must be met:

- (1) The person has a substantive investment in the facilities, tools, instruments, materials and knowledge used by the person to complete the work;
- (2) The person is not required to work exclusively for the other individual or entity;
- (3) The person is responsible for satisfactory completion of the work and may be held contractually responsible for failure to complete the work;
- (4) The parties have a contract that defines the relationship and gives contractual rights in the event the contract is terminated by the other individual or entity prior to completion of the work;
- (5) Payment to the person is based on factors directly related to the work performed and not solely on the amount of time expended by the person;
- (6) The work is outside the usual course of business for which the service is performed; or
- (7) The person has been determined to be an independent contractor by the federal Internal Revenue Service. [2011, c. 643, §8 (NEW); 2011, c. 643, §14 (AFF).]

[2011, c. 643, §8 (NEW); 2011, c. 643, §14 (AFF) .]

14. Insurance company. "Insurance company" means any casualty insurance company or association authorized to do business in this State that may issue policies conforming to subsection 19 and includes the Maine Employers' Mutual Insurance Company. Whenever in this Act relating to procedure the words "insurance company" or "insurer" are used they apply only to cases in which the employer has secured the payment of compensation and other benefits by insuring such payment under a workers' compensation insurance policy, instead of furnishing satisfactory proof of the employer's ability to pay compensation and benefits directly to the employer's employees.

An insurance carrier may not be qualified to issue a workers' compensation insurance policy covering any employees working in this State unless it has and continuously maintains an employee or claims agent within this State empowered to investigate claims arising under this chapter; sign agreements for the payment of compensation as provided by this chapter; and issue drafts or checks in payment of obligations arising under this chapter in amounts of at least \$1,000.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

15. Maximum medical improvement. "Maximum medical improvement" means the date after which further recovery and further restoration of function can no longer be reasonably anticipated, based upon reasonable medical probability.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

16. Permanent impairment. "Permanent impairment" means any anatomic or functional abnormality or loss existing after the date of maximum medical improvement that results from the injury.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

17. Private employer. "Private employer" includes corporations, including professional corporations, partnerships and natural persons. Any agricultural employer otherwise included under this Act is not included when harvesting 150 cords of wood or less each year from farm wood lots, provided that, in order to qualify for this exemption, the employer must be covered by an employer's liability insurance policy with total limits of not less than \$25,000 and medical payment coverage of not less than \$5,000.

[2001, c. 235, §1 (AMD) .]

18. Representatives. "Representatives" includes executors and administrators.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

19. Workers' compensation insurance policy. "Workers' compensation insurance policy" means a policy in such form as the Superintendent of Insurance approves, issued by any stock or mutual casualty insurance company or association that may now or hereafter be authorized to do business in this State, which in substance and effect guarantees the payment of the compensation, medical benefits and expenses of burial provided for, in such installment, at such time or times, and to such person or persons and upon such conditions as in this Act provided. Whenever a copy of a policy is filed, a copy certified by the Superintendent of Insurance is admissible as evidence in any legal proceeding wherein the original would be admissible.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 209, §1 (AMD). 1995, c. 560, §G21 (AMD). 1995, c. 560, §G29 (AFF). 1997, c. 600, §§3,4 (AMD). 1999, c. 201, §1 (AMD). 1999, c. 201, §2 (AFF). 1999, c. 364, §§1-3 (AMD). 2001, c. 235, §1 (AMD). 2001, c. 490, §1 (AMD). 2001, c. 518, §§1,2 (AMD). 2001, c. 710, §18 (AMD). 2001, c. 710, §19 (AFF). 2003, c. 344, §D27 (AMD). 2003, c. 423, §4 (AMD). 2003, c. 423, §5 (AFF). 2003, c. 437, §1 (AMD). 2003, c. 489, §2 (AMD). 2003, c. 608, §4 (AMD). 2007, c. 350, §§1, 2 (AMD). 2009, c. 142, §17 (AMD). 2009, c. 452, §§3, 4 (AMD). 2009, c. 529, §4 (AMD). 2011, c. 643, §§7, 8 (AMD). 2011, c. 643, §14 (AFF). 2011, c. 678, Pt. C, §§9, 10 (AMD). 2013, c. 63, §§1-3 (AMD). 2013, c. 111, §1 (AMD). 2013, c. 111, §2 (AFF). 2013, c. 133, §35 (AMD).

§103. COMMON-LAW DEFENSES LOST

In an action to recover damages for personal injuries sustained by an employee arising out of and in the course of the employee's employment, or for death resulting from such injuries, it is not a defense to an employer, except as hereinafter specified: [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Employee negligent. That the employee was negligent;

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Fellow employee negligent. That the injury was caused by the negligence of a fellow employee; or

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Employee assumed risk. That the employee has assumed the risk of the injury.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§104. APPLICABILITY TO CERTAIN ACTIONS AND EMPLOYERS; EXEMPTIONS

An employer who has secured the payment of compensation in conformity with sections 401 to 407 is exempt from civil actions, either at common law or under sections 901 to 908; Title 14, sections 8101 to 8118; and Title 18-A, section 2-804, involving personal injuries sustained by an employee arising out of and in the course of employment, or for death resulting from those injuries. An employer that uses a private employment agency for temporary help services is entitled to the same immunity from civil actions by employees of the temporary help service as is granted with respect to the employer's own employees as long as the temporary help service has secured the payment of compensation in conformity with sections 401 to 407. "Temporary help services" means a service where an agency assigns its own employees to a 3rd party to work under the direction and control of the 3rd party to support or supplement the 3rd party's work force in work situations such as employee absences, temporary skill shortages, seasonal work load conditions and special assignments and projects. These exemptions from liability apply to all employees, supervisors, officers and directors of the employer for any personal injuries arising out of and in the course of employment, or for death resulting from those injuries. These exemptions also apply to occupational diseases sustained by an employee or for death resulting from those diseases. These exemptions do not apply to an illegally employed minor as described in section 408, subsection 2. [1995, c. 297, §1 (AMD) .]

A design professional acting within the course and scope of providing professional services during the construction, erection or installation of any project or a design professional's employee who is acting within the course and scope of assisting or representing the design professional in the performance of design professional services on or adjacent to the site of the project's construction, erection or installation is immune from liability for any personal injury or death occurring at or adjacent to such a site, if compensation is paid to the injured person or decedent's representative for the injury or death under this Act, and the design professional has no duty under a written contract to assume responsibility for construction site safety. The immunity provided by this section to any design professional does not apply to the negligent preparation of design plans and technical specifications. Except as provided by this section, any waiver, oral or written, express or implied, of the design professional's immunity granted by this section is void and unenforceable as a matter of law. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 297, §1 (AMD) .

§105. PREDETERMINATION OF INDEPENDENT CONTRACTOR AND CONSTRUCTION SUBCONTRACTOR STATUS

1. Predetermination permitted. A worker, an employer or a workers' compensation insurance carrier, or any together, may apply to the board for a predetermination of whether the status of an individual worker, group of workers or a job classification associated with the employer is that of an employee or an independent contractor.

A. The predetermination by the board creates a rebuttable presumption that the determination is correct in any later claim for benefits under this Act. [1993, c. 120, §1 (AMD); 1993, c. 120, §6 (AFF).]

B. Nothing in this subsection requires a worker, an employer or a workers' compensation insurance carrier to request predetermination. [2009, c. 569, §1 (AMD).]

[2009, c. 569, §1 (AMD) .]

1-A. Predetermination permitted for construction subcontractors. A person, as defined in section 105-A, subsection 1, paragraph E, may apply to the board for a predetermination that the person performs construction work in a manner that would not make the person an employee of a hiring agent, as defined in section 105-A, subsection 1, paragraph D.

A. The predetermination issued by the board pursuant to this subsection is valid for one year and creates a rebuttable presumption that the determination is correct in any later claim for benefits under this Act. [2009, c. 569, §1 (NEW).]

B. Nothing in this subsection requires a person, as defined in section 105-A, subsection 1, paragraph E, a worker, an employer or a workers' compensation insurance carrier to request predetermination. [2009, c. 569, §1 (NEW).]

[2009, c. 569, §1 (NEW) .]

2. Premium adjustment. If it is determined that a predetermination does not withstand board or judicial scrutiny when raised in a subsequent workers' compensation claim, then, depending on the final outcome of that subsequent proceeding, either the workers' compensation insurance carrier shall return excess premium collected or the employer shall remit premium subsequently due in order to put the parties in the same position as if the final outcome under the contested claim were predetermined correctly.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Predetermination submission. A party may submit, on forms approved by the board, a request for predetermination regarding the status of a person or job description as an employee, construction subcontractor, as defined in section 105-A, subsection 1, paragraph B, or independent contractor. The request is deemed to have been approved if the board does not deny or take other appropriate action on the submission within 30 days.

[2013, c. 63, §4 (AMD) .]

4. Hearing. A hearing, if requested by a party within 10 days of the board's decision on a petition, must be conducted under the Maine Administrative Procedure Act. A ruling by the board or hearing officer under this section is final and not subject to review by the Superior Court.

[2013, c. 63, §5 (AMD) .]

5. Certificate. The board shall provide the petitioning party a certified copy of the decision regarding predetermination that is to be used as evidence at a later hearing on benefits.

[1993, c. 120, §1 (AMD); 1993, c. 120, §6 (AFF) .]

6. Rulemaking. The board is authorized to adopt reasonable rules pursuant to the Maine Administrative Procedure Act to implement the intent of this section, which is to afford speedy and equitable predetermination of employee, construction subcontractor, as defined in section 105-A, subsection 1, paragraph B, and independent contractor status.

[2009, c. 569, §1 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 65, §1 (AMD). 1993, c. 120, §1 (AMD). 1993, c. 120, §6 (AFF). 2009, c. 569, §1 (AMD). 2013, c. 63, §§4, 5 (AMD).

§105-A. CONSTRUCTION CONTRACTORS

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Construction site" means a location where a structure that is attached or will be attached to real property is constructed, altered or remodeled. [2009, c. 452, §5 (NEW).]

B. "Construction subcontractor" means an independent contractor if the construction subcontractor meets the definition of independent contractor in section 102, subsection 13-A. [2011, c. 643, §14 (AFF); 2011, c. 643, §9 (RPR).]

C. "Construction work" means any part of the construction, alteration or remodeling of a structure, including related landscaping and other site work performed in connection with the performance of such work, but not including surveying, engineering, examination or inspection of a construction site or the delivery of materials to a construction site. [2009, c. 452, §5 (NEW).]

D. "Hiring agent" means a person that hires or contracts with a person to perform construction work, but excludes an owner or occupant of real property who hires a person or persons to perform construction work on that real property. [2009, c. 452, §5 (NEW).]

E. "Person" means:

- (1) An individual;
- (2) A sole proprietor;
- (3) A working member of a partnership;
- (4) A working member of a limited liability company;
- (5) A parent, spouse or child of a sole proprietor, partner or working member of a limited liability company under section 102, subsection 11, paragraph A;
- (6) A working owner or part owner of a corporation; and
- (7) A working shareholder of a professional corporation. [2009, c. 452, §5 (NEW).]

[2009, c. 452, §5 (NEW); 2011, c. 643, §9 (AMD); 2011, c. 643, §14 (AFF) .]

2. Status of persons performing construction work. Beginning January 1, 2010, a person performing construction work on a construction site for a hiring agent is presumed to be the employee of the hiring agent for purposes of this Act, unless:

A. The person is a construction subcontractor; or [2009, c. 452, §5 (NEW).]

B. The person owns and operates an item of equipment weighing more than 7,000 pounds and is hired by the hiring agent to operate the equipment on the construction site or to use the equipment to transport materials to or from the site. A person who leases such an item of equipment from a person in the leasing

business, other than the hiring agent or an affiliate of the hiring agent, is regarded as the owner for the purposes of this paragraph. A truck with a gross vehicle weight rating greater than 7,000 pounds qualifies as an item of equipment under this paragraph. [2009, c. 452, §5 (NEW).]

[2009, c. 452, §5 (NEW) .]

3. Penalties. A person who is required to but fails to secure the payment of compensation with respect to persons deemed to be that person's employees under this section is subject to the penalties under section 324, subsection 3.

[2009, c. 452, §5 (NEW) .]

4. Insurer referral obligation. An insurer that believes in good faith that an insured employer withheld from it or from the State Tax Assessor records of payments to a person deemed to be the person's employee under this section may, but is not required to, refer the insured employer and person to the State Tax Assessor in order that the assessor may take appropriate action, and the insurer enjoys immunity for such actions.

[2009, c. 452, §5 (NEW) .]

5. Stop-work orders. In addition to any penalty imposed under section 324, subsection 3, if after a hearing the executive director determines that a hiring agent or construction subcontractor has knowingly failed to secure the payment to that hiring agent's or construction subcontractor's employees of the compensation provided for by this Act, the executive director or the executive director's designee shall issue a stop-work order pursuant to this subsection. The issuance of a stop-work order by the executive director or the executive director's designee constitutes final agency action.

A. A hiring agent or construction subcontractor must receive at least 3 business days' notice of a hearing regarding a stop-work order. The executive director or the executive director's designee shall stay the issuance of a stop-work order if the hiring agent or subcontractor provides evidence acceptable to the executive director or the executive director's designee that the hiring agent or subcontractor has provided and will continue to provide workers' compensation coverage for the employees of that hiring agent or subcontractor or for the individuals whose status as employees or independent contractors is in question. Providing such coverage may not be evidence at the hearing that the hiring agent or subcontractor was required to do so under this Act. [2009, c. 649, §1 (NEW).]

B. If the executive director or the executive director's designee finds at the hearing that the hiring agent or construction subcontractor knowingly failed to provide a workers' compensation insurance policy, the executive director or the executive director's designee shall issue a stop-work order effective immediately on the conclusion of the hearing to that hiring agent or construction subcontractor at the construction site at which the executive director or executive director's designee has determined a violation occurred, unless the hiring agent or subcontractor has provided coverage and will continue to do so pursuant to paragraph A. [2009, c. 649, §1 (NEW).]

C. A stop-work order issued pursuant to this subsection remains in effect until the executive director or the executive director's designee issues an order releasing the stop-work order upon finding that the hiring agent or construction subcontractor has come into compliance with the requirements of this subsection and has paid any penalty assessed under section 324, subsection 3 or has entered into a penalty payment agreement with the board. [2009, c. 649, §1 (NEW).]

D. A stop-work order issued pursuant to this subsection against a hiring agent or construction subcontractor applies to any successor firm, corporation or partnership of the hiring agent or construction subcontractor in the same manner as it applies to the hiring agent or construction subcontractor. [2009, c. 649, §1 (NEW).]

E. Any payment or performance bond issued on or in relation to a construction project subject to a stop-work order may not cover any exposure arising out of or during the shutdown of that project. [2009, c. 649, §1 (NEW).]

For purposes of this subsection, a violation is considered knowing if the hiring agent or construction subcontractor has previously obtained workers' compensation insurance and the insurance has been cancelled or the insurance has not been continued or renewed; has been notified in writing by the board of the need for workers' compensation insurance; or has had one or more previous violations of the requirement to secure the payment to that hiring agent's or construction subcontractor's employees of the compensation provided for by this Act.

[2009, c. 649, §1 (NEW) .]

6. Insurance coverage information for public construction projects. Insurance coverage information regarding construction subcontractors and independent contractors is controlled by this subsection.

A. At the onset of work on any construction project undertaken by the State, the University of Maine System or the Maine Community College System, the general contractor or designated project construction manager, if any, shall provide to the board a list of all construction subcontractors and independent contractors on the job site and a record of the entity to whom that construction subcontractor or independent contractor is directly contracted and by whom that construction subcontractor or independent contractor is insured for workers' compensation purposes. The list must be posted on the board's publicly accessible website and updated as needed. [2011, c. 403, §3 (NEW) .]

B. The board and the Department of Administrative and Financial Services, Bureau of General Services shall cooperate and provide notice to each other regarding the letting of state-funded construction projects and any stop-work order, debarment or other action as either may take or issue. [2011, c. 403, §3 (NEW) .]

C. This subsection provides minimum disclosure standards regarding construction subcontractors and independent contractors and does not preclude the contracting agency from setting more rigorous standards for construction work under its jurisdiction. [2011, c. 403, §3 (NEW) .]

D. If the general contractor or designated project construction manager fails to provide the board with the information required by paragraph A, that person is subject to a fine of not less than \$250. [2011, c. 403, §3 (NEW) .]

[2011, c. 403, §3 (NEW) .]

SECTION HISTORY

2009, c. 452, §5 (NEW). 2009, c. 649, §1 (AMD). 2011, c. 403, §3 (AMD).
2011, c. 643, §9 (AMD). 2011, c. 643, §14 (AFF).

§106. INVALIDITY OF WAIVER OF RIGHTS; CLAIMS NOT ASSIGNABLE

No agreement by an employee, unless approved by the board or by the Commissioner of Labor, to waive the employee's rights to compensation under this Act is valid. No claims for compensation under this Act are assignable or subject to attachment or liable in any way for debt, except for the enforcement of a current support obligation or support arrears pursuant to Title 19-A, chapter 65, subchapter II, article 3 or Title 19-A, chapter 65, subchapter III, or for reimbursement of general assistance pursuant to Title 22, section 4318. [1995, c. 694, Pt. D, §63 (AMD); 1995, c. 694, Pt. E, §2 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 694, §D63 (AMD). 1995, c. 694, §E2 (AFF).

§107. LIABILITY OF 3RD PERSONS; ELECTION OF EMPLOYEE; SUBROGATION

When an injury or death for which compensation or medical benefits are payable under this Act is sustained under circumstances creating in some person other than the employer a legal liability to pay damages, the injured employee may, at the employee's option, either claim the compensation and benefits or obtain damages from or proceed at law against that other person to recover damages. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If the injured employee elects to claim compensation and benefits under this Act, any employer having paid the compensation or benefits or having become liable for compensation or benefits under any compensation payment scheme has a lien for the value of compensation paid on any damages subsequently recovered against the 3rd person liable for the injury. If the employee or the employee's beneficiary fails to pursue the remedy against the 3rd party within 30 days after written demand by the employer, the employer is subrogated to the rights of the injured employee and is entitled to enforce liability in its own name or in the name of the injured party, the accounting for the proceeds to be made on the basis provided. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If the employee or the employee's beneficiary recovers damages from a 3rd person, the employee shall repay to the employer, out of the recovery against the 3rd person, the benefits paid by the employer under this Act, less the employer's proportionate share of cost of collection, including reasonable attorney's fees. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If the employer recovers from a 3rd person damages in excess of the compensation and benefits paid or for which the employer has become liable, then any excess must be paid to the injured employee, less a proportionate share of the expenses and cost of actions or collection, including reasonable attorney's fees. Settlement of any such subrogation claims and the distribution of the proceeds therefrom must have the approval of the court in which the subrogation action is pending or to which it is returnable; or if not in suit, of the board. When the court in which the subrogation action is pending or to which it is returnable is in vacation, the judge of the court, or, if the action is pending in or returnable to the Superior Court, any Justice of the Superior Court has the power to approve the settlement of the action and the distribution of the proceeds therefrom. The beneficiary is entitled to reasonable notice and the opportunity to be present in person or by counsel at the approval proceeding. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§108. PREFERENCE OF CLAIMS

A claim for compensation under this Act and any compensation payment scheme are entitled to a preference over the unsecured debts of the employer to the same amount as the wages of labor are preferred by the laws of this State. Nothing in this section may be construed as impairing any lien that the employee may have acquired. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§109. COMPILATION OF CLAIMS INFORMATION

A person or entity may not compile for the purpose of distribution and sale listings of employee names and information regarding their claims with the board. Any person or entity found by the board to have violated this section is subject to the remedy provision of the Maine Human Rights Act, Title 5, sections 4613 and 4614. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§110. COLLECTIVE BARGAINING

1. Permitted options. Subject to the limitation of subsection 2, the board shall recognize as valid and binding a provision in a collective bargaining agreement between an employer and a recognized bargaining agent establishing any of the following:

- A. Alternative dispute resolution systems that may include, but are not limited to, mediation or binding arbitration or the use of mediation and binding arbitration; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF).]
- B. Preferred provider systems for the delivery of health care services or treatment; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF).]
- C. The use of a designated or limited list of independent medical examiners; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF).]
- D. Light-duty, modified job or return-to-work programs; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF).]
- E. Vocational rehabilitation or retraining programs; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF).]
- F. A 24-hour coverage program. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF) .]

2. Limitation. An agreement pursuant to subsection 1 may not diminish an employee's entitlement to benefits guaranteed by this Act. Any agreement in violation of this subsection is null and void.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§8-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§111. ALTERNATIVE PROGRAMS

After consultation with the Superintendent of Insurance, the board may approve an agreement entered into between an employer and some or all of the employer's employees to secure the payment of compensation and benefits through an alternative program that is different from but not less than the compensation and benefits provided by this Act. The alternative program may not be approved by the board unless it provides for compensation and benefits in addition to those required by this Act and unless it is for a fixed period of time. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§112. WORKERS' COMPENSATION COVERAGE FOR FOREST FIREFIGHTERS

Notwithstanding Title 12, section 8901, subsection 2 and Title 12, sections 8902, 8905, 9201, 9202, 9204 and 9205, workers' compensation coverage is provided to forest fire wardens and laborers hired by municipalities for forest fire-fighting activities as follows. [1993, c. 439, §1 (NEW).]

1. Municipal responsibility. The municipality is responsible for workers' compensation costs for injuries that occur while the municipality is in actual control of forest fire-fighting activities.

[1993, c. 439, §1 (NEW) .]

2. State responsibility. The State is responsible for workers' compensation costs for injuries that occur while the State is in actual control of forest fire-fighting activities.

[1993, c. 439, §1 (NEW) .]

For purposes of this section, "actual control" means on-site supervisory responsibility for the entire command structure directing forest fire-fighting activities at the fire scene. A municipality is assumed to be in actual control until the State accepts or takes actual control. [1993, c. 439, §1 (NEW).]

SECTION HISTORY

1993, c. 439, §1 (NEW).

§113. EXEMPTION FOR NONRESIDENT EMPLOYEES; RECIPROCITY

1. Exemption. An employee who is employed in another state and that employee's employer are exempt from this Act with respect to that employee while the employee is temporarily in this State doing work for that employer if:

A. The employee is not a resident of this State and was not hired in this State; [1995, c. 70, §1 (NEW).]

B. The employer does not have a permanent place of business in the State; [1995, c. 70, §1 (NEW).]

C. The employee's presence in this State for purposes of conducting employment activities does not exceed any of the following periods:

(1) Five consecutive days;

(2) Ten days in any 30-day period; or

(3) Thirty days in any 360-day period; [1995, c. 70, §1 (NEW).]

D. The employer and employee are covered by the provisions of the workers' compensation laws or similar laws of the other state and that law applies to them while they are working in this State; [1995, c. 70, §1 (NEW).]

E. The employer has furnished workers' compensation insurance coverage under the workers' compensation laws or similar laws of the other state so as to cover the employee's employment while in this State; [1995, c. 70, §1 (NEW).]

F. The extraterritorial provisions of this Act covering employees in this State temporarily working in the other state are recognized in the other state; and [1995, c. 70, §1 (NEW).]

G. Employers and employees covered in this State are exempt from the application of the workers' compensation laws or similar laws of the other state under legislation comparable to this section.

[1995, c. 70, §1 (NEW) .]

[1995, c. 70, §1 (NEW) .]

2. Other state's laws prevail. If the exemption provided in subsection 1 applies, the workers' compensation laws or similar laws of the other state are the exclusive remedy against the employer in that state for any injury, whether resulting in death or not, received by an employee while working for that employer in this State.

[1995, c. 70, §1 (NEW) .]

3. Certificate of compliance. A certificate from a duly authorized official of the workers' compensation board or similar department or agency of the other state certifying that an employer is insured in that other state and has provided extraterritorial coverage insuring the employer's employees while working within this State is prima facie evidence that the employer carries such compensation insurance.

[1995, c. 70, §1 (NEW) .]

4. Reciprocal agreements. The board may enter into reciprocal agreements with workers' compensation agencies of other states adopting legislation similar to this section to ensure efficient administration of the Act.

[1995, c. 70, §1 (NEW) .]

SECTION HISTORY

1995, c. 70, §1 (NEW) .

§114. INDEPENDENT CONTRACTOR STATUS FOR TRUCKERS AND COURIERS

(REPEALED)

SECTION HISTORY

2011, c. 176, §1 (NEW). 2011, c. 643, §14 (AFF). 2011, c. 643, §10 (RP) .

Chapter 3: WORKERS' COMPENSATION BOARD

§151. WORKERS' COMPENSATION BOARD

1. Board established. Pursuant to Title 5, section 12004-G, subsection 35, the Workers' Compensation Board is established as an independent board composed of 7 members. The members of the board, including the executive director, must be appointed by the Governor within 30 days after a new board member is authorized or a vacancy occurs, subject to review by the joint standing committee of the Legislature having jurisdiction over labor matters and confirmation by the Legislature. Notwithstanding the provisions of Title 3, section 157, the designated committee shall complete its review of the appointments of the Governor within 15 days of the Governor's written notice of appointment and the vote of the Legislature must be taken no later than 7 days after the vote of the designated committee.

The board consists of 3 representatives of management, 3 representatives of labor and the executive director appointed pursuant to subsection 1-A. All management representatives must be appointed from a list provided by the Maine Chamber of Commerce and Industry or other bona fide organization or association of

employers. All labor representatives must be from a list provided by the Executive Board of the Maine AFL-CIO or other bona fide labor organization or association of employees representing at least 10% of the Maine work force. Any list submitted to the Governor must have at least 4 times the number of names as there are vacancies for the group represented by the vacancies.

A member of the board is not liable in a civil action for any act performed in good faith in the execution of duties as a board member.

A member of the board may not be a lobbyist required to be registered with the Commission on Governmental Ethics and Election Practices, a service provider to the workers' compensation system or a representative of a service provider to the workers' compensation system. In addition to the conflict of interest provisions in section 152, subsection 8, a member of the board may not take part in reaching a decision or recommendation in any matter that directly affects an insurer, self-insurer, group self-insurer or labor organization that the member represents.

Members of the board representing management and labor hold office for staggered terms of 4 years, commencing and expiring on February 1st, except for initial appointees and members appointed to fill unexpired terms.

[2009, c. 640, §1 (AMD) .]

1-A. Executive director. The Governor shall appoint an executive director, who is the chair and chief executive officer of the board. The executive director serves at the pleasure of the Governor. Except as otherwise provided, the executive director shall, at the direction of the board, hire personnel as necessary to administer this Act, subject to the Civil Service Law.

[2003, c. 608, §6 (NEW) .]

2. Removal. Board members representing management and labor hold office for the terms provided, unless removed, and until their successors are appointed and qualified. They must be sworn and may be removed by the Governor for inefficiency, willful neglect of duty or malfeasance in office, but only with the review and concurrence of the joint standing committee of the Legislature having jurisdiction over labor matters upon hearing in executive session or by impeachment. Before removing a board member, the Governor shall notify the President of the Senate and the Speaker of the House of Representatives of the removal and the reasons for the removal.

[2003, c. 608, §7 (AMD) .]

3. Vacancies. If a vacancy occurs during a term of a management or labor member, the Governor shall appoint a replacement to fill the unexpired part of the term. The replacement must be from the group represented by the member being replaced.

[2003, c. 608, §7 (AMD) .]

4. Chair.

[2003, c. 608, §8 (RP) .]

5. Voting requirements; meetings. The board may take action only by majority vote of its membership. The board may hold sessions at its central office or at any other place within the State and shall establish procedures through which members who are not physically present may participate by telephone or other remote-access technology. Regular meetings may be called by the executive director or by any 4 members of the board, and all members must be given at least 7 days' notice of the time, place and agenda of the meeting. A quorum of the board is 4 members, but a smaller number may adjourn until a quorum is present. Emergency meetings may be called by the executive director when it is necessary to take action before a regular meeting can be scheduled. The executive director shall make all reasonable efforts to notify

all members as promptly as possible of the time and place of any emergency meeting and the specific purpose or purposes for which the meeting is called. For an emergency meeting, the 4 members constituting a quorum must include at least one board member representing management and at least one board member representing labor.

[2003, c. 608, §9 (AMD) .]

6. Salary; expenses. A board member is entitled to a per diem of \$100 per day. Members of the board receive their actual, necessary, cash expenses while on official business of the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Leave of absence. An employer may not terminate the employment of an employee who is appointed as a member of the board because of the exercise by the employee of duties required as a board member. The member is entitled to a leave of absence from employment for the period of time required to perform the duties of a board member. During the leave of absence, the member may not be subjected to loss of time, vacation time, or benefits of employment, excluding salary.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Headquarters; regional offices. The board must have its central office in the Augusta area and such district offices as it may choose to establish. The board may hold sessions at any place within the State.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Seal. The board must have a seal bearing the words "Workers' Compensation Board of Maine."

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2003, c. 382, §1 (AMD). 2003, c. 608, §§5-9 (AMD). 2009, c. 640, §1 (AMD).

§151-A. MISSION STATEMENT

The board's mission is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation. [1997, c. 486, §1 (NEW).]

SECTION HISTORY

1997, c. 486, §1 (NEW).

§152. AUTHORITY OF BOARD; ADMINISTRATION

1. General responsibility. The board has general supervision over the administration of this Act and responsibility for the efficient and effective management of the board and its employees.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Rules. Subject to any applicable requirements of the Maine Administrative Procedure Act, the board shall adopt rules to accomplish the purposes of this Act. Those rules may define terms, prescribe forms and make suitable orders of procedure to ensure the speedy, efficient, just and inexpensive disposition of all proceedings under this Act.

The board shall adopt rules establishing a policy and procedures to safeguard the confidentiality of the records of the former Workers' Compensation Commission and the Workers' Compensation Board pertaining to individual injured employees. The policy must make records available on a need-to-know basis only and must include legitimate research purposes while protecting individual confidentiality.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2-A. Electronic filing rulemaking. The board shall adopt rules requiring the electronic filing of information required by this Act and by board rule. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

A. The rules must be developed through the consensus-based rule development process set forth in Title 5, section 8051-B and must include as participants representatives of employers, insurers and 3rd-party administrators. [2003, c. 425, §1 (NEW).]

B. The rules must include written standards and procedures for implementation of the standards, which may include definition of the applicable programming interface for in-state and out-of-state entities required to submit reports. The rules must relate specific forms required to be filed with data points in the standards. [2003, c. 425, §1 (NEW).]

Before adopting the rules, the board shall test the applicable application programming interfaces and standards to ensure that the program operates successfully.

[2003, c. 425, §1 (NEW) .]

3. Employment of executive director.

[2003, c. 608, §10 (RP) .]

4. Employment of general counsel. The board shall employ a general counsel, who is the legal adviser to the board and who shall perform such other duties as may be assigned by the board, and assistants as necessary. The general counsel and assistants to the general counsel are unclassified employees, serve at the pleasure of the board and are not subject to the Civil Service Law.

The board shall appoint a staff attorney to advise the advocates pursuant to section 153-A. The staff attorney is subject to the Civil Service Law and works under the direction of the general counsel.

[1997, c. 486, §2 (AMD) .]

5. Employment of and contracts with hearing officers and mediators. The board shall obtain the services of persons qualified by background and training to serve as hearing officers, who are authorized to take action and enter orders consistent with this Act in all cases assigned to them by the board, and mediators. In the exercise of its discretion, the board may obtain the services of hearing officers and mediators by either of the 2 following methods:

A. The board may contract for the services of hearing officers and mediators, in which case they must be paid reasonable per diem fees for their services plus reimbursement of their actual, necessary and reasonable expenses incurred in the performance of their duties, consistent with policies established by the board; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

B. The board may employ hearing officers and mediators to serve at the pleasure of the board and who are not subject to the Civil Service Law. They are entitled to receive reimbursement of their actual, necessary and reasonable expenses incurred in the performance of their duties, consistent with policies established by the board. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Hiring of personnel. The board shall appoint the directors of the bureaus and divisions of the board and their deputies and assistants, who are unclassified employees, serve at the pleasure of the board and are not subject to the Civil Service Law.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Powers and duties of board. The board has all powers as are necessary to carry out its functions under the law. The board may delegate any powers and duties as necessary.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Conflict of interest. Each member of the board and each employee, contractor, agent or other representative of the board are "executive employees" for purposes of Title 5, section 18 and are subject to the limitations of that section. In addition, Title 17, section 3104 is applicable, in accordance with its provisions, to all such representatives of the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Accepting gifts, grants or donations. The board may accept gifts, grants or donations for the use of the board as provided by rules adopted by the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Case administration. The board shall assume an active and forceful role in the administration of this Act to ensure that the system operates efficiently and with maximum benefit to both employers and employees. It shall continually monitor individual cases to ensure that benefits are provided in accordance with this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

11. Recommending legislative change. The board shall consider and recommend to the Legislature changes in this Act. Recommended changes must be forwarded to the Legislature annually on or before December 1st.

[1995, c. 103, §1 (AMD) .]

12. Advisory committees. The board may appoint advisory committees as it determines necessary to assist the board in matters that arise under this Act. Advisory committee members are not entitled to compensation but may be reimbursed for travel and reasonable expenses as determined by the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

13. Budget. The board shall administer its budget, with the assistance of the executive director.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

14. Reimbursement. The board shall impose reasonable charges for reimbursement for the provision of services, facilities and materials, including, but not limited to, reproduction and distribution of forms, reports and publications, photocopying and the use of facilities.

[1993, c. 145, §3 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 145, §3 (AMD). 1995, c. 103, §1 (AMD). 1997, c. 486, §2 (AMD). 2003, c. 425, §1 (AMD). 2003, c. 608, §10 (AMD).

§153. BOARD ACTIONS

In addition to other actions required of or permitted the board under this Act, the board shall perform the actions required by this section to ensure just and efficient administration of claims. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Monitor payments. The board shall monitor cases to ensure that:

A. Payments are initiated within the time limits established in section 205; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Payments to the employee provide the full amount of compensation to which the employee is entitled and are properly indicated on the memorandum of payment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Troubleshooter program. The board shall establish a troubleshooter program to provide information and assistance to participants in the workers' compensation system. The troubleshooter may meet or otherwise communicate with employees, employers, insurance carriers and health care providers in order to prevent or informally resolve disputes.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Construction. In interpreting this Act, the board shall construe it so as to ensure the efficient delivery of compensation to injured employees at a reasonable cost to employers. All workers' compensation cases must be decided on their merits and the rule of liberal construction does not apply. Accordingly, this Act is not to be given a construction in favor of the employee, nor are the rights and interests of the employer to be favored over those of the employee.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Information. The board shall require the employee, employer or insurer to provide it with any information it reasonably determines necessary to monitor cases, including, but not limited to, preinjury and postinjury wage statements.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Abuse investigation unit. The board shall provide adequate funding for an abuse investigation unit.

A. The board shall, subject to the Civil Service Law, appoint at least 2 abuse investigators who must be qualified by experience and training to perform their duties. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The unit shall, at the direction of the board, investigate all complaints or allegations of fraud, illegal or improper conduct or violation of this Act or rules of the board relating to workers' compensation insurance, benefits or programs, including those acts by employers, employees or insurers. All records, correspondence and reports of investigation in connection with actual or alleged fraud, illegal or improper conduct or violation of this Act or rules of the board and all records, correspondence and reports of criminal prosecution or civil action are confidential. The confidential nature of any such record, correspondence or report does not limit or affect the use of those materials in any prosecution or action or prevent the board, upon request, from providing information to another state agency for use by the agency in enforcing laws and rules. [2009, c. 520, §1 (AMD).]

C. Each employer or employee and each state, county, municipal or quasi-governmental agency shall cooperate fully with the unit and provide any information requested by it. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. The unit shall report all its findings to the board. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Whenever the board determines that a fraud, attempted fraud or violation of this Act or rules of the board may have occurred, the board shall report in writing all information concerning it to the Attorney General or the Attorney General's delegate for appropriate action, including a civil action for recovery of funds and criminal prosecution by the Attorney General. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2009, c. 520, §1 (AMD) .]

6. Mediation. The board shall establish a mediation program to provide mediation services to parties to workers' compensation cases.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Investigation. The board may, when the interests of any of the parties or when the administration of this Act demands, appoint a person to make a full investigation of the circumstances surrounding any industrial injury or any matter connected to an industrial injury, or conduct an audit pursuant to section 359 and report the same without delay to the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Impairment guidelines. The following provisions apply regarding impairment guidelines.

A. In order to reduce litigation and establish more certainty and uniformity in the rating of permanent impairment, the board shall establish by rule a schedule for determining the existence and degree of permanent impairment based upon medically or scientifically demonstrable findings. The schedule must be based on generally accepted medical standards for determining impairment and may incorporate all or part of any one or more generally accepted schedules used for that purpose, such as the American Medical Association's "Guides to the Evaluation of Permanent Impairment." Pending the adoption of a permanent schedule, "Guides to the Evaluation of Permanent Impairment," 3rd edition, copyright 1990, by the American Medical Association, is the temporary schedule and must be used for the purposes of this subsection. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The board shall collect and analyze data from Maine cases, studies from other states and generally accepted medical guidelines for occupational impairment to examine the feasibility and desirability of establishing an objectively ascertainable functional capacity standard to be used for determining eligibility for benefits under this Act consistent with section 213, subsection 2. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Audit and enforcement. The executive director shall establish an audit, enforcement and monitoring program by July 1, 1998, to ensure that all obligations under this Act are met, including the requirements of section 359. The functions of the audit and enforcement program include, but are not limited to, auditing timeliness of payments and claims handling practices of insurers, self-insurers, the Maine Insurance Guaranty Association and 3rd-party administrators; determining whether insurers, self-insurers, the Maine Insurance Guaranty Association and 3rd-party administrators are unreasonably contesting claims; and ensuring that all reporting requirements to the board are met. When auditing the Maine Insurance Guaranty Association, the program shall consider when the Maine Insurance Guaranty Association obtained the records of an insolvent insurer. The program must be coordinated with the abuse investigation unit established by section 153,

subsection 5 as appropriate. The program must monitor activity and conduct audits pursuant to a schedule developed by the deputy director of benefits administration. Audit working papers are confidential and may not be disclosed to any person outside of the board except the audited entity. For purposes of this subsection "audit working papers" means all documentary and other information acquired, prepared or maintained by the board during the conduct of an audit or investigation, including all intra-agency and interagency communications relating to an audit or investigation and draft reports or any portion of a draft report. The final audit report, including the underlying reconciled information, is not confidential. At the end of each calendar quarter, the executive director shall prepare a compliance report summarizing the results of the audits and reviews conducted pursuant to this subsection. The executive director shall submit the quarterly compliance reports to the board, the Bureau of Insurance and the Director of the Bureau of Labor Standards within the Department of Labor. An annual summary must be provided to the Governor and to the joint standing committees of the Legislature having jurisdiction over labor and banking and insurance matters by February 15th of each year. The quarterly compliance reports and the annual summaries must be made available to the public following distribution.

[2005, c. 603, §3 (AMD) .]

10. Annual report to Legislature. The board shall collect and analyze data from Maine cases on permanent impairment ratings and costs to employers associated with the compensation for partial incapacity pursuant to section 213. The board shall provide annually by January 31st a report to the joint standing committee of the Legislature having jurisdiction over labor matters regarding the data collected.

[2011, c. 647, §1 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1997, c. 486, §3 (AMD). 1999, c. 354, §2 (AMD). 2005, c. 603, §3 (AMD). 2009, c. 520, §1 (AMD). 2011, c. 647, §1 (AMD).

§153-A. ADVOCATE PROGRAM

1. Advocate program established. The board shall establish an advocate program to provide assistance to qualified employees who proceed to mediation and formal hearing.

[1997, c. 486, §4 (NEW) .]

2. Qualified employee. For purposes of this section, "qualified employee" means an employee who, with respect to an injury occurring on or after January 1, 1993, has participated in the troubleshooter program and has not informally resolved the dispute and has demonstrated to the board that legal counsel has not been retained.

[1997, c. 486, §4 (NEW) .]

3. Advocates and advocate attorneys. The executive director shall hire advocates and advocate attorneys under the authority of section 151, subsection 1-A, subject to the Civil Service Law, who must be qualified by experience and training.

A. The minimum qualifications for employment as an advocate must include at least the following:

- (1) A 6-year combination of appropriate experience, education and training in advocacy or dispute resolution;
- (2) Knowledge of administrative, adjudicatory or workers' compensation laws, rules and procedures;
- (3) Knowledge of legal documents, court procedures and rules of evidence; and

(4) Knowledge of medical and legal terminology and practices with respect to workers' compensation. [1997, c. 486, §4 (NEW).]

A-1. The minimum qualifications for employment as an advocate attorney must include at least admission to the practice of law in the State and current registration with the Board of Overseers of the Bar or eligibility for admission to practice law in the State, as long as the advocate attorney is admitted to practice law in the State and is registered with the Board of Overseers of the Bar within 12 months of the date the advocate attorney was hired. [2007, c. 312, §2 (NEW).]

B. The board shall ensure that advocates and advocate attorneys receive appropriate and ongoing education and training. [2007, c. 312, §2 (AMD).]

C. An advocate or advocate attorney may not represent before the board any insurer, self-insurer or 3rd-party administrator for a period of 2 years after terminating employment with the board. [2007, c. 312, §2 (AMD).]

[2007, c. 312, §2 (AMD) .]

4. Duties of advocates and advocate attorneys. Advocates and advocate attorneys have the following duties:

A. Assisting qualified employees in matters regarding workers' compensation claims, including negotiations; [1997, c. 486, §4 (NEW).]

B. Acting as an information resource to qualified employees on laws, decisions, rules, policies and procedures of the board; [1997, c. 486, §4 (NEW).]

C. Assisting and advocating on behalf of qualified employees to obtain appropriate rehabilitation, return to work and employment security services; [1997, c. 486, §4 (NEW).]

D. Meeting with or otherwise communicating with insurers, employers and health care and other authorized providers in order to assist qualified employees; [1997, c. 486, §4 (NEW).]

E. Assisting and advocating on behalf of qualified employees in any mediation or hearing proceeding under the jurisdiction of the board; and [1997, c. 486, §4 (NEW).]

F. Maintaining confidentiality of information and communications with respect to the assistance and representation provided to qualified employees. [1997, c. 486, §4 (NEW).]

[2007, c. 312, §3 (AMD) .]

5. Legal advice to advocates and advocate attorneys. The board's general counsel shall assign a staff attorney as necessary to advise advocates and, as necessary, advocate attorneys on the preparation of qualified employees' cases at the formal hearing stage.

[2007, c. 312, §4 (AMD) .]

6. Case management authority of advocates and advocate attorneys. An advocate or advocate attorney has the authority to:

A. Manage and prioritize the advocate's or advocate attorney's caseload to efficiently move cases through the board mediation and hearing process and to achieve resolution; [2007, c. 312, §5 (AMD).]

B. With the written approval of the staff attorney, decline cases or cease assistance to an employee when the advocate or advocate attorney after investigation finds:

- (1) Timely notice of the injury was not given by the employee to the employer, pursuant to this Act;
- (2) The statute of limitations has expired;

(3) The employee's case is based on an argument or issue adversely determined by the Supreme Judicial Court;

(4) The employee's case is based on a claim of discrimination governed by section 353;

(5) There is no record of medical assessment stating that the employee's injury was either caused by, aggravated by or precipitated by the employee's work or, when the issue is aggravation, there is no record of medical assessment stating that the employee's work aggravated a preexisting condition in a significant manner; or

(6) The employee has admitted to a fraudulent act, has been convicted of a fraudulent act by a court of competent jurisdiction or has been found to have committed a fraudulent act by the abuse investigation unit of the board; and [2007, c. 312, §5 (AMD).]

C. With the written approval of the staff attorney, present lump-sum settlements on cases pursuant to section 352. [1999, c. 410, §1 (NEW).]

A qualified employee whose case is declined or whose advocate or advocate attorney assistance ceases pursuant to this subsection may appeal the action to the executive director of the board, within 30 days of the action. The executive director's ruling on the appeal is final and is not subject to judicial review. If the executive director finds assistance by an advocate or advocate attorney should resume, the employee must be assigned to an advocate or advocate attorney other than the advocate or advocate attorney who declined the case or ceased assistance.

[2007, c. 312, §5 (AMD) .]

7. Rulemaking. In addition to the case management authority established in subsection 6, the board may establish by rule additional reasons for which the advocates may decline or cease assistance on cases. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 410, §1 (NEW) .]

SECTION HISTORY

1997, c. 486, §4 (NEW). 1999, c. 410, §1 (AMD). 2003, c. 608, §11 (AMD). 2007, c. 312, §§2-5 (AMD).

§154. DEDICATED FUND; ASSESSMENT ON WORKERS' COMPENSATION INSURERS AND SELF-INSURED EMPLOYERS

The Workers' Compensation Board Administrative Fund is established to accomplish the purposes of this Act. All income generated pursuant to this section must be recorded on the books of the State in a separate account and deposited with the Treasurer of State and be credited to the Workers' Compensation Board Administrative Fund. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Use of fund. All money credited to the Workers' Compensation Board Administrative Fund must be used to support the activities of the board and for no other purpose. Any balance remaining continues from year to year as a fund available for the purposes set out in this section and for no other purpose.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Expenditures. Expenditures from the Workers' Compensation Board Administrative Fund are subject to legislative approval and allocation in the same manner as appropriations are made from the General Fund. The joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs shall approve the allocation.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Assessment on workers' compensation insurance. The following provisions apply regarding the Workers' Compensation Board assessment on workers' compensation insurance.

A. Every insurance company or association that writes workers' compensation insurance in the State and that does business or collects premiums or assessments in the State, including newly licensed insurance companies and associations, shall pay to the board the assessment determined pursuant to this section for the purpose of providing partial support and maintenance of the board. [1995, c. 59, §1 (AMD).]

B. The assessment must be stated as a percentage of each employer's premium base. In determining the assessment percentage, consideration must be given to the balance in the Workers' Compensation Board Administrative Fund. [1995, c. 59, §1 (AMD).]

B-1. An employer's premium base for assessment purposes is defined as payroll times the filed manual rate applicable to the employer times the employer's current experience modification factor, if applicable. The calculation may not include any deductible credit, other than credits for the \$1,000 and \$5,000 indemnity deductibles and the \$250 and \$500 medical deductibles established pursuant to Title 24-A, sections 2385 and 2385-A. For policies written using retrospective rating, the premium base must be calculated in accordance with this paragraph regardless of the actual retrospective premium calculation.

The employer's premium base is subject to the final audit requirements of the Bureau of Insurance Rule, Chapter 470. If the audit results in a change in premium base, the amount of the assessment must be adjusted accordingly. [1995, c. 59, §1 (NEW).]

C. For each fiscal year, the initial assessment percentage must be determined by the board by May 1st of the prior fiscal year. Insurance companies or associations must begin collecting the initial assessment from all employers on July 1st of each year. In establishing the assessment percentage, the board shall estimate the expected premium base for the upcoming fiscal year based on the returns filed under paragraph D and anticipated trends in the insurance marketplace. The board shall consult with the Bureau of Insurance and other knowledgeable sources to help determine the trends. The board may adjust the assessment percentage at any time but shall provide written notice to the affected companies and associations at least 45 days prior to the effective date of the adjustment. The board may not adjust the assessment percentage more than 3 times in a fiscal year. The adjusted assessment percentage must be applied prospectively on policies with an effective date on or after the effective date of the adjustment. [1995, c. 59, §1 (AMD).]

D. Every insurance company or association subject to the assessment imposed by this section with an estimated annual payment of \$50,000 or more based on previous assessment returns may make payments quarterly. Each insurance company or association electing quarterly payments must on or before the last day of each January, each April, the 25th day of each June and the last day of each October file with the board on forms prescribed by the board a return for the quarter ending the last day of the preceding month, except the month of June, which is for the quarter ending June 30th and remit payment of the assessment based upon the results for the quarter reported. A final reconciled annual return must be filed on or before September 15th covering the prior fiscal year in which the previous assessment was levied. The final return must be certified by the company's or association's chief financial officer. Insurance companies or associations with an annual assessment estimate of under \$50,000 shall pay the assessment on or before June 1st and shall also file a quarterly and an annual return on forms prescribed by the board. Affiliated insurers may aggregate their collection volume in order to meet the \$50,000 assessment threshold as long as the affiliation is consistent with the standards defined in Title 24-A, section 222. Those qualifying insurance companies or associations that opt to consolidate their quarterly payments and reports may do so only if each individually licensed company or association is individually reported within each consolidated return. [1995, c. 59, §1 (AMD).]

[1995, c. 59, §1 (AMD) .]

4. Assessment on self-insured employers. Every self-insured employer approved pursuant to section 403 shall, for the purpose of providing partial support and maintenance of the board, pay an assessment on aggregate benefits paid by each member pursuant to section 404, subsection 4. This assessment must be a dollar amount.

[1995, c. 59, §2 (AMD) .]

5. Amounts of premiums and losses; distribution of assessment. The Bureau of Insurance shall provide to the board the amounts of gross direct workers' compensation premiums written by each insurance carrier and the amounts of aggregate benefits paid by each self-insurer and group self-insurer on or before April 1st of each year. Beginning with the assessment for the fiscal year beginning July 1, 1995 and thereafter, the total assessment must be distributed between insurance companies or associations and self-insured employers in direct proportion to the pro rata share of disabling cases attributable to each group for the most recent calendar year for which data is available. This distribution of the assessment must be determined on a basis consistent with the information reported by the Department of Labor, Bureau of Labor Standards, Research and Statistics Division in its annual Characteristics of Work-Related Injuries and Illnesses in Maine publication, provided that any segment of the market identified as "not-insured" be excluded from the calculation of proportionate shares. In consultation with the Director of Labor Standards, the board shall determine a date prior to the required assessment to establish the distribution.

[1995, c. 59, §3 (AMD) .]

6. Assessment. Assessments levied under this section are subject to the following.

A. The assessments levied under this section may not be designed to produce more than \$10,000,000 beginning in the 2008-09 fiscal year, more than \$10,400,000 beginning in the 2009-10 fiscal year, more than \$10,800,000 beginning in the 2010-11 fiscal year or more than \$11,200,000 beginning in the 2011-12 fiscal year. Assessments collected that exceed the applicable limit by a margin of more than 10% must be used to reduce the assessment that is paid by insured employers pursuant to subsection 3. Any amount collected above the board's allocated budget and within the 10% margin must be used to create a reserve of up to 1/4 of the board's annual budget. [2009, c. 109, §1 (AMD); 2009, c. 109, §2 (AFF) .]

B. The board, by a majority vote of its membership, may use its reserve to assist in funding its Personal Services account expenditures and All Other account expenditures and to help defray the costs incurred by the board pursuant to this Act including administrative expenses, consulting fees and all other reasonable costs incurred to administer this Act. The board shall notify the chairs and members of the joint standing committee of the Legislature having jurisdiction over labor matters whenever the board receives approval from the State Budget Officer and the Governor to use reserve funds to increase its allotment above the allocation authorized by the Legislature. Any collected amounts or savings above the allowed reserve must be used to reduce the assessment for the following fiscal year. [2007, c. 240, Pt. LL, §1 (NEW) .]

C. The board shall determine the assessments prior to May 1st annually and shall assess each insurance company or association and self-insured employer its pro rata share for expenditures during the fiscal year beginning the immediately following July 1st. Each self-insured employer shall pay the assessment on or before the immediately following June 1st. Each insurance company or association shall pay the assessment in accordance with subsection 3. [2007, c. 240, Pt. LL, §1 (NEW) .]

[2009, c. 109, §1 (AMD); 2009, c. 109, §2 (AFF) .]

7. Insurance company or association collections. Insurance companies or associations shall bill and collect assessments under this section on insured employers. The assessments must be separately stated amounts on all premium notices and may not be reported as premiums for any tax or regulatory purpose or for

the purpose of any other law. All collected payments must be submitted to the board with the next quarterly payment. The Bureau of Insurance shall report to the board all newly authorized workers' compensation carriers in order to facilitate notification to the new carrier of its obligations under this section.

[1995, c. 59, §5 (AMD) .]

8. Violations. Any insurance company, association or self-insured employer subject to this section that willfully fails to pay an assessment in accordance with this section commits a civil violation for which a forfeiture of not more than \$500 may be adjudged for each day following the due date for which payment is not made.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Deposit of funds; investment. All revenues derived from assessments levied against insurance companies, associations and self-insured employers described in this section must be reported and paid to the Treasurer of State and credited to the Workers' Compensation Board Administrative Fund. The Treasurer of State may invest the funds in accordance with state law. All interest must be paid to the fund.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Deposit of funds in Workers' Compensation Board Administrative Fund. The Treasurer of State shall deposit in the Workers' Compensation Board Administrative Fund funds collected pursuant to section 152, subsection 14.

[1993, c. 145, §5 (NEW) .]

11. Assessment errors.

[1995, c. 59, §6 (RP) .]

12. Audit. In consultation with the Bureau of Insurance, the board may audit all returns and investigate any issues relevant to the collection and payment of any assessment under this section.

[1995, c. 59, §7 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 145, §§4,5 (AMD). 1993, c. 619, §§2,3 (AMD). 1995, c. 59, §§1-7 (AMD). 1997, c. 486, §5 (AMD). 1999, c. 359, §1 (AMD). 2001, c. 393, §1 (AMD). 2001, c. 692, §1 (AMD). 2003, c. 93, §1 (AMD). 2003, c. 425, §2 (AMD). 2007, c. 240, Pt. LL, §1 (AMD). 2009, c. 109, §1 (AMD). 2009, c. 109, §2 (AFF).

Chapter 5: COMPENSATION AND SERVICES

§201. ENTITLEMENT TO COMPENSATION AND SERVICES GENERALLY

1. Entitlement. If an employee who has not given notice of a claim of common law or statutory rights of action, or who has given the notice and has waived the claim or rights, as provided in section 301, receives a personal injury arising out of and in the course of employment or is disabled by occupational disease, the employee must be paid compensation and furnished medical and other services by the employer who has assented to become subject to this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Injury while participating in rideshare programs. An employee injured while participating in a private, group or employer-sponsored car pool, van pool, commuter bus service or other rideshare program, having as its sole purpose the mass transportation of employees to and from work, for the purposes of this Act, may not be deemed to have received personal injury arising out of or in the course of employment. Nothing in the foregoing may be held to deny benefits under this Act to employees such as drivers, mechanics and others who receive remuneration for their participation in the rideshare programs.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Mental injury caused by mental stress. Mental injury resulting from work-related stress does not arise out of and in the course of employment unless it is demonstrated by clear and convincing evidence that:

A. The work stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The work stress, and not some other source of stress, was the predominant cause of the mental injury. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The amount of work stress must be measured by objective standards and actual events rather than any misperceptions by the employee.

A mental injury is not considered to arise out of and in the course of employment if it results from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination or any similar action, taken in good faith by the employer.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Preexisting condition. If a work-related injury aggravates, accelerates or combines with a preexisting physical condition, any resulting disability is compensable only if contributed to by the employment in a significant manner.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Subsequent nonwork injuries. If an employee suffers a nonwork-related injury or disease that is not causally connected to a previous compensable injury, the subsequent nonwork-related injury or disease is not compensable under this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Prior work-related injuries. If an employee suffers a work-related injury that aggravates, accelerates or combines with the effects of a work-related injury that occurred prior to January 1, 1993 for which compensation is still payable under the law in effect on the date of that prior injury, the employee's rights and benefits for the portion of the resulting disability that is attributable to the prior injury must be determined by the law in effect at the time of the prior injury.

[1997, c. 647, §1 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1997, c. 647, §1 (AMD).

§202. INJURY OR DEATH DUE TO WILLFUL INTENTION OR INTOXICATION

Compensation or other benefits are not allowed for the injury or death of an employee when it is proved that the injury or death was occasioned by the employee's willful intention to bring about the injury or death of the employee or of another, or that the injury or death resulted from the employee's intoxication while on duty. This provision as to intoxication does not apply if the employer knew at the time of the injury that the employee was intoxicated or that the employee was in the habit at that time of becoming intoxicated while on duty. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§203. INCARCERATION OF EMPLOYEE

1. Compensation while incarcerated. Compensation for incapacity under section 212 or 213 or under any prior workers' compensation laws may not be paid to any person during any period of incarceration imposed in this State or any other jurisdiction after conviction of a criminal offense, except in relation to compensable injuries suffered during incarceration and while the prisoner is:

A. Employed by a private employer; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Participating in a work release program; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. [2013, c. 133, §36 (RP).]

D. Employed in a program established under a certification issued by the United States Department of Justice under 18 United States Code, Section 1761; [2009, c. 529, §5 (AMD).]

E. Employed while in a supervised community confinement program pursuant to Title 34-A, section 3036-A; [2009, c. 529, §5 (AMD).]

F. A prisoner in a county jail under final sentence of 72 hours or less and is assigned to work outside of a county jail; or [2009, c. 529, §5 (NEW).]

G. Employed while in a community confinement monitoring program pursuant to Title 30-A, section 1659-A. [2009, c. 529, §5 (NEW).]

[2013, c. 133, §36 (AMD) .]

2. Compensation forfeited. All compensation that is not payable under subsection 1 is forfeited.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 293, §1 (AMD). 1995, c. 293, §2 (AFF). 2009, c. 142, §§18-20 (AMD). 2009, c. 529, §5 (AMD). 2013, c. 133, §36 (AMD).

§204. WAITING PERIOD; WHEN COMPENSATION PAYABLE

Compensation for incapacity to work is not payable for the first 7 days of incapacity, except that firefighters must receive compensation from the date of incapacity. In case incapacity continues for more than 14 days, compensation is allowed from the date of incapacity. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§205. BENEFIT PAYMENT

1. Prompt and direct payment. Compensation under this Act must be paid promptly and directly to the person entitled to that compensation at the employee's mailing address, or where the employee designates, without an award, except in cases when there is an ongoing dispute.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Time for payment. The first payment of compensation for incapacity under section 212 or 213 is due and payable within 14 days after the employer has notice or knowledge of the injury or death, on which date all compensation then accrued must be paid. Subsequent incapacity payments must be made weekly and in a timely fashion. Every insurance carrier, self-insured and group self-insurer shall keep a record of all payments made under this Act and of the time and manner of making the payments and shall furnish reports, based upon these records, to the board as it may reasonably require.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Penalty for delay. When there is not an ongoing dispute, if weekly compensation benefits or accrued weekly benefits are not paid by the employer or insurance carrier within 30 days after becoming due and payable, \$50 per day must be added and paid to the worker for each day over 30 days in which the benefits are not paid. Not more than \$1,500 in total may be added pursuant to this subsection. For purposes of ratemaking, daily charges paid under this subsection do not constitute elements of loss. For purposes of this subsection, "employer or insurance carrier" includes the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

[2009, c. 129, §5 (AMD); 2009, c. 129, §13 (AFF) .]

4. Payment of bills for medical or health care services. When there is no ongoing dispute, if bills for medical or health care services are not paid within 30 days after the carrier has received notice of nonpayment by certified mail from the provider of the medical or health care services or, if the bill was paid by the employee, from the employee who paid for the medical or health care services, \$50 or the amount of the bill due, whichever is less, must be added and paid to the provider of the medical or health care services or, if the bill was paid by the employee, to the employee who paid for the medical or health care services for each day over 30 days in which the bills for medical or health care services are not paid. Not more than \$1,500 in total may be added pursuant to this subsection. For purposes of this subsection, "carrier" includes the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

[2009, c. 129, §6 (AMD); 2009, c. 129, §13 (AFF) .]

5. Employer failure to provide notice. An employer who has notice or knowledge of the disability or death and fails to give notice to the carrier shall pay the penalty provided for in subsection 3 for the period during which the employer failed to notify the carrier.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Interest. When weekly compensation is paid pursuant to an award, interest on the compensation must be paid at the rate of 10% per annum from the date each payment was due, until paid.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Memorandum of payment. Upon making the first payment of compensation for incapacity or upon making a payment of compensation for impairment, the employer shall immediately forward to the board a memorandum of payment on forms prescribed by the board. This information must include, at a minimum, the following:

A. The names of the employee, employer and insurance carrier; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The date of the injury; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The names of the employee's other employers, if any, or a statement that there is no multiple employment, if that is the case; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. The initial weekly compensation rate. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Information. Information regarding wages must be reported as provided in section 303.

[1999, c. 354, §3 (RPR) .]

9. Discontinuance or reduction of payments. The employer, insurer or group self-insurer may discontinue or reduce benefits according to this subsection.

A. If the employee has returned to work with or has received an increase in pay from an employer that is paying compensation under this Act, that employer or that employer's insurer or group self-insurer may discontinue or reduce payments to the employee. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. In all circumstances other than the return to work or increase in pay of the employee under paragraph A, if the employer, insurer or group self-insurer determines that the employee is not eligible for compensation under this Act, the employer, insurer or group self-insurer may discontinue or reduce benefits only in accordance with this paragraph.

(1) If no order or award of compensation or compensation scheme has been entered, the employer, insurer or group self-insurer may discontinue or reduce benefits by sending a certificate by certified mail to the employee and to the board, together with any information on which the employer, insurer or group self-insurer relied to support the discontinuance or reduction. The employer may discontinue or reduce benefits no earlier than 21 days from the date the certificate was mailed to the employee, except that benefits paid pursuant to section 212, subsection 1 or section 213, subsection 1 may be discontinued or reduced based on the amount of actual documented earnings paid to the employee during the 21-day period if the employer files with the board the documentation or evidence that substantiates the earnings and the employer only reduces or discontinues benefits

for any week for which it possesses evidence of such earning. The certificate must advise the employee of the date when the employee's benefits will be discontinued or reduced, as well as other information as prescribed by the board, including the employee's appeal rights.

(2) If an order or award of compensation or compensation scheme has been entered, the employer, insurer or group self-insurer shall petition the board for an order to reduce or discontinue benefits and may not reduce or discontinue benefits until the matter has been resolved by a decree issued by a hearing officer. The employer, insurer or group self-insurer may reduce or discontinue benefits pursuant to such a decree pending a motion for findings of fact and conclusions of law or pending an appeal from that decree. Upon the filing of a petition, the employer may discontinue or reduce the weekly benefits being paid pursuant to section 212, subsection 1 or section 213, subsection 1 based on the amount of actual documented earnings paid to the employee after filing the petition. The employer shall file with the board the documentation or evidence that substantiates the earnings and the employer may discontinue or reduce weekly benefits only for weeks for which the employer possesses evidence of such earnings. [2011, c. 647, §2 (AMD).]

C. The employee may file a petition for review, contesting the employer's discontinuance or reduction of compensation under this subsection. Regardless of whether the employee files a petition prior to the date of the discontinuance or reduction, benefits may be discontinued or reduced as described in paragraph A or B. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. The board, within 21 days after the employee filed a petition for review, may enter an order providing for the continuation or reinstatement of benefits pending a hearing on the petition. The order must be based upon the information submitted by both the employer, insurer or group self-insurer and the employee under this subsection. Once a request for an order has been ruled upon, the matter may not be referred to mediation, but must be set for hearing. [1999, c. 354, §4 (AMD).]

E. In all cases under this subsection, the board shall provide for an expedited procedure that must be available upon request of any party. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. If benefits have been discontinued or reduced pursuant to paragraph A or B and the board, after hearing, determines that benefits have been wrongfully withheld, the board shall order payment of all benefits withheld together with interest at the rate of 6% a year. The employer shall pay this amount within 10 days of the order. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2011, c. 647, §2 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 354, §§3,4 (AMD). 2007, c. 218, §1 (AMD). 2009, c. 129, §§5, 6 (AMD). 2009, c. 129, §§13 (AFF). 2009, c. 280, §1 (AMD). 2009, c. 280, §2 (AFF). 2011, c. 647, §2 (AMD).

§206. DUTIES AND RIGHTS OF PARTIES AS TO MEDICAL AND OTHER SERVICES; COST

An employee sustaining a personal injury arising out of and in the course of employment or disabled by occupational disease is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Employer selection. The employer initially has the right to select for the employee a health care provider authorized to practice as such under the laws of the State.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Employee selection. After 10 days from the inception of health care under subsection 1, the employee may select a different health care provider by giving to the employer the name of the health care provider and a statement of intention to treat with the health care provider. The employer may file a petition objecting to the named health care provider selected by the employee and setting forth reasons for the objection. The issue of the health care provider must be set for mediation pursuant to section 313. If the objection is not resolved through mediation, after notice to all parties and a prompt hearing by a hearing officer, the hearing officer may order one of the following:

A. If the employer can not show cause why the employee should not commence or continue treatment with the health care provider of the employee's choice, the hearing officer shall order that the employer is responsible for payment for treatment received from the health care provider; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. If the employer can show cause why the employee should not commence or continue treatment with the health care provider of the employee's choice, the hearing officer shall order that the employer is not responsible and that the employee is responsible for payment for treatment received from the health care provider from the date the order is mailed. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Limitation. Once an employee receives treatment from a health care provider pursuant to subsection 2, the employee may not change health care providers more than once without approval from the employer or the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Specialist treatment. This section does not limit an employee's right to be treated by a specialist when a referral is made by the employee's health care provider. Once an employee has begun treatment with the specialist, the employee may not seek treatment from a different specialist in the same specialty without prior approval from the employer or the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Chiropractic care. An employee sustaining a personal injury arising out of and in the course of employment, provided the injury relates to the scope of a chiropractor's practice, as defined and regulated by law, is entitled to chiropractic services as provided by Title 32, chapter 9. A duly licensed chiropractor is competent to testify before the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Podiatric care. An employee sustaining personal injury arising out of and in the course of employment, provided the injury relates to the foot, is entitled to an examination, diagnosis and treatment for that injury from a podiatrist who is licensed in the State and who has been granted the degree of Doctor of Podiatric Medicine by an accredited school of podiatry recognized by the Council of Education of the American Podiatry Association. This examination may include diagnostic x rays. Such a podiatrist is competent to testify before the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Employee and employer duties. When any services are procured or aids are required by the employee, it is the employee's duty to see that the employer is given prompt notice of that procurement or requirement. The employer shall then make prompt payment for them to the provider or supplier or reimburse the employee, in accordance with section 205, subsection 4, if the costs are necessary and adequate and the charges reasonable, except that it is presumed that, in a jurisdiction outside the United States that has a socialized medical program, payment of the costs will be borne by the medical program and the employer is not responsible for those costs under this section unless the socialized medical program has made payment for services or aids and requests reimbursement from the employer for the actual amounts paid.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Physical aids. The employer shall furnish artificial limbs, eyes, teeth, eyeglasses, hearing aids, orthopedic devices and other physical aids made necessary by the injury and shall replace or renew them when necessary from wear and tear or physical change of the employee. Damage and destruction to artificial limbs, eyes, teeth, eyeglasses, hearing aids, orthopedic devices and other physical aids in the course of and arising out of employment is considered an injury for the purposes of this Act. In case such physical aids in use by the employee at the time of the injury are themselves injured or destroyed, the board in its discretion may require that they be repaired or replaced by the employer.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Medical reports. The employee or the employee's counsel shall serve upon the employer or opposing counsel, within 7 days of the date of receipt by the employee or counsel, complete copies of any medical reports or statements relating to any treatment or examination described in this section. The employer, carrier or their counsel shall serve upon the employee or opposing counsel, within 7 days of the receipt by the employer, carrier or counsel, complete copies of any medical reports or statements relating to any treatment or examination alleged by the employee or the employee's counsel to be covered by this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Treatment by prayer or spiritual means. Upon request of an employee, the employer or carrier may establish a program to pay for treatment by prayer or spiritual means by an accredited practitioner.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

11. Generic drugs. Providers shall prescribe generic drugs whenever medically acceptable for the treatment of an injury or disease for which compensation is claimed. An employee shall purchase generic drugs for the treatment of an injury or disease for which compensation is claimed if the prescribing provider indicates that generic drugs may be used and if generic drugs are available at the time and place of purchase under subsection 11-A. If an employee purchases a nongeneric drug when the prescribing provider has indicated that a generic drug may be used and a generic drug is available at the time and place of purchase, the insurer or self-insurer is required to reimburse the employee for the cost of the generic drug only. For purposes of this subsection, "generic drug" has the same meaning found in Title 32, section 13702-A, subsection 14.

[2013, c. 164, §1 (AMD) .]

11-A. Pharmacy choice. An employee who has been prescribed drugs for the treatment of an injury or disease for which compensation is claimed has the right to select the provider, pharmacy or pharmacist for dispensing and filling the prescription for the drugs.

For purposes of this subsection, "drug" has the same meaning as in Title 32, section 13702-A, subsection 11.

[2013, c. 164, §2 (NEW) .]

12. Petition. When there is any disagreement as to the proper costs of the services or aids, the periods during which they must be furnished, or the apportionment of the costs among the parties, any interested person may file a petition with the board for the determination of the issues.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

13. Employee not liable. Except as ordered pursuant to subsection 2, paragraph B, an employee is not liable for any portion of the cost of any provided medical or health care services under this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

14. Employer not liable. An employer is not liable under this Act for charges for health care services to an injured employee in excess of those established under section 209-A, except upon petition as provided. The board shall allow charges in excess of those provided under section 209-A against the employer if the provider satisfactorily demonstrates to the board that the services were extraordinary or that the provider incurred extraordinary costs in treating the employee as compared to those reasonably contemplated for the services provided.

[2011, c. 338, §1 (AMD) .]

15. Forms; compliance. The Superintendent of Insurance shall prescribe medical and health care expense forms for the purpose of collecting information as required by Title 24-A, section 2384-B. In the event the provider fails to properly complete and submit the prescribed form or to follow any fee schedule approved by the board, the insurer or self-insurer may withhold payment of medical and health care fees and the insurer or self-insurer is not required to file a notice of controversy but may simply notify the provider of the failure. In the case of a dispute, any interested party may petition the board to resolve the dispute.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2001, c. 60, §1 (AMD). 2007, c. 695, Pt. B, §24 (AMD). 2011, c. 338, §1 (AMD). 2013, c. 164, §§1, 2 (AMD).

§207. MEDICAL EXAMINATIONS OF EMPLOYEES; ACCEPTANCE OF TREATMENT OR EMPLOYMENT REHABILITATION

An employee being treated by a health care provider of the employee's own choice shall, after an injury and at all reasonable times during the continuance of disability if so requested by the employer, submit to an examination by a physician, surgeon or chiropractor authorized to practice as such under the laws of this State, to be selected and paid by the employer. The physician, surgeon or chiropractor must have an active practice of treating patients. For purposes of this section, "active practice" may be demonstrated by having active clinical privileges at a hospital. A physician or surgeon must be certified in the field of practice that treats the type of injury complained of by the employee. Certification must be by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or their successor organizations. A chiropractor licensed by the Board of Chiropractic Licensure, who has an active practice of treating patients may provide a 2nd opinion when the initial opinion was given by a chiropractor. Once an employer selects a health care provider to examine an employee, the employer may not request that the employee be examined by more than one other health care provider, other than an independent medical examiner appointed pursuant to section 312, without prior approval from the employee or a hearing officer. This provision does not limit an employer's right to request that the employee be examined by a specialist upon referral by the health care provider. Once the employee is examined by the specialist, the employer may not request that the employee be examined by a different specialist in the same specialty, other than an independent medical examiner appointed pursuant to section 312, without prior approval from the employee

or the board. The employee has the right to have a physician, surgeon or chiropractor of the employee's own selection present at such an examination, whose costs are paid by the employer. The employer shall give the employee notice of this right at the time the employer requests an examination. [2001, c. 278, §1 (AMD).]

The health care provider examining an employee under this section shall, prior to commencing the examination, advise the employee fully of all records, documents and other communications that the health care provider has available in conducting the examination. The health care provider shall also advise the employee and the employee's health care provider of the scope and purpose of the requested examination and all persons with whom the health care provider has communicated in preparation for the examination. Simultaneously with providing an oral or written report to the employer, the health care provider shall provide the same information to the employee and, if requested by the employee, to the employee's health care provider. [2001, c. 278, §2 (NEW).]

Nothing in this Act may be construed to require an employee who in good faith relies on treatment by prayer or spiritual means, in accordance with the tenets and practice of a recognized church or religious denomination, by a duly accredited practitioner of those healing methods, to undergo any medical or surgical treatment. Such an employee or the employee's dependents may not be deprived of any compensation payments to which the employee would be entitled if medical or surgical treatments were employed. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If any employee refuses or neglects to submit to any reasonable examination provided for in this Act, or in any way obstructs any such examination, or if the employee declines a service that the employer is required to provide under this Act, then such employee's rights to compensation are forfeited during the period of the infractions if the board finds that there is adequate cause to do so. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 365, §1 (AMD). 2001, c. 278, §§1,2 (AMD).

§208. MEDICAL INFORMATION

1. Certificate of authorization. Authorization from the employee for release of medical information by health care providers to the employer is not required if the information pertains to treatment of an injury or disease that is claimed to be compensable under this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Duties of health care providers. Duties of health care providers are as follows.

A. Except for claims for medical benefits only, within 5 business days from the completion of a medical examination or within 5 business days from the date notice of injury is given to the employer, whichever is later, the health care provider treating the employee shall forward to the employer and the employee a diagnostic medical report, on forms prescribed by the board, for the injury for which compensation is being claimed. The report must include the employee's work capacity, likely duration of incapacity, return to work suitability and treatment required. The board may assess penalties up to \$500 per violation on health care providers who fail to comply with the 5-day requirement of this subsection. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. If ongoing medical treatment is being provided, every 30 days the employee's health care provider shall forward to the employer and the employee a diagnostic medical report on forms prescribed by the board. An employer may request, at any time, medical information concerning the condition of the employee for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. A health care provider shall submit to the employer and the employee a final report of treatment within 5 working days of the termination of treatment, except that only an initial report must be submitted if the provider treated the employee on a single occasion. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. Upon the request of the employee and in the event that an employee changes or is referred to a different health care provider or facility, any health care provider or facility having medical records regarding the employee, including x rays, shall forward all medical records relating to an injury or disease for which compensation is claimed to the next health care provider. When an employee is scheduled to be treated by a different health care provider or in a different facility, the employee shall request to have the records transferred. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. A health care provider may not charge the insurer or self-insurer an amount in excess of the fees prescribed in section 209-A for the submission of reports prescribed by this section and for the submission of any additional records. [2011, c. 338, §2 (AMD).]

F. An insurer or self-insurer may withhold payment of fees for the submission of any required reports of treatment to any provider who fails to submit the reports on the forms prescribed by the board and within the time limits provided. The insurer or self-insurer is not required to file a notice of controversy under these circumstances, but must notify the provider that payment is being withheld due to the failure to use prescribed forms or to submit the reports in a timely fashion. In the case of dispute, any interested party may petition the board to resolve the dispute. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2011, c. 338, §2 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2011, c. 338, §2 (AMD).

§209. MEDICAL FEES; REIMBURSEMENT LEVELS

(REPEALED)

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2007, c. 240, Pt. JJJ, §5 (AMD). 2007, c. 311, §2 (AMD). 2011, c. 338, §3 (RP).

§209-A. MEDICAL FEE SCHEDULE

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Ancillary services and products" means those services and products that are necessary but peripheral to the medical procedure. [2011, c. 338, §4 (NEW).]

B. "Medical fee schedule" means a list of medical procedures and the medical codes used and fees charged for those medical procedures. [2011, c. 338, §4 (NEW).]

[2011, c. 338, §4 (NEW) .]

2. Medical fee schedule. In order to ensure appropriate limitations on the cost of health care services while maintaining broad access for employees to health care providers in the State, the board shall adopt rules that establish a medical fee schedule setting the fees for medical and ancillary services and products rendered by individual health care practitioners and health care facilities in accordance with the following:

A. The medical fee schedule for services rendered by individual health care practitioners must reflect the methodology underlying the federal Centers for Medicare and Medicaid Services resource-based relative value scale; [2011, c. 338, §4 (NEW).]

B. The medical fee schedule for services rendered by health care facilities must reflect the methodology and categories set forth in the federal Centers for Medicare and Medicaid Services severity-diagnosis related group system for inpatient services and the methodologies and categories set forth in the federal Centers for Medicare and Medicaid Services ambulatory payment classification system for outpatient services; and [2011, c. 338, §4 (NEW).]

C. The medical fee schedule must be consistent with the most current medical coding and billing systems, including the federal Centers for Medicare and Medicaid Services resource-based relative value scale, severity-diagnosis related group system, ambulatory payment classification system and healthcare common procedure coding system; the International Statistical Classification of Diseases and Related Health Problems report issued by the World Health Organization and the current procedural terminology codes used by the American Medical Association. [2011, c. 338, §4 (NEW).]

[2011, c. 338, §4 (NEW) .]

3. Annual updates. Notwithstanding Title 5, chapter 375, subchapter 2, the executive director of the board shall annually update the medical fee schedule developed pursuant to subsection 2. In order to facilitate the update, the executive director annually shall obtain from the Maine Health Data Organization the average total payments, including professional, facility, ancillary and patient cost-sharing contribution, across all providers in the Maine Health Data Organization database for the medical and ancillary services and products most commonly rendered during the immediately preceding calendar year under this Part.

[2011, c. 338, §4 (NEW) .]

4. Reimbursement rate if medical fee schedule not established or updated. If the board fails to adopt rules that establish a medical fee schedule in accordance with subsection 2 by December 31, 2011 or the executive director fails to annually update the medical fee schedule in accordance with subsection 3, the reimbursement rate for medical services is 105% of the private 3rd-party payor average payment rate for the provider or the amount agreed to in writing by the provider and the insurance company or self-insured employer prior to the rendering of service by the provider. For purposes of this subsection, "reimbursement rate for medical services" means the total payment allowed for the medical and ancillary services and products, including any amount to be paid by a 3rd-party payor and the amount to be paid by the patient to satisfy a copayment, deductible or coinsurance obligation.

[2011, c. 338, §4 (NEW) .]

5. Periodic updates to the medical fee schedule. In addition to the annual updates to the medical fee schedule required by subsection 3, the board shall undertake a comprehensive review of the medical fee schedule once every 3 years beginning in 2014. The board shall consider the following factors in setting or revising the medical fee schedule as required by this section:

A. The private 3rd-party payor average payment rates obtained from the Maine Health Data Organization pursuant to subsection 3; [2011, c. 338, §4 (NEW).]

B. Any material administrative burden imposed on providers by the nature of the workers' compensation system; and [2011, c. 338, §4 (NEW).]

C. The goal of maintaining broad access for employees to all individual health care practitioners and health care facilities in the State. [2011, c. 338, §4 (NEW).]

[2011, c. 338, §4 (NEW) .]

6. Associated services fee schedule. The board shall adopt rules that establish a fee schedule or other standards of reimbursement for providers regarding administrative, case management, medical and legal and other activities unique to the treatment of injured workers in the workers' compensation system.

[2011, c. 338, §4 (NEW) .]

7. MaineCare reimbursement. MaineCare must be paid 100% of any expenses incurred for the treatment of an injury of an employee under this Title.

[2011, c. 338, §4 (NEW) .]

SECTION HISTORY

2011, c. 338, §4 (NEW).

§210. MEDICAL UTILIZATION REVIEW

1. Rules. The board, in consultation with the appropriate professional organization representing the health care specialty involved, shall adopt rules establishing specific protocols pertaining to the extent and duration of treatment for specific injuries and illnesses.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Utilization review. For purposes of this section, "utilization review" means the initial prospective, concurrent or retrospective evaluation by an insurance carrier, self-insurer or group self-insurer of the appropriateness in terms of both the level and the quality of health care and health services provided an injured employee, based on medically accepted standards. Utilization review requires the acquisition of necessary records, medical bills and other information concerning any health care or health services.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Review. Utilization review must be performed by an insurance carrier, self-insurer or group self-insurer pursuant to a system established by the board that identifies the range of utilization of health care and health services.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Certification of insurance carrier. An insurance carrier that complies with criteria or standards established by the board must be certified by the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Consent of health care provider. By accepting payment under this chapter, a health facility or health care provider is deemed to have consented to submitting necessary records and other information concerning any health care or health services provided for utilization review pursuant to this section and to have agreed to comply with any decision of the board pursuant to this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Explanation of care or services. If a health facility or health care provider provides health care or a health service that is not usually associated with, is longer in duration in time than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the insurance carrier, self-insurer or group self-insurer to explain the necessity or the reasons why in writing.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Excessive charges, unjustified treatment. If an insurance carrier, self-insurer or group self-insurer determines that a health facility or health care provider has made any excessive charges or required unjustified treatment, hospitalization or visits, the health facility or health care provider may not receive payment under this chapter from the insurance carrier, self-insurer or group self-insurer for the excessive fees or unjustified treatment, hospitalization or visits, and is liable to return to the insurance carrier any such fees or charges already collected. The board may review the records and medical bills of any health facility or health care provider with regard to a claim that an insurance carrier, self-insurer or group self-insurer has determined is not in compliance with the schedule of charges or requires unjustified treatment, hospitalization or office visits.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Inappropriate services. If an insurance carrier determines that a health facility or health care provider improperly overutilized or otherwise rendered or ordered inappropriate health care or health services, or that the cost of the care or services was inappropriate, the health facility or health care provider may appeal to the board regarding that determination pursuant to procedures provided for under the system of utilization review.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Penalties. Any health facility or health care provider that knowingly submits false or misleading records or other information to an insurance carrier, self-insurer or group self-insurer or the board is guilty of a Class D crime.

[1993, c. 261, §1 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 261, §1 (AMD).

§211. MAXIMUM BENEFIT LEVELS

Effective January 1, 1993, the maximum weekly benefit payable under section 212, 213 or 215 is \$441 or 90% of state average weekly wage, whichever is higher. Beginning on July 1, 1994, the maximum benefit level is \$441 or 90% of the state average weekly wage as adjusted annually utilizing the state average weekly wage as determined by the Department of Labor, whichever is higher. If the injured employee's date of injury is on or after January 1, 2013, the maximum benefit level is \$441 or 100% of the state average weekly wage as adjusted annually utilizing the state average weekly wage as determined by the Department of Labor, whichever is higher. [2011, c. 647, §3 (AMD).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 560, §G22 (AMD). 2011, c. 647, §3 (AMD).

§212. COMPENSATION FOR TOTAL INCAPACITY

1. Total incapacity; date of injury prior to January 1, 2013. If the injured employee's date of injury is prior to January 1, 2013, while the incapacity for work resulting from the injury is total, the employer shall pay the injured employee a weekly compensation equal to 80% of the employee's after-tax average weekly wage, but not more than the maximum benefit under section 211. Compensation must be paid for the duration of the incapacity.

Any employee who is able to perform full-time remunerative work in the ordinary competitive labor market in the State, regardless of the availability of such work in and around that employee's community, is not eligible for compensation under this section, but may be eligible for compensation under section 213.

[2011, c. 647, §4 (AMD) .]

1-A. Total incapacity; date of injury on or after January 1, 2013. If the injured employee's date of injury is on or after January 1, 2013, while the incapacity for work resulting from the injury is total, the employer shall pay the injured employee a weekly compensation equal to 2/3 of the employee's gross average weekly wages, earnings or salary, but not more than the maximum benefit under section 211. Compensation must be paid for the duration of the incapacity.

Any employee who is able to perform full-time remunerative work in the ordinary competitive labor market in the State, regardless of the availability of such work in and around that employee's community, is not eligible for compensation under this section, but may be eligible for compensation under section 213.

[2011, c. 647, §5 (NEW) .]

2. Presumption of total incapacity. For the purposes of this Act, in the following cases it is conclusively presumed for 800 weeks from the date of injury that the injury resulted in permanent total incapacity and that the employee is unable to perform full-time remunerative work in the ordinary competitive labor market in the State. Thereafter the question of permanent and total incapacity must be determined in accordance with the facts, as they then exist. The cases are:

- A. Total and permanent loss of sight of both eyes; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- B. Actual loss of both legs or both feet at or above the ankle; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- C. Actual loss of both arms or both hands at or above the wrist; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- D. Actual loss of any 2 of the members or faculties in paragraph A, B or C; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- E. Permanent and complete paralysis of both legs or both arms or one leg and one arm; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- F. Incurable insanity or imbecility; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- G. Permanent and total loss of industrial use of both legs or both hands or both arms or one leg and one arm. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

For the purpose of this subsection such permanency may be determined no later than 30 days before the expiration of 500 weeks from the date of injury.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Specific loss benefits. In cases included in the following schedule, the incapacity is considered to continue for the period specified, and the compensation due is calculated based on the date of injury subject to the maximum benefit set in section 211. Compensation under this subsection is available only for the actual loss of the following:

- A. Thumb, 65 weeks; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- B. First finger, 38 weeks; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Second finger, 33 weeks; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. Third finger, 22 weeks; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Fourth finger, 16 weeks; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. The loss of the first phalange of the thumb, or of any finger, is considered to be equal to the loss of 1/2 of that thumb or finger, and compensation is 1/2 of the amounts specified in paragraphs A to E. The loss of more than one phalange is considered as the loss of the entire finger or thumb. The amount received for more than one finger may not exceed the amount provided in this schedule for the loss of a hand; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

G. Great toe, 33 weeks; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

H. A toe other than the great toe, 11 weeks. The loss of the first phalange of any toe is considered to be equal to the loss of 1/2 of that toe, and compensation is 1/2 of the amounts specified in paragraphs F and G. The loss of more than one phalange is considered the loss of the entire toe; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

I. Hand, 215 weeks. An amputation between the elbow and wrist that is 6 or more inches below the elbow is considered a hand; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

J. Arm, 269 weeks. An amputation above the point specified in paragraph I is considered an arm; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

K. Foot, 162 weeks. An amputation between the knee and the foot 7 or more inches below the tibial table, or plateau, is considered a foot; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

L. Leg, 215 weeks. An amputation above the point specified in paragraph K is considered a leg; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

M. Eye, 162 weeks. Eighty percent loss of vision of one eye constitutes the total loss of that eye. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2011, c. 647, §6 (AMD) .]

In case of the loss of one member while compensation is being paid for the loss of another member, compensation must be paid for the loss of the 2nd member for the period provided in this section. Payments for the loss of the 2nd member begin at the conclusion of the payments for the first member. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2011, c. 647, §§4-6 (AMD).

§213. COMPENSATION FOR PARTIAL INCAPACITY

1. Benefit and duration. While the incapacity for work is partial, the employer shall pay the injured employee a weekly compensation as follows.

A. If the injured employee's date of injury is prior to January 1, 2013, the weekly compensation is equal to 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the after-tax average weekly wage that the injured employee is able to earn after the injury, but not more than the maximum benefit under section 211. Compensation must be paid for the

duration of the disability if the employee's permanent impairment, determined according to subsection 1-A and the impairment guidelines adopted by the board pursuant to section 153, subsection 8, resulting from the personal injury is in excess of 15% to the body. In all other cases an employee is not eligible to receive compensation under this paragraph after the employee has received a total of 260 weeks of compensation under section 212, subsection 1, this paragraph or both. The board may in the exercise of its discretion extend the duration of benefit entitlement beyond 260 weeks in cases involving extreme financial hardship due to inability to return to gainful employment. This authority may be delegated by the board, on a case-by-case basis, to a hearing officer or a panel of 3 hearing officers. Decisions made under this paragraph must be made expeditiously. A decision under this paragraph made by a hearing officer or a panel of 3 hearing officers may not be appealed to the board under section 320, but may be appealed pursuant to section 322. [2011, c. 647, §7 (NEW) .]

B. If the injured employee's date of injury is on or after January 1, 2013, the weekly compensation is equal to 2/3 of the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the average gross weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefit under section 211. An employee is not eligible to receive compensation under this paragraph after the employee has received a total of 520 weeks of compensation under section 212, subsection 1-A, this paragraph or both. The board may in the exercise of its discretion extend the duration of benefit entitlement beyond 520 weeks in cases involving extreme financial hardship due to inability to return to gainful employment. This authority may be delegated by the board, on a case-by-case basis, to a hearing officer or a panel of 3 hearing officers. The board, hearing officer or panel shall make a decision under this paragraph expeditiously. A decision under this paragraph made by a hearing officer or a panel of 3 hearing officers may not be appealed to the board under section 320, but may be appealed pursuant to section 321-A.

Orders extending benefits beyond 520 weeks are not subject to review more often than every 2 years from the date of the board order or request allowing an extension. [2011, c. 647, §7 (NEW) .]

[2011, c. 647, §7 (RPR) .]

1-A. Determination of permanent impairment. For purposes of this section, "permanent impairment" includes only permanent impairment resulting from:

A. The work injury at issue in the determination and any preexisting physical condition or injury that is aggravated or accelerated by the work injury at issue in the determination; or [2001, c. 712, §2 (NEW); 2001, c. 712, §6 (AFF) .]

B. For dates of injury on or after January 1, 2002, the work injury at issue in the determination and:

(1) Any prior injury that arose out of and in the course of employment for which a report of injury was completed pursuant to section 303 and the employee received a benefit or compensation under this Title, which has not been denied by the board, and that combines with the work injury at issue in the determination to contribute to the employee's incapacity, except that a prior injury that was the subject of a lump-sum settlement approved pursuant to section 352 that had a finding of permanent impairment equal to or in excess of the then applicable permanent impairment threshold may not be included; or

(2) Any preexisting physical condition or injury that is aggravated or accelerated by the work injury at issue in the determination. [2001, c. 712, §2 (NEW); 2001, c. 712, §6 (AFF) .]

Except as set forth in this subsection, "permanent impairment" does not include a condition that is not caused, aggravated or accelerated by the work injury.

[2001, c. 712, §2 (NEW); 2001, c. 712, §6 (AFF) .]

1-B. Long-term partial incapacity; date of injury on or after January 1, 2013. After the exhaustion of benefits under subsection 1, paragraph B if the whole person permanent impairment resulting from the injury is in excess of 18% and if the employee is working and the employee's earnings, as measured by average weekly earnings over the most recent 26-week period documented by payroll records or tax returns, is 65% or less of the preinjury average weekly wage, the employer shall pay weekly compensation equal to 2/3 of the difference between the employee's average weekly wage at the time of the injury and the employee's postinjury wage, but not more than the maximum benefit under section 211. In order for the employee to qualify for benefits under this subsection, the employee's actual earnings must be commensurate with the employee's earning capacity, which includes consideration of the employee's physical and psychological work capacity as determined by an independent examiner under section 312. In addition, in order for the employee to qualify for benefits under this subsection, the employee must have earnings from employment for a period of not less than 12 months within a 24-month period prior to the expiration of the 520-week durational limit under subsection 1, paragraph B. Compensation under this subsection must be paid at a fixed rate.

While the employee is claiming or receiving extended partial incapacity benefits under this subsection, the employee shall complete and provide quarterly employment status reports and provide copies of current tax returns as early as practicable after the return is filed.

The employee's entitlement to extended partial incapacity benefits under this subsection is determined based upon the facts that exist at the time of expiration of 520 weeks of benefits under subsection 1, paragraph B. If the employee is not entitled to extended partial incapacity benefits upon the expiration of 520 weeks of benefits under subsection 1, paragraph B, the employee's entitlement to partial incapacity benefits expires. If the employee is entitled to extended partial incapacity benefits under this subsection, once the employee's earnings, as measured by average weekly earnings over the most recent 26-week period, are equal to or greater than the preinjury average weekly wage, the employee's entitlement to extended partial incapacity benefits under this subsection terminates permanently.

[2011, c. 647, §8 (NEW) .]

2. Threshold adjustment. Effective January 1, 1998 and every other January 1st thereafter, the board, using an independent actuarial review based upon actuarially sound data and methodology, must adjust the 15% impairment threshold established in subsection 1 so that 25% of all cases with permanent impairment will be expected to exceed the threshold and 75% of all cases with permanent impairment will be expected to be less than the threshold. The actuarial review must include all cases receiving permanent impairment ratings on or after January 1, 1993, irrespective of date of injury, but may utilize a cutoff date of 90 days prior to each adjustment date to permit the collection and analysis of data. The data must be adjusted to reflect ultimate loss development. In order to ensure the accuracy of the data, the board shall require that all cases involving permanent injury, including those settled pursuant to section 352, include an impairment rating performed in accordance with subsection 1-A and the guidelines adopted by the board and either agreed to by the parties or determined by the board. Each adjusted threshold is applicable to all cases with dates of injury on or after the date of adjustment and prior to the date of the next adjustment.

[2001, c. 712, §3 (AMD); 2001, c. 712, §6 (AFF) .]

3. Dates of injury between January 1, 1993 and January 1, 1998. An employee whose date of injury is between January 1, 1993 and January 1, 1998, who has not settled the claim pursuant to section 352 and whose impairment rating is 15% or less to the body but exceeds the adjusted threshold established pursuant to subsection 2 on January 1, 1998 is entitled to compensation for the duration of the disability. Reimbursement to the employer, insurer or group self-insurer for the payment of all benefits payable in excess of 260 weeks of compensation under this subsection must be made from the Supplemental Benefits Fund created in section 355-A.

[2001, c. 448, §1 (AMD) .]

3-A. Dates of injury on or after January 1, 2006 and before January 1, 2013. If the injured employee's date of injury is on or after January 1, 2006 and before January 1, 2013, the permanent impairment threshold is adjusted to a whole person impairment in excess of 12%.

[2011, c. 647, §9 (NEW) .]

4. Extension of 260-week limitation. Effective January 1, 1998 and every January 1st thereafter, the 260-week limitation contained in subsection 1 must be extended 52 weeks for every year the board finds that the frequency of such cases involving the payment of benefits under section 212 or 213 is no greater than the national average based on frequency from the latest unit statistical plan aggregate data for Maine and on a countrywide basis, adjusted to a unified industry mix. The 260-week limitation contained in subsection 1 may not be extended under this subsection to more than 520 weeks. For payments relating to injuries occurring before January 1, 2000, reimbursement to the employer, insurer or group self-insurer for the payment of all benefits for additional weeks payable pursuant to this subsection must be made from the Supplemental Benefits Fund created in section 355-A.

[2001, c. 448, §2 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 404, §1 (AMD). 2001, c. 448, §§1,2 (AMD). 2001, c. 712, §§1-3 (AMD). 2001, c. 712, §6 (AFF). 2003, c. 52, §1 (AMD). 2011, c. 647, §§7-9 (AMD).

§214. DETERMINATION OF PARTIAL INCAPACITY

1. Benefit determination. While the incapacity is partial, the employer shall pay the injured employee benefits as follows.

A. If an employee receives a bona fide offer of reasonable employment from the previous employer or another employer or through the Bureau of Employment Services and the employee refuses that employment without good and reasonable cause, the employee is considered to have voluntarily withdrawn from the work force and is no longer entitled to any wage loss benefits under this Act during the period of the refusal. [1995, c. 560, Pt. G, §23 (AMD); 1995, c. 560, Pt. G, §29 (AFF).]

B. If an injured employee's date of injury is prior to January 1, 2013 and the employee is employed at any job and the average weekly wage of the employee is less than that which the employee received before the date of injury, the employee is entitled to receive weekly benefits under this Act equal to 80% of the difference between the injured employee's after-tax weekly wage before the date of injury and the after-tax weekly wage that the injured employee is able to earn after the date of injury, but not more than the maximum weekly rate of compensation, as determined under section 211. [2011, c. 647, §10 (AMD).]

B-1. If an injured employee's date of injury is on or after January 1, 2013 and the employee is employed at any job and the average weekly wage of the employee is less than that which the employee received before the date of injury, the employee is entitled to receive weekly benefits under this Act equal to 2/3 of the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the average gross weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum weekly rate of compensation, as determined under section 211. [2011, c. 647, §11 (NEW).]

C. If an employee is employed at any job and the average weekly wage of the employee is equal to or more than the average weekly wage the employee received before the date of injury, the employee is not entitled to any wage loss benefits under this Act for the duration of the employment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. If the employee, after having been employed at any job pursuant to this subsection for 100 weeks or more, loses that job through no fault of the employee, the employee is entitled to receive compensation under this Act pursuant to the following.

(1) If, after exhaustion of unemployment benefit eligibility of an employee, the employment since the time of injury has not established a new wage earning capacity, the employee is entitled to receive compensation based upon the employee's wage at the original date of injury.

(2) If the employee has established a new wage earning capacity, the employee is entitled to wage loss benefits based on the difference between the normal and customary wages paid to those persons performing the same or similar employment, as determined at the time of termination of the employment of the employee, and the wages paid at the time of the injury. There is a presumption of wage earning capacity established for any employments totaling 250 weeks or more.

(3) If the employee becomes reemployed at any employment, the employee is then entitled to receive partial disability benefits as provided in paragraph B. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. If the employee, after having been employed at any job following the injury for less than 100 weeks, loses the job through no fault of the employee, the employee is entitled to receive compensation based upon the employee's wage at the original date of injury. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2011, c. 647, §§10, 11 (AMD) .]

2. Notice to Bureau of Employment Services. An insurance carrier or self-insurer shall notify the Bureau of Employment Services of the name of any injured employee who is unemployed and to whom the insurance carrier or self-insurer is paying benefits under this Act.

[1995, c. 560, Pt. G, §24 (AMD); 1995, c. 560, Pt. G, §29 (AFF) .]

3. Priority. The Bureau of Employment Services shall give priority to finding employment for those persons whose names are supplied under subsection 2.

[1995, c. 560, Pt. G, §24 (AMD); 1995, c. 560, Pt. G, §29 (AFF) .]

4. Notice of refusal; termination of benefits. The Bureau of Employment Services shall notify the board in writing of the name of any employee who refuses any bona fide offer of reasonable employment. Upon notification to the board, the board shall notify the insurance carrier or self-insurer who shall terminate the benefits of the employee pursuant to subsection 1, paragraph A.

[1995, c. 560, Pt. G, §24 (AMD); 1995, c. 560, Pt. G, §29 (AFF) .]

5. Reasonable employment defined. "Reasonable employment," as used in this section, means any work that is within the employee's capacity to perform that poses no clear and proximate threat to the employee's health and safety and that is within a reasonable distance from that employee's residence. The employee's capacity to perform may not be limited to jobs in work suitable to the employee's qualification and training.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 560, §§G23,24 (AMD). 1995, c. 560, §G29 (AFF). 2011, c. 647, §§10, 11 (AMD).

§215. DEATH BENEFITS

1. Death of employee; date of injury prior to January 1, 2013. If an injured employee's date of injury is prior to January 1, 2013 and if death results from the injury of the employee, the employer shall pay or cause to be paid to the dependents of the employee who were wholly dependent upon the employee's earnings for support at the time of the injury a weekly payment equal to 80% of the employee's after-tax average weekly wage, but not more than the maximum benefit under section 211, for a period of 500 weeks from the date of death. If the employee leaves dependents only partially dependent upon the employee's earnings for support at the time of injury, the employer shall pay weekly compensation equal to the same proportion of the weekly payments for the benefit of persons wholly dependent, as 80% of the amount contributed by the employee to such partial dependents bears to the annual earnings of the deceased at the time of injury. If, at the expiration of the 500-week period, any wholly or partially dependent person is less than 18 years of age, the employer shall continue to pay or cause to be paid the weekly compensation until that person reaches the age of 18.

If a dependent spouse dies or becomes a dependent of another person, the payments must cease upon the payment to the spouse of the balance of the compensation to which the spouse would otherwise have been entitled but in no event to exceed the sum of \$500.00. The remaining weeks of compensation, if any, are payable to those persons either wholly or partially dependent upon the employee for support at the employee's death. When, at the expiration of the 500-week period, any wholly or partially dependent person is less than 18 years of age, the employer shall continue to pay or cause to be paid the weekly compensation, until that person reaches the age of 18. The payment of compensation to any dependent child after the expiration of the 500-week period ceases when the child reaches the age of 18 years, if at the age of 18 years the child is neither physically nor mentally incapacitated from earning, or when the child reaches the age of 16 years and thereafter is self-supporting for 6 months. If the child ceases to be self-supporting thereafter, the dependency must be reinstated. As long as any of the 500 weeks of compensation remain, that compensation is payable to the person either wholly or partially dependent upon the deceased employee for support at the time of the employee's death, with the exception of a dependent spouse who becomes a dependent of another. If a wholly dependent or partially dependent child who reaches 18 years of age is either physically or mentally incapacitated so as to be unable to earn a living as determined by the board, the payments must continue until such time as the child either dies or is no longer physically or mentally incapacitated from earning.

[2011, c. 647, §12 (AMD) .]

1-A. Death of employee; date of injury on or after January 1, 2013. If an injured employee's date of injury is on or after January 1, 2013 and if death results from the injury of the employee, the employer shall pay or cause to be paid to the dependents of the employee who were wholly dependent upon the employee's earnings for support at the time of the injury a weekly payment equal to 2/3 of the employee's gross average weekly wages, earnings or salary, but not more than the maximum benefit under section 211, for a period of 500 weeks from the date of death. If the employee leaves dependents only partially dependent upon the employee's earnings for support at the time of injury, the employer shall pay weekly compensation equal to the same proportion of the weekly payments for the benefit of persons wholly dependent, as 2/3 of the amount contributed by the employee to such partial dependents bears to the annual earnings of the deceased at the time of injury. If, at the expiration of the 500-week period, any wholly or partially dependent person is less than 18 years of age, the employer shall continue to pay or cause to be paid the weekly compensation until that person reaches the age of 18.

If a dependent spouse dies or becomes a dependent of another person, the payments must cease upon the payment to the spouse of the balance of the compensation to which the spouse would otherwise have been entitled but in no event to exceed the sum of \$500.00. The remaining weeks of compensation, if any, are payable to those persons either wholly or partially dependent upon the employee for support at the employee's death. When, at the expiration of the 500-week period, any wholly or partially dependent person is less than 18 years of age, the employer shall continue to pay or cause to be paid the weekly compensation, until that person reaches the age of 18. The payment of compensation to any dependent child after the expiration of the 500-week period ceases when the child reaches the age of 18 years, if at the age of 18 years the child is

neither physically nor mentally incapacitated from earning, or when the child reaches the age of 16 years and thereafter is self-supporting for 6 months. If the child ceases to be self-supporting thereafter, the dependency must be reinstated. As long as any of the 500 weeks of compensation remain, that compensation is payable to the person either wholly or partially dependent upon the deceased employee for support at the time of the employee's death, with the exception of a dependent spouse who becomes a dependent of another. If a wholly dependent or partially dependent child who reaches 18 years of age is either physically or mentally incapacitated so as to be unable to earn a living as determined by the board, the payments must continue until such time as the child either dies or is no longer physically or mentally incapacitated from earning.

[2011, c. 647, §13 (NEW) .]

2. Death of an injured employee. The death of the injured employee prior to the expiration of the period within which the employee would receive weekly payments ends the disability and all liability for the remainder of the payments that the employee would have received in case the employee had lived is terminated, but the employer is liable for the following death benefits in lieu of any further disability indemnity.

A. If the injury received by the employee was the proximate cause of the employee's death and the deceased employee leaves dependents wholly or partially dependent on the employee for support, the death benefit is equal to the full amount that the dependents would have been entitled to receive under subsection 1 if the injury had resulted in immediate death. Benefits under this paragraph are payable in the same manner as if the injury resulted in immediate death. [2007, c. 361, §1 (AMD); 2007, c. 361, §2 (AFF).]

B. If an application for benefits has been filed but has not been decided by the board or is on appeal and the employee dies from a cause unrelated to the employee's injury, the proceedings may be continued in the name of the employee's personal representative. In such a case, any benefits awarded are payable up to time of death and must be paid to the same beneficiaries and in the same amounts as would have been payable if the employee had suffered a compensable injury resulting in death. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2007, c. 361, §1 (AMD); 2007, c. 361, §2 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2007, c. 361, §1 (AMD). 2007, c. 361, §2 (AFF). 2011, c. 647, §§12, 13 (AMD).

§216. BURIAL EXPENSES; INCIDENTAL COMPENSATION

If the employee dies as a result of the injury, the employer shall pay, in addition to any compensation and medical benefits provided for in this Act, the reasonable expenses of burial, not to exceed \$4,000 and an additional payment of \$3,000 as incidental compensation. Burial expense reimbursement must be paid to the person who has paid or who is responsible for paying the employee's burial expenses. The incidental compensation must be paid to the employee's estate. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§217. EMPLOYMENT REHABILITATION

When as a result of injury the employee is unable to perform work for which the employee has previous training or experience, the employee is entitled to such employment rehabilitation services, including retraining and job placement, as reasonably necessary to restore the employee to suitable employment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Services. If employment rehabilitation services are not voluntarily offered and accepted, the board on its own motion or upon application of the employee, carrier or employer, after affording the parties an opportunity to be heard, may refer the employee to a board-approved facility for evaluation of the need for and kind of service, treatment or training necessary and appropriate to return the employee to suitable employment. The board's determination under this subsection is final.

[2013, c. 63, §6 (AMD) .]

2. Plan ordered. Upon receipt of an evaluation report pursuant to subsection 1, if the board finds that the proposed plan complies with this Act and that the implementation of the proposed plan is likely to return the injured employee to suitable employment at a reasonable cost, it may order the implementation of the plan. Implementation costs of a plan ordered under this subsection must be paid from the Employment Rehabilitation Fund as provided in section 355, subsection 7. The board's determination under this subsection is final.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Order of implementation costs recovery. If an injured employee returns to suitable employment after completing a rehabilitation plan ordered under subsection 2, the board shall order the employer who refused to agree to implement the plan to pay reimbursement to the Employment Rehabilitation Fund as provided in section 355, subsection 7.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Additional payments. The board may order that any employee participating in employment rehabilitation receive additional payments for transportation or any extra and necessary expenses during the period and arising out of the employee's program of employment rehabilitation.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Limitation. Employment rehabilitation training, treatment or service may not extend for a period of more than 52 weeks except in cases when, by special order, the board extends the period up to an additional 52 weeks.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Loss of or reduction in benefits. If an employee unjustifiably refuses to accept rehabilitation pursuant to an order of the board, the board shall order a loss or reduction of compensation in an amount determined by the board for each week of the period of refusal, except for specific compensation payable under section 212, subsection 3.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Hearing. If a dispute arises between the parties concerning application of any of the provisions of subsections 1 to 6, any of the parties may apply for a hearing before the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Presumption. If an employee is participating in a rehabilitation plan ordered pursuant to subsection 2, there is a presumption that work is unavailable to the employee for as long as the employee continues to participate in employment rehabilitation.

[2011, c. 647, §14 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2011, c. 647, §14 (AMD). 2013, c. 63, §6 (AMD).

§218. WORKER REINSTATEMENT RIGHTS

Upon petition of an injured employee, the board may require, after hearing, that the employee be reinstated as required by this section. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Reinstatement rights. When an employee has suffered a compensable injury, the employee is entitled, upon request, to reinstatement to the employee's former position if the position is available and suitable to the employee's physical condition. If the employee's former position is not available or suitable, the employee is entitled, upon request, to reinstatement to any other available position suitable to the employee's physical condition.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Reasonable accommodation required. In order to facilitate the placement of an injured employee as required under this section, the employer must make reasonable accommodations for the physical condition of the employee unless the employer can demonstrate that no reasonable accommodation exists or that the accommodation would impose an undue hardship on the employer. In determining whether undue hardship exists, the board shall consider:

- A. The size of the employer's business; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- B. The number of employees employed by the employer; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- C. The nature of the employer's operations; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- D. Any other relevant factors. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Time period; discrimination prohibited. The employer's obligation to reinstate the employee continues until 2 years, or 3 years if the employer has over 200 employees, after the date of the injury. An employer who reinstates an employee under this section may not subsequently discriminate against that employee in any employment decision, including decisions related to tenure, promotion, transfer or reemployment following a layoff, because of the employee's assertion of a claim or right under this Act. Nothing in this subsection may be construed to limit any protection offered to an employee by section 353.

[2013, c. 63, §7 (AMD) .]

4. Limitations. This section does not obligate an employer to offer an injured employee employment or reemployment in:

- A. Supervisory or confidential positions within the meaning of the 29 United States Code, Section 152; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- B. Any position for which the employee is not qualified. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Failure to comply. The employer's failure to comply with the obligations under this section disqualifies the employer or insurance carrier from exercising any right it may otherwise have to reduce or terminate the employee's benefits under this Act. The disqualification continues as long as the employer fails to offer reinstatement or until the employee accepts other employment.

If any injured employee refuses to accept an offer of reinstatement for a position suitable to the employee's physical condition, the employee is considered to have voluntarily withdrawn from the work force and is no longer entitled to any wage loss benefits under this Act during the period of refusal.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Burden of proof. The petitioning party has the burden of proof on all issues regarding claims under this section except that the employer always retains the burden of proof regarding the availability or nonavailability of work.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Rehabilitation plans. All obligations under this section are suspended during the implementation of a rehabilitation plan under section 217.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Foreign workers. If an employee is prevented from accepting an offer of reinstatement because of residence in a foreign country or termination of status as a lawfully employable alien, the employee is deemed to have refused the offer.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2013, c. 63, §7 (AMD).

§219. LIGHT-DUTY WORK POOLS

Employers may form light-duty work pools for the purpose of encouraging the return to work of injured employees. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§220. REDUCTION OF BENEFITS DUE TO UNEMPLOYMENT COMPENSATION

1. Reduction for unemployment benefits. Compensation paid under this Act, except compensation under section 212, subsection 3 and lump sum settlements, to any employee for any period for which the employee is receiving or has received benefits under the Employment Security Law, Title 26, chapter 13, must be reduced by the amount of the unemployment benefits.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Notification. Before approving or awarding any compensation as limited in subsection 1, the board shall request that the Department of Labor:

A. Inform the board as to whether the claimant has received since the date of injury or is currently receiving unemployment benefits; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Notify the board in the event that the claimant subsequently applies for and receives unemployment benefits; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Notify the board whenever the claimant ceases to receive unemployment benefits. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

When the Department of Labor so notifies the board, the board shall notify the employer and employee, advise them of both the requirements of this section and the difference the employer must make in the employee's compensation. Upon receipt of this information, the employer shall appropriately decrease the compensation or, if the claimant has ceased to receive unemployment benefits, appropriately increase the compensation.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §A9-11 (AFF).

§221. COORDINATION OF BENEFITS

1. Application. This section applies when either weekly or lump sum payments are made to an employee as a result of liability pursuant to section 212 or 213 with respect to the same time period for which the employee is also receiving or has received payments for:

A. Old-age insurance benefit payments under the United States Social Security Act, 42 United States Code, Sections 301 to 1397f; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Payments under a self-insurance plan, a wage continuation plan or a disability insurance policy provided by the employer; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Pension or retirement payments pursuant to a plan or program established or maintained by the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

This section does not apply to payments made to an employee as a result of liability pursuant to section 212, subsection 2 or 3 for the specific loss period set forth by law. It is the intent of the Legislature that, because benefits under section 212, subsections 2 and 3 are benefits that recognize human factors substantially in addition to the wage loss concept, coordination of benefits should not apply to such benefits.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Definitions. As used in this section, the following terms have the following meanings.

A. "After-tax amount" means:

(1) For benefits paid on claims for which the date of injury is prior to January 1, 2013, the gross amount of any benefit under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5) reduced by the prorated weekly amount that would have been paid, if any, under the Federal Insurance Contributions Act, 26 United States Code, Sections 3101 to 3126, state income tax and federal income tax, calculated on an annual basis using as the number of exemptions the disabled employee's dependents plus the employee, and without excess itemized deductions. In determining the after-tax amount the tables provided for in section 102, subsection 1 must be used. The gross amount of any benefit under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5)

is presumed to be the same as the average weekly wage for purposes of the table. The applicable 80% of after-tax amount as provided in the table, multiplied by 1.25, is conclusive for determining the after-tax amount of benefits under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5); and

(2) For benefits paid on claims for which the date of injury is on or after January 1, 2013, the net weekly amount of any old-age insurance benefit or benefit under an employee benefit plan, reduced by the prorated weekly amount that would have been paid, if any, under the Federal Insurance Contributions Act, 26 United States Code, Sections 3101 to 3126, federal income and state income taxes, calculated on an annual basis. The after-tax amount of any benefit subject to income taxes must be determined by using the maximum number of dependents' allowances to which the employee is entitled and the standard deduction or zero bracket amount applicable to the employee's filing status. [2011, c. 647, §15 (RPR) .]

B. "Disability insurance policy" does not include a life insurance policy that includes a disability feature if the policy was put in place as a result of collective bargaining. [2009, c. 521, §1 (NEW) ; 2009, c. 521, §2 (AFF) .]

[2011, c. 647, §15 (AMD) .]

3. Coordination of benefits. Benefit payments subject to this section must be reduced in accordance with the following provisions.

A. The employer's obligation to pay or cause to be paid weekly benefits other than benefits under section 212, subsection 2 or 3 is reduced by the following amounts:

(1) Fifty percent of the amount of the old-age insurance benefits received or being received under the United States Social Security Act. For injuries occurring on or after October 1, 1995, such a reduction may not be made if the old-age insurance benefits had started prior to the date of injury or if the benefits are spouse's benefits;

(2) The after-tax amount of the payments received or being received under a self-insurance plan or a wage continuation plan or under a disability insurance policy provided by the same employer from whom benefits under section 212 or 213 are received if the employee did not contribute directly to the plan or to the payment of premiums regarding the disability insurance policy. If the self-insurance plans, wage continuation plans or disability insurance policies are entitled to repayment in the event of a workers' compensation benefit recovery, the insurance carrier shall satisfy the repayment out of funds the insurance carrier has received through the coordination of benefits provided for under this section;

(3) The proportional amount, based on the ratio of the employer's contributions to the total insurance premiums for the policy period involved, of the after-tax amount of the payments received or being received by the employee pursuant to a disability insurance policy provided by the same employer from whom benefits under section 212 or 213 are received, if the employee did contribute directly to the payment of premiums regarding the disability insurance policy;

(5) The proportional amount, based on the ratio of that employer's contributions to the total contributions to the plan or program, of the after-tax amount of the pension or retirement payments received or being received by the employee pursuant to a plan or program established or maintained by the same employer from whom benefits under section 212 or 213 are received, regardless of whether the employee contributed directly to the pension or retirement plan or program; and

(6) For those employers who do not provide a pension plan, the proportional amount, based on the ratio of the employer's contributions to the total contributions made to a qualified profit sharing plan under the United States Internal Revenue Code, Section 401(a) or any successor to the United States Internal Revenue Code, Section 401(a) covering a profit sharing plan that provides for the payment of benefits only upon retirement, disability, death, or other separation of employment to the extent that benefits are vested under the plan. [2013, c. 152, §1 (AMD) .]

B. A credit or reduction under this section may not occur because of an increase granted by the Social Security Administration as a cost-of-living adjustment granted after the benefits are coordinated. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. A credit or reduction under this section may not occur because of an increase in a pension or retirement plan or program granted after the benefits are coordinated. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. Except as provided in subsections 6 and 7, a credit or reduction of benefits otherwise payable for any week may not be taken under this section until there has been a determination of the benefit amount otherwise payable to the employee under section 212 or 213 and the employee has begun receiving the benefit payments. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Disability insurance benefit payments under the Social Security Act are considered payments from funds provided by the employer and are considered primary payments on the employer's obligation under section 212 or 213 as old-age benefit payments under the Social Security Act are considered pursuant to this section. However, social security disability insurance benefits may only be so considered if section 224 of the Social Security Act, 42 United States Code, Section 424a, is revised so that a reduction of social security disability insurance benefits is not made because of the receipt of workers' compensation benefits by the employee. The coordination of social security disability benefits commences on the date of the award certificate of the social security disability benefits. Any accrued social security disability benefits may not be coordinated. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. No savings or insurance of the injured employee independent of this Act may be taken into consideration in determining the compensation to be paid, nor may benefits derived from any source other than the employer be considered in fixing the compensation due. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

G. The employer shall pay or cause to be paid to the employee the balance due in either weekly or lump sum payments to satisfy any obligations remaining under section 212 or 213 after the application of this section. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2013, c. 152, §1 (AMD) .]

4. Notification and release of social security benefit information. The board shall adopt rules to provide for notification by an employer to an employee of possible eligibility for social security benefits and the requirements for establishing proof of application for those benefits. Notification must be promptly mailed to the employee after the date on which by reason of age the employee may be entitled to social security benefits. A copy of the notification of possible eligibility must be filed with the board by the employer. Within 30 days after receipt of the notification of possible employee eligibility the employee shall:

A. Make application for social security benefits; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Provide the employer or carrier with proof of that application; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Provide the employer or carrier with an authority for release of information which may be used by the employer to obtain necessary benefit entitlement and amount information from the social security administration. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The authority for release of information is effective for one year.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Release of benefit information. Within 30 days after either the date of first payment of compensation benefits under section 212 or 213 or 30 days after the date of application for any benefit under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5), whichever is later, the employee shall provide the employer with a properly executed authority for release of information which may be used by the employer to obtain necessary benefit entitlement and amount information from the appropriate source. The authority for release of information is effective for one year.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. New authority for release of information. If the employer is required to submit a new authority for release of information under subsection 4 or 5 in order to receive information necessary to comply with this section, the employee shall provide the new authority for release of information within 30 days of a request by the employer or insurance carrier.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Failure to provide release or application. If the employee fails to provide the proof of application or the authority for release of information required in subsection 4 or fails to provide the authority for release of information required in subsection 5 or 6, the employer may, with the approval of the board, discontinue the compensation benefits payable to the employee under section 212 or 213 until the proof of application and the authority for release of information is provided. Compensation benefits withheld must be reimbursed to the employee when the required proof of application, or the authority for release of information, or both, has been provided.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Early retirement. Nothing in this section may be considered to compel an employee to apply for early federal social security old-age insurance benefits or to apply for early or reduced pension or retirement benefits.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Reports. The employer taking a credit or making a reduction as provided in this section shall immediately report to the board the amount of any credit or reduction and, as requested by the board, furnish to the board satisfactory proof of the basis for a credit reduction.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Exceptions for certain disability payments. This section does not apply to any payments received or to be received under a disability insurance plan provided by the same employer if that plan is in existence on December 31, 1992. Any disability insurance plan entered into or renewed on or after January 1, 1993 may provide that the payments under that plan provided by the employer may not be coordinated pursuant to this section. With respect to volunteer firefighter and volunteer emergency medical services persons who are considered employees for purposes of this Act pursuant to section 102, the reduction of weekly benefits provided for disability insurance payments under subsection 3, paragraph A, subparagraphs (2) and (3) and subsection 3, paragraph D may be waived by the employer. An employer that is not a self-insurer may make the waiver provided for under this subsection only at the time a workers' compensation insurance policy is entered into or renewed.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 76, §1 (AMD). 2009, c. 521, §1 (AMD). 2009, c. 521, §2 (AFF). 2011, c. 647, §15 (AMD). 2013, c. 152, §1 (AMD).

§222. PROVISIONAL PAYMENT OF CERTAIN DISABILITY BENEFITS

1. No delay of benefits. Payment of benefits due a person under an insured disability plan or insured medical payments plan may not be delayed or refused because that person has filed a workers' compensation claim based on the same personal injury or disease.

[2001, c. 103, §1 (RPR) .]

2. Repayment. If a person has received benefits, as described in subsection 1, because of a personal injury or disease and has later prevailed on a workers' compensation claim based on the same personal injury or disease, the value of all such benefits may be offset by the employer or respective insurance carriers against the payments of workers' compensation benefits, and, if the benefits are not offset, the person shall repay to the employer or insurer, within 30 days of receiving the initial payment of workers' compensation benefits, the value of all the benefits received under subsection 1.

[2001, c. 103, §2 (AMD) .]

3. Rules. The Superintendent of Insurance shall adopt rules to implement this section.

A. These rules must impose any requirements on employers or health, disability or workers' compensation insurance carriers that the superintendent finds necessary or desirable to ease the financial burden on injured employees whose workers' compensation claims are controverted and who are awaiting board determinations on their claims. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The superintendent shall consult with the executive director of the board in formulating and adopting these rules. [2003, c. 608, §12 (AMD).]

[2003, c. 608, §12 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2001, c. 103, §§1,2 (AMD). 2003, c. 608, §12 (AMD).

§223. PRESUMPTION OF EARNINGS LOSS FOR RETIREES

1. Presumption. An employee who terminates active employment and is receiving nondisability pension or retirement benefits under either a private or governmental pension or retirement program, including old-age benefits under the United States Social Security Act, 42 United States Code, Sections 301 to 1397f, that was paid by or on behalf of an employer from whom weekly benefits under this Act are sought is presumed not to have a loss of earnings or earning capacity as the result of compensable injury or disease under this Act. This presumption may be rebutted only by a preponderance of evidence that the employee is unable, because of a work-related disability, to perform work suitable to the employee's qualifications, including training or experience. This standard of disability supersedes other applicable standards used to determine disability under this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Construction. This section may not be construed as a bar to an employee receiving medical benefits under section 206 upon the establishment of a causal relationship between the employee's work and the need for medical treatment.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§224. ADJUSTMENT TO PARTIAL INCAPACITY BENEFIT PAYMENTS FOR INJURIES PRIOR TO NOVEMBER 20, 1987

The annual adjustment made pursuant to former Title 39, sections 55 and 55-A must be made as follows. The preinjury average weekly wage must first be adjusted to reflect the annual inflation or deflation factors as computed by the Maine Unemployment Insurance Commission for each year from the date of injury to the date of calculation. Once this weekly benefit amount is calculated, the amount must continue to be adjusted annually so that it continues to bear the same percentage relationship to the average weekly wage in the State as computed by the Maine Unemployment Insurance Commission as it did at the time of the injury. This section clarifies the method of calculating the annual adjustment to benefits under former Title 39, sections 55 and 55-A and applies to all benefit calculations pursuant to those sections. [2001, c. 390, §1 (NEW); 2001, c. 390, §2 (AFF).]

SECTION HISTORY

2001, c. 390, §1 (NEW). 2001, c. 390, §2 (AFF).

Chapter 7: PROCEDURES

Subchapter 1: BOARD PROCEEDINGS ENACTED BY PL 1991, C. 885, PT. A, §8

§301. NOTICE OF INJURY WITHIN 90 DAYS

For claims for which the date of injury is prior to January 1, 2013, proceedings for compensation under this Act, except as provided, may not be maintained unless a notice of the injury is given within 90 days after the date of injury. For claims for which the date of injury is on or after January 1, 2013, proceedings for compensation under this Act, except as provided, may not be maintained unless a notice of the injury is given within 30 days after the date of injury. The notice must include the time, place, cause and nature of the injury, together with the name and address of the injured employee. The notice must be given by the injured employee or by a person in the employee's behalf, or, in the event of the employee's death, by the employee's legal representatives, or by a dependent or by a person in behalf of either. [2011, c. 647, §16 (AMD).]

The notice must be given to the employer, or to one employer if there are more employers than one; or, if the employer is a corporation, to any official of the corporation; or to any employee designated by the employer as one to whom reports of accidents to employees should be made. It may be given to the general superintendent or to the supervisor in charge of the particular work being done by the employee at the time of the injury. Notice may be given to any doctor, nurse or other emergency medical personnel employed by the employer for the treatment of employee injuries and on duty at the work site. If the employee is self-employed, notice must be given to the insurance carrier or to the insurance carrier's agent or agency with which the employer normally does business. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2011, c. 647, §16 (AMD).

§302. SUFFICIENCY OF NOTICE; KNOWLEDGE OF EMPLOYER; EXTENSION OF TIME FOR NOTICE

A notice given under section 301 may not be held invalid or insufficient by reason of any inaccuracy in stating any of the facts required for proper notice, unless it is shown that it was the intention to mislead and that the employer was in fact misled by the notice. Want of notice is not a bar to proceedings under this

Act if it is shown that the employer or the employer's agent had knowledge of the injury. Any time during which the employee is unable by reason of physical or mental incapacity to give the notice, or fails to do so on account of mistake of fact, may not be included in the computation of proper notice. In case of the death of the employee within that period, there is allowed for giving the notice 3 months after the death. [2011, c. 647, §17 (AMD).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2011, c. 647, §17 (AMD).

§303. REPORTS TO BOARD

When any employee has reported to an employer under this Act any injury arising out of and in the course of the employee's employment that has caused the employee to lose a day's work, or when the employer has knowledge of any such injury, the employer shall report the injury to the board within 7 days after the employer receives notice or has knowledge of the injury. An insured employer that has notice or knowledge of any such injury and fails to give timely notice to its insurer shall reimburse the insurer for any penalty that is due as a result of the late filing of the report of injury. The employer shall also report the average weekly wages or earnings of the employee, as defined in section 102, subsection 4, together with any other information required by the board, within 30 days after the employer receives notice or has knowledge of a claim for compensation under section 212, 213 or 215, unless a wage statement has previously been filed with the board. A copy of the wage information must be mailed to the employee. The employer shall report when the injured employee resumes the employee's employment and the amount of the employee's wages or earnings at that time. The employer shall complete a first report of injury form for any injury that has required the services of a health care provider within 7 days after the employer receives notice or has knowledge of the injury. The employer shall provide a copy of the form to the injured employee and retain a copy for the employer's records but is not obligated to submit the form to the board unless the injury later causes the employee to lose a day's work. The employer is also required to submit the form to the board if the board has finally adopted a major substantive rule pursuant to Title 5, chapter 375, subchapter 2-A to require the form to be filed electronically. [2013, c. 63, §8 (AMD).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 354, §5 (AMD). 2003, c. 471, §1 (AMD). 2013, c. 63, §8 (AMD).

§304. BOARD NOTICE

1. Inform employee. Immediately upon receipt of the employer's report of injury required by section 303, the board shall contact the employee and provide information explaining the compensation system and the employee's rights. The board shall advise the employee how to contact the board for further assistance and shall provide that assistance.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Notice to employer. The board shall notify the employer when a mediation or formal hearing is scheduled, when a notice of settlement is filed and when any other proceeding regarding a claim of an employee of that employer is scheduled.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Notice by board. Within 15 days of receipt of an employer's report of injury, as required by section 303, unless it has received a petition for award of compensation relating to the injured employee, the board shall take reasonable steps to notify the employee that, unless the employer disputes the claim, the employer

is required to pay compensation within the time limits established in section 205; that a petition for award may be filed; and that rights under this Act may not be protected unless a petition of award or memorandum of payment is on file with the board within 2 years of the injury.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§305. PETITION FOR AWARD; PROTECTIVE DECREE

In the event of a controversy as to the responsibility of an employer for the payment of compensation, any party in interest may file in the office of the board a petition for award of compensation setting forth the names and residences of the parties, the facts relating to the employment at the time of the injury, the knowledge of the employer or notice of the occurrence of the injury, the character and extent of the injury and the claims of the petitioner with reference to the injury, together with such other facts as may be necessary and proper for the determination of the rights of the petitioner. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If, following an injury that causes no incapacity for work, the employer and employee reach an agreement that the employee has received a personal injury arising out of and in the course of employment, a memorandum of such an agreement signed by the parties may be filed in the office of the board. The memorandum must set forth the names and residences of the parties, the facts relating to the employment at the time of the injury, the time, place and cause of the injury, and the nature and extent of the injury. Any member of the board is empowered, without the necessity of the filing of a petition for award, to render a protective decree based on that memorandum. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§306. TIME FOR FILING PETITIONS

1. Statute of limitations. Except as provided in this section, a petition brought under this Act is barred unless filed within 2 years after the date of injury or the date the employee's employer files a required first report of injury if required in section 303, whichever is later.

[2011, c. 647, §18 (AMD) .]

2. Payment of benefits. If an employer or insurer pays benefits under this Act, with or without prejudice, within the period provided in subsection 1, the period during which an employee or other interested party must file a petition is 6 years from the date of the most recent payment.

A. The provision of medical care for an injury or illness by or under the supervision of a health care provider employed by, or under contract with, the employer is a payment of benefits with respect to that injury or illness if:

- (1) Care was provided for that injury or illness on 6 or more occasions in the 12-month period after the initial treatment; and
- (2) The employer or the health care provider knew or should have known that the injury or illness was work-related.

For the purposes of this paragraph, "health care provider" has the same meaning as provided in rules of the board. [2001, c. 435, §1 (NEW); 2001, c. 435, §2 (AFF).]

[2001, c. 435, §1 (AMD); 2001, c. 435, §2 (AFF) .]

3. Establishment of injury. If the occurrence of a work-related injury is established by board decree, mediation report or agreement of the parties without the payment of benefits as provided in subsection 2, the period during which an employee or other interested party may file a petition is 6 years from the date of that decree, report or agreement.

[1999, c. 354, §6 (NEW); 1999, c. 354, §10 (AFF) .]

4. Physical or mental incapacity. If an employee is unable to file a petition because of physical or mental incapacity, the period of that incapacity is not included in the limitation period provided in subsection 1.

[1999, c. 354, §6 (NEW); 1999, c. 354, §10 (AFF) .]

5. Mistake of fact. If an employee fails to file a petition within the limitation period provided in subsection 1 because of mistake of fact as to the cause or nature of the injury, the employee may file a petition within a reasonable time, subject to the 6-year limitation provided in subsection 2.

[1999, c. 354, §6 (NEW); 1999, c. 354, §10 (AFF) .]

6. Death of employee. If an employee dies as a result of a work-related injury, a petition is barred unless filed within one year after the death or 2 years from the date of injury, whichever is later, but in any event not later than 6 years from the date of last payment.

[1999, c. 354, §6 (NEW); 1999, c. 354, §10 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 354, §10 (AFF). 1999, c. 354, §6 (RPR). 2001, c. 435, §1 (AMD). 2001, c. 435, §2 (AFF). 2011, c. 647, §18 (AMD).

§307. PROCEDURE FOR FILING PETITIONS; NO RESPONSE REQUIRED; MEDIATION

1. Petition. Any interested party may seek a determination of rights under this Act by filing with the board any petition authorized under this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Service upon responding party. Copies of all petitions filed under this Act must be served by certified mail, return receipt requested, to the other parties named in the petition. In the case of a petition by an employee, a copy of the petition must be served upon the employer, employer's insurer or group self-insurer.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. No response required. No response to a petition filed under this section is required.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Procedure. A petition filed under this section must be referred by the board to mediation.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Mediation. Mediation must be held in accordance with section 313, subsections 2 to 5.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§308. EMPLOYMENT

1. Return to employment. Any person receiving compensation under this Act who returns to employment or engages in new employment after that person's injury shall file a written report of that employment with the board and that person's previous employer within 7 days of that person's return to work. This report must include the identity of the employee, the employee's employer and the amount of weekly wages or earnings received or to be received by the employee. The board shall send the employee notice of the employee's responsibility to notify the board and the employer when the employee returns to work and the employee's responsibility to submit the reports required under this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Employment status reports. At the previous employer's request, any person receiving compensation under this Act who has not returned to that person's previous employment must submit quarterly employment status reports to that employer. The report is due 90 days after the date of injury, or after the filing of the report under subsection 3, and every 90 days thereafter. The report must be in a form prescribed by the board and must indicate whether the employee has been employed, changed employment or performed any services for compensation during the previous 90 days, the nature of the employment or services, the name and address of the employer or person for whom the services were performed and any other information that the board by rule may require. Any employer requesting a quarterly report under this subsection must provide the employee with the prescribed form at least 15 days prior to the date on which it is due.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§309. SUBPOENAS; EVIDENCE; DISCOVERY

1. Subpoenas. Any board member or designee of the board may administer oaths and any board member or designee of the board may issue subpoenas for witnesses and subpoenas duces tecum to compel the production of books, papers and photographs relating to any questions in dispute before the board, any matters involved in a hearing or an audit conducted pursuant to section 359. Witness fees in all proceedings under this Act are the same as for witnesses before the Superior Court. When a witness, subpoenaed and obliged to attend before the board or any member or designee of the board, fails to do so without reasonable excuse, the Superior Court or any Justice of the Superior Court may, on application of the Attorney General made at the written request of a member of the board, compel obedience by attachment proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued from that court or a refusal to testify in the court.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Evidence. The board or its designee need not observe the rules of evidence observed by courts, but shall observe the rules of privilege recognized by law. The board or its designee shall admit evidence if it is the kind of evidence on which reasonable persons are accustomed to relying in the conduct of serious affairs. The board or its designee may exclude irrelevant or unduly repetitious evidence.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Witnesses; discovery. All witnesses must be sworn. Sworn written evidence may not be admitted unless the author is available for cross-examination or subject to subpoena; except that sworn statements by a medical doctor or osteopathic physician relating to medical questions, by a psychologist relating to psychological questions, by a chiropractor relating to chiropractic questions, by a certified nurse practitioner who qualifies as an advanced practice registered nurse relating to advanced practice registered nursing questions or by a physician's assistant relating to physician assistance questions are admissible in workers' compensation hearings only if notice of the testimony to be used is given and service of a copy of the letter or report is made on the opposing counsel 14 days before the scheduled hearing.

Depositions or subpoenas of health care practitioners who have submitted sworn written evidence are permitted only if the hearing officer finds that the testimony is sufficiently important to outweigh the delay in the proceeding.

The board may establish procedures for the prefiling of summaries of the testimony of any witness in written form. In all proceedings before the board or its designee, discovery beyond that specified in this section is available only upon application to the board, which may approve the application in the exercise of its discretion.

[2005, c. 99, §1 (AMD) .]

4. Contempts before board. A person may not, in proceedings before the board disobey or resist any lawful order, process or writ; misbehave during a hearing or so near the place of hearing as to obstruct the hearing; neglect to produce, after having been ordered to do so, any pertinent document; or refuse to appear after having been subpoenaed or, upon appearing, refuse to be examined according to law.

If any person violates this subsection, the board shall certify the facts to a Justice of the Superior Court in the county where the alleged offense occurred and the justice may serve or cause to be served on that person an order requiring that person to appear before the justice on a day certain to show cause why the person should not be adjudged in contempt by reason of the facts so certified. The justice shall, upon the appearance of that person, in a summary manner, hear the evidence as to the acts complained of and, if it is such as to warrant doing so, punish that person in the same manner and to the same extent as for a contempt committed before the justice, or commit that person on the same conditions as if the doing of the forbidden act had occurred with reference to the process of the Superior Court or in the presence of the justice.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2005, c. 99, §1 (AMD) .

§310. PROTECTION

Except for statements made in proceedings before the board, a statement to any investigator or employer's representative, of any kind, oral or written, recorded or unrecorded, made by the injured employee is not admissible in evidence or considered in any way in any proceeding under this Act, except in accordance with this section. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

1. Admissible statements. A statement made to any investigator or employer's representative, of any kind, oral or written, recorded or unrecorded, made by the injured employee is admissible in evidence or may be considered in proceedings only if:

A. It is in writing; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. A true copy of the statement is delivered to the employee by certified mail; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The employee has been previously advised in writing of the following:

(1) That the statement may be used against the employee;

(2) That the employer or insurance carrier may have pecuniary interest adverse to the employee;

(3) That the employee may consult with counsel prior to making any statements;

(4) That the employee may decline to make any statement; and

(5) That the employer may not discriminate against the employee in any manner for refusing to make such a statement or exercising in any way the employee's rights under this Act. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

2. Exception. This section does not apply to agreements for the payment of compensation made pursuant to this Act or to the admissibility of statements to show compliance with the notice requirements of sections 301 and 302.

[1993, c. 1, §139 (COR).]

3. Application. This section applies only to employees injured prior to June 30, 1985.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). RR 1993, c. 1, §139 (COR).

§311. INADMISSIBLE STATEMENTS

No statement of any kind made by the injured employee to any investigator, employer or employer's representative, whether oral or written, recorded or unrecorded, may be admitted into evidence or considered in any way in any proceeding under this Act if it was obtained by means of duress on the part of the investigator, employer or employer's representative. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Duress defined. For the purpose of this section, "duress" is not limited to its common law definition, but includes:

A. Implied or expressed threats relating to the employment of the employee or the employment of a relative of the employee; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Implied or expressed threats of extensive litigation and appeals of the employee's claim; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Misleading, false or incomplete statements of law or any misleading, false or incomplete legal opinion given to the employee relating to the employee's eligibility for benefits under this Act; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. Misleading, false or incomplete statements of fact knowingly made to the employee; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. The taking of unfair advantage of an employee's physical, mental or economic problems or shortcomings; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. Interrogations or investigations conducted under such circumstances as to be severely intimidating to the employee. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Exception. This section does not apply to agreements for the payment of compensation made under this Act or to the admissibility of statements to show compliance with the notice requirements of sections 301 and 302.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Application. This section applies only to employees injured on or after June 30, 1985.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§312. INDEPENDENT MEDICAL EXAMINERS

1. Examiner system. The board shall develop and implement an independent medical examiner system consistent with the requirements of this section. As part of this system, the board shall, in the exercise of its discretion, create, maintain and periodically validate a list of not more than 50 health care providers that it finds to be the most qualified and to be highly experienced and competent in their specific fields of expertise and in the treatment of work-related injuries to serve as independent medical examiners from each of the health care specialties that the board finds most commonly used by injured employees. An independent medical examiner must be certified in the field of practice that treats the type of injury complained of by the employee. For an independent medical examiner who is a doctor of chiropractic, certification must be by a board recognized by the American Chiropractic Association or its successor organization. For an independent medical examiner who is a doctor of podiatric medicine, certification must be by a board recognized by the American Podiatric Medical Association or its successor organization. For an independent medical examiner who is a psychologist, licensure by the State Board of Examiners of Psychologists satisfies the certification requirement of this section. For all other medical examiners, certification must be by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or their successor organizations. The board shall establish a fee schedule for services rendered by independent medical examiners and adopt any rules considered necessary to effectuate the purposes of this section.

[2013, c. 63, §9 (AMD) .]

2. Duties. An independent medical examiner shall render medical findings on the medical condition of an employee and related issues as specified under this section. The independent medical examiner in a case may not be the employee's treating health care provider and may not have treated the employee with respect to the injury for which the claim is being made or the benefits are being paid. Nothing in this subsection precludes the selection of a provider authorized to receive reimbursement under section 206 to serve in the capacity of an independent medical examiner. Unless agreed upon by the parties or no other physician is reasonably available, a physician is not eligible to be assigned as an independent medical examiner if the physician has examined the employee at the request of an insurance company, employer or employee in

accordance with section 207 or has been closely affiliated with the insurance company at any time during the previous 52 weeks. An independent medical examiner selected and paid for by an employer to examine an employee in accordance with section 207 is limited to 12 such examinations per calendar year and shall notify the board of the name of the employee, the employer or the insurance company that requested the examination and the date of the examination within 10 days of the date of the examination.

[2011, c. 215, §2 (AMD) .]

3. Appointment. If the parties to a dispute can not agree on an independent medical examiner of their own choosing, the board shall assign an independent medical examiner from the list of qualified examiners to render medical findings in any dispute relating to the medical condition of a claimant, including but not limited to disputes that involve the employee's medical condition, improvement or treatment, degree of impairment or ability to return to work.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Rules. The board may adopt rules pertaining to the procedures before the independent medical examiner, including the parties' ability to propound questions relating to the medical condition of the employee to be submitted to the independent medical examiner. The parties shall submit any medical records or other pertinent information to the independent medical examiner. In addition to the review of records and information submitted by the parties, the independent medical examiner may examine the employee as often as the examiner determines necessary to render medical findings on the questions propounded by the parties.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Medical findings; fees. The independent medical examiner shall submit a written report to the board, the employer and the employee stating the examiner's medical findings on the issues raised by that case and providing a description of findings sufficient to explain the basis of those findings. It is presumed that the employer and employee received the report 3 working days after mailing. The fee for the examination and report must be paid by the employer.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Subsequent medical evidence. All subsequent medical evidence from the treating health care provider must be forwarded to the independent medical examiner no later than 14 days prior to the hearing. The independent medical examiner must be notified of the hearing and shall make a supplemental report if the subsequent medical evidence affects the medical findings of the independent medical examiner. If the independent medical examiner prepares a supplemental report, the report must be submitted to the board and the parties at least 3 days prior to the hearing.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Weight. The board shall adopt the medical findings of the independent medical examiner unless there is clear and convincing evidence to the contrary in the record that does not support the medical findings. Contrary evidence does not include medical evidence not considered by the independent medical examiner. The board shall state in writing the reasons for not accepting the medical findings of the independent medical examiner.

[2005, c. 24, §2 (AMD) .]

8. Immunity. Any health care provider acting without malice and within the scope of the provider's duties as an independent medical examiner is immune from civil liability for making any report or other information available to the board or for assisting in the origination, investigation or preparation of the report or other information so provided.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Annual review. The board shall create a review process to oversee on an annual basis the quality of performance and the timeliness of the submission of medical findings by the independent medical examiners.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2005, c. 24, §§1,2 (AMD). 2011, c. 215, §§1, 2 (AMD). 2013, c. 63, §9 (AMD).

§313. PROCEDURE UPON NOTICE OF CONTROVERSY OR OTHER INDICATION OF CONTROVERSY; MEDIATION

1. Procedure. Except as provided in section 205, subsection 9, paragraph D, upon filing of notice of controversy or other indication of controversy, the matter must be referred by the board to mediation.

[1999, c. 354, §7 (AMD) .]

2. Mediation. The mediator shall by informal means, which may include telephone contact, determine the nature and extent of the controversy and attempt to resolve it. The mediator is not bound by the rules of evidence or procedure, but shall make inquiry in the manner best calculated to ascertain the substantial rights of the parties and carry out the spirit of this Act. The mediator may require that the parties appear and submit relevant information.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Conclusion. At the conclusion of mediation, the mediator shall file a written report with the board stating the information required by section 305, 2nd paragraph and the legal issues in dispute. If an agreement is reached, the report must state the terms of the agreement and must be signed by the parties and the mediator. If a full agreement is not reached, the report must state the information required by section 305, 2nd paragraph, any terms that are agreed on by the parties and any facts and legal issues in dispute and the report must be signed by the parties and the mediator.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Cooperation; sanctions. The parties shall cooperate with the mediator assigned to the case. The assigned mediator shall report to the board the failure of a party to cooperate or to produce requested material. The board may impose sanctions against a party who does not cooperate or produce requested materials, including the following:

- A. Assessment of costs and attorney's fees; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- B. Reductions of attorney's fees; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]
- C. If the party is the moving party, suspension of proceedings until the party has cooperated or produced the requested material. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

For purposes of this subsection, "party" includes the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

[2009, c. 129, §7 (AMD); 2009, c. 129, §13 (AFF) .]

5. Duties of employer or representative of the employee, employer or insurer. The employer or representative of the employee, employer or insurer who participates in mediation must be familiar with the employee's claim and has authority to make decisions regarding the claim. The board may assess a forfeiture in the amount of \$100 against any employer or representative of the employee, employer or insurer who participates in mediation without full authority to make decisions regarding the claim. If a representative of the employer, insurer or employee participates in mediation or any other proceeding of the board, the representative shall notify the employer, insurer or employee of all actions by the representative on behalf of the employer, insurer or employee and any other actions at the proceeding.

For purposes of this subsection, "employer or representative of the employee, employer or insurer" includes the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

[2009, c. 129, §8 (AMD); 2009, c. 129, §13 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 354, §7 (AMD). 2009, c. 129, §§7, 8 (AMD). 2009, c. 129, §13 (AFF).

§314. ARBITRATION

Any case for which an application for a hearing has been filed may be heard by an arbitrator mutually agreed upon in writing by the parties. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Evidence. An arbitrator shall admit evidence in accordance with section 309, subsection 2.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Testimony. Testimony must be taken under oath and a record of the arbitration must be made. Any party, at that party's expense, may provide for a written transcript of the proceedings. The cost of any transcription ordered by the arbitrator for the arbitrator's own use must be paid for by the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Location of arbitration. The arbitrator shall conduct the hearing in the county in which the injury occurred or at a place agreed upon by all of the parties.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Arbitration decision. The arbitrator shall render the arbitration decision within 30 days after the close of the arbitration or the receipt of briefs, if required. The decision must be in writing, signed by the arbitrator and include a written opinion stating the arbitrator's findings of fact and conclusions of law. The decision must be filed with the board within 3 days of entry of the decision by the arbitrator.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Record. The decision is part of the record of the arbitration proceeding under this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Finality. The findings of fact made by the arbitrator acting within the arbitrator's powers, in the absence of fraud, are conclusive. If the arbitrator expressly finds that any party has or has not sustained the party's burden of proof, that finding is considered a conclusion of law and is reviewable in accordance with section 322. Any party may appeal the decision of the arbitrator to the Law Court pursuant to section 322 within 20 days of receipt of notice of the filing of the decision by the arbitrator.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Fee; rules. The board shall by rule provide for the amount of the fee to be paid to the arbitrator by the board and establish administrative processes to review, adopt and monitor arbitration plans.

[1995, c. 105, §1 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 105, §1 (AMD).

§315. TIME AND PLACE OF FORMAL HEARING

Upon filing of the mediator's report indicating that mediation has not resolved all issues in dispute, the matter must be referred to the board, which shall fix a time for hearing upon at least a 5-day notice given to all the parties or to the attorney of record of each party. All hearings must be held before a hearing officer employed by the board at such towns and cities geographically distributed throughout the State as the board designates. If the designated place of hearing is more than 10 miles from the place where the injury occurred, the employer shall provide transportation or reimburse the employee for reasonable mileage in traveling within the State to and from the hearing. The amount allowed for travel is determined by the board and awarded separately in the decree. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The board shall provide for an expedited process for the scheduling and hearing of matters involving medical care or the right to benefits for total incapacity. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§316. GUARDIANS AND OTHER REPRESENTATIVES FOR MINORS AND INCOMPETENTS

If an injured employee is a minor or is mentally incompetent or, when death results from the injury, if any of the employee's dependents entitled to compensation are minors or mentally incompetent at the time when any right, privilege or election accrues under this Act, the parent, guardian or next friend of the minor or incompetent, or some disinterested person designated by the board, may claim and exercise that right, privilege or election, or file any petition or answer, on behalf of the minor or incompetent. No limitation of time provided in this Act may run as long as the minor or incompetent has no parent living or guardian. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If the board has reasonable grounds for believing that compensation paid under this Act, either in weekly installments or in a lump sum, will be squandered or wasted by the injured employee or the employee's dependents, the board may designate in writing some disinterested person to act as trustee for the injured employee or the dependents. The trustee shall file an account at least once a year with the board showing the amounts of receipts and expenditures in behalf of the injured employee or the dependents. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§317. APPEARANCE BY AUTHORIZED OFFICER, EMPLOYEE OR ADVOCATE

The appearance before the board of an authorized officer, employee, advocate or representative of a party in any hearing, action or proceeding in which the party is participating or desires to participate is not an unauthorized practice of law and is not subject to any criminal sanction. If the appearance of such an officer, employee, advocate or representative prevents the efficient processing of any proceeding, the board, in its discretion, may remove that person from representation of the party. [1997, c. 486, §6 (AMD).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1997, c. 486, §6 (AMD).

§318. HEARING AND DECISION

The hearing officer shall hear those witnesses as may be presented or, by agreement, the claims of both parties as to the facts may be presented by affidavits. If the facts are not in dispute, the parties may file with the hearing officer an agreed statement of facts for a ruling on the applicable law. From the evidence or statements furnished, the hearing officer shall in a summary manner decide the merits of the controversy. The hearing officer's decision must be filed in the office of the board and a copy, attested by the clerk of the board, mailed promptly to all parties interested or to the attorney of record of each party. The hearing officer's decision, in the absence of fraud, on all questions of fact is final; but if the hearing officer expressly finds that any party has or has not sustained the party's burden of proof, that finding is considered a conclusion of law and is reviewable in accordance with section 322. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The hearing officer, upon motion by the petitioning party, may include a finding in the decree that the employer's refusal to pay the benefits at issue was not based on any rational grounds developed between the claim and formal hearing. Upon such a finding, the employer shall pay interest to the employee under section 205, subsection 6 at a rate of 25% per annum from the date each payment was due, instead of 10% per annum. [1999, c. 410, §2 (NEW).]

The hearing officer, upon the motion of a party made within 20 days after notice of the decision or upon its own motion, may find the facts specially and state separately the conclusions of law and file the appropriate decision if it differs from the decision filed before the request was made. Those findings and conclusions and the revised decision must be filed in the office of the board and a copy, attested by the clerk of the board, must be mailed promptly to all parties interested. The running of the time for appeal is terminated by a timely motion made pursuant to this section and the full time for appeal commences to run from the filing of those findings and conclusions and the revised decision. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

Clerical mistakes in decrees, orders or other parts of the record and errors arising from oversight or omission may be corrected by the board at any time of its own initiative, at the request of the hearing officer or on the motion of any party and after notice to the parties. During the pendency of an appeal, these mistakes may be corrected before the appeal is filed with the division and thereafter, while the appeal is pending, may be corrected with leave of the division. [2013, c. 63, §10 (AMD); 2013, c. 63, §16 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 410, §2 (AMD). 2013, c. 63, §10 (AMD). 2013, c. 63, §16 (AFF).

§319. PETITION FOR REOPENING

Upon the petition of either party, the board may reopen and review any compensation payment scheme, award or decree on the grounds of newly discovered evidence that by due diligence could not have been discovered prior to the time the payment scheme was initiated or prior to the hearing on which the award or decree was based. The petition must be filed within 30 days of the payment scheme, award or decree. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§320. REVIEW BY FULL BOARD

A hearing officer may request that the full board review a decision of the hearing officer if the decision involves an issue that is of significance to the operation of the workers' compensation system. Except when a motion is filed to find the facts specially and state separately the conclusions of law, the request must be made within 25 days of the issuance of a decision. If a motion is filed to find the facts specially and state separately the conclusions of law, the request must be made within 5 days of the issuance of a decision on the motion. There may be no such review of findings of fact made by a hearing officer. [2005, c. 25, §1 (AMD).]

If a hearing officer asks for review, the time for appeal is stayed and no further action may be taken until a decision of the board has been made. If the board reviews a decision of a hearing officer, any appeal must be from the decision of the board and must be made to the Law Court in accordance with section 322. The time for appeal begins upon the board's issuance of a written decision on the merits of the case or written notice that the board denies review. [2013, c. 63, §11 (AMD); 2013, c. 63, §16 (AFF).]

The board shall vote on whether to review the decision. If a majority of the board's membership fails to vote to grant review or the board fails to act within 60 days after receiving the initial request for review, the decision of the hearing officer stands, and any appeal must be made to the division in accordance with section 321-B. If the board votes to review the decision, the board may delegate responsibility for reviewing the decision of the hearing officer under this section to panels of board members consisting of equal numbers of representatives of labor and management. Review must be on the record and on written briefs only. Upon a vote of a majority of the board's membership, the board shall issue a written decision affirming, remanding, vacating or modifying the hearing officer's decision. The written decision of the board must be filed with the board and mailed to the parties or their counsel. If the board fails to adopt a decision by majority vote, the decision of the hearing officer stands and is subject to direct appellate review in the same manner as if the board had not voted to review the decision. [2013, c. 63, §12 (AMD); 2013, c. 63, §16 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2003, c. 608, §13 (AMD). 2005, c. 25, §1 (AMD). 2011, c. 647, §19 (AMD). 2013, c. 63, §§11, 12 (AMD). 2013, c. 63, §16 (AFF).

§321. REOPENING FOR MISTAKE OF FACT OR FRAUD

1. Agreements. Upon the petition of either party at any time, the board may annul any agreement that has been approved by the board if it finds that the agreement has been entered into through mistake of fact by the petitioner or through fraud. Except in the case of fraud on the part of the employee, an employee is not barred by any time limit from filing a petition to have the matters covered by the agreement determined in accordance with this Act as though the agreement had not been approved.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Compensation payment scheme. A party may petition the board, within one year of initiation of a payment scheme, award or decree, to reopen any case in which fraud on the part of the opposing party is alleged. If the board finds that the petitioning party exercised due diligence in investigating the initial claim and further finds that fraud occurred, the board may reopen the case as to any issue that may have been affected by the fraudulent act and the board may terminate or modify an employer's obligation to make payment upon a finding that fraud on the part of a party affected the employer's obligation to make payment. Except in the case of fraud on the part of the employee, an employee is not barred by any time limit from filing a petition to have any issues determined in accordance with this Act as though the payment scheme had not been initiated.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§321-A. APPELLATE DIVISION

1. Establishment. There is established within the board the Appellate Division, referred to in this subchapter as "the division."

[2011, c. 647, §20 (NEW) .]

2. Composition. The division is composed of full-time hearing officers who are appointed by the executive director of the board to serve on panels to review decisions under section 318. The executive director of the board shall appoint no fewer than 3 full-time hearing officers to serve as members of a panel. A hearing officer may not serve as a member of a panel that reviews a decision of that hearing officer. A hearing officer may be a member of more than one panel at the discretion of the executive director of the board.

[2011, c. 647, §20 (NEW) .]

3. Rules. The board shall adopt rules of procedure designed to provide a prompt and inexpensive review of a decision by a hearing officer. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 647, §20 (NEW) .]

SECTION HISTORY

2011, c. 647, §20 (NEW).

§321-B. APPEAL FROM HEARING OFFICER DECISION

1. Procedure. An appeal of a decision by a hearing officer pursuant to section 318 to the division must be conducted pursuant to this subsection.

A. A party in interest may file with the division a notice of intent to appeal a decision by a hearing officer pursuant to section 318 within 20 days after receipt of notice of the filing of the decision by the hearing officer. [2011, c. 647, §20 (NEW).]

B. At the time of filing an appeal under this section, the appellant shall file with the division a copy of the decision appealed. The failure of an appellant who timely files an appeal in accordance with paragraph A to provide a copy of the decision does not affect the jurisdiction of the division to determine the appeal on its merits unless the appellee shows substantial prejudice from that failure. [2013, c. 63, §13 (AMD); 2013, c. 63, §16 (AFF).]

[2013, c. 63, §13 (AMD); 2013, c. 63, §16 (AFF) .]

2. Basis. A finding of fact by a hearing officer is not subject to appeal under this section.

[2011, c. 647, §20 (NEW) .]

3. Action. The division, after due consideration, may affirm, vacate, remand or modify a decree of a hearing officer and shall issue a written decision. The written decision of the division must be filed with the board and mailed to the parties or their counsel.

[2013, c. 63, §14 (AMD); 2013, c. 63, §16 (AFF) .]

4. Publication of decisions. The division shall publish the decisions issued under subsection 3 and make them available to the public at such cost as is required to pay for suitable publication. The division shall distribute copies of all written decisions to the State Law Library and the county law libraries.

[2011, c. 647, §20 (NEW) .]

SECTION HISTORY

2011, c. 647, §20 (NEW). 2013, c. 63, §§13, 14 (AMD). 2013, c. 63, §16 (AFF).

§322. APPEAL FROM DECISION OF HEARING OFFICER OR BOARD

1. Appeals. Any party in interest may present a copy of the decision of the division or a decision of the board, if the board has reviewed a decision pursuant to section 320, to the clerk of the Law Court within 20 days after receipt of notice of the filing of the decision by the division or the board. Within 20 days after the copy is filed with the Law Court, the party seeking review by the Law Court shall file a petition seeking appellate review with the Law Court that sets forth a brief statement of the facts, the error or errors of law that are alleged to exist and the legal authority supporting the position of the appellant.

[2011, c. 647, §21 (AMD) .]

2. Procedures. The Law Court shall establish and publish procedures for the review of petitions for appellate review of decisions of the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Discretionary appeal; action. Upon the approval of 3 or more members of a panel consisting of no fewer than 5 Justices of the Law Court, the petition for appellate review may be granted. If the petition for appellate review is denied, the decision of the board is final. The petition must be considered on written briefs only.

If the petition for appellate review is granted, the clerk of the Law Court shall notify the parties of the briefing schedule consistent with the Maine Rules of Civil Procedure and in all respects the appeal before the Law Court must be treated as an appeal in an action in which equitable relief has been sought, except that there may be no appeal upon findings of fact. The Law Court may, after due consideration, reverse, modify or affirm any decision of the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2011, c. 647, §21 (AMD).

§323. ENFORCEMENT OF BOARD DECISION

Any decision of the board is enforceable by the Superior Court by any suitable process, including execution against goods, chattel and real estate and proceedings for contempt for willful failure or neglect to obey the orders or decrees of the court or in any other manner that decrees for equitable relief are enforced. Any party in interest may present copies, certified by the clerk of the board, of any order or decision of the board or of any memorandum of agreement approved by the board to the clerk of courts for the county in which the injury occurred or, if the injury occurred outside the State, to the clerk of courts for Kennebec County. Any Justice of the Superior Court shall then render a pro forma decision in accordance with the order, decision or memorandum and cause all interested parties to be notified. The decision has the same effect and all proceedings in relation to the decision are the same as though rendered in an action in which equitable relief is sought, duly heard and determined by the court. The decision must be for enforcement of a board decision, order or agreement. Appeals from a board decision, order or agreement must be in accordance with section 322. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§324. COMPENSATION PAYMENTS; PENALTY

1. Order or decision. The employer or insurance carrier shall make compensation payments within 10 days after the receipt of notice of an approved agreement for payment of compensation or within 10 days after any order or decision of the board awarding compensation. If the board enters a decision awarding compensation, and a motion for findings of fact and conclusions of law is filed with the hearing officer or an appeal is filed with the division pursuant to section 321-B or the Law Court pursuant to section 322, payments may not be suspended while the motion for findings of fact and conclusions of law or appeal is pending. The employer or insurer may recover from an employee payments made pending a motion for findings of fact and conclusions of law or appeal to the division or the Law Court if and to the extent that the hearing officer, division or the Law Court has decided that the employee was not entitled to the compensation paid. The board has full jurisdiction to determine the amount of overpayment, if any, and the amount and schedule of repayment, if any. The board, in determining whether or not repayment should be made and the extent and schedule of repayment, shall consider the financial situation of the employee and the employee's family and may not order repayment that would work hardship or injustice. The board shall notify the Commissioner of Health and Human Services within 10 days after the receipt of notice of an approved agreement for payment of compensation or within 10 days after any order or decision of the board awarding compensation identifying the employee who is to receive the compensation. For purposes of this subsection, "employer or insurance carrier" includes the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

[2013, c. 63, §15 (AMD) .]

2. Failure to pay within time limits. An employer or insurance carrier who fails to pay compensation, as provided in this section, is penalized as follows. For purposes of this subsection, "employer or insurance carrier" includes the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

A. Except as otherwise provided by section 205, if an employer or insurance carrier fails to pay compensation as provided in this section, the board may assess against the employer or insurance carrier a fine of up to \$200 for each day of noncompliance. If the board finds that the employer or insurance carrier was prevented from complying with this section because of circumstances beyond its control, a fine may not be assessed.

(1) The fine for each day of noncompliance must be divided as follows: Of each day's fine amount, the first \$50 is paid to the employee to whom compensation is due and the remainder must be paid to the board and be credited to the Workers' Compensation Board Administrative Fund.

(2) If a fine is assessed against any employer or insurance carrier under this subsection on petition by an employee, the employer or insurance carrier shall pay reasonable costs and attorney's fees related to the fine, as determined by the board, to the employee.

(3) Fines assessed under this subsection may be enforced by the Superior Court in the same manner as provided in section 323. [2007, c. 265, §1 (AMD).]

B. Payment of a fine assessed under this subsection is not considered an element of loss for the purpose of establishing rates for workers' compensation insurance. [2007, c. 265, §1 (AMD).]

[2009, c. 129, §10 (AMD); 2009, c. 129, §13 (AFF) .]

3. Failure to secure payment. If any employer who is required to secure the payment to that employer's employees of the compensation provided for by this Act fails to do so, the employer is subject to the penalties set out in paragraphs A, B and C. The failure of any employer to procure insurance coverage for the payment of compensation and other benefits to the employer's employees in compliance with sections 401 and 403 constitutes a failure to secure payment of compensation within the meaning of this subsection.

A. The employer is guilty of a Class D crime. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The employer is liable to pay a civil penalty of up to \$10,000 or an amount equal to 108% of the premium, calculated using Maine Employers' Mutual Insurance Company's standard discounted standard premium, that should have been paid during the period the employer failed to secure coverage, whichever is larger, payable to the Employment Rehabilitation Fund. [1999, c. 354, §8 (AMD) .]

C. The employer, if organized as a corporation, is subject to administrative dissolution as provided in Title 13-C, section 1421 or revocation of its authority to do business in this State as provided in Title 13-C, section 1532. The employer, if organized as a limited liability company, is subject to administrative dissolution as provided in Title 31, section 1592. The employer, if licensed, certified, registered or regulated by any board authorized by Title 5, section 12004-A or whose license may be revoked or suspended by proceedings in the District Court or by the Secretary of State, is subject to revocation or suspension of the license, certification or registration. [2011, c. 113, Pt. B, §20 (AMD) .]

Prosecution under paragraph A does not preclude action under paragraph B or C.

If the employer is a corporation, partnership, limited liability company, professional corporation or any other legal business entity recognized under the laws of the State, any agent of the corporation or legal business entity having primary responsibility for obtaining insurance coverage is liable for punishment under this section. Criminal liability must be determined in conformity with Title 17-A, sections 60 and 61.

[2011, c. 113, Pt. B, §20 (AMD) .]

4. Certificate. Notwithstanding any other provision of law or rule of evidence, the certificate of the executive director, under seal of the board, must be received in any court in this State as prima facie evidence of facts pertaining to insurance coverage records contained in the certificate or within the documents attached to the certificate.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 354, §8 (AMD). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF). 2003, c. 344, §D28 (AMD). 2007, c. 240, Pt. JJJ, §6 (AMD). 2007, c. 265, §1 (AMD). 2007, c. 311, §3 (AMD). 2009, c. 129, §§9, 10 (AMD). 2009, c. 129, §13 (AFF). 2009, c. 520, §2 (AMD). 2011, c. 113, Pt. B, §20 (AMD). 2011, c. 361, §1 (AMD). 2013, c. 63, §15 (AMD).

§325. COSTS; ATTORNEY'S FEES ALLOWABLE

1. Costs and attorney's fees. Except as otherwise provided by law, by the Maine Rules of Civil Procedure or by rule of court, each party is responsible for the payment of the party's own costs and attorney's fees. In the event of a disagreement as to those costs or fees, an interested party may apply to the board for a hearing.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Restriction on attorney's fees. An attorney representing an employee in a proceeding under this Act may receive a fee from that client for an activity pursuant to the Act only as provided in this section. The fees and payment of fees to all attorneys for services provided to employees under this Act are subject to the approval of the board. The board may approve the payment of attorney's fees by the employee for services provided to the employee pursuant to this Act. Any attorney who violates this section must forfeit any fee in the case and is liable in a court suit to pay damages to the client equal to 2 times the fee charged to that client.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Rules. The board shall adopt rules to prescribe maximum attorney's fees and the manner in which the amount is determined and paid by the employee. The maximum attorney's fees prescribed by the board in a case tried to completion may not exceed 30% of the benefits accrued, after deducting reasonable expenses incurred on behalf of the employee, or be based on a weekly benefit amount after coordination that is higher than 2/3 of the state average weekly wage at the time of injury. The board may by rule allow attorney's fees to be increased above or decreased below the amount specified in the rule when in the discretion of the board that action is determined to be appropriate.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Attorney's fees for lump-sum settlements. Attorney's fees for lump-sum settlements pursuant to section 352 must be determined as follows:

A. Before computing the fee, reasonable expenses incurred on the employee's behalf must be deducted from the total settlement, including:

- (1) Medical examination fee and witness fee;
- (2) Any other medical witness fee, including cost of subpoena;
- (3) Cost of court reporter service; and
- (4) Appeal costs; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

B. The computation of the fee, based on the amount resulting after deductions according to paragraph A, may not exceed:

- (1) Ten percent of the first \$50,000 of the settlement;
- (2) Nine percent of the first \$10,000 over \$50,000 of the settlement;
- (3) Eight percent of the next \$10,000 over \$50,000 of the settlement;
- (4) Seven percent of the next \$10,000 over \$50,000 of the settlement;
- (5) Six percent of the next \$10,000 over \$50,000 of the settlement; and
- (6) Five percent of any amount over \$90,000 of the settlement. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Attorney's fees in cases in which the injury occurred prior to January 1, 1993. In cases in which the injury to the employee occurred prior to January 1, 1993, the amount of the attorney's fees is determined by the law in effect at the date of the injury and is payable by the employer. If the employee attended a mediation pursuant to section 313 after January 1, 1993 and was represented by an attorney, the attorney's fees may include compensation from the date of the mediation session.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§326. DEATH OF PETITIONER

No proceedings under this Act abate because of the death of the petitioner, but may be prosecuted by the employee's legal representatives or by any person entitled to compensation by reason of the death under this Act. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§327. WHEN EMPLOYEE KILLED OR UNABLE TO TESTIFY

In any claim for compensation, when the employee has been killed or is physically or mentally unable to testify, there is a rebuttable presumption that the employee received a personal injury arising out of and in the course of employment, that sufficient notice of the injury has been given and that the injury or death was not occasioned by the willful intention of the employee to injure or kill the employee or another. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§328. CARDIOVASCULAR INJURY OR DISEASE AND PULMONARY DISEASE SUFFERED BY A FIREFIGHTER OR RESULTING IN A FIREFIGHTER'S DEATH

Cardiovascular injury or disease and pulmonary disease suffered by a firefighter or resulting in a firefighter's death are governed by this section. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Firefighter defined. For the purposes of this section, "firefighter" means an active member of a municipal fire department or of a volunteer firefighters association if that person is a member of a municipal fire department or volunteer firefighters association and if that person aids in the extinguishment of fires, regardless of whether or not that person has administrative duties or other duties as a member of the municipal fire department or volunteer firefighters association.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Presumption. There is a rebuttable presumption that a firefighter received the injury or contracted the disease arising out of and in the course of employment, that sufficient notice of the injury or disease has been given and that the injury or disease was not occasioned by the willful intention of the firefighter to cause self-injury or injury to another if the firefighter has been an active member of a municipal fire department or a volunteer firefighters association, as defined in Title 30-A, section 3151, for at least 2 years prior to a cardiovascular injury or the onset of a cardiovascular disease or pulmonary disease and if:

A. The disease has developed or the injury has occurred within 6 months of having participated in fire fighting, or training or drill that actually involves fire fighting; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The firefighter had developed the disease or had suffered the injury that resulted in death within 6 months of having participated in fire fighting, or training or drill that actually involved fire fighting. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§328-A. COMMUNICABLE DISEASE CONTRACTED BY EMERGENCY RESCUE OR PUBLIC SAFETY WORKER

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Body fluids" means blood and body fluids containing visible blood and other potentially infectious materials, as defined in a regulation of the Occupational Safety and Health Administration, 29 Code of Federal Regulations, 1910.1030 (2001). For purposes of potential transmission of meningococcal meningitis or tuberculosis, "body fluids" includes respiratory, salivary and sinus fluids, including droplets, sputum and saliva, mucus and other fluids through which infectious airborne organisms can be transmitted between persons. [2001, c. 663, §1 (NEW).]

B. "Corrections officer" has the same meaning as in Title 25, section 2801-A, subsection 2. [2001, c. 663, §1 (NEW).]

C. "Emergency medical services person" means a person licensed as an emergency medical services person under Title 32, chapter 2-B who is employed by, or provides voluntary service to, an ambulance service as defined in Title 32, section 83 or a nontransporting emergency medical service as defined in Title 32, section 83. [2001, c. 663, §1 (NEW).]

D. "Emergency rescue or public safety worker" means a person who:

(1) Is a firefighter, emergency medical services person, law enforcement officer or corrections officer; and

(2) In the course of employment, runs a high risk of occupational exposure to hepatitis, meningococcal meningitis or tuberculosis. [2001, c. 663, §1 (NEW).]

E. "Employer" includes an entity for which a person provides volunteer services. [2001, c. 663, §1 (NEW).]

F. "Firefighter" means an active member of a municipal fire department or a volunteer fire association as defined in Title 30-A, section 3151. [2001, c. 663, §1 (NEW).]

G. "Hepatitis" means hepatitis A, hepatitis B, hepatitis C or any other strain of hepatitis generally recognized by the medical community. [2001, c. 663, §1 (NEW).]

H. "High risk of occupational exposure" means a risk that is incurred because a person subject to the provisions of this section, in performing the basic duties associated with that person's employment:

(1) Provides emergency medical treatment in a nonhealth-care setting where there is a potential for the transfer of body fluids between persons;

(2) At the site of an accident, fire or other rescue or public safety operation, or in an emergency rescue or public safety vehicle, handles body fluids in or out of containers or works with or otherwise handles needles or other sharp instruments exposed to body fluids;

(3) Engages in the pursuit, apprehension and arrest of persons suspected of violating the law and, in performing such duties, risks exposure to body fluids; or

(4) Is responsible for the custody and physical restraint, when necessary, of prisoners or inmates within a prison, jail or other criminal detention facility or while on work detail outside the facility or while being transported and, in performing such a duty, risks exposure to body fluids. [2001, c. 663, §1 (NEW).]

I. "Law enforcement officer" has the same meaning as in Title 25, section 2801-A, subsection 5. [2001, c. 663, §1 (NEW).]

J. "Occupational exposure," in the case of hepatitis, meningococcal meningitis or tuberculosis, means an exposure that occurs during the performance of job duties that may place a worker at risk of infection. [2001, c. 663, §1 (NEW).]

[2001, c. 663, §1 (NEW) .]

2. Presumption. There is a rebuttable presumption that an emergency rescue or public safety worker who contracts hepatitis, meningococcal meningitis or tuberculosis has a disease arising out of and in the course of employment, that sufficient notice of the disease has been given and that the disease was not occasioned by the willful intention of the emergency rescue or public safety worker to cause self-injury or injury to another if the emergency rescue or public safety worker complies with the requirements of subsections 3 to 5.

[2001, c. 663, §1 (NEW) .]

3. Written verification. In order to qualify for the presumption set forth in subsection 2, an emergency rescue or public safety worker must sign a written affidavit declaring that, to the best of the person's knowledge and belief:

A. In the case of a medical condition caused by hepatitis, the person has not:

(1) Been exposed, through transfer of body fluids, to any person known to have sickness or medical conditions derived from hepatitis outside the scope of the person's employment as an emergency rescue or public safety worker;

(2) Had a transfusion of blood or blood components, other than a transfusion arising out of an accident or injury happening in connection with the person's employment as an emergency rescue or public safety worker, or received any blood products for the treatment of a coagulation disorder;

(3) Engaged in unsafe sexual practices or other high-risk behavior, as identified by the Centers for Disease Control and Prevention or the Surgeon General of the United States, or had sexual relations with a person known by the emergency rescue or public safety worker to have engaged in such unsafe sexual practices or other high-risk behavior; or

(4) Used intravenous drugs not prescribed by a physician. [2001, c. 663, §1 (NEW).]

B. In the case of meningococcal meningitis, in the 10 days immediately preceding diagnosis the person was not exposed outside the scope of the person's employment as an emergency rescue or public safety worker to any person known to have meningococcal meningitis or known to be an asymptomatic carrier of the disease. [2001, c. 663, §1 (NEW).]

C. In the case of tuberculosis, the person has not been exposed, outside the scope of the person's employment as an emergency rescue or public safety worker, to any person known by the emergency rescue or public safety worker to have tuberculosis. [2001, c. 663, §1 (NEW).]

A person who has tested negative for hepatitis or tuberculosis at the time of employment or during employment as an emergency rescue or public safety worker may satisfy the affidavit requirement in paragraph A, subparagraph (2) or paragraph C by making the required declaration with respect to the period of time since the person's last negative test for hepatitis or tuberculosis, respectively.

[2001, c. 663, §1 (NEW) .]

4. Required medical tests; preemployment physical. In order to be entitled to the presumption set forth in subsection 2:

A. An emergency rescue or public safety worker, at the time of or during employment as an emergency rescue or public safety worker and prior to diagnosis, must have undergone standard, medically acceptable tests for evidence of the disease for which the presumption is sought or evidence of the medical conditions derived from the disease, which tests failed to indicate the presence of infection. This paragraph does not apply in the case of meningococcal meningitis and does not apply to an emergency rescue or public safety worker employed or serving in that capacity on the effective date of this section; and [2001, c. 663, §1 (NEW).]

B. On or after the effective date of this section, the emergency rescue or public safety worker has undergone a preemployment physical examination that tested for and failed to reveal any evidence of hepatitis or tuberculosis if the person's employer requires such preemployment physical examination and tests. [2001, c. 663, §1 (NEW).]

[2001, c. 663, §1 (NEW) .]

5. Immunization. Whenever any standard, medically recognized vaccine or other form of immunization or other prophylaxis exists for the prevention of a communicable disease for which a presumption is granted under this section, if medically indicated in the given circumstances pursuant to immunization policies established by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention, an emergency rescue or public safety worker may be required by the worker's employer to undergo the immunization or other prophylaxis unless the worker's physician determines in writing that the immunization or other prophylaxis would pose a significant risk to the worker's health. Absent such written declaration, failure or refusal by an emergency rescue or public safety worker to undergo such immunization or other prophylaxis disqualifies the worker from the benefits of the presumption.

[2001, c. 663, §1 (NEW) .]

6. Record of exposures. To the extent required by any state or federal law or regulation:

A. An employer shall maintain a record of any known or reasonably suspected exposure of an emergency rescue or public safety worker in its employ to the diseases described in this section and shall immediately notify the employee of that exposure; and [2001, c. 663, §1 (NEW).]

B. An emergency rescue or public safety worker shall file an incident or accident report with the worker's employer of each instance of known or suspected occupational exposure to hepatitis, meningococcal meningitis or tuberculosis. [2001, c. 663, §1 (NEW).]

[2001, c. 663, §1 (NEW) .]

7. Liability if services performed for more than one employer. If an emergency rescue or public safety worker was employed by more than one employer, the employer in whose employ the person was last injuriously exposed to the risk of the disease contracted and the insurer on the risk at the time of that last exposure, if any, are the only entities liable for the disease.

[2001, c. 663, §1 (NEW) .]

8. Effect of presumption on life and disability insurance coverage. The presumption set forth in subsection 2 does not apply in determining eligibility for life or disability benefits unless otherwise provided in the insurance contract.

[2001, c. 663, §1 (NEW) .]

9. Effect of presumption on disability retirement. The presumption set forth in subsection 2 is effective for purposes of determining whether a disability is work-related for purposes of determining eligibility for disability retirement in the Maine Public Employees Retirement System. This presumption does not affect any eligibility requirement other than the requirement that the disability be work-related.

[2001, c. 663, §1 (NEW); 2007, c. 58, §3 (REV) .]

SECTION HISTORY

2001, c. 663, §1 (NEW). 2007, c. 58, §3 (REV).

§328-B. CANCER SUFFERED BY A FIREFIGHTER

Cancer suffered by a firefighter is governed by this section. [2009, c. 408, §1 (NEW) .]

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Cancer" means kidney cancer, non-Hodgkin's lymphoma, colon cancer, leukemia, brain cancer, bladder cancer, multiple myeloma, prostate cancer, testicular cancer or breast cancer. [2009, c. 408, §1 (NEW) .]

B. "Employed" means to be employed as an active duty firefighter or to be an active member of a volunteer fire association with no compensation other than injury and death benefits. [2009, c. 408, §1 (NEW) .]

C. "Firefighter" means a member of a municipal fire department or volunteer fire association whose duties include the extinguishment of fires. [2009, c. 408, §1 (NEW) .]

[2009, c. 408, §1 (NEW) .]

2. Presumption. If a firefighter who contracts cancer has met the requirements of subsections 3, 6 and 7, there is a rebuttable presumption that the firefighter contracted the cancer in the course of employment as a firefighter and as a result of that employment, that sufficient notice of the cancer has been given and that the disease was not occasioned by any willful act of the firefighter to cause the disease.

[2009, c. 408, §1 (NEW) .]

3. Medical tests. In order to be entitled to the presumption in subsection 2, during the time of employment as a firefighter, the firefighter must have undergone a standard, medically acceptable test for evidence of the cancer for which the presumption is sought or evidence of the medical conditions derived from the disease, which test failed to indicate the presence or condition of cancer.

[2009, c. 408, §1 (NEW) .]

4. Liability if services performed for more than one employer. If a firefighter who contracts cancer was employed as a firefighter by more than one employer and qualifies for the presumption under subsection 2, and that presumption has not been rebutted, the employer and insurer at the time of the last substantial exposure to the risk of the cancer are liable under this Part.

[2009, c. 408, §1 (NEW) .]

5. Retired firefighter. This section applies to a firefighter who is diagnosed with cancer within 10 years of the firefighter's last active employment as a firefighter or prior to attaining 70 years of age, whichever occurs first.

[2009, c. 408, §1 (NEW) .]

6. Length of service. In order to qualify for the presumption under subsection 2, the firefighter must have been employed as a firefighter for 5 years and regularly responded to firefighting or emergency calls.

[2009, c. 408, §1 (NEW) .]

7. Written verification. In order to qualify for the presumption under subsection 2, a firefighter must sign a written affidavit declaring, to the best of the firefighter's knowledge and belief, that the firefighter's diagnosed cancer is not prevalent among the firefighter's blood-related parents, grandparents or siblings and that the firefighter has no substantial lifetime exposures to carcinogens that are associated with the firefighter's diagnosed cancer other than exposure through firefighting.

[2009, c. 408, §1 (NEW) .]

SECTION HISTORY

2009, c. 408, §1 (NEW).

§329. INTERPRETER REQUIRED

An employee whose native language is not English and who does not understand the English language to the degree necessary to reasonably understand and participate in proceedings that affect the employee's rights is entitled to have an interpreter present at all proceedings before the board or a hearing officer relating to that employee's rights. The board shall provide and pay the cost of the interpreter. To the extent possible, the board shall seek advice from the Department of Labor in locating appropriate interpreters to meet the needs of employees in the workers' compensation system. [1999, c. 202, §1 (NEW) .]

SECTION HISTORY

1999, c. 202, §1 (NEW).

Subchapter 2: MISCELLANEOUS ENACTED BY PL 1991, C. 885, PT. A, §8

§351. NONRESIDENTS

If an employee receiving weekly payments under this Act ceases to reside in the State or if the employee's residence at the time of the injury is in another state, the board upon application of either party may, in its discretion, having regard to the welfare of the employee and the convenience of the employer, authorize payments to be made monthly or quarterly instead of weekly. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§352. LUMP-SUM SETTLEMENTS

1. Agreement. An insurer, self-insurer or self-insured group and an employer and employee may by agreement discharge any liability for compensation, in whole or in part, by the employer's payment of an amount to the employee if:

A. The insurer, the employer, the employee or the employee's dependents petition the board for an order commuting all payments for future benefits to a lump sum; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Six months' time has elapsed from the date of an injury; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The provisions of this section have been met and the agreement has been approved by the board. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Policy. The board shall by rule adopt policies establishing the circumstances under which lump-sum payments may be approved under this section. The circumstances must be at least as restrictive as those set forth in this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Review. Before approving any lump-sum settlement, the board shall review the following factors with the employee:

A. The employee's rights under this Act and the effect a lump-sum settlement would have on those rights, including, if applicable, the effect of the release of an employer's liability for future medical expenses; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The purpose for which the settlement is requested; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The employee's post-injury earnings and prospects, considering all means of support, including the projected income and financial security resulting from proposed employment, self-employment or any business venture or investment and the prudence of consulting with a financial or other expert to review the likelihood of success of these projects; [1997, c. 654, §2 (AMD).]

D. Any other information, including the age of the employee and of the employee's dependents, that would bear upon whether the settlement is in the best interest of the claimant; and [1997, c. 654, §2 (AMD).]

E. The existence of a child support debt of which notification has been sent pursuant to Title 19-A, section 2360-A. [1997, c. 654, §3 (NEW).]

[1997, c. 654, §§2, 3 (AMD) .]

4. Procedure. The board shall initiate the review within 14 days of receipt of a request for a settlement review. An employer is considered a party for the purposes of this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Approval. The board may not approve any lump-sum settlement unless there is an agreement pursuant to subsection 1 or, in the event the employer refuses to agree to the settlement, the board has reviewed the proposed agreement and finds it to be in the best interests of the parties, and unless:

A. The employee has fully participated in the review process, except in circumstances amounting to good cause; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The board finds the settlement to be in the employee's best interest in light of the factors reviewed with the employee under subsection 3; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. In the case of a lump-sum settlement that requires the release of an employer's liability for future medical expenses of the employee, the board finds that the parties would be unlikely to reach agreement on the amount of the lump-sum payment without the release of liability for future medical expenses. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Monitoring of lump-sum settlement recipients. The board shall establish and maintain a program to monitor the postsettlement employment experience of employees who settle their claims pursuant to this section to help develop future policy. The Department of Labor shall cooperate with the board in the establishment and operation of this monitoring program.

[1995, c. 560, Pt. G, §25 (AMD) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 560, §G25 (AMD). 1997, c. 654, §§2,3 (AMD).

§353. DISCRIMINATION

An employee may not be discriminated against by any employer in any way for testifying or asserting any claim under this Act. Any employee who is so discriminated against may file a petition alleging a violation of this section. The matter must be referred to a hearing officer for a formal hearing under section 315, but any hearing officer who has previously rendered any decision concerning the claim must be excluded. If the employee prevails at this hearing, the hearing officer may award the employee reinstatement to the employee's previous job, payment of back wages, reestablishment of employee benefits and reasonable attorney's fees. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

This section applies only to an employer against whom the employee has testified or asserted a claim under this Act. Discrimination by an employer who is not the same employer against whom the employee has testified or asserted a claim under this Act is governed by Title 5, section 4572, subsection 1, paragraph A. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§354. MULTIPLE INJURIES; APPORTIONMENT OF LIABILITY

1. Applicability. When 2 or more occupational injuries occur, during either a single employment or successive employments, that combine to produce a single incapacitating condition and more than one insurer is responsible for that condition, liability is governed by this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Liability to employee. If an employee has sustained more than one injury while employed by different employers, or if an employee has sustained more than one injury while employed by the same employer and that employer was insured by one insurer when the first injury occurred and insured by another insurer when the subsequent injury or injuries occurred, the insurer providing coverage at the time of the last injury shall initially be responsible to the employee for all benefits payable under this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Subrogation. Any insurer determined to be liable for benefits under subsection 2 must be subrogated to the employee's rights under this Act for all benefits the insurer has paid and for which another insurer may be liable. Apportionment decisions made under this subsection may not affect an employee's rights and benefits under this Act. There may be no reduction of an employee's entitlement to any benefits under this Act payable by an insurer based on a prior work-related injury that was the subject of a lump sum settlement approved by the board prior to the date of the injury for which the insurer is responsible. The board has jurisdiction over proceedings to determine the apportionment of liability among responsible insurers.

[2009, c. 301, §1 (AMD); 2009, c. 301, §2 (AFF) .]

4. Consolidation. The board may consolidate some or all proceedings arising out of multiple injuries.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1999, c. 354, §9 (AMD). 2009, c. 301, §1 (AMD). 2009, c. 301, §2 (AFF).

§355. EMPLOYMENT REHABILITATION FUND

If an employee who has completed a rehabilitation program under section 217, whether implementation is approved or ordered by the board, subsequently sustains a personal injury arising out of and in the course of employment and that injury, in combination with the prior injury, results in a reduction in earning capacity that is substantially greater in duration or degree, or both, than that which would have resulted from the subsequent injury alone, taking into account the age, education, employment opportunities and other factors related to the employee, the employer at the time of the subsequent injury is entitled to reimbursement from the Employment Rehabilitation Fund, referred to in this section as the "fund," as provided in this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Fund administration and contributions. There is established a special fund, known as the Employment Rehabilitation Fund, for the sole purpose of making payments in accordance with this Act. The fund is administered by the board. The Treasurer of State is the custodian of the fund. All money and securities in the fund must be held in trust by the Treasurer of State for the purpose of making payments under this Act and are not money or property for the general use of the State. The fund does not lapse.

The Treasurer of State may disburse money from the fund only upon written order of the board. The Treasurer of State shall invest the money of the fund in accordance with law. Interest, income and dividends from the investments must be credited to the fund.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Limitations. An employer is not entitled to reimbursement from the fund in the event of subsequent injury if an injured employee returns to the employee's preinjury job with the same employer without the provision of significant rehabilitation services or significant modification of the workplace.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Reimbursement. The employer must be reimbursed at least quarterly from the fund for any weekly wage replacement benefits for which the employer is liable under section 212, 213 or 215 and that are paid by that employer.

A. An employer entitled to reimbursement under this section remains liable to the employee for all payments otherwise required from the employer by this Act and remains responsible for carrying out the rehabilitation efforts required by this Act as a result of the subsequent injury. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The board shall order a reduction, suspension or termination of reimbursement of an employer under this section if the board finds that the employer has not made a bona fide effort to return the employee to continuing suitable employment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Apportionment. Reimbursement under this section must be reduced by the amount of any contribution paid to the employer by any other employer for wage replacement benefits on the basis of apportioned liability under section 354.

A. If insurers disagree on the apportionment of liability in a case under this section, the matter must be considered by the board before an insurer may file a petition under section 354. The board shall encourage agreement between the insurers and, if agreement can not be achieved, shall make a recommendation on the apportionment of liability. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Employer knowledge. An employer otherwise entitled to reimbursement under this section is entitled to that reimbursement regardless of whether the employer has knowledge at any time that the employee had completed an approved rehabilitation plan.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Hiring incentive; wage credit. If an employer hires an employee after the employee has completed a rehabilitation program under section 217, that subsequent employer may apply for a wage credit under this subsection. For the purposes of this subsection, the term "employer" does not include the insurer of a subsequent employer or the same employer for whom an employee worked when the employee sustained the injury for which the employee received rehabilitation.

A. The subsequent employer must file an application for a wage credit by providing the board, within 2 weeks after the close of the first 90 days of employment of the employee, with a statement of the total direct wages, earnings or salary the employer paid to the employee for the first 90 days of employment along with such verification as may be required by rule of the board. Within 2 weeks after the close of the first 180 days of employment, the subsequent employer must provide to the board a supplemental report of the direct wages, earnings and salary for the 2nd 90-day period, along with the required verification. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The board shall compute the wage credit, which consists of a sum equal to 50% of the average weekly direct wages, earnings or salary for the 90-day period listed in the subsequent employer's application or statement, but may not exceed the amount of workers' compensation benefits that the employee did not receive because of the employment but would have been entitled to for the wage credit period, based on the average weekly workers' compensation benefits during the most recent 60-day period in which the employee did receive benefits preceding the employee's hiring by the employer.

(1) On adequate verification of the application or statement, the board shall pay the amount for each 90-day period in a lump sum to the subsequent employer within 30 days of receiving the application or statement.

(2) The board shall bill these sums to the insurer or self-insurer that was responsible for payment of the compensation received by the employee immediately before the employee's hiring by the subsequent employer. When the sum is received from the insurer or self-insurer, the board shall deposit it in the fund. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. If the employment with the subsequent employer is terminated by the employer without good cause before the completion of 12 consecutive months of employment, the subsequent employer shall return to the board all wage credits received by the employer for that employee and all sums paid into the fund by the insurer or self-insurer must be returned to that insurer or self-insurer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. When the wage credit is paid from the fund to an employer, the insurer or self-insurer who paid the sum into the fund has no further obligation to pay any sums into the fund for any future reemployment of that employee, except as provided in paragraph E.

(1) Total wage credit payments under a plan may not exceed a period of 180 days, not including periods subject to refunds under paragraph C.

(2) The board shall inform subsequent employers of the number of days of wage credits available, if it is less than 180 days. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Wage credit payments are not dependent on the receipt by the fund of payments from an insurer or self-insurer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Plan implementation costs; payment; reimbursement. The actual and direct costs of implementing plans ordered by the board under section 217, subsection 2 must be paid from the fund. Payments must be made directly to the rehabilitation providers or other persons who provide services under the plan. Upon an order of recovery of plan implementation costs under section 217, subsection 3, the board shall assess the employer who refused to agree to implement the plan under section 217 an amount equal to 180% of the costs paid from the fund under this subsection. An employer may appeal the imposition or amount of this assessment to the board. The employee may not be a party to this appeal.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Jurisdiction. The board has jurisdiction over all claims brought against the fund.

A. The fund is not bound as to any question of law or fact by reason of any award or any adjudication to which the fund was not a party or in relation to which the fund was not notified, at least 21 days prior to the award or adjudication, that the fund might be subject to liability for the injury or death of an employee. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. An employer shall notify the board of any possible claim for subsequent injury reimbursement against the fund as soon as practicable, but in no event later than one year after the injury or death of an employee. Failure to provide timely notice bars the claim. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Legal representation. The Attorney General shall provide legal representation for any claim made under this section, including the enforcement of an assessment made under subsection 7 or the defense of an employer's appeal of that assessment.

A. The reasonable expense of prosecution or defense by the Attorney General of assessments to or claims against the fund, subject to the approval of the board, are payable out of the fund. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The Attorney General may not prosecute an assessment against the State or defend the fund against any claim brought by the State. The board may hire, using money from the fund, private counsel for this purpose. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Effect on obligations of prior employers. The availability of reimbursement under this section does not limit or reduce the obligation of any previous employer to provide benefits under this Act to the employee.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

11. Freedom from liability. The State is not liable for any claim against the fund that is in excess of the fund's current ability to pay. If any claim against the fund is denied due to an inadequate fund balance, that claim is entitled to priority over later claims when an adequate balance is restored.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

12. Applicability. Reimbursement under this section is available solely with respect to employees who are injured and rehabilitated after November 20, 1987.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

13. Reimbursement.

[2001, c. 448, §3 (RP) .]

14. Funding; assessments. This subsection governs funding of the Employment Rehabilitation Fund.

A. The board may levy an assessment when the balance in the fund is insufficient to meet obligations of the fund under this section. The assessment must be levied on each insurer based on its actual paid losses during the previous calendar year. [2001, c. 448, §4 (NEW) .]

B. Every insurer shall keep as permanent records a record of the amount and date of each loss paid. The records must be open for inspection at all times. Every insurer shall, on or before the 60th day following the end of a calendar quarter, render a report to the State Tax Assessor stating the amount of losses paid by the insurer during the preceding calendar quarter. That report must contain any further information the board prescribes by rule. [2001, c. 448, §4 (NEW) .]

C. The State Tax Assessor shall pay daily all receipts from any assessment and any receipts received under paragraph F to the Treasurer of State. The Treasurer of State shall deposit all receipts as received in the fund. [2001, c. 448, §4 (NEW) .]

D. The State Tax Assessor or the State Tax Assessor's duly authorized agent or the board, for the purpose of determining the truth or falsity of any statement or return made by the insurer, may:

- (1) Enter any place of business of an insurer to inspect any books or records of the insurer;
- (2) Notwithstanding any other provision of law, inspect any records or reports filed by an insurer with the Superintendent of Insurance; and
- (3) Delegate these powers to the Superintendent of Insurance or the superintendent's deputies, agents or employees. [2001, c. 448, §4 (NEW) .]

E. Whenever any insurer fails to pay any assessment due under this subsection within the time specified by the board, the Attorney General shall enforce payment by civil action against that insurer for the amount of the assessment in the Superior Court in and for the county or the District Court in the division in which that insurer has the insurer's place of business, or in the Superior Court of Kennebec County. [2001, c. 448, §4 (NEW).]

F. In every case of the death of any employee when there is no person entitled to compensation, the employer shall pay to the Treasurer of State a sum equal to 100 times the average weekly wage in the State as computed by the Department of Labor to be credited to the fund. [2001, c. 448, §4 (NEW).]

G. For the purposes of this subsection, "insurer" means an insurance company or association that does business or collects premiums for workers' compensation insurance in this State or an individual or group self-insurer under this Act, including the State and any other public or governmental authority. [2001, c. 448, §4 (NEW).]

[2001, c. 448, §4 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2001, c. 448, §§3,4 (AMD).

§355-A. SUPPLEMENTAL BENEFITS FUND

1. Creation of fund. The Supplemental Benefits Fund, referred to in this section and sections 355-B to 356 as the "fund," is created to reimburse insurers and self-insurers for their payments of compensation to employees under section 213, subsections 3 and 4.

[2001, c. 448, §5 (NEW) .]

2. Administration of fund. The Supplemental Benefits Fund is administered by the Supplemental Benefits Oversight Committee in accordance with this section and sections 355-B to 356. The Treasurer of State is the custodian of the fund. All money and securities in the fund must be held in trust by the Treasurer of State for the purpose of making payments under this Act and are not money or property for the general use of the State. The fund does not lapse. Investment decisions regarding the fund are made by the Supplemental Benefits Oversight Committee or the service agent, as provided in section 355-B, subsection 10. Interest, income and dividends from investments must be credited to the fund. The Treasurer of State may disburse money from the fund only upon written order of the Supplemental Benefits Oversight Committee or the committee's duly appointed service agent.

[2001, c. 448, §5 (NEW) .]

3. Freedom from liability. The State, members of the Supplemental Benefits Oversight Committee, service agents and subcontractors of a service agent are not liable for any claim against the fund that is in excess of the fund's ability to pay. If any claim against the fund is denied due to an inadequate fund balance, that claim has priority over later claims when an adequate balance is restored.

[2001, c. 448, §5 (NEW) .]

SECTION HISTORY

2001, c. 448, §5 (NEW).

§355-B. SUPPLEMENTAL BENEFITS OVERSIGHT COMMITTEE

The Supplemental Benefits Oversight Committee, referred to in this section and sections 355-C and 356 as the "committee," is created and charged with the duty to monitor, facilitate and provide general oversight in the administration of reimbursement of workers' compensation benefit obligations of the fund pursuant to section 213, subsections 3 and 4. [2001, c. 448, §5 (NEW).]

1. Members. The committee consists of 5 members, appointed by the Governor as follows:

A. Two members must represent employers. One must be appointed from the list provided by the Maine State Chamber of Commerce or its successor organization. One must be an approved self-insured employer, appointed from the list provided by the Maine Council of Self-insurers or its successor organization; [2001, c. 448, §5 (NEW).]

B. One member must represent insurers and must be appointed from the list provided by the Superintendent of Insurance; [2001, c. 448, §5 (NEW).]

C. One member must represent labor interests and must be appointed from the list provided by the Maine AFL-CIO or its successor organization; and [2001, c. 448, §5 (NEW).]

D. One member must be an at-large member who possesses skills and experience suited to the functions of the committee. [2001, c. 448, §5 (NEW).]

[2001, c. 448, §5 (NEW) .]

2. Terms. Except for members of the initial committee, members are appointed for terms of 3 years. Committee members may serve multiple terms. Of the initial committee member appointments, one member must be appointed for a term of one year, 2 must be appointed for terms of 2 years and 2 must be appointed for terms of 3 years, at the discretion of the Governor. The committee is not authorized to begin transacting business until the Governor has made all 5 initial committee appointments.

A. The Governor may remove a member for cause. [2001, c. 448, §5 (NEW).]

B. If a vacancy occurs on the committee after initial appointments are made, the committee may select an alternate member representing the same entity represented by the vacant position to serve until the Governor makes a new appointment. The Governor shall make appointments to fill vacancies in the same manner in which the member whose leaving caused the vacancy was appointed. [2001, c. 448, §5 (NEW).]

[2001, c. 448, §5 (NEW) .]

3. Alternate members. The Governor shall appoint 3 alternate members for each member appointed under subsection 1. An alternate for a member appointed under subsection 1, paragraphs A to C must be named from the alternate member list provided by the same entity that provided the list for appointment of the member. An alternate member may serve on the committee in the event of a vacancy pursuant to subsection 2, paragraph B or when a member has a conflict of interest pursuant to subsection 5. An alternate member is entitled to the same compensation and protections from liability as a member when serving on the committee.

[2001, c. 448, §5 (NEW) .]

4. Voting; quorum. A quorum consists of 4 members of the committee. Each member has one vote that must be exercised. A decision may not be made by the committee without at least 3 affirmative votes. A member who does not vote is considered to have voted in the negative.

[2001, c. 448, §5 (NEW) .]

5. Conflict of interest. A member may not participate in any matter in which that member has an actual or potential conflict of interest. A member may not participate in deliberations on such a matter and may not vote on that matter. A conflict of interest exists if the member, the person that employs that member or the person that the member represents is financially interested in the matter. If a member is unable to participate in a matter pursuant to this subsection, the committee shall select an alternate member representing the same interest from the alternate members appointed pursuant to subsection 3. The alternate member serves under this subsection for the limited purpose of deciding the financial responsibility, if any, of the fund to an insurer or self-insurer regarding a reimbursement request concerning which a member of the committee is precluded from participating pursuant to this subsection.

[2001, c. 448, §5 (NEW) .]

6. Compensation. A member of the committee receives a per diem of \$100 per day and reimbursement of actual and necessary expenses while attending to the business of the fund. Per diem and expenses are paid from the fund.

[2001, c. 448, §5 (NEW) .]

7. Liability. A member of the committee is not liable in a civil action for any act performed in good faith in the execution of duties as a member of the committee. The fund must indemnify a member against judgments, fines, amounts paid in settlement, reasonable costs and expenses, including attorney's fees, and any other liabilities that may be incurred as a result of legal actions or threatened legal actions, except in relation to matters in which the member is adjudged to be liable by reason of willful misconduct in the performance of duties or obligations to the committee.

[2001, c. 448, §5 (NEW) .]

8. Legal representation. The committee, directly or through a service agent, may seek the advice and counsel of the Attorney General or retain private counsel through service contracts. The Attorney General may not prosecute an assessment against the State or defend the fund against any claims brought by the State. Reasonable costs of legal representation by the Attorney General or attorneys contractually retained by the committee or its service agent are chargeable to the fund.

[2001, c. 448, §5 (NEW) .]

9. Board proceedings. Neither the fund nor the committee has standing or authority to participate directly or indirectly in any proceeding before the board regarding the level or duration of benefits payable to an employee.

[2001, c. 448, §5 (NEW) .]

10. Fund management; fiduciary duty. Each member of the committee is held to account as a fiduciary in the administration of the fund's assets. Management and investment of the assets of the account by the committee or a service agent must conform to prudent investor standards. The committee shall maintain complete and accurate records of investments, money and other assets comprising the corpus of the fund. The committee shall provide to the board on the first business day of January, April, July and October each year an accounting respecting the fund's assets and transactions relating to activities of the committee. The board shall promptly notify the joint standing committee of the Legislature having jurisdiction over labor matters of any concerns raised by those reports.

[2001, c. 448, §5 (NEW) .]

11. Records and proceedings of committee. For the purposes of Title 1, chapter 13, subchapter I:

A. Records in the possession of the committee that relate to individual workers' compensation claims, claims for reimbursement by insurers and self-insurers under section 213, subsection 3 or 4 or claims settlement activities are not public records; and [2001, c. 448, §5 (NEW).]

B. Proceedings of the committee relating to individual workers' compensation claims, claims for reimbursement by insurers and self-insurers under section 213, subsection 3 or 4 or claims settlement activities are not public proceedings. [2001, c. 448, §5 (NEW).]

[2001, c. 448, §5 (NEW) .]

12. Rulemaking. The committee may adopt procedural rules in accordance with Title 5, chapter 375 as necessary to facilitate timely and proper administration of the affairs of the fund. These rules are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 448, §5 (NEW) .]

SECTION HISTORY

2001, c. 448, §5 (NEW).

§355-C. POWERS AND DUTIES OF COMMITTEE; REIMBURSEMENT

The committee shall review and evaluate requests for reimbursement of workers' compensation benefits paid or payable under section 213, subsections 3 and 4. [2001, c. 448, §5 (NEW).]

1. Power to bind fund. The committee has power to bind the fund with respect to the monetary value of each settlement reimbursable from the fund.

[2001, c. 448, §5 (NEW) .]

2. Request for reimbursement; information required. A request for reimbursement from the fund must include:

A. If the claim for reimbursement is made pursuant to section 213, subsection 3, evidence that the claimant employee's date of injury is on or after January 1, 1993 and before January 1, 1998. If the claim for reimbursement is made under section 213, subsection 4, evidence that the claimant employee's date of injury is on or after January 1, 1993 and before January 1, 2000; [2001, c. 448, §5 (NEW).]

B. Complete medical reports, agreements or orders relating to the employee's permanent impairment; [2001, c. 448, §5 (NEW).]

C. Evidence that the insurer or self-insurer has paid or is liable for payment of 260 weeks of indemnity benefits pursuant to section 212 or 213; [2001, c. 448, §5 (NEW).]

D. Evidence that the benefit payments for which reimbursement is requested were paid or are payable under section 213; [2001, c. 448, §5 (NEW).]

E. Verification that the insurer or self-insurer has adjusted and is adjusting the claim for which reimbursement is requested in a manner that is consistent with usual and customary claims service provided by the insurer or self-insurer for claims that are not subject to reimbursement under section 213. At a minimum, verification must include evidence that the insurer or self-insurer has monitored the claimant employee's medical condition and investigated return-to-work options applicable in the circumstance; and [2001, c. 448, §5 (NEW).]

F. Such other information or requirements as the committee may prescribe. [2001, c. 448, §5 (NEW).]

[2001, c. 448, §5 (NEW) .]

3. Determinations. The committee shall review requests for reimbursement within 14 days of receipt of the request or within a longer period of time if mutually acceptable to the parties. The committee shall issue a final determination, designated as such, to each insurer or self-insurer that has requested reimbursement. An insurer or self-insurer may petition the board for a hearing before a hearing officer within 30 days of notice of the determination. Review by the board is limited to errors of law and abuse of discretion.

[2001, c. 448, §5 (NEW) .]

4. Effect of board decrees. The fund and the committee are bound to the same extent as the employee and insurer or self-insurer by decrees of the board.

[2001, c. 448, §5 (NEW) .]

5. Effect of mediation agreement or consent decree. The fund is bound as to any question of law or fact by reason of a mediation agreement under section 313 or a consent decree, provided the committee was given notice of the terms of the agreement or decree at least 21 days before the effective date of the agreement or decree and did not object. The fund is not bound by the agreement or decree if the committee provides a written objection to the proposed terms of the agreement or decree to the insurer or self-insurer.

[2001, c. 448, §5 (NEW) .]

6. Effect of independent medical examiner's report . The fund is bound to the same extent as the employee and the insurer or self-insurer by findings contained in an independent medical examiner's report provided pursuant to section 312.

[2001, c. 448, §5 (NEW) .]

7. Service agent. The committee, by contract, may delegate day-to-day business operations of the fund and duties and powers of the committee regarding reimbursement requests or assessments to a service agent qualified under this subsection. Pursuant to the contract, a service agent retained under this subsection must be held to account as a fiduciary in the administration of the assets of the fund and in the conduct of the business affairs of the fund.

A. The committee shall enter into written contracts with persons or entities qualified by good business reputation, training, education and experience to perform day-to-day duties in administering the fund's responsibilities set forth in section 213, subsections 3 and 4. Such a person is referred to in this section and sections 355-A, 355-B and 356 as the "service agent." A service agent must hold all licenses, registrations and permits required to engage in activities or undertake responsibilities delegated pursuant to the contract. [2001, c. 448, §5 (NEW) .]

B. A service agent may subcontract with attorneys acceptable to the committee to advise or represent the fund in legal actions as necessary. Expenses of the service agent and attorneys retained by the service agent, upon approval by the committee, are paid from the fund. [2001, c. 448, §5 (NEW) .]

C. A service agent shall acknowledge and reimburse claims of insurers and self-insurers consistent with terms of any proposed or executed settlement among parties to the settlement, provided that the service agent has been accorded notice and opportunity to participate regarding the terms and conditions of the settlement and that the commitment to reimburse the insurer or self-insurer is in the best interest of the fund. [2001, c. 448, §5 (NEW) .]

D. A service agent may be empowered, by contract, to levy assessment in the name of the fund, institute assessment collection procedures, including legal action if necessary, process requests for reimbursement from the fund in a timely manner, deposit money in the fund with the Treasurer of State if such funds are not needed to meet immediate cash flow demands and commit the fund to agreed levels of insurer or self-insurer reimbursement based upon review and assessment of prospects of consensual settlements. [2001, c. 448, §5 (NEW) .]

E. A service agent shall make recommendations to the committee regarding rule-making standards considered necessary to the proper administration of the fund. [2001, c. 448, §5 (NEW).]

[2001, c. 448, §5 (NEW) .]

SECTION HISTORY

2001, c. 448, §5 (NEW).

§356. FUNDING OF SUPPLEMENTAL BENEFITS FUND

1. Assessment.

[2001, c. 448, §6 (RP) .]

1-A. Assessment. The committee may levy an assessment against insurers to provide funds to meet the obligations of the fund for reimbursement pursuant to section 213, subsections 3 and 4. The committee may also delegate its duties and powers under this section to a service agent pursuant to section 355-C, subsection 7.

A. To the extent practicable, the committee shall make an assessment on June 1st of each year in which the fund is obligated to make reimbursement. The amount of the assessment must be an amount estimated to be sufficient to reimburse qualified insurers during the next 12 months. Supplementary assessments may be levied during the 12-month period if exigent conditions arise and the balance in the fund is inadequate to discharge reimbursements in a timely manner. No more than 2 supplementary assessments may be levied in any 12-month period. [2001, c. 448, §6 (NEW).]

B. The assessment must be distributed between insurance carriers and self-insured employers in direct proportion to the pro rata share of disabling cases attributable to each of the payor classifications for the most recent calendar year for which data are available. The distribution of the assessment must be determined on a basis consistent with the information reported by the Department of Labor, Bureau of Labor Standards, Research and Statistics Division in its annual "Characteristics of Work-Related Injuries and Illnesses in Maine" publication. Any segment of the market identified in the publication as "not insured" must be excluded from the calculation of proportionate shares.

(1) In consultation with the Director of the Bureau of Labor Standards, the committee shall determine a date prior to the required assessment to establish a distribution. On or before May 1st of each year, the Department of Professional and Financial Regulation, Bureau of Insurance shall provide to the committee the amounts of gross direct workers' compensation premiums written by each licensed insurance carrier and the amount of aggregate benefits paid by each individual and group self-insurer for the preceding calendar year. [2001, c. 448, §6 (NEW).]

C. An assessment against insurers must be based on premiums charged to employers pursuant to section 154, subsection 3, paragraph B-1. The assessment must be stated as a percentage of each employer's premium base. Insurers shall apply the percentage to premiums collected beginning on July 1st. If a supplementary assessment is levied, the committee shall notify insurers of the new percentage and the insurers shall apply the new percentage to premiums written beginning on the 31st day following notification.

(1) The total value of assessments collected from insurers pursuant to this section must be credited to the fund. Each insurer that collects workers' compensation premiums or assessments shall file with the committee on a form prescribed by the committee a return certified by the insurer's chief financial officer specifying assessment collections relating to the calendar quarter next preceding the 15th day of April, July, October and January of each year in which an assessment is applicable. Affiliated insurers may consolidate payments made to the fund if each carrier is licensed and premium reports respecting that insurer are individually reported within the consolidated return. Payment of amounts collected pursuant to this section must be remitted to the fund at the time the premium return is filed with the committee.

(2) The Department of Professional and Financial Regulation, Bureau of Insurance shall report to the board, the committee and any service agent all newly authorized workers' compensation carriers in order to facilitate notification to those carriers of their obligation under this section.

(3) Any insurance carrier subject to this section that willfully fails to pay an assessment in accordance with this section commits a civil violation for which a forfeiture of not more than \$500 may be adjudged for each day following the due date for which the payment is not made. [2001 , c. 448 , §6 (NEW) .]

D. Except for newly approved workers' compensation self-insurers, each self-insurer must be assessed a dollar amount based on the proportion that the self-insurer's aggregate benefits paid as reported pursuant to section 154, subsection 5 bears to the aggregate benefits paid by all self-insurers as so reported. If a supplementary assessment is levied, the committee shall notify self-insurers 30 days prior to the date upon which the assessment is due.

(1) The total value of assessments collected from self-insured employers under this section must be credited to the fund. Each self-insurer shall file with the committee on a form prescribed by the committee a return certified by the self-insurer's chief financial officer attesting to the accuracy of the amount owed to the fund. Payment of the assessment must be remitted to the fund at the time the return is filed with the committee. The form and payment are due on the later of July 1st and 30 days after the committee levies the assessment.

(2) The Department of Professional and Financial Regulation, Bureau of Insurance shall report to the board, the committee and any service agent all newly approved workers' compensation self-insurers in order to facilitate notification to those self-insurers of their obligation under this section. A newly approved self-insurer that has historically purchased a policy or policies of workers' compensation covering workers' compensation exposures in this State shall pay assessment to the fund based on the assessment percentage applicable to insurers until the self-insurer has paid benefits for 12 months.

(3) A self-insurer subject to this section that willfully fails to pay an assessment in accordance with this section commits a civil violation for which a forfeiture of not more than \$500 may be adjudged for each day following the due date for which the payment is not made. [2001 , c. 448 , §6 (NEW) .]

E. Rates and premiums charged for workers' compensation policies may not be considered excessive if a surcharge calculated pursuant to this section is made to recoup assessments paid to the fund. Any surcharge so made must be specifically identified upon the policies or other evidence of coverage. Such surcharges are not subject to premium taxes. [2001 , c. 448 , §6 (NEW) .]

[2001 , c. 448 , §6 (NEW) .]

2. Death of an employee.

[2001 , c. 448 , §6 (RP) .]

3. Records and reports.

[2001 , c. 448 , §6 (RP) .]

4. Appropriation of money received.

[2001 , c. 448 , §6 (RP) .]

5. Inspections.

[2001 , c. 448 , §6 (RP) .]

6. Civil action. Whenever any insurer fails to pay any assessment due under this section within the time limit, the Attorney General shall enforce payment by civil action against that insurer for the amount of the assessment in the Superior Court in and for the county or the District Court in the division in which that insurer has the insurer's place of business, or in the Superior Court of Kennebec County.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Insurer defined. For the purposes of this section, "insurer" means an insurance company or association that does business or collects premiums for workers' compensation insurance in this State or an individual or group self-insurer under this Act, including the State and other public or governmental authority.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 560, §G26 (AMD). 2001, c. 448, §6 (AMD).

§357. INFORMATION FROM INSURANCE COMPANIES

1. Completion of forms. Every insurance company insuring employers under this Act shall fill out any blanks and answer all questions submitted that may relate to policies, premiums, amount of compensation paid and such other information as the board or the Superintendent of Insurance may determine important, either for the proper administration of this Act or for statistical purposes.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Explanation of reserving policy. Every insurance company subject to Title 24-A, chapter 25, subchapter II-B shall, not later than 30 days after filing its annual statement, file with the Superintendent of Insurance a detailed explanation of its reserve policy in regard to claims under this Act, including specific reserve guidelines.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§358. REPORTS AND DATA COLLECTION

(REPEALED)

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). RR 1993, c. 1, §140 (COR). 1997, c. 486, §7 (RP).

§358-A. REPORTS AND DATA COLLECTION

1. Workers' compensation system annual report. The board, in consultation with the Superintendent of Insurance and the Director of the Bureau of Labor Standards within the Department of Labor, shall submit an annual report to the Governor and the joint standing committees of the Legislature having jurisdiction over labor and banking and insurance matters by February 15th of each year regarding the status of the workers' compensation system. At a minimum, the report must include an assessment of the board's implementation of the following provisions:

- A. The number of individual cases monitored to ensure the provision of benefits in accordance with law, pursuant to section 152, subsection 10; [1997, c. 486, §8 (NEW).]

B. The number of cases monitored to ensure the payments are initiated within the time limits of sections 205 and 324 and the adequacy of compensation provided pursuant to section 153, subsection 1; [1997, c. 486, §8 (NEW).]

C. The number of investigations performed pursuant to section 153, subsection 7; [1997, c. 486, §8 (NEW).]

D. The number of lump-sum settlements cases monitored and a summary of postsettlement employment experience pursuant to section 352, subsection 6; [1997, c. 486, §8 (NEW).]

E. The number of audits performed and an assessment of compliance with this Act based on audit results pursuant to section 359, subsection 1; [1997, c. 486, §8 (NEW).]

F. The number of penalties assessed and the reasons for the assessments pursuant to section 205, subsection 3; section 313, subsection 4; section 324, subsections 2 and 3; section 359, subsection 2; and section 360; and [1997, c. 486, §8 (NEW).]

G. The results of the monitoring program giving side-by-side information compilations for the past 5 years pursuant to section 359, subsection 3. [1997, c. 486, §8 (NEW).]

The report must contain specific data regarding compliance, including benchmarks measuring individual insurer's, self-insurer's, or 3rd-party administrator's compliance with the provisions of this Act and any penalties assessed. Benchmarks must be developed by the board with input from insurers, self-insurers and 3rd-party administrators and other parties the board considers appropriate. The board shall also report on the utilization of troubleshooters, advocates and retained legal counsel, with correlating outcomes.

[1997, c. 486, §8 (NEW) .]

2. Data collection and interpretation. The Director of the Bureau of Labor Standards within the Department of Labor, the Superintendent of Insurance and the board's executive director shall meet at least 3 times a year with appropriate staff and other state agencies to review the areas of data collection pertaining to the workers' compensation system, as well as to interpret and coordinate appropriate data collection programs to carry out the purposes of this Act. The Director of the Bureau of Labor Standards shall chair this group.

The Director of the Bureau of Labor Standards, the Superintendent of Insurance and the board's executive director shall provide jointly or individually any further occasional reports that they consider necessary to the improved function and administration of this Act and the occupational disease laws.

[1997, c. 486, §8 (NEW) .]

3. Occupational injuries and illnesses. The Director of the Bureau of Labor Standards within the Department of Labor shall provide an annual report concerning the number and character of occupational injuries and illnesses and their effects, as required under Title 26, section 42.

The board's executive director shall assist the Director of the Bureau of Labor Standards to ensure that necessary information regarding the administrative processes, costs and other factors related to this Act and the occupational disease laws are included in the report. The Commissioner of Health and Human Services and the Director of the Bureau of Health shall provide the Director of the Bureau of Labor Standards with any information in their possession related to occupational injuries and illnesses.

[1997, c. 486, §8 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

4. Loss costs data.

[2013, c. 52, §1 (RP) .]

5. Rehabilitation data. The board shall develop a system for collecting rehabilitation data and provide any reports considered necessary for the improved function and administration of rehabilitation under this Act.

[1997, c. 649, §1 (NEW) .]

SECTION HISTORY

1997, c. 486, §8 (NEW). 1997, c. 649, §1 (AMD). 2003, c. 689, §B7 (REV). 2013, c. 52, §1 (AMD).

§359. AUDITS; PENALTY; MONITORING

1. Audits. The board shall audit claims, including insurer, self-insurer, Maine Insurance Guaranty Association and 3rd-party administrator claim files, on an ongoing basis to determine whether insurers, self-insured employers, the Maine Insurance Guaranty Association and 3rd-party administrators have met their obligations under this Act and to identify the disputes that arose, the reasons for the disputes, the method and manner of their resolution, the costs incurred, the reasons for attorney involvement and the services rendered by the attorneys.

If as a result of an examination and after providing the opportunity for a hearing the board determines that any compensation, interest, penalty or other obligation is due and unpaid to an employee, dependent, service provider or any other entity, the board shall issue a notice of assessment detailing the amounts due and unpaid in each case and shall order the amounts paid to the unpaid party or parties.

[2009, c. 129, §11 (AMD); 2009, c. 129, §13 (AFF) .]

2. Penalty. In addition to any other penalty assessment permitted under this Act, the board may assess civil penalties not to exceed \$25,000 upon finding, after hearing, that an employer, insurer or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims. The board shall certify its findings to the Superintendent of Insurance, who shall take appropriate action so as to bring any such practices to a halt. This certification by the board is exempt from the provisions of the Maine Administrative Procedure Act. The amount of any penalty assessed pursuant to this subsection must be directly related to the severity of the pattern of questionable claims-handling techniques or repeated unreasonably contested claims. All penalties collected pursuant to this subsection must be deposited in the General Fund. An insurance carrier's payment of any penalty assessed under this section may not be considered an element of loss for the purpose of establishing rates for workers' compensation insurance.

[2007, c. 265, §2 (AMD) .]

3. Monitoring. No later than July 1, 1993 the board shall implement a monitoring program to evaluate and compare the cost, utilization and performance of the workers' compensation system for each calendar year beginning with 1988. The information compiled must include the number of injuries occurring and claims filed as compared to employment levels, the type and cost of the benefits provided, attorney involvement and litigation levels, and the long-term, postinjury economic status of injured workers, as well as any other data that is actuarially valid and can be utilized to accomplish the purposes of this Act, including rulemaking and recommending legislation.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §A9-11 (AFF). 2005, c. 603, §4 (AMD). 2007, c. 265, §2 (AMD). 2009, c. 129, §11 (AMD). 2009, c. 129, §13 (AFF).

§360. PENALTIES

1. Reporting violations. The board may assess a civil penalty not to exceed \$100 for each violation on any person:

A. Who fails to file or complete any report or form required by this Act or rules adopted under this Act; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Who fails to file or complete such a report or form within the time limits specified in this Act or rules adopted under this Act. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. General authority. The board may assess, after hearing, a civil penalty in an amount not to exceed \$1,000 for an individual and \$10,000 for a corporation, partnership or other legal entity for any willful violation of this Act, fraud or intentional misrepresentation. The board may also require that person to repay any compensation received through a violation of this Act, fraud or intentional misrepresentation or to pay any compensation withheld through a violation of this Act, fraud or misrepresentation, with interest at the rate of 10% per year.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Appeal. A decision of the board under this section is deemed to be final agency action subject to appeal to the Superior Court, as provided in Title 5, chapter 375, subchapter 7. Notwithstanding Title 5, section 11004, execution of a penalty assessed under this section is stayed during the pendency of any appeal under this subsection. The Attorney General shall represent the board in any appeal under this subsection or the board may retain private counsel for that purpose.

[2007, c. 78, §1 (AMD) .]

4. Enforcement and collection. Penalties assessed under this section are in addition to any other remedies available under this Act and are enforceable by the Superior Court under section 323.

A. The Attorney General shall prosecute any action necessary to recover penalties assessed under this section or the board may retain private counsel for that purpose. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. If any person fails to pay any penalty assessed under this section and enforcement by the Superior Court is necessary:

(1) That person shall pay the costs of prosecuting the action in Superior Court, including reasonable attorney's fees; and

(2) If the failure to pay was without due cause, any penalty assessed on that person under this section must be doubled. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. All penalties assessed under this section are payable to the General Fund. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Not an element of loss. An insurance carrier's payment of any penalty assessed under this section may not be considered an element of loss for the purpose of establishing rates for workers' compensation insurance.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Maine Insurance Guaranty Association. The provisions of this section apply to the Maine Insurance Guaranty Association under Title 24-A, chapter 57, subchapter 3.

[2009, c. 129, §12 (NEW); 2009, c. 129, §13 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 2007, c. 78, §1 (AMD). 2009, c. 129, §12 (AMD). 2009, c. 129, §13 (AFF).

§361. PAYMENT TO THE WORKERS' COMPENSATION BOARD ADMINISTRATIVE FUND; ENFORCEMENT

1. Payment. All penalties assessed under this Act are payable to the Workers' Compensation Board Administrative Fund, unless otherwise provided by law. Upon certification by the board that certain amounts in the Workers' Compensation Board Administrative Fund attributable to penalties assessed pursuant to this Act are not required to support the activities of the board, the Treasurer of State shall transfer funds in the amount certified by the board to the General Fund.

[2007, c. 26, §1 (NEW) .]

2. Enforcement and collection. All penalties assessed under this Act are enforceable by the Superior Court under section 323.

A. The Attorney General shall prosecute any action necessary to recover penalties payable to the Workers' Compensation Board Administrative Fund, Employment Rehabilitation Fund or General Fund, or the board may retain private counsel for that purpose. [2007, c. 26, §1 (NEW).]

B. If a person fails to pay a penalty assessed under this Act that is payable to the Workers' Compensation Board Administrative Fund, Employment Rehabilitation Fund or General Fund and enforcement by the Superior Court is necessary:

(1) That person shall pay the costs of prosecuting the action in Superior Court, including reasonable attorney's fees; and

(2) If the failure to pay was without due cause, any penalty assessed on that person under this Act must be doubled. [2007, c. 26, §1 (NEW).]

[2007, c. 26, §1 (NEW) .]

SECTION HISTORY

1993, c. 145, §6 (NEW). 2007, c. 26, §1 (RPR).

Chapter 9: INSURANCE AND SELF-INSURANCE

§401. LIABILITY OF EMPLOYER

1. Private employers. Every private employer, including an independent contractor who hires and pays employees, is subject to this Act and shall secure the payment of compensation in conformity with this section and sections 402 to 407 with respect to all employees, subject to the provisions of this section. Unless employed by a private employer, a person engaged in harvesting forest products is subject to this Act and shall secure the payment of compensation in conformity with this section and sections 402 to 407 with respect to that person individually if that person is an employee as defined in section 102, subsection 11, paragraph B-1.

A private employer who has not secured the payment of compensation under this section and sections 402 to 407 is not entitled, in a civil action brought by an employee or the employee's representative for personal injuries or death arising out of and in the course of employment, to the defense set forth in section 103. The employee of any such employer may, instead of bringing a civil action, claim compensation from the employer under this Act.

The following employers are not liable under this section for securing the payment of compensation in conformity with this section and sections 402 to 407 with respect to the employees listed, nor deprived of the defenses listed in section 103:

A. Employers of employees engaged in domestic service; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Employers of employees engaged in agriculture or aquaculture as seasonal or casual laborers, if the employer maintains coverage by an employer's liability insurance policy with total limits of not less than \$25,000 and medical payment coverage of not less than \$5,000.

(1) As used in this subsection, "casual" means occasional or incidental. "Seasonal" refers to laborers engaged in agricultural or aquacultural employment beginning at or after the commencement of the planting or seeding season and ending at or before the completion of the harvest season; and [2001, c. 235, §2 (AMD).]

C. Employers of agricultural or aquacultural laborers, if the employer maintains an employer's liability insurance policy with total limits of not less than \$100,000 multiplied by the number of full-time equivalent agricultural or aquacultural laborers employed by that employer and medical payment coverage of not less than \$5,000, and either:

- (1) The employer has 6 or fewer concurrently employed agricultural or aquacultural laborers; or
- (2) The employer has more than 6 agricultural or aquacultural laborers but the total number of hours worked by all such laborers in a week does not exceed 240 and has not exceeded 240 at any time during the 52 weeks immediately preceding an injury.

For purposes of this paragraph, seasonal and casual workers, immediate family members of unincorporated employers and immediate family members of bona fide owners of at least 20% of the voting stock of an incorporated employer are not considered agricultural or aquacultural laborers.

"Immediate family members" means parents, spouses, brothers, sisters and children and the spouses of parents, brothers, sisters and children. [2013, c. 87, §1 (RPR).]

The burden of proof to establish an exempt status under this subsection is on the employer claiming the exemption.

[2013, c. 87, §1 (AMD) .]

2. Governmental bodies. The State and every county, city and town is subject to this Act and shall secure the payment of compensation in conformity with sections 402 to 407.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Failure to conform. The failure of any private employer or of any person engaged in harvesting forest products not exempt under subsection 1 or of any governmental body, as defined in subsection 2, to procure insurance coverage for the payment of compensation pursuant to sections 402 to 407 constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3, and subjects the employer or a person engaged in harvesting forest products to the penalties prescribed by that section. For purposes of this subsection, the term "insurance coverage" includes authorization by the Superintendent of Insurance to self-insure.

[1999, c. 364, §5 (AMD) .]

3-A. Cancellation notice requirements. Any person engaged in harvesting forest products not exempt under subsection 1 shall provide within 3 business days of the cancellation written notification to the landowner to whom the person is under contract of a cancellation of that person's workers' compensation insurance policy. That person shall provide identical notice to any employee who was covered by the canceled workers' compensation insurance policy. A person engaged in harvesting forest products not exempt under subsection 1 who is found in noncompliance with these notification requirements is liable for a civil forfeiture of not less than \$50 nor more than \$100 for each day of noncompliance.

[2001, c. 622, §1 (NEW) .]

4. Liability of landowner. A landowner subject to this Act who contracts to have wood harvested from the landowner's property by a contractor who, as an employer, is subject to this Act and who has not complied with the provisions of this section and who does not comply with the provisions of this section prior to the date of an injury or death for which a claim is made is liable to pay to any person employed by the contractor in the execution of the work any compensation under this Act that the landowner would have been liable to pay if that person had been immediately employed by the landowner.

A landowner is not liable for compensation if at the time the landowner enters into the contract with the contractor, the landowner applies for and receives a predetermination of the independent status of the contractor as set forth in section 105, the landowner requests and receives a certificate of independent status, issued by the board on an annual basis to a contractor, certifying that the contractor harvests forest products in a manner that would not make the contractor an employee of the landowner or the landowner requests and receives a certificate of insurance, issued by the contractor's insurance carrier, certifying that the contractor has obtained the required coverage and indicating the effective dates of the policy, and if the landowner requests and receives at least annually similar certificates indicating continuing coverage during the performance of the work. A landowner who receives a predetermination of the contractor's status as independent contractor or a certificate of independent status is only relieved of liability under this paragraph if the contract for wood harvesting expressly states that the independent contractor will not hire any employees to assist in the wood harvesting without first providing the required certificate of insurance to the landowner.

Notwithstanding section 105, subsection 1, paragraph A, a predetermination under section 105 related only to a person engaged in harvesting forest products is a conclusive presumption that the determination is correct and section 105, subsection 2 does not apply to that determination. Each party involved in or affected by the predetermination must be provided information on the workers' compensation laws and the effect of independent contractor status in relation to those laws. A predetermination under section 105 related to a person engaged in harvesting forest products is effective for one calendar year or the duration of the contract, whichever is shorter.

A landowner required to pay compensation under this section is entitled to be indemnified by the contractor and may recover the amount paid in an action against that contractor. A landowner may demand that the contractor enter into a written agreement to reimburse the landowner for any loss incurred under this section due to a claim filed for compensation and other benefits. The employee is not entitled to recover at common law against the landowner for any damages arising from such injury if the employee takes compensation from that landowner.

Landowners willfully acting to circumvent the provisions of this section by using coercion, intimidation, deceit or other means to encourage persons who would otherwise be considered employees within the meaning of this Act to pose as contractors for the purpose of evading this section are liable subject to the provisions of section 324, subsection 3. Nothing in this section may be construed to prohibit an employee from becoming a contractor subject to the provisions of section 102, subsection 13-A.

[2011, c. 643, §12 (AMD); 2011, c. 643, §14 (AFF) .]

5. Workplace health and safety training programs. The following workplace health and safety plan requirements apply to all employers in the State required to secure payment of compensation in conformity with this Title.

A. The Commissioner of Labor or the commissioner's designee shall adopt rules regarding workplace health and safety programs. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The Superintendent of Insurance shall communicate to the Department of Labor the names of employers that receive in any policy year an experience rating of 2 or more. The Department of Labor shall notify each employer on that list that the employer is required to undertake a workplace health and safety program and the department shall provide a statistical evaluation of the employer's workplace health and safety experience and enclose a set of workplace health and safety options, including on-site consultation, education and training activities and technical assistance. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The employer shall submit a workplace health and safety plan to the Department of Labor for review and comment, complete the elements of the plan and notify the Department of Labor of its completion. The plan may include attendance at a community college in the State or the Department of Labor workplace health and safety training programs. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF); 2003, c. 20, Pt. OO, §2 (AMD); 2003, c. 20, Pt. OO, §4 (AFF).]

D. The Department of Labor shall notify the Superintendent of Insurance of any employer that fails to complete the workplace health and safety program as required by this section and the rules adopted pursuant to paragraph A. The Superintendent of Insurance shall assess a surcharge of 10% on that employer's workers' compensation insurance premium or the imputed premium for self-insurers, which must be paid to the Treasurer of State, who shall credit that amount to the Safety Education and Training Fund, as established by Title 26, section 61. Employers who fail to complete a required workplace health and safety program and who are assessed a surcharge prior to January 1, 1994 must be assessed a surcharge of 5%. Employers who fail to complete a required workplace health and safety program and who are assessed a surcharge after January 1, 1994 must be assessed a surcharge of 10%. [2003, c. 673, Pt. Q, §4 (AMD).]

E. The Commissioner of Labor shall report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters and the joint standing committee of the Legislature having jurisdiction over labor matters by October 1, 1993 on the rules adopted, performance by employers and any surcharges imposed by the Superintendent of Insurance. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2003, c. 673, Pt. Q, §4 (AMD) .]

5-A. Working group on data collection and injury prevention. The Department of Labor, Bureau of Labor Standards shall convene a working group beginning not later than October 1, 2003 to evaluate data on work-related injuries and identify ways to reduce the incidence of such injuries. The bureau shall include in the group representatives of the board, labor, employers, occupational health practitioners, safety experts, insurers and others that the bureau considers useful and necessary to the group. The group shall review existing data collection efforts and the structure within State Government for evaluating and improving injury prevention efforts in the workplace. The group shall identify ways to improve data collection, analysis and injury prevention programs in the State. The bureau shall report the recommendations of the group by January 1, 2005 and January 1, 2006 to the Governor and to the joint standing committees of the Legislature having jurisdiction over labor matters and over insurance matters. Those committees are authorized to report out legislation in response to the recommendations to the First Regular Session of the 122nd Legislature and the Second Regular Session of the 122nd Legislature. The bureau may continue the group as long as it considers such a group useful in understanding the causes and promoting prevention of work-related injuries in the State.

[2003, c. 471, §2 (NEW) .]

6. Nonresident employers. A nonresident employer whose employees work in the State shall obtain coverage under this Act from an insurer or self-insurer authorized in the State unless exempt under section 113 or unless the employer would be exempt if located in the State.

[1997, c. 366, §1 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 120, §2 (AMD). 1997, c. 359, §1 (AMD). 1997, c. 366, §1 (AMD). 1999, c. 364, §§4-6 (AMD). 1999, c. 610, §1 (AMD). 2001, c. 235, §§2,3 (AMD). 2001, c. 622, §1 (AMD). 2003, c. 20, §OO2 (AMD). 2003, c. 20, §OO4 (AFF). 2003, c. 471, §2 (AMD). 2003, c. 673, §Q4 (AMD). 2011, c. 643, §§11, 12 (AMD). 2011, c. 643, §14 (AFF). 2013, c. 87, §1 (AMD).

§402. PREPAYMENT OF PREMIUM

An insurance company that issues workers' compensation insurance policies may not require prepayment of premium more than 1/4 year in advance. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§403. INSURANCE BY ASSENTING EMPLOYER; REQUIREMENTS AS TO SELF-INSURERS

An employer subject to this Act shall secure compensation and other benefits to the employer's employees in one or more of the ways described in this section. The failure of any employer subject to this Act to procure insurance coverage for the payment of compensation and other benefits to the employer's employees in one of the ways described in this section constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3 and subjects the employer to the penalties prescribed by that section. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Insuring under workers' compensation insurance policy. The employer may comply with this section by insuring and keeping insured the payment of such compensation and other benefits under a workers' compensation insurance policy. The insurance company shall file with the board notice, in the form required by the board, of the issuance of any workers' compensation policy to an employer. The insurance may not be cancelled within the time limited in such policy for its expiration until at least 30 days after the insurance company mails to the board and to the employer a notice of the cancellation of the insurance. In the event that the employer has obtained a workers' compensation policy from another insurance company, or has otherwise secured compensation as provided in this section, and such insurance or other security becomes effective prior to the expiration of the 30-day notice period, cancellation takes effect on the effective date of the other insurance or on receipt of security.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Pilot projects.

[2001, c. 48, §1 (AMD); 2001, c. 48, §2 (AFF); T. 39-A, §403, sub-§2, ¶ D (RP) .]

3. Proof of solvency and financial ability to pay; trust. The employer may comply with this section by furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and depositing cash, satisfactory securities, irrevocable standby letters of

credit issued by a qualified financial institution or a surety bond with the superintendent, in such sum as the superintendent may determine pursuant to subsection 8, the Treasurer of State to be listed as beneficiary of the bond or the irrevocable standby letter of credit and the bond or the irrevocable standby letter of credit to be conditional upon the faithful performance of this Act relating to the payment of compensation and benefits to any injured employee. In case of cash or securities being deposited, or drawn on a surety bond or letter of credit, the cash or securities must be placed in an account at interest by the Treasurer of State, and the accumulation of interest on the cash or securities so deposited must be credited to the account and may not be paid to the employer to the extent that the interest is required to secure the employer's self-insurance obligations, including the amount needed to support any present value discounting in the determination of the amount of the deposit. Any security deposit must be held by the Treasurer of State in trust for the benefit of the self-insurer's employees for the purposes of making payments under this Act. If the superintendent determines that the self-insurer has experienced a deterioration in financial condition that adversely affects the self-insurer's ability to pay obligations under this Act, the security amount may be in excess of the minimum amount required by this Title.

A self-insurer may, with the approval of the Superintendent of Insurance, use the following types of security to satisfy the self-insurer's responsibility to post security required by the superintendent: a surety bond; an irrevocable standby letter of credit; cash deposits and acceptable securities; and an actuarially determined fully funded trust. For purposes of this section, "tangible net worth" means equity less assets that have no physical existence and depend on expected future benefits for their ascribed value. Unless disapproved by the superintendent pursuant to paragraph C, subparagraphs (5) and (6), a group self-insurer that maintains a trust actuarially funded to the confidence level required by the superintendent may use an irrevocable standby letter of credit as follows: only in an amount not greater than the difference between the funding to the required confidence level and funding to the confidence level reduced by 10 percentage points; only as long as the trust assets are not used as collateral for the letter of credit; and only as long as the value of trust assets, excluding the value of the letter of credit, is at least equal to the present value, evaluated to the 65% confidence level, of ultimate incurred claims, claims settlement costs and, if determined necessary by the superintendent, administrative costs.

A. An individual self-insurer providing an irrevocable standby letter of credit as security shall file with the Superintendent of Insurance a letter of credit, on a form approved by the superintendent, copies of any agreements or other documents establishing the terms and conditions of the employer's reimbursement obligations to the financial institution issuing the letter of credit, together with copies of any required security agreements, mortgages or other agreements or documents granting security for the employer's reimbursement obligations and any other agreements that contain conditions, restrictions or limitations of any kind upon the employer, the superintendent or the Treasurer of State. The form of letter of credit approved by the superintendent must include, but is not limited to, all terms specifically required by this subsection and all terms reasonably required to secure the payment of compensation and benefits to claimants as required under this Act.

In order to issue an irrevocable standby letter of credit as security under this paragraph, a financial institution or its parent company must either:

- (1) Maintain a long-term unsecured debt rating of at least A by either Moody's Investors Service, Inc. or Standard and Poor's Corporation;
- (2) Maintain a short-term commercial paper rating within the 3 highest categories established by Moody's Investors Service, Inc. or Standard and Poor's Corporation; or
- (3) Be certified in writing by the Superintendent of Financial Institutions to be well capitalized and well managed in accordance with the criteria set forth in Title 9-B, section 446-A, subsections 1 and 2. The Superintendent of Insurance shall keep the certification confidential, except from the subject financial institution, in accordance with Title 9-B, section 226.

The Superintendent of Insurance may adopt rules to establish additional qualifications for financial institutions issuing irrevocable standby letters of credit. Rules adopted pursuant to this paragraph are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.

The irrevocable standby letter of credit must be the individual obligation of the issuing financial institution, may not be subject to any agreement, condition, qualification or defense between the financial institution and the employer and may not in any way be contingent on reimbursement by the employer. If the rating of an issuing financial institution that has issued an irrevocable standby letter of credit pursuant to this section falls below the required standard, the employer shall obtain a new irrevocable standby letter of credit from a qualified financial institution or shall provide other eligible security of equal value approved by the Superintendent of Insurance. The irrevocable standby letter of credit is automatically extended for one year from the date of expiration unless, 90 days prior to any expiration date, the issuing financial institution notifies the Superintendent of Insurance that the financial institution elects not to renew the irrevocable standby letter of credit.

An irrevocable standby letter of credit that has been issued by a qualified financial institution and accepted by the Superintendent of Insurance binds the issuing financial institution to pay one or more drafts drawn by the Treasurer of State, as directed by the superintendent, as long as the draft does not exceed the total amount of the irrevocable standby letter of credit. Any draft presented by the Treasurer of State, as directed by the superintendent, must be promptly honored if accompanied by the certification of the superintendent that any obligation under this chapter has not been paid when due or that a proceeding in bankruptcy has been initiated by or with respect to the employer in a court of competent jurisdiction.

If the Superintendent of Insurance certifies that the superintendent has been notified by the issuing financial institution that the irrevocable standby letter of credit expires by its terms in 30 days or less and that the irrevocable standby letter of credit was not replaced within 15 days after that notice to the superintendent by other eligible security of equal value approved by the superintendent, then the financial institution must remit within 15 days the full amount of the irrevocable letter of credit to the Treasurer of State without further certification.

Any proceeds from a draw on such an irrevocable standby letter of credit by the Treasurer of State, as directed by the Superintendent of Insurance, must be held by the Treasurer of State on behalf of workers' compensation claimants to secure payment of claims until either the superintendent authorizes the Treasurer of State to release those proceeds to the employer upon provision by the employer of replacement security adequate to meet the requirements for security set by the superintendent or the superintendent directs distribution of the proceeds in accordance with this Title.

To the extent not inconsistent with state law, the letter of credit is subject to and governed by the International Standby Practices 1998 or successor practices governing standby letters of credit duly adopted by the International Chamber of Commerce. If any legal proceedings are initiated with respect to payment of the letter of credit, those proceedings are subject to the State's courts and law. [2011, c. 180, §1 (AMD).]

B. The Superintendent of Insurance shall prescribe the form of the surety bond that may be used to satisfy, in whole or in part, the self-insurer's responsibility under this section to post security. The bond must be continuous, be subject to nonrenewal only upon not less than 60 days' notice to the superintendent, cover payment of all present and future liabilities incurred under this Act while the bond is in force and cover payments that become due while the bond is in force that are attributable to injuries incurred in prior periods and otherwise unsecured by cash, irrevocable standby letters of credit or acceptable securities. A bond must be held until all payments secured by the bond have been made or until the bond has been replaced by other eligible security approved by the superintendent that covers all outstanding liabilities. Payments under the bond are due within 30 days after notice has been given to the surety by the board that the principal has failed to make a payment required under the terms of an award, agreement or governing law. A trust established to satisfy the requirements of this section may not be funded by a surety bond. [2007, c. 75, §1 (AMD).]

C. A self-insurer may establish an actuarially determined fully funded trust, funded at a level sufficient to discharge those obligations incurred by the employer pursuant to this Act as they become due and payable from time to time, as long as the Superintendent of Insurance requires that the value of trust assets be at least equal to the present value of ultimate expected incurred claims and claims settlement

costs, plus required safety margins and, if determined necessary by the superintendent, administrative costs for the operation of the plan of self-insurance. For the purpose of determining whether an actuarially determined fully funded trust has a surplus of funds in excess of that required by this subsection, the superintendent shall consider, based upon the group's audit for all completed plan years, only the following assets held outside the trust account: cash up to \$10,000; accounts receivable, limited to amounts collected and deposited in the trust account by the date of the surplus distribution; accrued interest on trust account assets that will be collected and deposited in the trust account within 6 months from the date of the surplus determination; tangible assets that will be converted to cash and deposited in the trust account prior to the distribution date of any surplus; and a letter of credit to be used to partially fund the trust to the extent allowed under this section and rules adopted by the superintendent, as supported in the actuarial review. The superintendent shall consider cash held outside the trust account in excess of \$10,000 if the self-insurer provides, to the superintendent's satisfaction, documentation regarding why the money is being held outside the trust account. An actuarially determined fully funded trust must be funded as follows, as determined by the superintendent.

(1) For individual and group self-insurers, the amount of security must be determined based upon an actuarial review. The actuarial review must take into consideration the use by a group self-insurer of any irrevocable standby letter of credit. Except as provided in subparagraph (3), initial funding for each plan year must be maintained at the 90% or higher confidence level. Funding after the completion of the initial plan year may be established no lower than the 75% confidence level if the following has occurred:

- (a) A year considered for reduction is completed;
- (b) The supporting actuarial review includes an evaluation of the completed year experience with claims evaluated not less than 6 months from the end of the plan year, or in the case of a group self-insurer in existence for at least 36 months, not less than 4 months from the end of the plan year; and
- (c) For individual self-insurers, prior approval from the superintendent is obtained.

For the purposes of determining the confidence level, all completed years at the same confidence level may be aggregated. For individual self-insurers, funds may not be released from the trust or transferred between years except as approved by the superintendent. The governing body of a group self-insurer may at any time declare a surplus of funds above the required confidence level, but may only release funds after the completion of any plan year. The superintendent may request information regarding any such declaration. Any distribution of surplus must be based upon an actuarial review of all outstanding obligations for all completed plan years, an audited financial statement of the group for all completed plan years and a surplus distribution worksheet for all completed plan years on a form approved by the superintendent. The group self-insurer must provide the required information within 10 days after the distribution. Any surplus declared or distributed pursuant to this paragraph is subject to adjustment after review by the superintendent within 60 days of the receipt of the required information. Any deficit below the required confidence level, as determined by the superintendent, that results from a distribution under this paragraph must be funded within 45 days from the date of the notice by the superintendent.

(2) A group self-insurer may elect to fund at a higher confidence level through the use of cash, marketable securities or reinsurance. If a member of a group self-insurer terminates membership in the group for any reason, that member shall fund the member's proportionate share of the liabilities and obligations of the trust to the 95% confidence level. If for any reason the departing member fails to fund the member's proportionate share of the trust's exposure to the 95% level of confidence, the trust is responsible for that member's liabilities and obligations to the trust. If the superintendent finds that a material risk to the trust's ability to satisfy its liabilities and obligations in full exists due to the failure of one or more departing members to fund the departing members' proportionate share of those liabilities and obligations to the 95% confidence level or due to the failure of the group trust to enforce the funding requirement, the superintendent shall consider the unfunded share of the trust's exposure when approving a determination of a surplus or deficit in the trust.

(3) Subject to prior approval by the superintendent in accordance with subparagraph (5), a self-insurer that has successfully maintained an actuarially determined fully funded trust for a period of 5 or more consecutive years may fund all years, including the prospective fund year, at the 75% or higher confidence level in the aggregate and a group self-insurer that has successfully maintained an actuarially determined fully funded trust for a period of 10 or more consecutive years may fund all years, including the prospective fund year, at the 65% or higher confidence level in the aggregate.

(4) Trust assets must consist of cash or marketable securities of a type and risk character as specified in subsection 9. The trustee shall submit a report to the superintendent not less frequently than quarterly that lists the assets comprising the corpus of the trust, including a statement of their market value and the investment activity during the period covered by the report. The trust must be established and maintained subject to the condition that trust assets may not be transferred or revert in any manner to the employer except to the extent that the superintendent finds that the value of the trust assets exceeds the present value of incurred claims and claims settlement costs with an actuarially indicated margin for future loss development. In all other respects, the trust instrument, including terms for certification, funding, designation of trustee and payout, must be as approved by the superintendent, except that the value of the trust account must be actuarially calculated at least annually by a casualty actuary who is a member of the American Academy of Actuaries and adjusted to the required level of funding.

(5) In determining whether a self-insurer that maintains an actuarially determined fully funded trust qualifies for a reduction in the required confidence level pursuant to subparagraph (1) or (3) or is subject to an enhanced confidence level pursuant to subparagraph (6), the superintendent shall consider the financial condition of the self-insurer in relation to the potential workers' compensation liabilities. The factors the superintendent may consider include the self-insurer's liquidity, leverage, tangible net worth, size and net income. For group self-insurers, the superintendent's review must be based on the aggregate financial condition of the group members. At the request of the superintendent, a group self-insurer shall report relevant financial information, on a form prescribed by the superintendent, at such intervals as the superintendent directs. The superintendent may establish additional review criteria or procedures by rule. Rules adopted pursuant to this subparagraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

(6) If the superintendent determines, based on an evaluation of a self-insurer's financial condition pursuant to subparagraph (5), that the confidence level at which the self-insurer has been authorized to fund its trust is not sufficient to provide adequate security for the self-insurer's reasonably anticipated potential workers' compensation liabilities, the superintendent shall make a determination of the appropriate confidence level and order the self-insurer to take prompt action to increase funding to that level within 60 days. [2011 , c . 98 , §1 (AMD) .]

D. Notwithstanding any provision of this chapter, authorization to self-insure may not be conditioned on a bond or security deposit that is in excess of \$50,000 for the State, the University of Maine System or any county, city or town with a state-assessed valuation equal to or in excess of \$300,000,000 and either a bond rating equal to or in excess of the 2nd highest standard as set by a national bond rating agency or a net worth equal to or in excess of \$35,000,000. If a county, city or town that is a self-insurer relies upon a bond rating to qualify under this paragraph, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value must be incorporated in the annual audit of the county, city or town, together with disclosure of funds appropriated to discharge incurred claims expenses. [1997 , c . 126 , §7 (AMD) .]

E. In consideration of a self-insuring entity's application for authorization to operate a plan of self-insurance, the Superintendent of Insurance may require or permit an applicant to employ valid risk transfer by the utilization of primary reinsurance, subject to the provisions of subsection 8. Standards respecting the application of reinsurance must be contained in a rule adopted by the superintendent pursuant to the Maine Administrative Procedure Act. Reinsurance must be defined as insurance covering workers' compensation exposures in excess of risk retained by a self-insurer. [1995 , c . 398 , §2 (NEW) .]

F. An employer may be eligible for approved self-insurance status pursuant to this Act if the employer submits a written guarantee of the obligations incurred pursuant to this Act, the guarantee to be issued by a United States or Canadian corporation that is a member of an affiliated group of which the employer is a member, and which corporation is solvent and demonstrates an ability to pay the compensation and benefits, and the guarantee is in a form acceptable to the Superintendent of Insurance. The guarantor shall provide audited annual financial statements and such other information as the superintendent may require, including quarterly financial statements, and the employer shall provide a cash deposit, satisfactory securities, irrevocable standby letters of credit issued by a qualified financial institution or a surety bond as otherwise required by this Act in an amount not less than \$100,000. The guarantor is deemed to have submitted to the jurisdiction of the board and the courts of this State for purposes of enforcing the guarantee. The guarantor, in all respects, is bound by and subject to the orders, findings, decisions or awards rendered against the employer for payment of compensation and any penalties or forfeitures provided under this Act. The superintendent, following hearing, may revoke the self-insured status of the employer if at any time the assets of the guarantor become impaired or encumbered or are otherwise found to be inadequate to support the guarantee. [1995, c. 398, §2 (NEW).]

G. A subsidiary employer may be eligible for approved self-insurance status pursuant to this Act if: the subsidiary employer files an application jointly with a qualified parent corporation that has direct ownership of a majority voting interest of the subsidiary employer; the parent corporation and subsidiary employer submit an irrevocable contract of assignment, on a form approved by the Superintendent of Insurance, of the subsidiary employer's obligations incurred pursuant to this Act; the parent corporation is solvent and demonstrates an ability to pay the compensation and benefits of the subsidiary employer; and the subsidiary employer meets all other requirements for application and qualification as a self-insurer under this chapter and under any applicable rules adopted by the superintendent. If the parent corporation is not a United States corporation, the superintendent may, in the superintendent's sole discretion, establish the conditions of any approval of the foreign parent corporation or deny the application of the foreign parent corporation. As part of its application for approval, a foreign parent corporation must provide the following information to the superintendent: evidence that its country of domicile has substantially similar laws with respect to submission to the jurisdiction of the board and the courts of this State for the purposes of payment of workers' compensation claims of the subsidiary employer; audited financial statements, as otherwise required by this Act, prepared in the English language by a certified public accountant licensed in a state in the United States in accordance with generally accepted auditing standards as prescribed by the American Institute of Certified Public Accountants; and security, as otherwise required by the Act, in United States currency. The irrevocable contract of assignment and application must be signed by a duly authorized officer of each corporation and the application must include a board of directors' resolution from each entity as evidence of each officer's authority to enter into the contract. The superintendent may determine the subsidiary employer's eligibility for self-insurance authority and the amount of required security based upon the parent corporation's consolidated financial statement, as long as the employer complies with paragraph H. A subsidiary employer currently authorized to self-insure need not pay the application fee required of a new applicant in order to file an application to qualify under this subsection, but the subsidiary employer and parent corporation must provide all information required under this subsection as if they were a new applicant. Once the subsidiary employer becomes authorized to self-insure under this section, the parent corporation assumes liability for all prior workers' compensation liabilities incurred by the subsidiary employer during the period of self-insurance prior to the date of authorization under this subsection, unless the subsidiary employer files an alternative plan approved by the superintendent. The parent corporation and the subsidiary employer must both be named on the certificate of authorization for self-insurance authority. Upon issuance of a certificate of authorization pursuant to this subsection, the following applies.

- (1) The parent corporation is deemed to have submitted to the jurisdiction of the board and the courts of the State for the purposes of payment of workers' compensation claims of the subsidiary employer and is deemed to have submitted to the jurisdiction of the superintendent for purposes

of implementation of this Act. The parent corporation, in all respects, is bound by and subject to all orders, findings, decisions or awards rendered against the subsidiary employer for payment of compensation and any penalties or forfeitures provided under this Act.

(2) A subsidiary employer authorized under this subsection and the parent corporation are considered one employer for the purposes of membership in the Maine Self-Insurance Guarantee Association. In the event of termination, transfer, insolvency, dissolution or bankruptcy of a subsidiary employer qualifying under this subsection, the parent corporation assumes all assessment obligations of the subsidiary employer for its period of self-insurance and is not considered a new member of the association.

(3) If the subsidiary employer fails for any reason to pay compensation and benefits as required under this Act, the parent corporation stands in the place of the subsidiary employer and is deemed to be the employer, subject to all requirements and provisions of this Act. For the purposes of payment of benefits and compensation under this Act, an employee of the subsidiary employer is deemed to be concurrently employed by both corporations. Concerning notification of injury to an employee of the subsidiary employer, notice to or knowledge of the occurrence of the injury on the part of the subsidiary employer is deemed notice or knowledge on the part of the parent corporation. The transfer, insolvency, dissolution or bankruptcy of a subsidiary employer qualifying under this subsection does not relieve the parent corporation from payment of compensation for injuries or death sustained by an employee during the time the subsidiary employer was approved for self-insurance authority under this subsection and the parent corporation continues to be deemed an employer until such time as all outstanding workers' compensation claims have been discharged.

(4) The transfer, insolvency, dissolution or bankruptcy of a parent corporation causes the termination of the subsidiary employer's authorization to self-insure and a termination plan must be filed pursuant to subsection 14. [1995, c. 398, §2 (NEW).]

H. Each individual self-insurer shall submit with its application, and not less frequently than annually thereafter, a financial statement of current origin that has been audited by a certified public accountant. When a self-insurer qualifies on the basis of a financial guarantee or on the basis of an irrevocable contract of assignment, the Superintendent of Insurance may accept an audited financial statement of the guarantor or parent corporation in satisfaction of this requirement and may also require combining statements provided in an array that is reconciled to the consolidated report. [1995, c. 398, §2 (NEW).]

[2011, c. 98, §1 (AMD); 2011, c. 180, §1 (AMD) .]

4. Group self-insurers; application. Except for the provision relating to individual public employer self-insurers, subsection 3 is equally applicable in all respects to group self-insurers. Any employer or group of employers desiring to become a self-insurer shall submit to the Superintendent of Insurance with an application for self-insurance, in a form prescribed by the superintendent, the following:

A. A payroll report for each participating employer of the group for the 3 preceding annual fiscal periods; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. A report of compensation losses incurred, payments plus reserves, by each participating employer of the group for the periods described in paragraph A; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. A sworn itemized statement of the group's assets and liabilities; satisfactory proof of financial ability to pay compensation for the employers participating in the group plan; and the group's reserves, their source and assurance of continuance; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. A description of the safety organization maintained by the employer or group for the prevention of injuries; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. A statement showing the kind of operations performed or to be performed; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. An indemnity agreement in a form prescribed by the superintendent that jointly and severally binds the group and each member to comply with the provisions of this Act; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

G. Any other agreements, contracts or other pertinent documents relating to the organization of the employers in the group. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If, upon examination of the sworn financial statement and other data submitted, the superintendent is satisfied as to the ability of the employer or group to make current compensation payments and that the employer's or group's tangible assets make reasonably certain the payment of all obligations that may arise under this Act, the application must be granted subject to the terms and conditions setting out the exposure of cash deposits or securities or an acceptable surety bond, as required by the superintendent. Except to the extent provided in subsection 4-A, security against shock or catastrophe loss must be provided either by depositing securities with the board in such amount as the superintendent may determine or by filing with the superintendent and the board an insurance carrier's certificate of a standard self-insurer's reinsurance contract issued to the self-insurer or group in a form approved by the superintendent, providing coverage against losses arising out of one occurrence in such amounts as the superintendent may determine, or a combination of the foregoing, satisfactory to the superintendent. Notwithstanding any provision of this chapter, no specific or aggregate reinsurance may be required of any individual public employer that is self-insured and qualifies for the alternative security requirements of subsection 3, paragraph D.

Yearly reports in a form prescribed by the superintendent must be filed by each self-insurer or group. The superintendent may, in addition, require the filing of quarterly financial status reports whenever the superintendent has reason to believe that there has been a deterioration in the financial condition of either an individual or group self-insurer that adversely affects the individual's or group's ability to pay expected losses. The reports must be filed within 30 days after the superintendent's request or at such time as the superintendent shall otherwise set.

After approving any application for self-insurance, the superintendent shall promptly notify the board and forward to it copies of the application and all supporting materials.

[2003, c. 315, §1 (AMD) .]

4-A. Group self-insurance reinsurance account. As an alternative to obtaining a reinsurance contract providing coverage against losses arising out of one occurrence, an individual or group self-insurer authorized under this section may, with the approval of the Superintendent of Insurance, participate in a group self-insurance reinsurance account, referred to in this subsection as "an account," as provided in this subsection. A group self-insurer authorized under the laws of another state may participate in an account through a protected cell arrangement as provided in paragraph L. More than one account may be established pursuant to this subsection. An account established pursuant to this subsection may be established as either an independent private entity or an instrumentality of the State, but the debts and liabilities of an account established as an instrumentality of the State are not debts and liabilities of the State. An account established as an instrumentality of the State within 24 months of its formation, with the approval of the Superintendent of Insurance, may transfer all of its assets and liabilities into an account established as an independent private entity.

A. A group self-insurer that is subject to joint and several liability pursuant to subsection 4, paragraph F, a group self-insurer authorized under the laws of another state and that executes an agreement that its members will be jointly and severally liable in accordance with the provisions of paragraph L or an individual self-insurer authorized under this section that executes an agreement to be responsible for contingent assessment liability in accordance with the provisions of paragraph F may apply to reinsure through an account.

- (1) Upon the petition of 4 or more authorized group self-insurers, the Superintendent of Insurance may approve an account for the deposit of funds in lieu of reinsurance.
- (2) The account must indemnify its participating self-insurer members for claims incurred during the account's operation. The purpose of the account is to accumulate funds to provide coverage against losses arising out of one occurrence in excess of established retention levels consistent with the plan of operation established pursuant to paragraph B.
- (3) A self-insurer is deemed to be a member of the account for reinsurance coverage for purposes of a claim if the self-insurer is a member of the account when an injury occurs or a covered occupational disease loss is incurred.
- (4) A self-insurer that reinsures through an account shall continue to make payments into that account in accordance with the plan of operation established pursuant to paragraph B.
- (5) A self-insurer's participation in an account is considered as a component of the self-insurer's renewal application. A self-insurer's membership in an account is considered adequate protection against losses arising out of a single occurrence unless the Superintendent of Insurance determines, after considering the financial condition and catastrophic loss exposure of both the self-insurer and the account, that it is necessary to maintain additional reinsurance protection, maintain a lower self-insured retention level or provide some other form of additional security, singly or in combination. [2013, c. 172, §1 (AMD).]

B. An account must operate in accordance with a plan of operation established by the group self-insurer members and approved by the Superintendent of Insurance.

- (1) Those group self-insurers creating an account shall submit to the Superintendent of Insurance a plan of operation and any amendments to it that are necessary to ensure the fair, reasonable and equitable administration of the account. The plan of operation is effective upon approval by the superintendent. Any amendments subsequent to the plan's initial approval must be submitted to the superintendent by the plan's board of directors and are effective upon approval by the superintendent.
- (2) The plan of operation must:
 - (a) Create a board of directors and initial bylaws, including the terms and conditions of board membership and the manner by which board members are initially appointed and are replaced when vacancies occur;
 - (b) Establish the procedures by which all the powers and duties of the account are performed, including, but not limited to, defining the date and conditions pursuant to which the account will commence coverage for claims by participating group self-insurer members and establishing provisions for determining limits of exposure for the account;
 - (c) Establish procedures for handling assets of a fund created pursuant to paragraph C;
 - (d) Establish underwriting rules and criteria by which rates are to be established;
 - (e) Establish procedures by which claims may be filed with the account;
 - (f) Establish an investment policy for a fund created pursuant to paragraph C;
 - (g) Establish procedures for records to be kept of all financial transactions of the account, its agents and the board of directors;
 - (h) Establish procedures for withdrawal from the account by a self-insurer member, which must, at a minimum, require 90 days' notice from the withdrawing self-insurer member to the board of directors and the Superintendent of Insurance;
 - (i) Establish, subject to approval by the Superintendent of Insurance, a minimum level of funding to be achieved by the account;
 - (j) Contain additional provisions necessary or proper for the execution of the powers and duties of the board of directors and the ability of the account to meet its obligations; and

(k) Establish a standard per occurrence retention level for claims covered by the account.
[2013, c. 172, §1 (AMD) .]

C. The bylaws of an account established pursuant to this subsection must establish the powers and duties of the board of directors of an account and must include the authority:

- (1) To administer a self-insurance specific reinsurance account fund, to be known in this subsection as "a fund," which must receive payments from participating self-insurer members of the account as required by paragraph A. The costs of administration by the board of directors and expenses of the account must be borne by the fund;
- (2) In its discretion, to secure reinsurance for the fund's exposure and to otherwise invest the assets of the fund to effectuate the purpose of the account, subject to the approval of the Superintendent of Insurance;
- (3) To accept or reject applications of self-insurers to be underwritten by the account, subject to the approval of the Superintendent of Insurance;
- (4) To accept or reject applications of a self-insurer member to self-insure any exposure for one occurrence at a level other than the standard retention level provided in the plan of operation established pursuant to paragraph B, subject to:
 - (a) Compliance with applicable provisions of the plan of operation established pursuant to paragraph B;
 - (b) Notice to and prior approval by the Superintendent of Insurance; and
 - (c) For other retention levels, a statement from that member's actuary that the member has adequately funded its additional exposure;
- (5) To create a mechanism for assessing participating self-insurer members if funds are insufficient to pay the claims of the account;
- (6) To retain actuarial assistance to be used in the establishment of loss reserves, reinsurance and risk management for the account, and in the development of underwriting criteria and premium rates for self-insurer members. Rates are subject to approval by the Superintendent of Insurance;
- (7) To associate with a participating self-insurer member in the defense, investigation or settlement of any claim, suit or proceeding that appears to involve indemnity by the account. This authority does not create a duty to investigate, handle, settle or defend any claims, suits or proceedings against a self-insurer member;
- (8) To borrow funds;
- (9) To amend the bylaws and plan of operation established pursuant to paragraph B, subject to the approval of the Superintendent of Insurance; and
- (10) To exercise such other powers as are established in the plan of operation established pursuant to paragraph B. [2013, c. 172, §1 (AMD) .]

D. An account is subject to examination and regulation by the Superintendent of Insurance. The board of directors of an account shall submit, within 120 days after the close of each fiscal year, an audited financial report and an actuarial report for the preceding fiscal year in a form approved by the superintendent. When the superintendent considers it necessary, the superintendent may require an account to maintain specific or aggregate reinsurance at such retention levels as the superintendent determines to be appropriate. [2003, c. 315, §2 (NEW) .]

E. The Superintendent of Insurance may address any deficiency in reserves, assets or reinsurance of an account in accordance with this paragraph.

- (1) The Superintendent of Insurance may conduct, upon reasonable notice, an examination to determine the financial condition of an account. An examiner duly qualified by the superintendent may examine the loss reserves, assets, liabilities, excess insurance and working capital of an account. If the superintendent finds that the reserves, excess insurance or assets may be inadequate,

or that an account does not have working capital in an amount establishing the financial strength and liquidity of an account to pay claims promptly and showing evidence of the financial ability of an account to meet its obligations to self-insurer members, the superintendent shall notify an account of the inadequacy. Upon notification, the account within 30 days, or such other time as the superintendent approves, shall file with the superintendent its written plan specifying remedial action to be taken and the time frame for implementation of that plan.

(2) If the Superintendent of Insurance determines, after reviewing the information filed pursuant to paragraph D, that a hazardous financial condition exists, the superintendent shall notify an account of the condition. Upon notification, an account shall implement within 30 days, or such other time as the superintendent approves, its plan to correct any deficiencies and within 90 days shall file with the superintendent proof of remedial action taken. If the superintendent is satisfied that the plan submitted to improve the inadequate condition of an account is sufficient, the superintendent shall notify the account. The account shall report quarterly to the superintendent until any deficiencies and their causes have been corrected.

(3) The Superior Court may appoint the Superintendent of Insurance to act as receiver, in the same manner as for a delinquent insurer pursuant to Title 24-A, section 4360, if the superintendent proves by clear and convincing evidence that a hazardous financial condition exists and that an account is unable or unwilling to take meaningful corrective action. [2009, c. 232, §2 (AMD).]

F. A self-insurer's liability for participating in an account is governed by this paragraph.

(1) Each participating self-insurer in an account has a contingent assessment liability in accordance with the plan of operation established pursuant to paragraph B for payment of claims and expenses incurred while a member of the account and must execute an agreement acknowledging that it is responsible for the prompt payment of all assessments necessary to ensure that the account is fully funded and that, if any participant in the account fails to pay an assessment when due for any reason, the remaining participants are liable for the shortfall.

(2) Each contract or other document certifying participation in the account, issued by the account, must contain a statement of the contingent liability of participating self-insurers. [2009, c. 232, §2 (AMD).]

G. An account is exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real or personal property. [2003, c. 315, §2 (NEW).]

H. This subsection does not create any liability on the part of, and a cause of action of any nature does not arise against, any self-insurer member, an account or its agents or employees, the board of directors of an account or its individual members or the Superintendent of Insurance or the superintendent's representatives for any acts or omissions taken by them in the performance of their powers and duties under this subsection. The immunity established by this subsection does not extend to willful neglect or malfeasance that would otherwise be actionable. [2009, c. 232, §2 (AMD).]

I. Assets of an account's fund may be used exclusively for payment of expenses of the account and payment of claims against the account and for no other purpose, except that an account established as an independent private entity pursuant to this subsection may issue such dividends to its members as are approved by the superintendent. [2003, c. 671, Pt. A, §12 (AMD).]

J. The Superintendent of Insurance shall adopt rules to administer and effectuate the intent of this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2003, c. 315, §2 (NEW).]

K. In the event of dissolution of an account established as an instrumentality of the State pursuant to this subsection, all assets remaining after the satisfaction of all outstanding claims must be distributed to the Treasurer of State to be included in the Maine Self-Insurance Guarantee Association. [2003, c. 671, Pt. A, §12 (AMD).]

L. With the approval of the Superintendent of Insurance, a self-insurance reinsurance account may create one or more protected cells under its plan of operation for the purpose of reinsuring obligations of group self-insurers that are organized under the laws of another state. Any protected cell and all participating group self-insurers and their member employers are subject to the jurisdiction and oversight of the Superintendent of Insurance with respect to all matters relating to their participation on the account.

- (1) Any out-of-state self-insurer that participates in the account may do so only through participation in a protected cell. An employer or group authorized by the Superintendent of Insurance to self-insure its Maine liabilities pursuant to this section is considered an out-of-state insurer to the extent that it is reinsuring out-of-state liabilities beyond the scope of its Maine self-insurance plan.
- (2) The establishment of protected cells under this paragraph is a pilot project, limited to at most 2 protected cells, and approval of a protected cell or of a group self-insurer to participate in a protected cell is at the discretion of the Superintendent of Insurance. The Superintendent of Insurance may adopt rules pursuant to paragraph J to establish the terms and conditions of the pilot project, including criteria for the minimum and maximum size of a protected cell.
- (3) A separate account must be established for each protected cell. All contributions from participants in a protected cell must be deposited into the protected cell account. Funds in a protected cell account may be used only for the payment of claims and expenses associated with that protected cell, which may include a reasonable administrative fee paid periodically into the general account. Notwithstanding any other provision of this subsection, participants in a protected cell are not liable for claims or expenses of any other protected cell or of the general account, and the general account is not liable for the claims of any protected cell or any expenses associated with such claims or otherwise specifically attributable to the protected cell.
- (4) The minimum funding level for any protected cell may not be lower than the minimum funding level, calculated in accordance with the plan of operation and subject to paragraph E, that would apply to the general account with the same loss exposure and duration of operation. If the protected cell account falls short of the minimum funding level at any time, the reinsurance account must assess all protected cell participants. If a participating group self-insurer fails to pay any assessment in full when due, the reinsurance account must assess the group's member employers. All assessments are enforceable by the Superintendent of Insurance through an adjudicatory proceeding under the Maine Administrative Procedure Act or through an action in the Superior Court.
- (5) Each protected cell must have its own board of directors, at least 2/3 of whom must be chosen by the protected cell's participants. The plan of operation shall provide for a reasonable allocation of authority between the reinsurance account's board of directors and the protected cell's board of directors.
- (6) No later than April 1st of each year, each reinsurance account with one or more protected cells must pay a regulatory assessment to the Bureau of Insurance from each protected cell account in the amount of 11/100 of 1% of the total standard reinsurance premium for the preceding calendar year for all participants in the protected cell for the level of coverage provided by the reinsurance account.
- (7) All groups participating in a protected cell must provide the reinsurance account and the Superintendent of Insurance with financial and actuarial information sufficient to evaluate loss exposure and financial condition. All information provided to the superintendent by protected cell participants and their member employers is confidential pursuant to subsection 15. All protected cell participants and their member employers must authorize their domiciliary regulator to provide any information requested by the superintendent, which is confidential to the extent provided in Title 24-A, section 216, subsection 5.

(8) In evaluating the risk exposure of an out-of-state group self-insurer and in determining whether groups from different states may participate in the same protected cell, the reinsurance account and the Superintendent of Insurance shall consider any relevant differences in the states' regulatory frameworks for group self-insurance and in their workers' compensation benefit laws.

(9) A group self-insurer may not become a participant in a protected cell unless the group and all of its member employers have provided written acknowledgments to the Superintendent of Insurance that they are jointly and severally liable for the obligations of the protected cell and are subject to the jurisdiction of the superintendent and courts of the State for the enforcement of those obligations.

(10) Any disputes between self-insured members, the self-insurance reinsurance account and any protected cell, including but not limited to any dispute arising out of or relating to any enforcement order or mechanism imposed by the Superintendent of Insurance, must be resolved in this State and pursuant to the laws of this State. [2009 , c. 232 , §2 (NEW) .]

[2013 , c. 172 , §1 (AMD) .]

5. Group self-insurance; participation. Participation in a group self-insurance plan is governed by the following provisions.

A. Any group of employers may adopt a plan for self-insurance, as a group, for the payment of compensation under this Act to their employees. A group may not be approved to operate a self-insurance plan in the form of a corporation, partnership or limited liability company. Under a group self-insurance plan the group shall assume the liability of all the employers within the group and pay all compensation for which the employers are liable under this chapter. When the plan is adopted, the group shall furnish satisfactory proof to the Superintendent of Insurance of its financial ability to pay the compensation for the employers in the group and its revenues, their source and assurance of continuance. The superintendent shall require the deposit with the board of such securities as the superintendent determines necessary of the kind prescribed in subsection 9 or the filing of a bond issued by a surety company authorized to transact business in this State, in an amount to be determined to secure its liability to pay the compensation of each employer as above provided in accordance with subsection 9. The surety bond must be approved as to form by the superintendent. The superintendent may also require that any agreements, contracts and other pertinent documents relating to the organization of the employers in the group be filed with the superintendent at the time the application for group self-insurance is made. The application must be on a form prescribed by the superintendent. The superintendent has the authority to deny the application of the group to pay the compensation for failure to satisfy any applicable requirement of this section. The superintendent shall approve or disapprove an application within 90 days. The group qualifying under this paragraph is referred to as a self-insurer. [1995 , c. 594 , §2 (AMD) .]

B. An employer participating in group self-insurance is not relieved from the liability for compensation prescribed by this chapter, except by the payment of the compensation by the group self-insurer or by the employer. As between the employee and the group self-insurer, notice to or knowledge of the occurrence of the injury on the part of the employer is deemed notice or knowledge, as the case may be, on the part of the group self-insurer; jurisdiction of the employer is, for the purpose of this chapter, jurisdiction of the group self-insurer and the group self-insurer is in all things bound by and subject to the orders, findings, decisions or awards rendered against the participating employer for the payment of compensation under this chapter. The insolvency or bankruptcy of a participating employer does not relieve the group self-insurer from the payment of compensation for injuries or death sustained by an employee during the time the employer was a participant in group self-insurance. The group self-insurer shall promptly notify the Superintendent of Insurance and the board, on a prescribed form, of the addition of any participating employer or employers. The approval of the superintendent is not necessary in order to add participating employers to the group self-insurer. Notice of termination of a participating employer is not effective until at least 10 days after notice of that termination, on a prescribed form, has been filed in the offices of the superintendent and the board or sent to both offices by registered

mail. The group self-insurer shall give notice of the termination of any participating member to all other participating members at least quarterly each year. Written notice must be given to any new participating member at the time of admission that the specific membership of the group and its members as prescribed in this section is not affected by the group's failure to provide its members with prior or immediate notice of changes in the membership of the group if notice is given at least quarterly, as long as the termination or admission of members was effected in compliance with all group agreements and bylaws and this section and the rules adopted pursuant to it. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Each group self-insurer, in its application for self-insurance, shall set forth the names and addresses of its officers, directors, trustees and general manager. Notice of any change in the officers, directors, trustees or general manager must be given to the Superintendent of Insurance and the board within 10 days of the change. An officer, director, trustee or employee of the group self-insurer may not represent or participate directly or indirectly on behalf of an injured worker or the worker's dependents in any workers' compensation proceeding. All employees of employers participating in group self-insurance are deemed to be included under the group self-insurance plan. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. If for any reason the status of a group self-insurer under this paragraph is terminated, the securities, the surety bond, the letter of credit or the deposit required by this section continues to be held by the Superintendent of Insurance or Treasurer of State and remains subject to the control of the board until all claims secured by the securities, surety bond, letter of credit or deposit have been discharged. When all such claims have been discharged or after such period as the Superintendent of Insurance determines proper, the superintendent may accept in lieu thereof, and for the additional purpose of securing such further and future contingent liability as may arise from prior injuries to workers and be incurred by reason of any change in the condition of such workers warranting the board making subsequent awards for payment of additional compensation, a policy of insurance furnished by the group self-insurer, its successor or assigns or other entity carrying on or liquidating such self-insurance group. The policy must be in a form approved by the superintendent and issued by any insurance company licensed to issue this class of insurance in the State. It may only be issued for a single complete premium payment in advance by the group self-insurer. It must be given in an amount determined by the superintendent and when issued is noncancellable for any cause during the continuance of the liability secured and so covered. [2011, c. 180, §2 (AMD).]

E. The Superintendent of Insurance may provide for the administration of this section relating to self-insurance in the manner prescribed in Title 24-A, section 212. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. If an employer is a partnership or a sole proprietorship and is a member of a self-insurance group associated pursuant to this section, the employer may elect to include as an employee any member of the partnership or owner of the sole proprietorship for purposes of obtaining workers' compensation coverage under this Act. In the event of such an election, the electing employer shall serve upon the group self-insurance association written notice naming the partner or sole proprietor to be covered, and an election is deemed not to have been made within this Act until such notice has been given. By making such an election, the partnership member or sole proprietor is deemed to have stipulated that for premium payment purposes the annual salary or wage of the electing partnership member or sole proprietor is the average weekly wage in the State as computed by the Department of Labor multiplied by 52 and rounded to the nearest \$100. The assumed average annual wage must be adjusted as of July 1st using the average weekly wage from the prior calendar year. [1995, c. 560, Pt. G, §27 (AMD).]

G. Fee schedules applicable to group self-insurers are those set forth in Title 24-A, section 601. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

H. Each group self-insurer shall record its loss expense and experience in accordance with Title 24-A, section 2323. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

I. Annual examinations of each group self-insurer, as required by the Superintendent of Insurance, must be performed by public accountants acceptable to the superintendent and reports must be rendered to the superintendent within a reasonable period, as determined by the superintendent, subsequent to the group self-insurers elected fiscal year. The examinations must be conducted pursuant to generally accepted accounting principles, as they are consistent with precepts prescribed by the superintendent, that place sound values on assets and liabilities of group self-insurers. Other examinations of the affairs, transactions, accounts, records and assets of each group self-insurer and of any person as to any matter relevant to the financial affairs of the group self-insurer must be conducted as often as the superintendent determines advisable. The expense of examination of a group self-insurer must be borne by the group that is examined. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

J. In any fiscal year, a group self-insurer may not be required to obtain aggregate reinsurance with a policy limit that exceeds a multiple of 1.5 of its annual standard workers' compensation premium for that fiscal year. The Superintendent of Insurance may set lower policy limits for aggregate reinsurance when, in the superintendent's judgment, lower limits may be prudent. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

K. Upon approval by the Superintendent of Insurance, a group self-insurer may dedicate a portion of its unimpaired surplus to increase its self-insured retention level under the aggregate reinsurance policy by an amount equal to the amount of surplus so dedicated. The superintendent before granting approval shall consider among other factors:

- (1) The level of alternate revenues available to the group self-insurer to cover the further assumed costs; and
- (2) The adequacy of the fund's surplus to meet obligations of the group self-insurer.

At the expiration of a period of 10 calendar days after the superintendent has received a plan for the dedication of a portion of the unimpaired surplus of a group self-insurer to increase its self-insured retention level and any additional information the superintendent has determined necessary, the plan is deemed approved unless prior to the expiration of that time period it has been affirmatively approved or disapproved by the superintendent. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

L. Upon the filing of a plan that meets the approval of the Superintendent of Insurance, a group self-insurer may be authorized to issue subordinated loan certificates, the proceeds of which must be made part of the group self-insurer's surplus account and be available as other surplus funds for dedication to increase the self-insured retention level. To the extent that the proceeds of these loan certificates are utilized by a group self-insurer to increase its self-insured retention in any fiscal year, the aggregate proceeds of the loan certificates so utilized may not exceed 25% of the annual standard premium for that fiscal year. The obligation to redeem these loan certificates after the proceeds of the loan certificates have been dedicated to increase the aggregate excess self-insured retention level of the group self-insurer is subordinate to covered claims and may not be redeemed after the dedication without the approval of the superintendent. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2011, c. 180, §2 (AMD) .]

6. Annual renewal; actuarial evaluation. Renewal and actuarial evaluation are governed by this subsection.

A. Any approval granted by the Superintendent of Insurance to an individual self-insurer or group self-insurer must be for a term of not more than one year. A complete application for renewal of approval to self-insure must be submitted to the superintendent not less than 21 days prior to the self-insurer's renewal date, except that evidence of reinsurance coverage may be submitted up to 3 working days prior to renewal. Notwithstanding this paragraph, when a self-insurer has made a timely and complete application for renewal, the existing authorization does not expire until the renewal has been determined

by the superintendent. A renewal application must contain: all reports, statements and other data required to be filed annually under rules adopted by the superintendent; copies of any proposed reinsurance contracts, binders or cover notes; evidence of security posted; notice of any changes in servicing arrangements; and notice of any change in control of the self-insurer and its effect, if any, on guarantees provided pursuant to subsection 3. The superintendent may refuse to grant or renew self-insurance approval based upon any of the following grounds:

- (1) Failure to submit any information that is required by law or rule or is reasonably requested by the superintendent;
- (2) Failure of a self-insurer to establish that it has met all applicable requirements of law or rule;
- (3) Fraud or misrepresentation in the application; or
- (4) Any ground upon which approval may be suspended or revoked as provided in subsection 13.

The effective date of any notice of nonrenewal under this subsection is on or after the date of the notice. A notice of nonrenewal under this subsection may not include nonrenewal for any approved period of self-insurance prior to the notice. [1995, c. 398, §3 (AMD).]

B. Each individual self-insured employer, except an employer utilizing an actuarially fully funded trust pursuant to subsection 3, is required to obtain an actuarial evaluation of undischarged claims and claims settlement liabilities at least once every 3 years, unless the requirement is waived by the superintendent. The superintendent may waive the triennial actuarial evaluation if the number of outstanding claims is not of sufficient volume to permit a credible actuarial analysis. This review and evaluation must be performed by a casualty actuary who is a member of the American Academy of Actuaries. Upon approval to self-insure, the Superintendent of Insurance shall indicate the deadline for that self-insurer to complete an actuarial review. In addition to this triennial review, the superintendent may require the reserves and liabilities of a self-insurer to be reviewed and evaluated as often as the superintendent determines necessary.

Any self-insurer that develops an imputed annual standard premium not exceeding \$50,000 and demonstrates that it has provided security for its workers' compensation exposures in an amount that is at least 135% of its case-based claims reserves, as evaluated annually, is excused from providing an actuarial evaluation in any year in which these conditions are satisfied. For the purposes of this subsection, "case-based claims reserves" means undischarged claims that have arisen during the period of self-insurance and of which the employer has had formal notice. This exception may not be construed to limit the superintendent's authority to require an actuarial evaluation when the superintendent determines one is necessary. [1995, c. 594, §3 (AMD).]

C. Each individual self-insurer except a public employer shall demonstrate in its initial or renewal application that it has working capital adequate to its operating needs. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. When a self-insurer's reinsurance contract expires on a date other than the renewal date for its self-insurance approval, the self-insurer shall file evidence of any required reinsurance coverage no later than 3 working days before the date of expiration of its coverage. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Each renewal application filed by an individual or group self-insurer that has secured its obligations in whole or part by maintaining a trust fund must include a certification that no political contributions have been made from the trust fund in violation of subsection 18. [2003, c. 424, §1 (NEW).]

[2003, c. 424, §1 (AMD) .]

7. Self-insurance. "Self-insurance," as used in this section, means the system of securing compensation as provided in subsections 3 to 16.

[1993, c. 510, §2 (AMD) .]

8. Security deposit and reinsurance requirements for individual self-insurers. The following security deposit and reinsurance requirements apply to individual self-insurers.

A. Each individual self-insurer shall post a bond, security deposit or letter of credit in an amount that, except as otherwise provided in this paragraph, is no less than the loss and loss adjustment expense portion of the annual standard premium, as defined in section 404, subsection 4, paragraph E, for the prospective fiscal coverage period plus outstanding incurred liabilities minus recoveries from all reinsurance and subrogation reduced to net collections. Outstanding incurred liabilities for an individual self-insurer must be developed to ultimate from a current actuarial evaluation of undischarged claims and claims settlement liabilities performed by a casualty actuary who is a member of the American Academy of Actuaries or its successor organization, except that if a current actuarial evaluation is not available the outstanding incurred liabilities may be developed from current case reserves by applying the ratio of ultimate loss and claim settlement reserves to current loss and claim settlement reserves from the most recent actuarial evaluation.

- (1) A self-insurer's minimum required security level may not be less than \$50,000.
- (2) The minimum required security level for a self-insurer with consistently reported outstanding case reserves less than \$500,000 is 25% of the annual standard premium for the prospective fiscal coverage period, plus outstanding incurred liabilities, minus recoveries from all reinsurance and subrogation reduced to net collections. Outstanding incurred liabilities may be estimated by applying a development ratio of 2.5 to current case reserves.
- (3) An individual self-insurer may reduce its minimum required security level by an amount not to exceed the self-insurer's demonstrated working capital, as determined by the Superintendent of Insurance on the basis of a current audited statement of financial condition, as long as:
 - (a) The self-insurer has a tangible net worth equal to or in excess of \$10,000,000;
 - (b) The self-insurer has had positive net earnings demonstrated by certified statements of financial condition audited by a certified public accountant for at least 3 of the 5 latest fiscal years, including one of the 2 most recent years, and its mean annual earnings for the 5 latest fiscal years are at least equal to the normal annual premium for the prospective fiscal coverage period, or it was eligible to make an alternative election, under Statement of Financial Accounting Standard No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions, that would have otherwise satisfied these earnings requirements;
 - (c) The reduction does not exceed \$10,000,000 and does not reduce the minimum required security level below \$100,000; and
 - (d) The self-insurer is not organized as a sole proprietorship, partnership or limited liability company, except that the superintendent may authorize a limited liability company to deduct demonstrated working capital from its minimum required security level by rules adopted under this section. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.
- (3-A) An individual self-insurer that is a transmission and distribution utility as defined in Title 35-A, section 102, subsection 20-B with an investment grade credit rating may reduce its required security level by up to \$10,000,000, as long as:
 - (a) The self-insured transmission and distribution utility has a tangible net worth equal to or in excess of \$200,000,000;
 - (b) The self-insured transmission and distribution utility has had positive net earnings demonstrated by certified statements of financial condition audited by a certified public accountant for at least 3 of the 5 latest fiscal years, including one of the 2 most recent years, and its mean annual earnings for the 5 latest fiscal years are at least equal to the normal annual premium for the prospective fiscal coverage period, or it was eligible to make an alternative

election, under Statement of Financial Accounting Standard No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions, that would have otherwise satisfied these earnings requirements;

(c) The self-insured transmission and distribution utility has credit facility equal to or in excess of twice its outstanding workers' compensation liabilities; and

(d) The reduction does not exceed \$10,000,000 and does not reduce the minimum required security level below \$100,000.

(4) With the superintendent's approval, affiliated individual self-insurers may post security on a consolidated basis.

Within 30 days after receiving notice from the superintendent, the self-insurer shall post the required bond, security deposit or letter of credit. This deadline may be extended by the superintendent for good cause, but may not exceed one year from the deadline for compliance as stated in the notice given to the self-insurer.

A bond, security deposit or letter of credit in excess of the amount prescribed by this subsection may be required if the superintendent determines that the self-insurer has experienced a deterioration in financial condition that adversely affects the self-insurer's ability to pay expected losses.

A judgment creditor other than a claimant for benefits under this Act does not have a right to levy upon the self-insurer's assets held in deposit pursuant to this paragraph. [2003, c. 38, §1 (AMD).]

B. All individual self-insurers shall maintain specific reinsurance unless the Superintendent of Insurance, in the superintendent's discretion, waives such a requirement. Specific reinsurance must generally have a limit of at least \$2,000,000. Higher limits may be required for those businesses with a high risk of multiple injury from a single occurrence. The retention underlying specific reinsurance policies must be the lowest retention generally available for businesses of similar size and exposure, but may, at the superintendent's discretion, be established at higher levels consistent with the employer's claims experience and financial condition.

All individual self-insurers shall maintain aggregate reinsurance unless the superintendent, in the superintendent's discretion, waives this requirement. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The Superintendent of Insurance may adopt rules establishing specific requirements applicable to security deposits and reinsurance, including, but not limited to, provisions governing standards for waiver of reinsurance, use of trusts in lieu of security deposits and release or application of deposit funds. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[2003, c. 38, §1 (AMD) .]

9. Acceptable deposit funds or investments for trust funds. In addition to cash, the deposit funds or permissible investments for trust funds acceptable to the Superintendent of Insurance as a security deposit are bonds, notes and bills that are issued by and are the direct obligation of the United States Treasury; commercial paper rated as either "A-1" or "P-1" by Moody's Investors Service, Inc., Standard and Poor's Corporation or the rating equivalent of Fitch Investors Service, Inc. or any other nationally recognized statistical rating agency; money market funds rated "Aam" or "AAm-G" or better by Standard and Poor's Corporation or the rating equivalent of any other nationally recognized statistical rating agency; certificates of deposit issued by a duly chartered commercial bank or thrift institution in the State protected by the Federal Deposit Insurance Corporation if the bank or institution possesses assets of at least \$100,000,000 and maintains a ratio of capital to assets equal to or greater than 6 1/2%; bonds that are issued by United States corporations, corporations acceptable to the superintendent or United States public entities and that are rated "A" or better by Standard and Poor's Corporation, or the rating equivalent of Moody's Investors Service, Inc., Fitch Investors Service, Inc. or any other nationally recognized statistical rating agency; and other investments specifically approved by the superintendent. If an investment is downgraded so that it no longer meets the

requirements of this subsection, its value may not be considered in determining whether a deposit or trust has surplus available for distribution, and the superintendent has discretion to discount or disallow the value of the investment for purposes of determining whether additional security is required.

Investments must be diversified in a prudent manner to ensure that funds are maintained at a sufficient level to discharge workers' compensation obligations incurred by the employer pursuant to this Title as those obligations become due and payable. At least 30% of the portfolio must consist of cash, direct obligations of the United States Treasury, commercial paper, money market funds or certificates of deposit. No more than 5% of the portfolio, other than cash and direct obligations of the United States, may be concentrated in a single issuer, and the superintendent shall establish standards to limit concentration in a single industry or market sector.

[2013, c. 172, §2 (AMD) .]

10. Form of reinsurance contracts. All reinsurance contracts issued or renewed after the effective date of this subsection must be issued by companies that meet the requirements of subsection 11 and must name the self-insurer and the Maine Self-Insurance Guarantee Association as coinsureds to the extent of their respective interests. These reinsurance contracts must recognize the Maine Self-Insurance Guarantee Association's rights of recovery, within the terms of coverage provided by the contract, for payments made by the association to or on behalf of claimants regarding covered claims and for claims in the course of settlement, the value of which when reduced to payments will create an obligation on the part of the reinsurance carrier to reimburse the association to the extent of funds disbursed by the association to discharge covered claims. The requirements of this subsection apply to any reinsurance contract issued to any individual or group self-insurer as part of a self-insurance program approved for use within this State and are in addition to any other requirement applicable to reinsurance contracts imposed by law or rule.

Reinsurance contracts must further specify that the reinsurance carrier and the Maine Self-Insurance Guarantee Association may enter into agreements on the terms of settlement and distribution of benefits accruing to claimants within the limits of the authority of the parties to make settlements with respect to any coverage year.

To the extent that the Maine Self-Insurance Guarantee Association succeeds to a recovery of benefits from any reinsurance carrier on behalf of claimants, those benefits must be timely disbursed by the association to or on behalf of claimants as they become due and payable pursuant to this Act. Funds recovered under reinsurance contracts on behalf of claimants must be applied consistent with the terms of coverage under the contract to loss, loss adjustment expense and attorneys' fees that are payable under this Act.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

11. Qualifications for reinsurance carriers. A workers' compensation contract or policy issued after the effective date of this section may not be recognized by the Superintendent of Insurance in considering the ability of an individual or group self-insurer to fulfill its financial obligations under this Act, unless the contract or policy is issued by an admitted insurance company or a reinsurance company that meets on a continuous basis the requirements of Title 24-A, chapter 9, subchapter III and the reinsurance company has been approved by the superintendent to issue in this State contracts of primary workers' compensation reinsurance, or by Lloyd's of London, a syndicate of unincorporated alien insurers that has established and maintains United States trust funds consistent with the requirements of Title 24-A, chapter 9, subchapter III. Each contract of primary workers' compensation reinsurance that is proposed for use in this State must be filed for approval in the manner set out in Title 24-A, section 2412. Insofar as is practicable, a contract so approved may be modified with less than 30 days advance filing notice if the superintendent determines the modifications suggested are not contrary to provisions of Title 24-A, section 2412, this Title or Bureau of Insurance Rule Chapter 250 and are necessary to effect required reinsurance coverage to authorize the self-insurer to operate a plan of workers' compensation self-insurance.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

12. Qualifications for claims personnel. Persons who investigate, settle or negotiate the settlement of claims on behalf of self-insurers or employees of self-insurers are required to be licensed as insurance adjusters pursuant to Title 24-A, chapter 16.

[1997, c. 457, §54 (AMD) .]

13. Revocation or termination of self-insurance privilege. The following may constitute grounds for denial of the right of any individual or group to continue the option of self-insurance:

A. Failure to comply with rules adopted by the Superintendent of Insurance or any provisions of this Act within 14 days of notice of such failure or such other time as may be established by order of the superintendent; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Failure to comply with any lawful order of the Superintendent of Insurance; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. Repeated failure to comply with rules of the Superintendent of Insurance or any provisions of this Act; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. Committing an unfair or deceptive act or practice as defined in Title 24-A, sections 2151 to 2167; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

E. Deterioration of financial condition adversely affecting the self-insurer's ability to pay expected losses; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

F. Failure to pay any lawful assessment of the Maine Self-Insurance Guarantee Association. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

Notwithstanding Title 5, section 10051, the superintendent is expressly granted the authority to revoke or suspend the right of an individual or group to continue the option to self-insure after a hearing held on not less than 7 days' notice in accordance with Title 5, chapter 375, subchapter IV and Title 24-A, chapter 3.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

14. Reportable events; termination of self-insurance authority; application for continuing self-insurance authority and nonrenewal or revocation order. A self-insurer must report the occurrence of events as required by this subsection. An employer may elect to voluntarily terminate its authority to self-insure at any time or may make application for continuing authority to self-insure subject to the requirements of this subsection and any rules adopted by the Superintendent of Insurance. The superintendent may make a determination that an employer's authority to self-insure has terminated in accordance with this subsection and any rules adopted by the superintendent or may grant approval of an application for continuing self-insurance authority. For the purposes of this subsection, "employer" includes a successor employer assuming all workers' compensation liabilities of an approved self-insured employer as a result of the occurrence of one of the events in paragraph A.

A. In order for the superintendent to make a determination as to whether the occurrence of an event results in a termination of an individual employer's self-insured plan or results in a need for modification of the terms and conditions of the plan, an approved self-insurer must report any of the following events to the superintendent at least 45 days in advance of the event's occurrence, if known, or no later than 10 days after the event's occurrence, if not known in advance:

- (1) The sale of 20% or more of the common stock or net assets of the self-insurer;
- (2) A division of the business;
- (3) A spin-off of the business;
- (4) A leveraged buyout of the business;

- (5) A reorganization of the business;
- (6) A change in business form;
- (7) An acquisition by or merger of the business with another entity;
- (8) A change in a partnership agreement;
- (9) A change in the membership or managers of a limited liability company;
- (10) Dissolution of a partnership or a limited liability company;
- (11) Cessation of business in the State; or
- (12) Any other event affecting the ownership of the business or the structure of the business as identified in rules adopted by the superintendent.

Notwithstanding any other provision of this paragraph, an employer that elects to apply to continue to self-insure under paragraph C must notify the superintendent 45 days in advance of the event's occurrence and must file an application for continuing authority to self-insure with the superintendent 30 days in advance of the event's occurrence. At the discretion of the superintendent and if good cause is shown, an employer may submit an application to continue to self-insure less than 30 days in advance of the event's occurrence. [1995, c. 594, §6 (NEW).]

B. If a self-insured employer elects to terminate its self-insurance program, or a portion of its program, it must submit written notice and a written termination plan to the superintendent at least 30 days in advance of the proposed termination date. In the event that a self-insurer elects to terminate its approval in this State without filing a plan acceptable to the superintendent, the superintendent shall issue an order prescribing the terms and conditions of the termination. The termination plan must specify, but is not limited to, procedures for claims handling, reservation of assets or other security acceptable to the superintendent to be maintained in the State to discharge claims liabilities and other obligations under this Act and a description of how ultimate reserves were determined. The termination plan must contain a written agreement that the self-insurer continues to be subject to informational filings respecting changes in ownership, financial condition, and actuarial evaluation of claims, claims expense reserves and loss transfers when determined necessary by the superintendent to ensure that claims are adequately secured. The plan must also comply with the terms and conditions prescribed by rule by the superintendent. To protect the interests of claimants, the superintendent may require a further deposit to be held in trust by the Treasurer of State or may require full funding of workers' compensation liabilities. [1995, c. 594, §6 (NEW).]

C. If the self-insured employer and any successor employer elect to continue to self-insure after the occurrence of an event in paragraph A, the employer and any successor employer must file notice of intent to continue to self-insure with an application for continuing authority to self-insure. In order to qualify to file for continuing self-insurance authority, any successor employer must assume 100% of the liabilities of the predecessor self-insured employer and must show that the business in the State remains substantially the same.

- (1) The notice of intent and application to continue to self-insure must be received by the superintendent 30 days prior to the event's occurrence. The application must be made on a form approved by the superintendent and include the application fee required in Title 24-A, section 601. Within 7 days of receipt by the superintendent of the application to continue to self-insure, the employer and any successor employer must provide all information requested by the superintendent to allow the superintendent to make a determination under this section.
- (2) While the application is pending, the superintendent may request any other information from the applicant determined by the superintendent to be necessary for review of the application. The applicant must promptly provide any additional information upon request in the most expeditious manner.

(3) While the application is pending and during the 30-day period following a denial of an application for continuing self-insurance authority, the employer and any successor employer must maintain the security and reinsurance as required by the employer's certificate of authority, must continue to comply with all other provisions of the employer's certificate of authority and must provide any additional security determined by the superintendent to be necessary under the circumstances. During the application period, the self-insurance authority of the employer continues, consistent with the terms and conditions of the employer's certificate of authority.

(4) Failure to provide the information when requested or failure to comply with the terms and conditions of the employer's certificate of authority or with any additional conditions prescribed by the superintendent will result in automatic termination of the employer's authority to self-insure and the issuance of an order by the superintendent that prescribes the terms and conditions of a termination plan. [1995, c. 594, §6 (NEW).]

D. The superintendent shall notify the employer in writing within 30 days of receipt of all requested information whether the employer's application for continuing self-insurance authority is approved or denied. The superintendent's notice must specify the reasons for the denial or must specify the terms and conditions for continuing self-insurance authority as prescribed by this section and any rules adopted by the superintendent.

(1) In making a determination, the superintendent must consider, among other things, whether the successor employer has assumed 100% of the workers' compensation liabilities of the employer, whether the successor employer qualifies for self-insurance authority pursuant to subsection 3 and whether the successor employer maintains substantially the same business operations as the predecessor self-insured employer. The superintendent may also consider, among other things, whether the successor employer employs a substantially greater number of employees than did the predecessor employer. For purposes of this subparagraph, the successor employer has assumed 100% of the workers' compensation liabilities of the employer if the successor employer is unconditionally liable for payment of all benefits that are the obligations of the self-insured employer, regardless of date of injury and notwithstanding agreements for reimbursement from reinsurers or other entities agreeing to reimburse the successor employer for payments associated with self-insurance obligations.

(2) If the superintendent denies the application, the effective date of the termination is 30 days from the date of the superintendent's notice. The self-insurer may request a hearing on this decision within 30 days from the date of the notice. Upon a request for hearing, there is no automatic stay of the superintendent's decision, but the effective date of termination may be stayed by order of the superintendent. Prior to the effective date of the termination, the employer must file a termination plan consistent with paragraph B. After denial of an application, a successor employer may apply for authority to self-insure its workers' compensation obligations pursuant to this section. [1995, c. 594, §6 (NEW).]

E. If at any time the superintendent determines that a self-insurer has failed to notify the superintendent of the occurrence of any of the events identified in paragraph A, the self-insurer may be subject to penalties pursuant to Title 24-A, section 12-A, if it is determined that the occurrence of the event had a substantial impact on the financial condition of the self-insured employer. As soon as the superintendent notifies the self-insurer that the superintendent has determined that the self-insurer failed to notify the superintendent of the occurrence of any of these events, the self-insurer must comply with this subsection. [1995, c. 594, §6 (NEW).]

F. If a self-insurer's approval is revoked or not renewed pursuant to subsection 6 or 13, the superintendent must issue an order that prescribes terms and conditions related to the termination of the plan. The terms of the order must conform to, but need not be limited to, the requirements of paragraph B. [1995, c. 594, §6 (NEW).]

G. Any order issued pursuant to this subsection, including an order directing a self-insurer to produce relevant information, may be enforced as provided by Title 24-A, section 214. [1995, c. 594, §6 (NEW).]

H. A self-insurer approved by the superintendent to continue self-insurance authority under paragraph D is not subject to assessments as a new member of the Maine Self-Insurance Guarantee Association. The self-insurer is subject to applicable annual assessments or postinsolvency assessments levied by the Maine Self-Insurance Guarantee Association. [1995, c. 594, §6 (NEW).]

I. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1995, c. 594, §6 (NEW).]

[1995, c. 594, §6 (RPR) .]

15. Confidentiality of information. All written, printed or graphic matter or any mechanical or electronic data compilation from which information can be obtained, directly or after translation into a form susceptible of visual or aural comprehension, all information contained in the minutes of trustee meetings and all information relating to individual compensation cases, that a self-insurer is required to file with or make available to the superintendent under this section, section 404 or rules adopted pursuant to it are confidential and are not public records.

The confidential nature of this information does not limit or affect its use by the superintendent in administering this Act, including, but not limited to, communications with the service agent, the Workers' Compensation Board or the Maine Self-Insurance Guarantee Association.

[1993, c. 349, §73 (AMD) .]

16. Registration of self-insurers. Registration of self-insurers is governed as follows.

A. All employers claiming the status of self-insurer as defined by this Title shall apply for registration with the Bureau of Insurance on forms prescribed by the Superintendent of Insurance. The application must contain a statement identifying the employer as a self-insurer, which includes the legal organization and name of each self-insuring employer. The superintendent may require the submission of any further information the superintendent deems necessary in order to determine whether a self-insurer has been approved pursuant to this section. If an employer is unable to establish that it has been approved to act as a self-insurer, the superintendent shall deny the application for registration. Upon denial of registration, an employer may make application for approval to act as a self-insurer in accordance with all requirements of this Act and the rules adopted pursuant to this Act. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. On January 1st of each year, the Superintendent of Insurance shall promulgate an official list of self-insurers that are approved and registered as of that date and the list of self-insurers must be forwarded to the Maine Self-Insurance Guarantee Association. The superintendent shall add to the list at any time during the year the name or names of any self-insurer or self-insurers the superintendent has approved and registered subsequent to the promulgation of the list and shall similarly delete the name or names of any self-insurer or self-insurers whose authority to self-insure has been terminated. Additions to or deletions from the official list of self-insurers must be forwarded to the Maine Self-Insurance Guarantee Association when made. Failure to become registered pursuant to this subsection terminates an employer's authority to self-insure under this Act. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

17. Report required. In order to comply with Title 26, section 61, subsection 1-A, on or before March 1st of each year, every individual workers' compensation self-insurer and workers' compensation group self-insurer shall file a report with the superintendent showing the amount of total actual paid workers' compensation losses and the total actual paid workers' compensation medical payments for the previous calendar year.

[1997, c. 126, §9 (NEW) .]

18. Prohibition against using funds for political contributions. Once deposited into a trust fund created to comply with the requirements of this section, funds and assets may not be withdrawn for the purpose of making a contribution to a political candidate or political action committee required to file a report under Title 21-A, chapter 13, subchapter 2 or 4.

[2003, c. 424, §2 (NEW) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). RR 1993, c. 1, §141 (COR). 1993, c. 349, §73 (AMD). 1993, c. 491, §1 (AMD). 1993, c. 510, §§1,2 (AMD). 1995, c. 36, §1 (AMD). 1995, c. 150, §1 (AMD). 1995, c. 277, §1 (AMD). 1995, c. 398, §§2-4 (AMD). 1995, c. 560, §G27 (AMD). 1995, c. 594, §§2-6 (AMD). 1995, c. 619, §7 (AMD). 1997, c. 126, §§7-9 (AMD). 1997, c. 457, §54 (AMD). 1999, c. 113, §30 (AMD). 1999, c. 790, §A53 (AMD). 2001, c. 44, §14 (AFF). 2001, c. 48, §§1,11 (AMD). 2001, c. 48, §§2,14 (AFF). 2001, c. 224, §1 (AMD). 2003, c. 38, §1 (AMD). 2003, c. 315, §§1,2 (AMD). 2003, c. 424, §§1,2 (AMD). 2003, c. 671, §§A11,12 (AMD). 2005, c. 98, §§1,2 (AMD). 2007, c. 75, §1 (AMD). 2009, c. 232, §2 (AMD). 2011, c. 98, §1 (AMD). 2011, c. 180, §§1, 2 (AMD). 2013, c. 172, §§1, 2 (AMD).

§404. MAINE SELF-INSURANCE GUARANTEE ASSOCIATION

1. Created; purpose. There is created the Maine Self-Insurance Guarantee Association, a nonprofit unincorporated legal entity referred to in this section as the "association," to provide mechanisms for the payment of covered claims under self-insurance coverage, to avoid excessive delay in payment, to avoid financial loss to claimants because of the insolvency of a self-insurer and to assist, when called upon to do so by the Superintendent of Insurance, in the detection of self-insurer insolvencies. It is declared that the Maine Self-Insurance Guarantee Association is an instrumentality of the State, but the debts and liabilities of the association do not constitute debts and liabilities of the State.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Membership required. All self-insurers, under this Title, must be members of the association as a condition of authority to self-insure in this State, except public employers that are individual self-insurers and qualify for the alternative security requirements of section 403, subsection 3, paragraph D and group self-insurers whose membership consists exclusively of public employers and whose members have in the aggregate a state-assessed valuation equal to or in excess of \$5,000,000,000. The association shall perform its functions under a plan of operation established or amended, or both, and approved by the superintendent and shall exercise its powers through the board of directors established in this section.

A. A self-insurer is deemed to be a member of the association for purposes of another self-insurer's insolvency, as defined in subsection 6, when:

- (1) The self-insurer is a member of the association when an insolvency occurs; or
- (2) The self-insurer has been a member of the association at some point in time during the 36-month period immediately preceding the insolvency in question. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. A self-insurer is deemed to be a member of the association for purposes of its own insolvency when:

- (1) The self-insurer is a member of the association when the insolvency occurs, but claims relating to a compensable event that occurred prior to the date the self-insurer joined the association are not included under this paragraph; or

(2) The self-insurer becomes insolvent after leaving the association, but claims relating to a compensable event that occurred prior to the date the self-insurer joined the association are not included under this paragraph, and claims relating to a compensable event that occurred after the self-insurer ceased to be an approved self-insurer are not afforded coverage under this paragraph. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. In determining the membership of the association pursuant to paragraphs A and B, no employer claiming self-insurer status may be deemed to be a member of the association, unless that employer is at that time registered as a self-insurer by the Superintendent of Insurance pursuant to section 403, subsection 16. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. In determining membership in the association for the purposes of annual postinsolvency assessments, a successor employer approved for continuing self-insurance authority under section 403, subsection 14 or a successor employer qualifying and receiving a refund under section 403, subsection 14, paragraph H, subparagraph (1) is deemed to be a member of the association from the date of the former employer's initial self-insurance authorization. [1995, c. 594, §7 (NEW).]

E. In determining membership in the association for the purposes of annual or postinsolvency assessments, an employer that ceases to be an approved self-insurer under this Act at the time an insolvency occurs or has occurred, or during the 36-month period immediately preceding an insolvency, continues to be a member of the association for the purposes of annual or postinsolvency assessments even if that employer is acquired or merges with another entity, dissolves, ceases to do business in the State or otherwise changes business form resulting in a new legal entity. An employer qualifying for membership under this paragraph shall notify the Maine Self-Insurance Guarantee Association of all changes affecting ownership and provide information necessary for the association to be able to levy assessments. In addition to any other remedies provided by law, the superintendent is authorized to issue an order amending the terms and conditions of the termination plan of any former self-insurer in order to enforce this paragraph. [1995, c. 594, §7 (NEW).]

[1997, c. 126, §10 (AMD) .]

3. Board of directors. The board of directors of the association consists of at least 7 persons serving terms as established in the plan of operation pursuant to subsection 5. The members of the board must be selected by the member self-insurers, subject to the approval of the Superintendent of Insurance. Vacancies on the board must be filled for the remaining period of the term in the same manner as initial appointments, except that vacancies may be filled by majority vote of the remaining directors, subject to the approval of the superintendent, until the next annual meeting of the members.

In approving selections to the board, the superintendent shall consider among other things whether all member self-insurers are fairly represented.

Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Powers and duties of association. The powers and duties of the association are as follows.

A. The association:

(2) Shall assess each member of the association as follows:

(a) Each individual self-insurer must be annually assessed an amount equal to 1% of the annual standard premium that would have been paid by that individual self-insurer during the prior calendar year; payment to the association must be made by September 15th following the close of that calendar year. When any such assessment is paid based in whole or in part upon

estimates of annual standard premium for the prior calendar year, the next year's assessment must include an adjustment of the assessment of that prior year based on actual audited annual standard premium;

(b) Each group self-insurer must be annually assessed an amount equal to .1% of the total annual standard premium that would have been paid by all the members of that group self-insurer during the prior calendar year; payment to the association must be made by September 15th following the close of that calendar year. When any such assessment is paid based in whole or in part upon estimates of annual standard premium for the prior calendar year, the next year's assessment must include an adjustment of the assessment of that prior year based on actual audited annual standard premium;

(c) Each member self-insurer must be notified of the assessment at least 30 days before it is due;

(d) If a self-insurer is a member of the association for less than a full calendar year, the annual standard premium must be adjusted by that portion of the year the self-insurer is not a member of the association;

(e) If application of the contribution rates referred to in divisions (a) and (b) would produce an amount in excess of the limits of the fund established in subparagraph (3), an equitable proration must be made; and

(f) Upon notification by the superintendent, pursuant to subsection 7, paragraph C, of the existence and identity of a new member self-insurer and regardless of the size of the fund referred to in subparagraph (3), the association shall assess each new member self-insurer annually, whether individual or group, in accordance with divisions (a) and (b) for the first 30 months of its membership in the association. An individual or group self-insurer may not discount or reduce its assessment during the first 30 months of membership as determined in accordance with the superintendent's notification of new member status;

(3) Shall administer a fund, to be known as the Maine Self-Insurance Guarantee Fund, which must receive the assessments required in subparagraph (2). This fund may not exceed \$2,000,000, except that once the fund reaches \$2,000,000, the fund may not exceed \$2,000,000 plus all subsequent initial assessments of new member self-insurers that are required to be made in subparagraph (2), division (f) and interest income. In the event the fund drops below \$2,000,000, and if the association determines it necessary in order to carry out the purpose of this section, the association is authorized to levy annual assessments as required in subparagraph (2) in addition to postinsolvency assessments as required by paragraph C. The costs of administration by the association must be borne by the fund and the association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the fund to effectuate the purpose of the association, subject to the approval of the Superintendent of Insurance.

(a) The association may purchase primary excess insurance from an insurer licensed in this State for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one or more of its members. Any excess insurance so purchased must be limited to coverage of postassessment liability of the association's members and the association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered funds available that have not been raised by imposition of any preassessment or postassessment. The association may obtain from each member any information it may reasonably require in order to facilitate the securing of this primary excess insurance. The association shall establish reasonable safeguards designed to ensure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Is obligated to the extent of covered claims occurring prior to the determination of the self-insurer's insolvency or occurring after such determination but prior to the obtaining of workers' compensation insurance by the self-insurer as otherwise required under this Title. Nothing in this

section obligates the association to pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this section.

(a) For the purposes of this subsection, "covered claim" means an unpaid claim against an insolvent self-insurer that relates to an injury that occurs while the self-insurer is a member of the association and that is compensable under this Act;

(5) After paying any claim resulting from a self-insurer's insolvency, is subrogated to the rights of the injured employee and dependents and is entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Shall assess the fund in an amount necessary to pay:

(a) The obligations for the association under this section subsequent to an insolvency;

(b) The expenses of handling covered claims subsequent to an insolvency;

(c) The costs of examinations under subsection 8; and

(d) Other expenses authorized by this chapter;

(7) Shall investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association may review settlements to which an insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Shall notify the persons that the Superintendent of Insurance directs under subsection 7;

(9) Shall handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Superintendent of Insurance, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association;

(11) Shall pay the other expenses of the association authorized by this section; and

(12) Shall establish in the plan of operation a mechanism to calculate the assessments required by subparagraphs (1), (2) and (3) by a simple and equitable means to convert from policy or fund years that are different from a calendar year. [1997, c. 126, §11 (AMD).]

B. The association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The following pertains to postinsolvency assessment.

(1) In the event the assets of the fund are not sufficient to pay the obligations of the association, the association shall make an additional assessment as follows.

(a) Each individual self-insurer must be assessed an amount not in excess of 4% each year of the annual standard premium that would have been paid by the individual self-insurer during the prior calendar year. The assessments of each member individual self-insurer must be in the proportion that the annual standard premium of the individual self-insurer for the preceding calendar year bears to the annual standard premium of all member self-insurers for the preceding calendar year.

(b) Each group self-insurer must be assessed an amount not in excess of .2% each year of the total annual standard premium that would have been paid by all the members of that group self-insurer during the prior calendar year. The assessments of each member group self-insurer must be in the proportion that the annual standard premium of the group self-insurer for the preceding calendar year bears to the annual standard premium of all member self-insurers for the preceding calendar year.

(2) Each member self-insurer must be notified of the assessment no later than 30 days before it is due.

(3) The association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subparagraph (3), must bear interest at the rate to be established by the board, but not exceed the discount rate of the Federal Reserve Bank, Boston, Massachusetts, on the due date of the assessment, plus 4% annually, computed from the due date of the assessment.

(5) The association shall establish in the plan of operations a mechanism to calculate the assessments required by subparagraph (1) by a simple and equitable means to convert from policy or fund years that are different from a calendar year. [2001, c. 224, §2 (AMD).]

D. An individual self-insurer may not be assessed in any calendar year an amount greater than 4% of the annual standard premium that would have been paid by that self-insurer during the prior calendar year. A group self-insurer may not be assessed in any calendar year an amount greater than .25% of the total annual standard premium that would have been paid by all the members of that group self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the association shall secure financing as provided for in the plan of operation.

There must be established in the plan of operations a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from a policy or a fund year that is different from a calendar year. [2001, c. 224, §2 (AMD).]

E. For the purposes of this subsection, "annual standard premium for an individual self-insurer" means the annual premium produced by applying the advisory loss costs multiplied by 1.2, rating rules, excluding any premium discount, and experience rating procedure approved by the Superintendent of Insurance for the designated workers' compensation advisory organization pursuant to Title 24-A, section 2382-B, to the exposure and experience of the individual self-insurer. [1993, c. 491, §2 (AMD).]

F. For the purposes of this subsection, "annual standard premium for a group self-insurer" means the total annual premium that would have been paid by all members of that group using the advisory loss costs multiplied by 1.2, rating rules, excluding any premium discount, and experience rating procedure approved by the Superintendent of Insurance for the designated workers' compensation advisory organization pursuant to Title 24-A, section 2382-B, to the exposure and experience of the self-insurance group members. [1993, c. 491, §2 (AMD).]

[2001, c. 224, §2 (AMD).]

5. Plan of operation. The plan of operation is as follows.

A. The association shall submit to the Superintendent of Insurance a plan of operation and any amendments to it that are necessary to ensure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments to it become effective upon approval in writing by the superintendent. If the association fails to submit a suitable plan of operation or if the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, adopt rules that are necessary to administer this section. These rules continue in force until modified by the superintendent or the rules are superseded by a plan submitted by the association and approved by the superintendent. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. All member self-insurers shall comply with the plan of operation. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The plan of operation must:

(1) Establish the procedures by which all the powers and duties of the association under subsection 4 will be performed;

(2) Establish procedures for handling assets of the association;

(3) Adopt a reasonable mechanism and procedure to achieve equity in assessing the funds required in subsection 4, paragraph A, subparagraphs (1), (2) and (3); subsection 4, paragraph C, subparagraph (1); and subsection 4, paragraph D.

Consideration must be given to adjustments for audited payroll, differential effects caused by rate changes and other relevant factors;

(4) Establish the amount and method of reimbursing members of the board of directors under subsection 3;

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. A list of such claims must be periodically submitted to the association;

(6) Establish regular places and times for meetings of the board of directors;

(7) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(8) Provide that any member self-insurer aggrieved by any final action or decision of the association may appeal to the Superintendent of Insurance within 30 days after the action or decision;

(9) Establish the procedures by which selections for the board of directors are submitted to the Superintendent of Insurance; and

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Insolvency. A self-insurer is insolvent for the purposes of this section under the following circumstances:

A. Determination of insolvency by a court of competent jurisdiction; or [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. Institution of bankruptcy proceedings by or regarding the member self-insurer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Powers and duties of superintendent. The powers and duties of the Superintendent of Insurance are as follows.

A. The Superintendent of Insurance shall notify the association of the existence of an insolvent member self-insurer within 30 days of the date the superintendent receives notice of an insolvency pursuant to the standards set forth in subsection 6. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The Superintendent of Insurance may:

(1) Require that the association notify the insureds of the insolvent self-insurer and any other interested parties of the insolvency and of their rights under this section. Such notifications must be made by mail at their last known addresses, when available, but if required information for notification is not available, notice by publication in a newspaper of general circulation in this State is sufficient; and

(2) Revoke the designation of any servicing facility if the superintendent finds that claims are being handled unsatisfactorily. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. The Superintendent of Insurance shall notify the association of the existence and identity of each self-insurer that is a new member of the association within 30 days of the superintendent's determination of the self-insurer's membership. [1995, c. 398, §6 (NEW).]

D. On or before May 15th of each year, the Bureau of Insurance shall provide to the Maine Self-Insurance Guarantee Association the annual standard workers' compensation premium for each individual and group workers' compensation self-insurer and each individual and group workers' compensation self-insurer's payroll by class and experience modification factor for the previous calendar year. For the purposes of this paragraph, the definitions of annual standard premium in subsection 4 apply. The Maine Self-Insurance Guarantee Association may request additional information from workers' compensation self-insurers to verify the accuracy of the amounts reported. [1997, c. 126, §12 (NEW).]

[1997, c. 126, §12 (AMD) .]

8. Examination of association. The association is subject to examination and regulation by the Superintendent of Insurance. The board of directors shall submit, by March 30th of each year, a financial report for the preceding calendar year in a form approved by the superintendent.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Tax exemption. The association is exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real or personal property.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Immunity. There is no liability on the part of, and a cause of action of any nature does not arise against, any member self-insurer, the association or its agents or employees, the board of directors or its individual members, or the Superintendent of Insurance or the superintendent's representatives for any acts or omissions taken by them in the performance of their powers and duties under this chapter. The immunity established by this subsection does not extend to willful neglect or malfeasance that would otherwise be actionable.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

11. Nonduplication of recovery. Any person having a covered claim that may be recovered under more than one insurance or self-insurance guarantee association or its equivalent shall seek recovery first from the association of the place of residence of the claimant. Any recovery under this section must be reduced by the amount of recovery from any other insurance guarantee association or its equivalent.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

12. Stay of proceedings. All proceedings under this Act to which the insolvent insurer is a party either before the board or a court in this State and the running of all time periods against either the insolvent self-insurer or the association under this Act are stayed for 60 days from the date of notice to the association of the insolvency in order to permit the association to investigate, prosecute or defend properly any petition, claim or appeal under this Act. The payment of weekly compensation for incapacity under former Title 39, section 54, 54-A, 54-B, 55, 55-A, 55-B, 56, 56-A, or 56-B or under section 212 or 213 must be made during the time periods in which proceedings affecting the payment of weekly compensation are stayed.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

13. Disposition of assets upon dissolution. In the event of dissolution of the association, all assets remaining after provision for satisfaction of all outstanding claims must be distributed to the Treasurer of State for establishment of a reserve to satisfy potential claims against the association and, when all claims are satisfied, for inclusion in the general assets of the State.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

14. Statistical advisory organization.

[2011, c. 83, §3 (RP) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 491, §2 (AMD). 1993, c. 610, §3 (AMD). 1995, c. 398, §§5,6 (AMD). 1995, c. 594, §§7,8 (AMD). 1997, c. 126, §§10-12 (AMD). 2001, c. 224, §2 (AMD). 2011, c. 83, §3 (AMD).

§405. VOLUNTARY ELECTION

Any private employer, any of whose employees are exempt from this Act, may become subject to this Act with respect to the employer's employees and the act of the employer in securing the payment of compensation to such employee or class of employees in conformity with sections 401 to 407 constitutes the employer's election to become subject to this Act without any further act on the employer's part, but only for that employee or that class of employees for whom the employer has secured compensation as provided in sections 401 to 407, except that, for any employer who secures compensation by making a contract of workers' compensation insurance, the election is deemed to have been made on the effective date of the insurance policy. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§406. NOTICES OF ASSENT TO BE POSTED

A notice in a form as the board approves, stating that the employer has conformed to this Act, together with other information as the board determines, must be posted by the employer and kept posted by the employer in each of the employer's mills, factories or places of business. The notice must be conspicuous and posted in a place accessible to the employer's employees. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§407. PRESERVATION OF EXISTING EMPLOYER STATUS

An employer with a currently approved workers' compensation policy or a currently accepted self-insurance policy under sections 401 to 407 is deemed to be in compliance with this Act until the expiration or cancellation date of the current assent based on the policy or plan. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§408. WAIVER OF RIGHT OF ACTION; MINORS

Except as provided in subsection 2, an employee of an employer who has secured the payment of compensation as provided in sections 401 to 407 is deemed to have waived the employee's right of action at common law and under section 104 to recover damages for the injuries sustained by the employee. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Legally employed minors. A minor is deemed sui juris for the purpose of this Act if the minor's employer was not in violation of Title 26, section 771, 772 or 773 at the time of the minor's injury. No other person has any cause of action or right to compensation for an injury to that minor employee except as provided in this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Illegally employed minors. A minor is not deemed to have waived the minor's right of action at common law and under section 104 if the minor's employer was in violation of Title 26, section 771, 772 or 773 at the time of the minor's injury.

A. The minor employee, the minor's parent or guardian or any other person, as permitted by common law or statute, may file a civil action permitted under this subsection. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. The minor employee is entitled to compensation under this Act in addition to any right of action permitted under this subsection. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. If the employer is self-insured for liability under this Act, any award received by the minor in an action permitted under this subsection must be reduced by the amount of compensation received under this Act. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

D. If the employer is insured for liability under this Act, the employer is considered a 3rd party under section 107, and the employer's insurer is entitled to all rights of subrogation, contribution or other rights granted to an employer under section 107. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§409. ASSESSMENT FOR THE EXPENSES OF ADMINISTERING THE SELF-INSURER'S WORKERS' COMPENSATION PROGRAM

The Superintendent of Insurance shall annually make an assessment on self-insuring employers approved pursuant to section 403, respecting the operations of each self-insurer conducted in the State to defray the cost of administration of the Bureau of Insurance. On or before March 1st of each year, every individual workers' compensation self-insurer and group workers' compensation self-insurer shall report to the superintendent the self-insurer's experience modification factor for the previous calendar year. The superintendent shall calculate the amount of annual standard premium that would have been paid during the previous calendar year for every individual workers' compensation self-insurer and group workers' compensation self-insurer. The annual assessment upon approved self-insuring employers must be calculated using the imputed annual standard premium relating to business operations in the State that each self-insurer would have paid during the previous calendar year pursuant to manual rates established by the principal rating organization in the State and using the experience rating procedure approved by the Superintendent of Insurance for that self-insurer. For the purposes of this section, the definitions of annual standard premium in section 404, subsection 4 apply. The assessment must be applied to the budget of the bureau for the fiscal year commencing July 1st. The assessment must be in an amount not exceeding 11/100 of 1% of the imputed annual standard premium. When the superintendent calculates the amount of the annual assessment, the superintendent may consider, among other things, the staffing level required to administer workers' compensation self-insurance oversight responsibilities of the bureau. All information filed by self-insurers in compliance with this section is confidential in accordance with section 403, subsection 15. [1997, c. 126, §13 (AMD).]

1. Annual standard premium. The superintendent shall utilize the annual standard premium for each approved self-insurer as calculated by the Bureau of Insurance pursuant to this section in determining the amount of the assessment.

[1997, c. 126, §14 (AMD) .]

2. Expense of examination. The expense of examination of group self-insurers subject to section 403, subsection 5, paragraph I is payable by the person examined.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Minimum assessment. In any year in which a self-insurer has no annual standard premium in the State or in which the annual standard premium is not sufficient to produce at the rate prescribed by law an amount equal to or in excess of \$100, the minimum assessment payable by any self-insurer is \$100.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Notification of assessment. On or before July 1st, next following receipt of the report from the Maine Self-Insurance Guarantee Association, the Superintendent of Insurance shall notify each self-insurer of the assessment due.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Time of payment. Payment must be made on or before August 10th.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Revocation or termination. If the assessment is not paid on or before the prescribed date, the right of any individual or group to continue the option of self-insurance may be revoked or terminated by the Superintendent of Insurance.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Recalculation of assessment. Immediately following the close of the fiscal year ending June 30, 1987, and at the close of each 2nd succeeding fiscal year, the Superintendent of Insurance shall recalculate the assessment on each self-insurer subject to this section. If, in any instance, any assessment paid under this section is based in whole or in part on the annual standard premium estimated in the calendar year utilized for assessment purposes, the recalculation must recognize the actual audited annual standard premium, as available, for each affected self-insurer. Actual expenditures of the Bureau of Insurance during the preceding fiscal year must also be recognized. On or before October 1st, the Superintendent of Insurance shall render to each self-insurer a statement showing the difference between the self-insurer's respective recalculated assessment and the amount paid during the preceding biennium. Any overpayment of annual assessment resulting from complying with the requirements of this section must be refunded or, at the option of the assessed party, applied as a credit against the assessment for the succeeding fiscal year. Any overpayment of \$100 or less must be applied as a credit against the assessment for the succeeding fiscal year.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Deposit with Treasurer of State. The Superintendent of Insurance shall deposit all payments made pursuant to this section with the Treasurer of State. The money must be used for the sole purpose of paying the expenses of the Bureau of Insurance for administration of the Self-insurer's Workers' Compensation Program.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Exclusions. This section does not apply to the State or the University of Maine System.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Applicability. This section applies with respect to fiscal years commencing on or after July 1, 1986.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 313, §40 (AMD). 1997, c. 126, §§13,14 (AMD).

Part 2: OCCUPATIONAL DISEASE LAW ENACTED BY PL 1991, C. 885, PT.A, §8

Chapter 15: OCCUPATIONAL DISEASE LAW

§601. SHORT TITLE

This chapter may be known and cited as the "Occupational Disease Law." [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§602. APPLICATION

Except as otherwise specifically provided, incapacity to work or death of an employee arising out of and in the course of employment and resulting from an occupational disease must be treated as the happening of a personal injury arising out of and in the course of the employment, within the meaning of the former Workers' Compensation Act or the Maine Workers' Compensation Act of 1992, and all the provisions of the applicable Act apply to that occupational disease. This chapter applies only to cases in which the last exposure to an occupational disease in an occupation subject to the hazards of that disease occurred in the State and after January 1, 1946. [1995, c. 462, Pt. A, §80 (AMD).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 462, §A80 (AMD).

§603. OCCUPATIONAL DISEASE DEFINED

As used in this chapter, the term "occupational disease" means only a disease that is due to causes and conditions characteristic of a particular trade, occupation, process or employment and that arises out of and in the course of employment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§604. FALSE REPORTS

Compensation is not payable for an occupational disease if the employee who was employed on January 1, 1946 or who, at the time of entering into the employment of the employer by whom the compensation would otherwise be payable, falsely represents in writing that the employee has not previously been disabled, laid off or compensated in damages or otherwise because of such disease. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§605. AGGRAVATION OF OCCUPATIONAL DISEASE

When an occupational disease is aggravated by any other disease or infirmity not itself compensable, or death or incapacity from any other cause not itself compensable is aggravated, prolonged, accelerated or in any way contributed to by an occupational disease, the compensation payable must be reduced and limited to the proportion only of the compensation that would be payable if the occupational disease were the sole

cause of the incapacity or death as the occupational disease, as a causative factor, bears to all the causes of that incapacity or death, the reduction in compensation to be effected by reducing the number of weekly or monthly payments or the amounts of the payments as, under the circumstances of the particular case, may be for the best interest of the claimant or claimants. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§606. DATE FROM WHICH COMPENSATION IS COMPUTED; EMPLOYER LIABLE

The date when an employee becomes incapacitated by an occupational disease from performing the employee's work in the last occupation in which the employee was injuriously exposed to the hazards of the occupational disease is the date of the injury equivalent to the date of injury under the former Workers' Compensation Act or the Maine Workers' Compensation Act of 1992. When compensation is payable for an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of the occupational disease and the insurance carrier, if any, on the risk when the employee was last exposed under that employer, are liable. The amount of the compensation must be based on the average wages of the employee on the date of injury. Notice of injury and claim for compensation must be given to the employer in whose employment the employee was last injuriously exposed to the hazards of the occupational disease. On the date of incapacity, if the employee is no longer working in the same occupation in which the employee incurred the last injurious exposure, then the average wages as of the date of injury of comparable employees employed full-time in the same occupation as the employee at the time of the employee's last injurious exposure must be used to determine the amount of compensation. The only employer and insurance carrier liable are the last employer in whose employment the employee was last injuriously exposed to the hazards of the disease during a period of 60 days or more and the insurance carrier, if any, on the risk when the employee was last so exposed, under that employer. [2007, c. 313, §1 (AMD).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 462, §A81 (AMD). 2007, c. 313, §1 (AMD).

§607. NOTICE OF INCAPACITY; FILING OF CLAIM

Sections 301 to 307 with reference to giving notice, making claims and filing petitions apply to cases under this chapter, except that, in cases under this chapter, the date of incapacity defined in section 606 is equal to the date of injury in sections 301 to 307, and the notice under section 301 must include the employee's name and address, the nature of the occupational disease, the date of incapacity, the name of the employer in whose employment the employee was last injuriously exposed for a period of 60 days to the hazards of the disease and the date when employment with that employer ceased. After compensation payments for an occupational disease have been legally discontinued, claim for further compensation for that occupational disease not due to further exposure to an occupational hazard tending to cause that disease are barred if not made within one year after the last previous payment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§608. PARTIAL INCAPACITY

Compensation is payable for partial incapacity due to occupational diseases as provided in section 213. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§609. COMPENSATION LIMITS

Compensation for partial or total incapacity or death from occupational disease is payable as provided in sections 212, 213 and 215. Compensation is not payable for incapacity by reason of occupational diseases unless the incapacity results within 3 years after the last injurious exposure to the occupational disease in the employment. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The 3-year limitation under this section does not apply to a full-time firefighter who files a claim for an occupationally related cancer under this chapter and whose last injurious exposure to a carcinogen in the employer's employment occurred after January 1, 1985. For the purposes of this section, "full-time firefighter" means a regular full-time member, active or retired, of a municipal fire department if that person has aided in the extinguishment of fires, whether or not that person had administrative duties or other duties as a member of the municipal fire department. [1993, c. 1, §142 (NEW).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). RR 1993, c. 1, §142 (COR).

§610. EXAMINATION OF EMPLOYEES

An employer may request any of the employer's employees or prospective employees to be examined for the purpose of ascertaining if any of them are in any degree affected by an occupational disease or peculiarly susceptible to an occupational disease. Refusal to submit to such an examination bars that employee or prospective employee from compensation or other benefits provided by this chapter resulting from exposure to the hazards of occupational disease subsequent to the employee's refusal and while in the employ of the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§611. IMPARTIAL MEDICAL ADVICE

On request of a party or on its own motion the board may in occupational disease cases appoint one or more competent and impartial physicians. Upon order of the board, the fees and expenses of the health care provider or health care providers must be paid by the employer. These appointees shall examine the employee and inspect the industrial conditions under which the employee has worked in order to determine the nature, extent and probable duration of the occupational disease, the likelihood of its origin in the industry and the date of incapacity. Section 207 applies to the filing and subsequent proceedings on the report of the appointees and to examinations and treatments by the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If a claim is made for death from an occupational disease, an autopsy may be ordered by the board under the supervision of impartial appointees. All proceedings for or payments of compensation to any claimant refusing to permit such an autopsy when ordered are suspended on and during the continuance of such a refusal. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§612. OCCUPATIONAL LOSS OF HEARING

In case of loss of hearing resulting from occupational disease, the following rules are applicable in determining eligibility for compensation and the period during which compensation is payable. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Definition. As used in this chapter, "occupational hearing loss" means a sensorineural loss of hearing in one or both ears due to prolonged exposure to injurious noise in employment. Injurious noise means sound capable of producing occupational hearing loss.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Limitations on sound frequencies. Losses of hearing due to industrial noise for compensation purposes is limited to the frequencies of 500, 1,000 and 2,000 cycles per second. Loss of hearing ability for frequency tones above 2,000 cycles per second does not constitute disability for hearing.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Determination of hearing loss. The percent of hearing loss, for purposes of the determination of compensation claims for occupational deafness, must be calculated as the average, in decibels, of the thresholds of hearing for the frequencies of 500, 1,000 and 2,000 cycles per second. Hearing levels must be measured by means of pure-tone air-conduction audiometric instruments calibrated in accordance with American National Standards Institute Standards S3.6-1969-R 1973 and S3.13-1972, referred to in this section as the "ANSI standard," or American Standards Association Standard Z24.5, 1951, referred to in this section as the "ASA standard," and in an area with ambient noise level within the limits specified in American National Standards Institute Criteria for Background Noise in Audiometric Room Standard S3.1, 1960-R 1977. If the losses of hearing average 25 decibels or less under the ANSI standard or 15 decibels or less under the ASA standard in the 3 frequencies, the losses of hearing do not constitute a compensable hearing disability. If the losses of hearing average 92 decibels or more under the ANSI standard or 82 decibels or more under the ASA standard in the 3 frequencies, then the losses are deemed a 100% compensable hearing loss.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Compensation payable. Permanent partial disability is payable as follows:

A. For total occupational deafness of one ear, 50 weeks of compensation; [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

B. For total occupational deafness of both ears, 200 weeks of compensation; and [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. For partial occupational deafness in one or both ears, compensation is payable for those periods as are proportionate to the relation that the hearing loss bears to the amount provided in this subsection for total loss of hearing in one or both ears, as the case may be. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The amount of hearing loss must be reduced by the average amount of hearing loss from nonoccupational causes found in the population at any given age.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Measurement of hearing impairment. In measuring hearing impairment, the lowest measured losses in each of the 3 frequencies must be added together and divided by 3 to determine the average decibel loss. For every decibel of loss exceeding 15 decibels under the ASA standard or 25 decibels under the ANSI standard, an allowance of 1 1/2% must be made up to the maximum of 100%, which is reached at 82 decibels under the ASA standard or 92 decibels under the ANSI standard.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Hearing impairment in both ears. In determining the percentage of loss in both ears, the percentage of impairment in the better ear is multiplied by 5. The resulting figure is added to the percentage of impairment in the poorer ear, and the sum of the 2 divided by 6. The final percentage represents the hearing impairment for both ears.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Deductions by age. Before determining the percentage of hearing impairment, in order to allow for the average amount of hearing loss from nonoccupational causes found in the population at any given age, 1/2 decibel for each year of the employee's age over 40 at the time of last exposure to industrial noise must be deducted from the total average decibel loss.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. Filing of claims. A claim for compensation for occupational deafness may not be filed until after the employee has been separated from the occupational noise for a period of at least 30 days. The last day of this period is the date of disability. "Separation from the occupational noise" means the use of hearing protective devices or equipment, including noise attenuators and ear plugs.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. Employers limit of liability. An employer is liable for the entire occupational deafness to which the employment has contributed, except that, if previous deafness is established by a hearing test or by other competent evidence, whether or not the employee was exposed to noise within 30 days preceding the test, the employer is not liable for previous loss so established. In addition, the employer is not liable for any loss for which compensation has previously been paid or awarded.

An employer is not liable for the payment of compensation for occupational deafness unless the employee claiming benefits has worked for the employer in employment exposing the employee to harmful noise for a total period of at least 90 days.

Consideration may not be given to the question of whether or not the ability of an employee to understand speech is improved by the use of a hearing aid.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

10. Restriction on liability. Compensation is not payable for temporary disability for loss of hearing due to exposure to injurious noise in employment.

[2001, c. 1, §47 (COR) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). RR 2001, c. 1, §47 (COR).

§613. SILICOSIS

In the absence of evidence in favor of the claim, disability or death from silicosis is presumed not to be due to the nature of any occupation, unless during the 15 years immediately preceding the date of disability the employee was exposed to the inhalation of silica dust over a period of at least 2 years. If the employee has been employed by the same employer during the whole of the 2-year period, the employee's right to compensation against such employer is affected by the fact that the employee had been employed during any part of the 2-year period outside of the State. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§614. SPECIAL PROVISIONS FOR ASBESTOS-RELATED DISEASES

1. Definition. As used in this section, the term "asbestos-related disease" means a disease caused by exposure to asbestos.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Scope. This section applies only to asbestos-related diseases caused or contributed to by a last injurious exposure to asbestos that occurred on or after November 30, 1967.

Except as otherwise provided in this section, all provisions of this chapter apply to asbestos-related diseases.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Aggravation of condition. Section 605 does not apply to asbestos-related diseases.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. Last employer liable; notice. Notwithstanding section 606, the only employer and insurance carrier liable is the last employer in whose employment the employee was last injuriously exposed to asbestos, and the insurance carrier, if any, on the risk when the employee was last so exposed under that employer. Notice of incapacity under section 607 must include the name of that employer and the date when employment with that employer ceased.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. Compensation limit. The 3-year limit provided in section 609 does not apply to asbestos-related diseases.

Nothing in this section may be construed to require retroactive payments of compensation for periods of incapacity that occurred prior to October 1, 1983 or retroactive payments of death benefits for periods of time prior to October 1, 1983. Compensation for claims permitted under this section is payable only for periods of incapacity occurring after October 1, 1983.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. Further compensation. Notwithstanding section 607, after compensation payments for incapacity or death caused by an asbestos-related disease have been legally discontinued, a claim for further compensation for that disease not due to further exposure to asbestos in that employment is barred if not made within 40 years after the last previous payment.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. Compensation benefits. Compensation under this section is paid as follows.

A. If an employee is determined to be entitled to compensation for periods of total incapacity occurring on or after October 1, 1983, or if a dependent of an employee is determined to be entitled to full death benefits for periods occurring on or after October 1, 1983, and the employee became incapacitated or died on or after November 30, 1967 and before January 1, 1972, then the weekly compensation paid is equal to 2/3 of the average weekly wage in the State, as computed by the Department of Labor, that exists on the date the worker files a claim for compensation. If an employee is determined to be entitled to compensation for periods of partial incapacity occurring on or after October 1, 1983, and the employee became incapacitated on or after November 30, 1967 and before January 1, 1972, then the weekly compensation paid is equal to 2/3 of the difference, due to the injury, between the average weekly wage in the State, as computed by the Department of Labor, that exists on the date the worker files a claim for compensation and the weekly wages, earnings or salary that the employee is able to earn after the claim is filed. If a dependent of an employee is determined to be entitled to partial death benefits for periods occurring on or after October 1, 1983 and the employee died on or after November 30, 1967 and before January 1, 1972, then the weekly compensation paid is equal to the same proportion of the weekly payment provided in this paragraph for full death benefits, as the total amount contributed by the employee to such partial dependents for their support during the year prior to incapacity bears to the employee's earnings during that period. [1995, c. 560, Pt. G, §28 (AMD).]

B. If an employee is determined to be entitled to compensation for periods of total or partial incapacity occurring on or after October 1, 1983 or if a dependent of an employee is determined to be entitled to full or partial death benefits for periods occurring on or after October 1, 1983 and the employee became incapacitated or died on or after January 1, 1972 and before October 1, 1983, then the initial weekly compensation paid is equal to the compensation that would have been paid had compensation payments begun at the time the employee became incapacitated or died and that compensation had been adjusted annually as provided in former Title 39, section 54, 55 or 58, whichever section was applicable. This subsection may not be interpreted as providing for any adjustment for inflation in excess of the adjustment provided in former Title 39, section 54, 55 or 58. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

C. If an employee becomes incapacitated or dies on or after October 1, 1983, but before June 30, 1985, then compensation is payable in the same manner and amounts as provided in former Title 39, sections 54, 55 and 58. If an employee becomes incapacitated or dies on or after June 30, 1985 but before November 20, 1987, then compensation is payable in the same manner and amount as provided in former Title 39, sections 54-A, 55-A and 58-A. If an employee becomes incapacitated or dies on or after November 20, 1987 but before January 1, 1993, compensation is payable in the same manner and amount as provided in former Title 39, sections 54-B, 55-B and 58-A. If an employee becomes incapacitated or dies on or after January 1, 1993, compensation is payable in the same manner and amount as provided in sections 212, 213 and 215. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

[1995, c. 560, Pt. G, §28 (AMD) .]

8. Section not applicable. This section does not apply to an asbestos-related disease of any worker who, at the time of the last injurious exposure to asbestos, was covered by the federal Longshore and Harbor Workers' Compensation Act of March 4, 1927, Chapter 509, 33 United States Code, Section 901, or the Federal Employees Compensation Act, 5 United States Code, Section 8101. A worker is deemed to be covered by one of those acts if, at the time of the worker's last injurious exposure to asbestos, the worker was an employee, as defined by those federal acts, and was employed in employment that is subject to any of those federal acts.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1995, c. 560, §G28 (AMD).

§615. DISABILITY DUE TO RADIOACTIVE PROPERTIES

Notwithstanding section 606 or any other provision of this chapter, the employee need not be exposed to radioactive substances for a period of 60 days or more, and the time for filing claims does not begin to run in cases of incapacity due to exposure to radioactive substances until the later of the time after incapacity or the time the person claiming benefits knew, or by exercise of reasonable diligence should have known of the causal relationship between the employment and the employee's incapacity. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

Part 3: EMPLOYER'S LIABILITY ENACTED BY PL 1991, C. 885, PT. A, §8

Chapter 19: EMPLOYER'S LIABILITY

§901. DEFINITION OF EMPLOYER'S LIABILITY; RIGHTS OF EMPLOYEE

An employer is liable under this Part if personal injury is caused to an employee, who, at the time of the injury, is in the exercise of due care, by reason of: [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

1. Defects in ways, works or machinery. A defect in the condition of the ways, works or machinery connected with or used in the business of the employer, which arose from, or had not been discovered or remedied in consequence of, the negligence of the employer or of a person in the employer's service who had been entrusted by the employer with the duty of seeing that the ways, works or machinery were in proper condition;

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. Negligence of employee in superintending capacity. The negligence of a person in the service of the employer who was entrusted with and was exercising superintendence and whose sole or principal duty was that of superintendence or, in the absence of a superintendent, of a person acting as superintendent with the authority or consent of the employer; or

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. Negligence of employee in charge of railroad equipment. The negligence of a person in the service of the employer who was in charge or control of a signal, switch, locomotive engine or train on a railroad.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

The employee or the employer's legal representatives, subject to sections 902 to 909, have the same rights to compensation and of action against the employer as if the employee had not been an employee, nor in the service, nor engaged in the work of the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

A car that is in use by, or that is in possession of, a railroad corporation is deemed a part of the ways, works or machinery of the corporation that uses it or has it in possession, within the meaning of subsection 1, whether it is owned by the railroad corporation or by some other company or person. One or more cars in motion, whether attached to an engine or not, constitute a train within the meaning of subsection 3, and whoever, as a part of the person's duty for the time being, physically controls or directs the movements of a signal, switch, locomotive engine or train is deemed to be a person in charge or control of a signal, switch, locomotive engine or train within the meaning of said subsection. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§902. ACTIONS FOR DAMAGES FOR DEATH IN ADDITION TO THOSE FOR INJURY

If the injury described in section 901 results in the death of the employee, and the death is not instantaneous or is preceded by conscious suffering, and if there is any person who would have been entitled to bring an action under section 903, the legal representatives of the employee may, in the action brought under section 901, recover damages for the death in addition to those for the injury. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§903. SURVIVING SPOUSE OR NEXT OF KIN; ACTIONS BY

If, as the result of the negligence of an employer, or of a person for whose negligence an employer is liable under section 901, an employee is instantly killed or dies without conscious suffering, the surviving spouse or, if the employee leaves no surviving spouse, the next of kin, who, at the time of the employee's death, were dependent upon the wages of the employee for support, have a right of action for damages against the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§904. MEASURE OF DAMAGES IN EVENT OF DEATH

If, under either section 902 or 903, damages are awarded for the death, they must be assessed with reference to the degree of culpability of the employer or of the person for whose negligence the employer is liable. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The amount of damages that may be awarded in an action under section 901 for a personal injury to an employee, in which no damages for the death of the employee are awarded under section 902, may not exceed \$4,000. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The amount of damages that may be awarded in an action under section 901, if damages for the death of the employee are awarded under section 902, may not exceed \$5,000 for both the injury and the death, and must be apportioned by the jury between the legal representatives of the employee and the persons who would have been entitled, under section 903, to bring an action for the death of the employee if it had been instantaneous or without conscious suffering. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

The amount of damages that may be awarded in an action brought under section 903 may not be less than \$500 or more than \$5,000. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§905. NOTICE OF INJURY; REQUISITES; SUFFICIENCY; LIMITATION OF ACTIONS

An action for the recovery of damages for injury or death under sections 901 to 904 may not be maintained unless notice of the time, place and cause of the injury is given to the employer within 60 days and the action is commenced within one year after the accident that causes the injury or death. The notice must be in writing, signed by the person injured or by a person in behalf of the person. If it is impossible from

physical or mental incapacity for the person injured to give the notice within the time provided in this section, the person may give it within 10 days after the incapacity has been removed, and if the person dies without having given the notice and without having been for 10 days at any time after the injury of sufficient capacity to give it, the person's executor or administrator may give such notice within 60 days after appointment. A notice given under this section is not invalid or insufficient solely by reason of an inaccuracy in stating the time, place or cause of the injury, if it is shown that there was no intention to mislead and that the employer was not in fact misled by the inaccuracy. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

If a notice given under this section is claimed by the employer to be insufficient for any reason, the employer shall notify in writing the person giving it within 10 days, stating the insufficiency claimed to exist, and the person whose duty it is to give the notice may, within 30 days, give a new notice with the same effect as if originally given. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§906. LIABILITY NOT BARRED BY CONTRACTS WITH INDEPENDENT CONTRACTORS

If an employer enters into a contract, written or verbal, with an independent contractor to do part of the employer's work, or if an independent contractor enters into a contract with a subcontractor to do all or any part of the work comprised in the contractor's contract with the employer, the contract or subcontract does not bar the liability of the employer for injuries to the employees of the contractor or subcontractor, caused by any defect in the condition of the ways, works, machinery or plant, if they are the property of the employer or are furnished by the employer and if the defect arose, or had not been discovered or remedied, through the negligence of the employer or of some person entrusted by the employer with the duty of seeing that they were in proper condition. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§907. EMPLOYEE'S KNOWLEDGE OF DEFECT OR NEGLIGENCE

An employee or the employee's legal representatives are not entitled under sections 901 to 904 to any right of action for damages against the employer if the employee knew of the defect or negligence that caused the injury and failed within a reasonable time to give, or cause to be given, information about the defect to the employer or to some person superior to the employee in the service of the employer who was entrusted with general superintendence. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§908. SCOPE OF SECTIONS 901 TO 907; EFFECT OF JUDGMENT OR SETTLEMENT

Sections 901 to 907 do not apply to injuries caused to domestic servants or farm laborers by fellow employees or to those engaged in cutting, hauling or driving logs. Nothing in sections 901 to 907 may be construed to abridge any common-law rights or remedies which the employee may have against the employer, but a judgment recovered under sections 901 to 907 or a settlement of any action commenced or claim made

for death or injury under the provisions of those sections is a bar to any claim made or action begun to recover for the same injury or the same death, under the common law or under any other statute. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

§909. CONTRACTS FOR EXEMPTION

A person may not, by a special contract with the employer's employees, exempt the employer or another person from liability under which the employer may be to them for injuries suffered by them in the employment of the employer and resulting from the negligence of the employer or the other person, or of a person in the employ of the employer. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY

1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

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