CHAPTER 43
SURETY INSURANCE CONTRACTS

Section
3101. Contracts subject to general provisions.
3102. Acceptance as surety on bonds.
3103. Premiums on bonds.
3104. Notice of authorization to registers of probate.
3105. Estoppel to deny corporate power.

§ 3101. Contracts subject to general provisions

All contracts of surety insurance delivered or issued for delivery in this State and covering subjects resident, located, or to be performed in this State are also subject to the applicable provisions of chapter 27 (the insurance contract) and to other applicable provisions of this Title.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Principal and Surety ⇐52.
Encyclopedias
C.J.S. Principal and Surety §§ 292, 295.
WESTLAW Research
Principal and Surety cases: 309k[add key number]

§ 3102. Acceptance as surety on bonds

Any insurer duly authorized to transact surety insurance in this State may be accepted as surety upon the bond of any person required by the laws of the State to execute a bond. If such insurer shall furnish satisfactory evidence of its ability to provide all the security required by law, no additional surety may be exacted, but other surety or sureties may, in the discretion of the official authorized to approve such bond, be required. Such insurer may be released from its liability on the same terms and conditions as are by law prescribed for the release of individuals. It is the true intent and meaning of this section to

enable corporations created for that purpose to become surety on bonds required by law, subject to all the rights and liabilities of private individuals.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Principal and Surety ⇐52, 57.
Encyclopedias
C.J.S. Principal and Surety §§ 292, 294, 295.
WESTLAW Research
Principal and Surety cases: 309k[add key number]

§ 3103. Premiums on bonds

Any court or officer whose duty it is to pass upon the account of any person required by law to give a bond may, whenever such person has given any such surety insurer as surety upon the bond, allow in the settlement of such account a reasonable sum for the expense of procuring such surety. The premiums on account of all official bonds required by law to be given by county officials shall be paid from the treasuries of their several counties.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Trusts ⇐312.
Encyclopedias
C.J.S. Trusts § 394.
WESTLAW Research
Trusts cases: 390k[add key number]

§ 3104. Notice of authorization to registers of probate

Whenever any surety insurer is authorized to transact business in this State, the superintendent shall maintain the name of such insurer and the names of all agents of such insurer who have been licensed by him, their places of residence and the dates when their licenses will expire, and the names and addresses of all attorneys-in-fact registered with him.
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12; 1977, c. 330.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1977 Amendment. Laws 1977, c. 330 repealed and replaced this section, which formerly read:

"Whenever any surety insurer is authorized to transact business in this State, the superintendent shall forthwith transmit to each register of probate the name of such insurer and the names of all agents of such insurer who have been licensed by him, their places of residence and the dates when their licenses will expire, and the names and addresses of all attorneys in fact registered with him whose addresses are in the county of such register. He shall from time to time communicate to the registers of probate the names of all surety insurers which become authorized or cease to be authorized to transact business in this State. The registers shall preserve such lists on the files of the courts."

Library References

American Digest System
Insurance ⇐9.
Encyclopedias
C.J.S. Insurance § 73.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3105. Estoppel to deny corporate power

Any insurer which shall execute any bond as surety under section 3102 shall be estopped in any proceedings to enforce the liability which it shall have assumed to incur, to deny its corporate power or the authority of its attorney in fact within the scope of his power of attorney filed in accordance with section 413, to execute such instrument or assume such liability or the authority of any licensed agent to countersign such instrument.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Principal and Surety ⇐56.
Encyclopedias
C.J.S. Principal and Surety §§ 294, 295.
WESTLAW Research
Principal and Surety cases: 309k[add key number]

CHAPTER 45
TITLE INSURANCE CONTRACTS

Section
3201. Contracts subject to general provisions.

§ 3201. Contracts subject to general provisions

All contracts of title insurance delivered or issued for delivery in this State and covering subjects located in this State are subject to the applicable provisions of chapter 27 (the insurance contract) and to other applicable provisions of this Title.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐426.1, 507.1.
Encyclopedias
C.J.S. Insurance §§ 877 et seq., 966 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

CHAPTER 47

ORGANIZATION, CORPORATE POWERS, PROCEDURES OF DOMESTIC LEGAL RESERVE STOCK AND MUTUAL INSURERS

SUBCHAPTER I

ORGANIZATION AND GENERAL POWERS

Library References

American Digest System
Insurance ⇐31.1 et seq.
Encyclopedias
C.J.S. Insurance § 91 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3301. Scope of chapter

This chapter applies only as to domestic stock and mutual insurers transacting insurance on the cash premium or legal reserve plan.
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 788, § 107, eff. April 1, 1974.

Historical and Statutory Notes

Amendments

1973 Amendment. Laws 1973, c. 788, § 107, deleted from the end: "and applies as to such insurers in particular as follows:

"1. To each such insurer hereafter organized.

"2. To each such insurer heretofore organized under general laws."

§ 3302. Insurers to be organized under this Title

All domestic stock and mutual legal reserve insurers hereafter organized shall be organized under this Title, and not otherwise.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐32, 52.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3303. Reservation of power

The Legislature shall have power to amend, repeal or modify this Title at pleasure.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Statutes ⇐149.
Encyclopedias
C.J.S. Statutes §§ 150, 279.
WESTLAW Research
Statutes cases: 361k[add key number]

§ 3304. Applicability of general corporation statutes

Domestic stock and mutual insurers shall be governed by the applicable provisions of the general statutes of this State relating to private corporations organized for profit, as such statutes are now or hereafter may be constituted, except where such general statutes are in conflict with the express provisions of this Title and the reasonable implications thereof, and in which case the provisions of this Title shall govern.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐32, 52.

Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3305. "Stock," "mutual" insurers defined

1. A "stock" insurer is as defined in section 400.

2. A "mutual" insurer is as defined in section 401.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

Words and Phrases
Words and Phrases (Perm.Ed.)

§ 3306. Incorporation of domestic stock, mutual insurers

1. This section applies to stock and mutual insurers hereafter incorporated in this State. Such an insurer may be formed for the purpose of transacting any kind or kinds of insurance, as well as annuity business.

2. **Incorporators.** Three or more individuals, none of whom is less than 18 years of age, may incorporate a stock insurer; 10 or more such individuals may incorporate a mutual insurer. At least a majority of the incorporators must be citizens of the United States of America.

3. **Certificate of organization.** The incorporators shall execute a certificate of organization in quadruplicate, and at least a majority of the incorporators shall acknowledge their execution thereof under oath. The certificate of organization shall state and show:

A. The name of the corporation, which must be generally indicative of the business to be transacted and be subject to section 408 (name of insurer); if a mutual, the word "mutual" must be a part of the name. An alternative name or names may be specified for use in foreign countries, or in jurisdictions wherein conflict of name with that of another insurer or organization might otherwise prevent the corporation from being authorized to transact insurance therein;

B. The duration of its existence, which may be perpetual;

C. The kinds of insurance, as defined in this Title, which the corporation is formed to transact;

D. If a stock corporation, its authorized capital and the number of shares of stock into which divided. The capital stock shall consist entirely of common stock of one uniform class, par value not less than $1.00 per share, each outstanding share of which shall have equal rights in every respect with every other such share, except that treasury stock shall not have dividend or voting rights. Shares without par value shall not be authorized;

E. If a stock corporation the extent, if any, to which shares of its stock shall be subject to assessment;

F. If a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred. Such liability shall be as stated in the certificate of organization, but shall not be less than 1 or more than 6 times the premium for the member's policy at the annual premium rate for a term of one year;

G. If a mutual corporation, the amount, if any, of its guaranty capital shares, the number and par value of shares into which divided, the voting and other rights of such shares, and the conditions under which such shares shall or may be retired by the corporation, all consistent with section 3358 (guaranty capital shares);

H. The number of directors, not less than 3, who shall constitute the board of directors and conduct the affairs of the corporation; and the names, addresses and terms of the members of the initial board of directors, who shall conduct the corporation's affairs for the term specified in the certificate, but for not more than one year after date of incorporation;

I. The city or town, and county in this State in which the corporation's principal place of business is to be located;

J. The name, residence address and national citizenship of each incorporator;

K. Other provisions, not inconsistent with law, deemed appropriate by the incorporators, and including, in the case of life insurers, the power to act as trustee with respect to proceeds of maturity or death benefits payable under life insurance or annuity contracts issued or assumed by it.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 625, § 148, eff. July 5, 1973.

Historical and Statutory Notes

Amendments

1973 Amendment. Laws 1973, c. 625, § 148, lowered, in the first sentence of subsec. 2, the minimum age requirement to "18" years of age from "21" following "is less than".

Laws 1967, c. 92, § 2.
Laws 1967, c. 93, § 1.
Laws 1969, c. 132, § 11.
Former §§ 502, 507, 510 of title 24.

Derivation:
R.S.1954, c. 60, §§ 30, 35, 38.

Library References

American Digest System
Insurance ⇐32, 52.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3307. Certificate of organization, approval and filing

1. The incorporators of a proposed insurer shall deliver the quadruplicate originals of the certificate of organization to the superintendent. The superintendent shall deliver one set of such originals to the Attorney General of this State, and the Attorney General shall examine the same. If the Attorney

General finds that the certificate of organization complies with law, he shall so certify in writing and return the original of the certificate of organization, so certified, to the superintendent.

2. When the certificate of organization has been so approved and returned by the Attorney General, the superintendent shall also endorse his approval upon each set thereof and return the quadruplicate originals of the certificate of organization to the incorporators. The incorporators shall then file one of such sets with the Secretary of State of this State, one set with the superintendent bearing the certification of the Secretary of State, one set for recording in the registry of deeds of the county in this State in which the corporation's principal place of business is to be located, and shall retain the remaining set in the corporate records.

3. For filing the certificate of organization of a mutual insurer, the Secretary of State shall charge and collect a filing fee of $25; except that if it is a mutual insurance corporation with provision for guaranty capital shares, the Secretary of State shall charge and collect for the filing of the certificate of organization the same amount as would be payable by a stock insurance corporation having a like amount of authorized capital stock.

4. If the Attorney General finds that the proposed certificate of organization does not comply with law, he shall refuse to approve the same and shall return the set thereof to the superintendent, together with a written statement of the respects in which he finds that the certificate does not so comply. The superintendent shall thereupon return all sets of the proposed certificate of organization to the proposed incorporators together with the Attorney General's written statement.

5. The Secretary of State shall not permit the filing in that office of any such certificate unless the same bears the superintendent's approval endorsed thereon as hereinabove provided.

6. The approval of the Attorney General or superintendent, as hereinabove provided for, shall be deemed to relate only to the form and contents of the certificate, and shall not constitute approval or commitment as to any other aspect or operation of the proposed insurer or relative to its entitlement, if any, to a certificate of authority.

7. The superintendent and Attorney General shall perform all duties required of them under this section within a reasonable time after the certificate of organization has been submitted to the superintendent as provided in subsection 1.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Library References

American Digest System
Insurance ⇐32, 52.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3308. Certificate of Secretary of State

1. Upon filing with him of the certificate of organization of a proposed insurer as provided in section 3307, subsection 2, and payment of the charges and fees therefor, the Secretary of State shall issue to the corporation his certificate of organization in the following form:

"STATE OF MAINE

"Be it known, that whereas" (names of the incorporators) "have associated themselves with the intention of forming a corporation, under the name of ....., for the purpose" (here the purpose declared in the certificate of organization shall be inserted,) "with a capital stock of $....., and have complied with the provisions of the statutes of the State in such case made and provided, as appear from the certificate of organization, duly approved by the Insurance Superintendent and recorded in this office: Now, therefore, I, ..., Secretary of State of Maine, hereby certify that" (incorporators' names) "their associates and successors, are legally organized and established as, and are hereby made, an existing corporation under the name of the ..... company, with all the powers, rights and privileges, and subject to the duties, liabilities and restrictions which by law appertain thereto. Witness my official signature, hereunto subscribed, and the seal of the State of Maine hereunto affixed, this ..... day of ....., A.D. 19..." (In case of purely mutual companies, so much as relates to capital stock shall be omitted.)

2. The Secretary of State shall sign the same, and cause the seal of the State to be thereto affixed, and such certificate shall have the force and effect of a special charter and be conclusive evidence of the organization and establishment of such corporation. The certificate shall be duly recorded in the office of the Secretary of State, and a duly authenticated copy of such record may be used in evidence, with like effect as the original certificate.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, § 42.
Laws 1969, c. 132, § 11.
Former § 514 of title 24.

Library References

American Digest System
Insurance ⇐32, 52.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3309. Completion of incorporation; general powers, duties

The incorporation of an insurer shall be effective as of the date of issuance by the Secretary of State of his certificate as provided for in section 3308; and

thereupon the corporation shall be vested with all the powers, rights and privileges, and be subject to all the duties, liabilities and restrictions applicable to insurer corporations; subject to qualification and application for, and issuance to the corporation of, a certificate of authority as an insurer by the superintendent under this Title.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐36, 57.
Encyclopedias
C.J.S. Insurance §§ 99 et seq., 110.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3310. Amendment of certificate of organization; change of principal place of business

1. A stock insurer may amend its certificate of organization for any lawful purpose by authorization or vote of stockholders as provided for business corporations in general under the laws of this State applicable to such business corporations.

2. A mutual insurer may amend its certificate of organization for any lawful purpose by affirmative vote of a majority of those of its members entitled to vote and present or represented by proxy at a lawful meeting of its members of which the notice given members included due notice of the proposal to amend and the substance of such proposal, and by affirmative vote of the holders of at least ⅔ of the insurer's outstanding guaranty capital shares, if any.

3. Upon adoption of such an amendment, the insurer shall make in quadruplicate under its corporate seal a certificate, sometimes referred to as a "certificate of amendment", setting forth such amendment and the date and manner of the adoption thereof. The certificate shall be executed by the insurer's president or vice-president and secretary or assistant secretary and duly sworn to by one of them. The insurer shall deliver to the superintendent the quadruplicate originals of the certificate for review, certification and approval or disapproval by the Attorney General and the superintendent, and filing and recording, all as provided for original certificates of organization under section 3307. The Secretary of State shall charge and collect for the use of the State a fee of $20 for filing and recording the certificate of amendment of a mutual insurer. The amendment shall be effective when duly approved and filed with the Secretary of State.

4. An insurer may change its principal place of business without amendment of its certificate of organization, by resolution of its board of directors. A copy of such resolution, duly certified under oath by the corporate secretary, shall be

executed in quadruplicate and filed with the superintendent, the Secretary of State, the registry of deeds of the county in which the insurer's principal place of business was theretofore located, and in the corporate records. If the principal place of business is thereby changed to another county of this State, the insurer shall also file in the registry of deeds of such county a copy, duly certified by the superintendent, of its certificate of organization and of each amendment thereto, and a certified copy of the resolution by which the principal place of business was so changed.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, §§ 33, 46, 69.

Laws 1955, c. 289.
Laws 1957, c. 56.
Laws 1963, c. 50.
Laws 1965, c. 467, §§ 2, 3.
Laws 1967, c. 92, §§ 1, 5.
Laws 1969, c. 132, § 11.
Former §§ 505, 518, 594 of title 24.

Library References

American Digest System
Insurance ⇐32, 52 et seq.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3311. Insurance business exclusive; exceptions

1. No domestic insurer heretofore or hereafter formed shall engage in any business other than the insurance business and in business activities reasonably and necessarily incidental to such insurance business.

2. Except that:

A. A title insurer may also engage in business as an escrow agent

B. Any insurer may also engage in business activities reasonably related t the management, supervision, servicing of, and protection of its interests a to its lawful investments;

C. An insurer may own subsidiaries or subsidiaries owning other subsidia ies which may engage in such businesses all as provided for in section 111 (stocks of subsidiaries) or in section 1157 (investment in subsidiaries)

D. An insurer may utilize its facilities to perform administrative service for any governmental body, unit or agency; and

E. An insurer transacting business of a type described in section 702, lif insurance; section 703, annuity; or section 704, health insurance; or an combination of those types of business, may engage in any other business i

which it is otherwise qualified to engage to the extent and in the manner approved by the superintendent.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1987, c. 399, §§ 17, 18.

Historical and Statutory Notes

Amendments

1987 Amendment. Laws 1987, c. 399, in subsec. 2, in par. C, added "or in section 1157 (investment in subsidiaries)", and added par. E.

Library References

American Digest System
Insurance ⇐36, 57.
Encyclopedias
C.J.S. Insurance §§ 99 et seq., 110.
WESTLAW Research
Insurance cases: 217k[add key number]

SUBCHAPTER II

PROVISIONS APPLYING ONLY TO MUTUAL INSURERS

Section

Library References

American Digest System
Insurance ⇐5, 8, 52.
Encyclopedias
C.J.S. Insurance §§ 69, 72, 96, 104 et seq., 1413.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3352. Mutual insurers, initial qualifications

1. When hereafter newly organized, a mutual insurer may be authorized to transact any one of the kinds of insurance listed in the schedule contained in subsection 2 or any combination of such kinds as provided in subsection 3.

2. When applying for an original certificate of authority, the insurer must be otherwise qualified therefor under this Title, and must have received and accepted bona fide applications as to substantial insurable subjects for insurance coverage of a substantial character of the kind of insurance proposed to be transacted, must have collected in cash the full premium therefor at a rate not less than that usually charged by other insurers for comparable coverages, must have surplus funds on hand and deposited as of the date such insurance coverages are to become effective, or, in lieu of such applications, premiums and surplus, may deposit and thereafter maintain surplus, all in accordance with that part of the following schedule which applies to each kind of insurance the insurer proposes to transact:

(A) Kind of Ins.	(B) Min.No. of Apps. Accepted	(C) Min.No. Subjects Covered	(D) Minimum Premium Collected	(E) Minimum Amount Ins.Ea. Subject	(F) Maximum Amount Ins.Ea. Subject (5)	(G) Deposit Minimum Surplus Fund (6)	(H) Deposit Surplus in Lieu (7)
Life (1)	500	500	Annual	$ 2,500	$50,000	$1,000,000	$1,250,-000
Health (2)	500	500	Quarterly	100 (wkly. indem.)	300 (wkly. indem.)	500,000	750,-000
Property (3)	100	250	Annual	10,000	100,000	500,000	750,-000
Casualty (4)	250	500	Annual	25,000	100,000	750,000	1,000,000

The following provisions are respectively applicable to the foregoing schedule and provisions as indicated by like numerals appearing in such schedule:

(1) No group insurance or term policies for terms of less than 10 years may be included.

(2) No group, blanket or family plans of insurance may be included. In lieu of weekly indemnity, a like premium value in medical, surgical and hospital benefits may be provided. Any accidental death or dismemberment benefit provided shall not exceed $15,000.

(3) Only insurance of the owner's interest in real property may be included.

(4) Such insurance must include coverage of legal liability for bodily injury and property damage, to which the maximum and minimum insured amounts apply.

(5) The maximums provided for in column (F) are net of applicable reinsurance.

(6) The deposit of surplus in the amount specified in columns (G) and (H) must thereafter be maintained unimpaired. The deposit is subject to chapter 15 (administration of deposits).

(7) Deposit surplus, when utilized, in lieu of the alternative procedure of accepting deposit application funds shall be in those amounts enumerated for each identified kind of insurance.

Expendable surplus: In addition to surplus deposited and thereafter to be maintained as shown in columns (G) or (H), the insurer when first authorized must have on hand surplus funds, which it can thereafter expend in the conduct of its business, in amount not less than 50% of the applicable deposited and maintained surplus required of it under the schedule set up in this subsection.

Notwithstanding the requirements for expendable surplus otherwise required by this section for newly organized insurance companies seeking a certificate of authority in this State, any such insurer may transact legal services insurance, to the extent provided for in chapter 38,[1] without additional expendable funds, if the corporation is otherwise qualified for a certificate of authority to transact the business of health, life and health or multiple lines insurance, and possesses and thereafter maintains, in addition to the amounts enumerated in the table in this subsection, an additional amount of unimpaired basic surplus of not less than $500,000.

3. An insurer may initially qualify for authority to transact both life and health insurances by fulfilling the foregoing requirements as to each such kind of insurance; and may in like manner initially qualify for authority to transact both property and casualty insurance. An insurer shall not, however, so qualify to transact any other combination of such insurances, except as provided in section 3357.

4. Domestic mutual insurers, possessing a certificate of authority to conduct business solely on an assessment plan upon the effective date of this subsection, and newly organized assessment plan mutual insurers authorized after the effective date of this subsection shall be governed as to surplus funds requirements by the provisions of chapter 51.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1969, c. 177, § 57, eff. Jan. 2, 1970; 1983, c. 709, §§ 2, 3; 1983, c. 801, § 12.

[1] Section 2881 et seq. of this title.

Historical and Statutory Notes

Amendments

1969 Amendment. Laws 1969, c. 177, § 57, redesignated, in subsec. 2, pars. A to F as pars. (1) to (6).

1983 Amendments. Laws 1983, c. 709, § 2, repealed and replaced subsec. 2, which formerly set out a surplus schedule.

Laws 1983, c. 709, § 3, added subsec. 4.

Laws 1983, c. 801, § 12, in subsec. 2, added last par. authorizing an insurer to transact legal services insurance without expending additional funds if the insurer is otherwise qualified to transact health, life and health, or multiple lines insurance, and maintains an additional unimpaired basic surplus of not less than $500,000.

Derivation:

R.S.1954, c. 60, §§ 36, 37.
Laws 1967, c. 92, § 3.
Laws 1969, c. 132, § 11.
Former §§ 508, 509 of title 24.

§ 3353. Qualifying applications for insurance; bond or deposit

1. Before soliciting any applications for insurance required under section 3352 as qualification for the original certificate of authority, the incorporators of the proposed insurer shall file with the superintendent a corporate surety bond in the penalty of $15,000, in favor of the State of Maine and for use and benefit of the State of Maine and of applicant members and creditors of the corporation. The bond shall be conditioned as follows:

A. For the prompt return to applicant members of all premiums collected in advance;

B. For payment of all indebtedness of the corporation; and

C. For payment of costs incurred by the State of Maine in event of any legal proceedings for liquidation or dissolution of the corporation;

all in the event the corporation fails to complete its organization and secure a certificate of authority within one year after the date of its certificate of organization.

2. In lieu of such bond, the incorporators may deposit with the commissioner $15,000 in cash or United States government bonds, negotiable and payable to the bearer, with a market value at all times of not less than $15,000 and to be held in trust upon the same conditions as required for the bond.

3. The superintendent shall release and discharge any such bond filed or deposit or remaining portion thereof held under this section upon settlement and termination of all liabilities against it.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐58.
Encyclopedias
C.J.S. Insurance §§ 112, 113.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3354. Qualifying applications for insurance; solicitation

1. Upon receipt of the superintendent's approval of the bond or deposit as provided in section 3353, the directors and officers of the proposed domestic mutual insurer may commence solicitation of such requisite applications for insurance policies as they may accept, and may receive deposits of premiums thereon.

2. All such applications shall be in writing signed by the applicant, covering subjects of insurance resident, located or to be performed in this State.

3. All such applications shall provide that:

A. Issuance of the policy is contingent upon the insurer qualifying for and receiving a certificate of authority;

B. No insurance is in effect unless and until the certificate of authority has been issued; and

C. The prepaid premium or deposit, and membership or policy fee, if any, shall be refunded in full to the applicant if organization is not completed and the certificate of authority is not issued and received by the insurer before a specified reasonable date, which date shall be not later than one year after the date of the certificate of organization.

4. All qualifying premiums collected shall be in cash.

5. Solicitation for such qualifying applications for insurance shall be by licensed agents of the corporation, and the superintendent shall, upon the corporation's application therefor, issue temporary agent's licenses expiring on the date specified pursuant to subsection 3, paragraph C to individuals qualified as for a resident agent's license except as to the taking or passing of an examination. The superintendent may suspend or revoke any such license for any of the causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of agents in general under chapter 17.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐11, 58.
Encyclopedias
C.J.S. Insurance §§ 60 et seq., 112, 113.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3355. Deposit of qualifying premiums; effective date of insurance

1. All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance therein shall be deposited in trust in a bank or trust company in this State under a written trust agreement consistent

with this section and with section 3354, subsection 3, paragraph C. The corporation shall file an executed copy of such trust agreement with the superintendent.

2. Upon issuance to the corporation of a certificate of authority as an insurer for the kind or kinds of insurance for which such applications were solicited, all funds so held in trust shall become the funds of the insurer, and the insurer shall thereafter in due course issue and deliver its policies for which premiums had been paid and accepted. The insurance provided by such policies shall be effective as of the date of the certificate of authority or thereafter as provided by the respective policies.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐58, 175(1).
Encyclopedias
C.J.S. Insurance §§ 112, 113, 329 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3356. Failure to complete and qualify

If the proposed domestic mutual insurer fails to complete its organization and to secure its original certificate of authority within one year from and after date of its certificate of organization, its corporate powers shall cease, and the superintendent shall return or cause to be returned to the persons entitled thereto all advance deposits or payments of premium held in trust under section 3355.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐58.
Encyclopedias
C.J.S. Insurance §§ 112, 113.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3357. Authority to transact additional kinds of insurance

After being authorized to transact one kind or combination of kinds of insurance as provided in section 3352, a mutual insurer may be authorized by the

superintendent to transact such additional kinds of insurance as are permitted under section 409 (combinations of insuring powers), while otherwise in compliance with this Title and while maintaining unimpaired surplus and guaranty capital funds in an amount not less than the amount of paid-in capital stock required to be maintained by a like domestic stock insurer transacting the same kinds of insurance.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐57(2).
Encyclopedias
C.J.S. Insurance § 110.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3358. Guaranty capital shares

1. A mutual insurer formed to transact or transacting any kind of insurance shall have the right to provide for guaranty capital shares in its certificate of organization. Outstanding guaranty capital shares at the par value thereof shall take the place of a like amount of basic surplus otherwise required for authority to transact insurance.

2. Shares of guaranty capital stock shall have a par value of $100 each, and shall be paid for in cash. Nothing in this Title shall be deemed to prohibit the sale of such shares at a price above such par value in order to provide the insurer with capital surplus.

3. Only one class of such guaranty capital shares shall be provided for, and each such share outstanding shall have equal voting, dividend, retirement and other rights with every other such share. Each such share shall have one vote on matters coming to a vote at meetings of the insurer's shareholders and members. Policyholders of the insurer shall have the same voting rights as would exist in the absence of such guaranty capital.

4. Noncumulative dividends, not exceeding in any one year 12% or lesser reasonable amount as determined by prevailing rates for loans of similar risk characteristics at the time the shares are issued, may be declared and paid by the insurer on outstanding guaranty capital shares out of that portion of the insurer's expendable surplus representing net realized earnings from its operations; and may be so paid even though the amount of the insurer's expendable surplus is then less in amount than any prior total of expendable contributed, borrowed or paid-in surplus. Such a dividend may be paid in cash or in guaranty capital shares, or part in each. An amount equal to the par value of shares so distributed as dividend shall be transferred from the insurer's earned surplus account to its guaranty capital shares account.

5. If the guaranty capital becomes impaired, the impairment shall be cured as provided in section 3423 (impairment of capital funds).

6. The insurer shall retire and cancel the guaranty capital shares, in part and in whole as soon as is reasonably possible, out of expendable surplus resulting from net realized earnings from its operations, or out of surplus created through issuance of agreements authorized by section 3415. The insurer shall retire and cancel the guaranty capital shares in their entirety when such retirement would, in the superintendent's opinion, leave the insurer with surplus as to policyholders reasonably adequate to enable it to continue to transact the kinds and volume of insurance business transacted.

7. In any liquidation of the insurer, outstanding guaranty capital shares shall have the same rights and priority as to the insurer's assets as are possessed by the stockholders of a like stock insurer.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12; 1981, c. 501, § 44.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1981 Amendment. Laws 1981, c. 501, § 44, in subsec. 4, in first sentence, substituted "12% or lesser reasonable amount as determined by prevailing rates for loans of similar risk characteristics at the time the shares are issued" for "7% of the amount paid to the insurer for the same".

Derivation:

R.S.1954, c. 60, §§ 35, 36.
Laws 1967, c. 92, §§ 2, 3.
Laws 1969, c. 132, § 11.
Former §§ 508, 509 of title 24.

Library References

American Digest System
Insurance ⇐52.
Encyclopedias
C.J.S. Insurance § 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3359. Bylaws

1. A domestic mutual insurer shall have bylaws for the government of its affairs. The insurer's initial board of directors shall adopt original bylaws, subject to the approval of the insurer's members at the next meeting of members.

2. The bylaws shall contain provisions, consistent with this Title, relating to:

A. The voting rights of members;

B. Election of directors, and the number, qualifications, terms of office and powers of directors;

C. Annual and special meetings of members;

D. The number, designation, election, terms and powers and duties of the respective corporate officers;

E. Deposit, custody, disbursement and accounting for corporate funds;

F. Fidelity bonds covering such officers and employees of the insurer as handle its funds, to be issued by a corporate surety and to be in such amount as may be reasonable; and

G. Such other matters as may be customary, necessary or convenient for the management or regulation of corporate affairs.

3. The insurer shall promptly file with the superintendent a copy, certified by the insurer's secretary, of its bylaws and of every modification thereof or addition thereto. The superintendent shall disapprove any bylaw provision deemed by him, after a hearing held thereon, to be unlawful, unreasonable, inadequate, unfair or detrimental to the proper interests or protection of the insurer's members or any class thereof. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision so disapproved.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐54.
Encyclopedias
C.J.S. Insurance § 107.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3360. Members are policyholders

1. Each policyholder of a domestic mutual insurer, other than of a reinsurance contract, is a member of the insurer with all rights and obligations of such membership, as the charter and as the policy shall so specify.

2. Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee or fiduciary may be a member of a domestic, foreign or alien mutual insurer. Any officer, stockholder, trustee or legal representative of any such corporation, board, association or estate may be recognized as acting for or on its behalf for the purpose of such membership, and shall not be personally liable upon any contract of insurance for acting in such representative capacity.

3. Any domestic corporation may participate as a member of a mutual insurer as an incidental purpose for which such corporation is organized, and as much granted as the rights and powers expressly conferred.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐55.
Encyclopedias
C.J.S. Insurance § 108.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3361. Meetings of members, in general

1. Meetings of members of a domestic mutual insurer shall be held in the city or town of its principal office in this State, except as may otherwise be provided in the insurer's bylaws with the superintendent's approval.

2. Each such insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its members to fill vacancies existing or occurring in the board of directors, receive and consider reports of the insurer's officers as to its affairs and transact such other business as may properly be brought before it.

3. Written notice of the time and place of the annual meeting of members shall be given members not less than 30 days prior to the meeting. Notice may be given by imprinting the notice plainly on the policies issued by the insurer or in any other appropriate manner. Any change of the date or place of the annual meeting shall be made only by an annual meeting of members. Notice of such change, among other appropriate methods, may be given:

A. By imprinting such new date or place on all policies which will be in effect as of the date of such changed meeting; or

B. Unless the superintendent otherwise orders, notice of the new date or place need be given only through policies issued after the date of the annual meeting at which such change was made and in premium notices and renewal certificates issued during the 24 months immediately following such meeting.

4. If more than 6 months are allowed to elapse after an annual meeting of members is due to be held and without such annual meeting being held, the superintendent shall, upon written request of any officer, director or member of the insurer, cause written notice of such meeting to be given to the insurer's members, and the meeting shall be held as soon as reasonably possible thereafter.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, §§ 39, 45.
Laws 1967, c. 381, § 1.
Laws 1969, c. 132, § 11.
Former §§ 511, 517 of title 24.

Library References

American Digest System
Insurance ⇐55.
Encyclopedias
C.J.S. Insurance § 108.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3362. Special meetings of members

1. A special meeting of the members of a mutual insurer may be held for any lawful purpose. The meeting shall be called by the corporate secretary pursuant to request of the insurer's president or of its board of directors, or upon request in writing signed by not less than 1/10 of the insurer's members. The meeting shall be held at such time as the secretary may fix, but not less than 10 nor more than 30 days after receipt of the request. If the secretary fails to issue such call, the president, directors or members making the request may do so.

2. Not less than 10 days' written notice of the meeting shall be given. Notice addressed to the insurer's members at their respective post-office addresses last of record with the insurer and deposited, postage prepaid, in a letter depository of the United States post office, shall be deemed to have been given when so mailed. In lieu of mailed notice, the insurer may publish the notice in such publication or publications as shall afford a majority of its members a reasonable opportunity to have actual advance notice of the meeting. The notice shall state the purposes of the meeting, and no business shall be transacted at the meeting of which notice was not so given.

1969, c. 132, § 1, eff. Jan. 1, 1970.

§ 3363. Voting rights of members

1. Each member of a mutual insurer is entitled to one vote upon each matter coming to a vote at a meeting of members, or to such other vote as may be provided for on a reasonable basis in the insurer's bylaws with the superintendent's approval.

2. A member shall have the right to vote in person or by his written proxy filed with the corporate secretary not less than 20 days prior to the meeting. No such proxy shall be made irrevocable, nor be valid beyond the earlier of the following dates:

A. The date of expiration set forth in the proxy; or

B. The date of termination of membership; or

C. 5 years from the date of execution of the proxy.

3. No member's vote upon any proposal to divest the insurer of its business or assets, or the major part thereof, shall be registered or taken, except in person or by proxy newly executed and specific as to the matter to be voted upon.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

§ 3364. Contingent liability of members

1. Except as provided otherwise in section 3367 with respect to nonassessable policies, each member of a domestic mutual insurer shall have a contingent liability, pro rata and not one for another, for the discharge of its obligations, which contingent liability shall not be greater than 6 times the annual premium for the member's policy at the annual premium rate, as shall be specified in the insurer's certificate of organization or bylaws.

2. Every policy issued by the insurer shall contain a plain and legible statement of the contingent liability upon either the face or back thereof.

3. Termination of the policy of any such member shall not relieve the member of contingent liability for his proportion of the obligations of the insurer which accrued while the policy was in force.

4. Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1981, c. 501, § 45.

Historical and Statutory Notes

Amendments

1981 Amendment. Laws 1981, c. 501, § 45, in subsec. 1, substituted "not be greater" for "be in such maximum amount not less than 1 or more".

Derivation:

R.S.1954, c. 60, § 35.
Laws 1967, c. 92, § 2.
Laws 1969, c. 132, § 11.
Former § 507 of title 24.

§ 3365. Levy of contingent liability

1. If at any time the assets of a domestic mutual insurer are less than its liabilities, exclusive of guaranty capital shares, if any, at par value, and the minimum amount of surplus required to be maintained by it under this Title for authority to transact the kinds of insurance being transacted, and the deficiency is not cured from other sources, its directors may, if the same is approved by the superintendent as being reasonable and in the best interests of the insurer and its members, levy an assessment only on its members who held the policies providing for contingent liability at any time within the 12 months next preceding the date the levy was authorized by the board of directors, and such members shall be liable to the insurer for the amount so assessed.

2. The levy of assessment shall be for such an amount as is required to cure such deficiency and to provide a reasonable amount of working funds above such minimum amount of surplus, but such working funds so provided shall not exceed 5% of the sum of the insurer's liabilities and such minimum required surplus as of the date of the levy.

3. As to the respective policies subject to the levy, the assessment shall be computed upon the basis of premium earned during the period covered by the levy.

4. No member shall have an offset or counterclaim against any assessment for which he is liable, on account of any claim for unearned premium or loss payable.

5. As to life insurance, any part of such an assessment upon a member which remains unpaid following notice of assessment, demand for payment, and lapse of a reasonable waiting period as specified in such notice, may, if approved by the superintendent as being in the best interests of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held or to be held by the insurer to the credit of the member's policy.
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, § 35.
Laws 1967, c. 92, § 2.
Laws 1969, c. 132, § 11.
Former § 507 of title 24.

Library References

American Digest System
Insurance ⇐191 to 193.
Encyclopedias
C.J.S. Insurance §§ 367 et seq., 378 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3366. Enforcement of contingent liability

1. The insurer shall notify each member of the amount of assessment to be paid, and the date—not less than 20 days after mailing date—by which payment is to be made, by written notice mailed to the member at his address last of record with the insurer. Failure of the member to receive the notice so mailed, within the time specified therein for the payment of the assessment or at all, shall be no defense in any action to collect the assessment.

2. If a member fails to pay the assessment within the period specified in the notice, the insurer may institute suit to collect the same.
1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐195.
Encyclopedias
C.J.S. Insurance § 369 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3367. Nonassessable policies; limits of assessability; use of funds; combination operations

1. A domestic mutual insurer may extinguish the contingent liability to assessment of its members as to cash premium plan policies in force and may omit provisions imposing contingent liability in such policies currently issued while it has and maintains surplus, as determined by its financial statement filed with the superintendent as of the year end next preceding, of not less than $100,000 as to an insurer formed prior to January 1, 1968, and of not less than $200,000 as to an insurer formed after January 1, 1968.

2. If the insurer after qualifying to issue such a nonassessable policy fails to maintain the applicable above requirement, it shall cease to issue nonassessable policies until it has again met and maintained the requirement for a period of one year.

3. Any assessment levied under the contingent liability provisions of the policy shall be for the exclusive benefit of the holders of policies subject to contingent liability, and such policyholders shall not be liable to assessment in an amount greater in proportion to the total deficiency than the ratio that the deficiency attributable to the contingently liable business bears to the total deficiency. An assessment shall apply only to the holders of the type of policy or plan under which the deficiency occurred, and funds received from the assessment shall be for the exclusive benefit of such holders.

4. Nothing in this chapter shall be deemed to prohibit a domestic mutual insurer formed prior to January 1, 1968 from at any one time transacting, in respective departments or divisions of its operations, insurance business on any two or all of the following bases:

A. Cash premium plan, without contingent liability to assessment, and issuance of nonassessable policies if qualified therefor as above provided in this section;

B. Cash premium plan, with contingent liability to assessment; and

C. Assessment plan.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐192.
Encyclopedias
C.J.S. Insurance § 378 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

SUBCHAPTER III

PROVISIONS APPLYING TO STOCK AND MUTUAL INSURERS

Section

Library References

American Digest System
Insurance ⇐32 et seq., 52 et seq.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3408. Home office, records, assets to be in State; exceptions

1. Every domestic insurer shall have and maintain its principal place of business and home office in this State, and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer.

2. Every domestic insurer shall have and maintain its assets in this State, except as to:

A. Real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this State;

B. Such property of the insurer as may be customary, necessary and convenient to enable and facilitate the operation of its branch offices located outside this State as referred to in subsection 4; and

C. United States public obligations and other corporate securities for which definitive certificates have not been issued, but are issued through the book-entry systems of federal reserve banks or depository trust companies. Insurers investing in securities in book-entry form shall make available at the time of examination the following:

(1) A copy of the custodial or safekeeping agreement entered into by the insurer and the custodian, a state-chartered bank, a member bank of the federal reserve system or a depository trust company if the deposit was made directly to the entity, which sets forth the provisions for the use of the book-entry securities on behalf of the insurer by the custodian. The agreement shall provide for a standard of responsibility on the part of the custodian which shall be the responsibility of a bailee for hire under the law of the jurisdiction of the custodian's state of domicile. The agreement shall provide that the securities held by the custodian are subject to the instructions of the insurer and may be withdrawn immediately upon demand of the insurer; and

(2) Affidavits evidencing ownership of the book-entry securities signed by a responsible official of the custodian and stating that the custodian is holding the securities for the insurer pursuant to the terms of the custodial agreement. These book-entry securities shall be treated as "admitted assets" of the insurer on production of the affidavit.

The required custodial agreement and affidavit shall conform to such standards as may be prescribed from time to time by the Superintendent of Insurance.

3. No person shall remove all or a material part of the records or assets of a domestic insurer from this State, except pursuant to a plan of merger, consolidation or bulk reinsurance approved by the superintendent under this Title, or for such reasonable purposes and periods of time as may be approved by the superintendent in writing in advance of such removal, or conceal such records or assets or such material part thereof from the superintendent. Any person who removes or attempts to remove such records of assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this State with the intent to remove the same from this State, or who conceals or attempts to conceal the same from the superintendent, in violation of this section, shall upon conviction thereof be guilty of a felony, punishable by a fine of not more than $10,000 or by imprisonment for not more than 5 years, or by both in the discretion of the court. Upon any removal or attempted removal of such records of assets, or upon retention of such records or assets or material

part thereof outside this State, beyond the period therefor specified in the superintendent's consent under which the records were so removed thereat, or upon concealment of or attempt to conceal records or assets in violation of this section, the superintendent may institute delinquency proceedings against the insurer pursuant to chapter 57.

4. This section shall not be deemed to prohibit or prevent an insurer from:

A. Establishing and maintaining regional home offices or branch offices in other states or countries where necessary or convenient to the transaction of its business, and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the superintendent at his request;

B. Having, depositing or transmitting funds and assets of the insurer in or to jurisdictions outside of this State required by the law of such jurisdiction or as reasonably and customarily required or convenient in the regular course of its business.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12; 1981, c. 501, §§ 46, 47.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1981 Amendment. Laws 1981, c. 501, § 46, in subsec. 2, par. A, substituted a semicolon for a comma and deleted "and" following "State"; and, in subsec. 2, par. B, substituted a semicolon for a period and added "and" at end.

Laws 1981, c. 501, § 47, added subsec. 2, par. C.

§ 3409. Vouchers for expenditures

1. No insurer shall make any disbursement of $50 or more, unless such disbursement is evidenced by a voucher or other document correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf of the person receiving the money, or made through an electronic or wire funds transfer system supported by accurate records identifying the payor, payee, date of electronic or wire transfer payment, and the nature of the disbursement so made.

2. If the disbursement is for services and reimbursement, the voucher or other document, or some other writing referred to therein, shall describe the services and itemize the expenditures.

3. If in particular instance a required voucher cannot be obtained, the expenditure must be supported by an affidavit executed by an officer of the insurer stating the reasons for such inability and the particulars of such expenditure as otherwise required in this section.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1981, c. 501, § 47–A.

Historical and Statutory Notes

Amendments

1981 Amendment. Laws 1981, c. 501, § 47–A, in subsec. 1, inserted "such disbursement is" and added ", or made through an electronic or wire funds transfer system supported by accurate records identifying the payor, payee, date of electronic or wire transfer payment, and the nature of the disbursement so made"; and, in subsec. 3, substituted "a required voucher" for "such a voucher" and "required in this section" for "hereinabove required".

Library References

American Digest System
Insurance ⇐11.
Encyclopedias
C.J.S. Insurance § 60 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3410. Destruction of records

1. An insurer may destroy its obsolete records after expiration of such reasonable period after completion of the transactions to which they relate as the insurer may deem proper. The insurer may so destroy its closed files relating to losses and claims arising under its policies after the first to occur of the following events:

A. Completion of a regular examination of the insurer by the superintendent and to which the closed file was subject; or

B. Expiration of 6 years after the file was duly closed.

2. Records preserved on microfilm or other similar process and freely retrievable shall not be deemed to have been destroyed.

3. This section shall not relieve the insurer of any responsibility or liability otherwise arising under law with respect to the existence and availability of any record.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐9.
Encyclopedias
C.J.S. Insurance § 73.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3411. Directors

1. The affairs of every domestic insurer shall be managed by a board of directors consisting of not less than 7 directors or more than 21 directors.

2. Directors, other than initial directors named in the insurer's certificate of organization, shall be elected by the members or stockholders of a domestic

insurer at the annual meeting of stockholders or members. Directors may be elected for terms of not more than 3 years each and until their successors are elected and have qualified; and if to be elected for terms of more than one year the insurer's bylaws may provide for a staggered term system under which the terms of a proportionate part of the members of the board of directors shall expire on the date of each annual meeting of stockholders or members. A directorship becoming vacant before expiration of the term may be filled by the board of directors for the remainder of the term.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Historical and Statutory Notes

Derivation:
R.S.1954, c. 60, §§ 27, 66.

Laws 1969, c. 132, § 11.
Former §§ 591, 652 of title 24.

Library References

American Digest System
Insurance ⇐35, 56.
Encyclopedias
C.J.S. Insurance §§ 98, 109.
WESTLAW Research
Insurance cases: 217k[add key number]

Notes of Decisions

1. Preorganization agreement

A written agreement to take and secure a certain number of shares in an insurance company before its organization does not make the subscribers thereto stockholders in the company, unless such proposal has been accepted by the company after it has been organized. Starrett v. Rockland Fire & Marine Ins. Co. (1876) 65 Me. 374.

The duties of keeping a true list of the stockholders and of the number of shares held by each, were enjoined by former § 591 of Title 24 (repealed); no vote of the directors was necessary to authorize the secretary to perform these acts. Starrett v. Rockland Fire of Marine Ins. Co. (1976) 65 Me. 374.

§ 3412. Officers; notice of change

1. An insurer's board of directors shall elect one of their number as president, and shall elect a corporate secretary and such other officers as may be provided for in the bylaws or otherwise required by law. Any such officer shall serve for such term as may be fixed in the bylaws or by the board of directors, but shall be subject to removal as an officer by the board of directors at any time.

2. Each officer shall have such powers and duties as may be prescribed by or pursuant to the insurer's charter or bylaws.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Historical and Statutory Notes

Derivation:
R.S.1954, c. 60, §§ 28, 41, 66.

Laws 1969, c. 132, § 11.
Former §§ 513, 591, 653 of title 24.

Library References

American Digest System
Insurance ⇐35, 56.
Encyclopedias
C.J.S. Insurance §§ 98, 109.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3413. Prohibited pecuniary interest of officials and others; use of confidential information prohibited

1. Any officer or director, or any member of any committee or any employee of a domestic insurer, having the duty or power of investing or handling the insurer's funds, shall not deposit or invest such funds except in the insurer's name; shall not borrow the funds of the insurer; or be pecuniarily interested in any loan, pledge, deposit, security, investment, sale, purchase, exchange, reinsurance or other similar transaction or property of the insurer except as a stockholder, member, employee or director, unless the transaction is authorized or approved by the insurer's board of directors, with knowledge and recording of such pecuniary interest, by affirmative vote of not less than 2/3 of the directors; and shall not take or receive to his own use any fee, brokerage, commission, gift or other similar consideration for or on account of any such transaction made by or on behalf of the insurer.

2. No director, officer or employee of a domestic insurer shall directly or indirectly use for his own private pecuniary advantage confidential information concerning the insurer or its past, existing or proposed affairs or transactions acquired by him in the course of his services as such director, officer or employee. The amount of any financial gain realized directly or indirectly by any such individual and accompanied by violation of this subsection shall belong to the insurer, and shall be recoverable by the insurer by civil suit. This subsection shall not apply as to transactions in shares of a stock insurer which are subject to section 16 of the Securities Exchange Act of 1934, as amended.[1]

3. No insurer shall guarantee the financial obligation of any of its officers or directors.

4. This section shall not prohibit such a director, officer, member of a committee, or employee from becoming a policyholder of the insurer and enjoying the usual rights of a policyholder or from participating as beneficiary in any pension trust, deferred compensation plan, profit sharing plan, stock option plan or similar plan authorized by the insurer and to which he may be eligible; or prohibit any director or member of a committee from receiving a reasonable fee for lawful services actually rendered to the insurer.

5. The superintendent may, by regulation from time to time, define and permit additional exceptions to the prohibition contained in subsection 1 solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer, or to a corporation or firm in which a director is interested, for necessary services performed or sales or purchases made to or

for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of such director, corporation or firm.
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

[1] 15 U.S.C.A. § 78p.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐35, 56.
Witnesses ⇐184(1).
American Digest System
C.J.S. Insurance §§ 98, 109.
C.J.S. Witnesses § 252.
WESTLAW Research
Insurance cases: 217k[add key number]
Witnesses cases: 410k[add key number]

§ 3414. Management, commission, exclusive agency contracts

1. No domestic insurer shall hereafter make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the material exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, or, if an officer, director or otherwise part of the insurer's management, is to receive any commission, bonus or compensation based upon the volume of the insurer's business or transactions, unless the contract is filed with and not disapproved by the superintendent. The contract shall become effective in accordance with its terms unless disapproved by the superintendent within 20 days after date of filing, subject to such reasonable extension of time as the superintendent may require by notice given within such 20 days. Any disapproval shall be delivered to the insurer in writing stating the grounds therefor.

2. Any such contract shall provide that any such manager, producer of its business or contract holder shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, with specification of the emoluments received therefrom by the respective directors, officers and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.

3. The superintendent shall disapprove any such contract if he finds that it:

A. Subjects the insurer to excessive charges; or

B. Is to extend for an unreasonable length of time; or

C. Does not contain fair and adequate standards of performance; or

D. Contains other inequitable provision or provisions which impair the proper interests of stockholders or members of the insurer.

4. The superintendent may, after a hearing held thereon, disapprove any such contract theretofore permitted to become effective, if he finds that the contract should be disapproved on any of the grounds referred to in subsection 3.

5. This section does not apply as to contracts entered into prior to January 1, 1970, or to amendment of such contracts other than extensions thereof.

6. This section shall not be deemed to prohibit receipt of commissions on insurance written personally by a director or officer who is duly licensed and regularly engaged in business as an insurance agent or broker; or to prohibit receipt of vested commissions by a director or officer based upon insurance business theretofore written by him.
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12; 1973, c. 625, § 149, eff. July 5, 1973.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1973 Amendment. Laws 1973, c. 625, § 149, in subsec. 5, substituted "January 1, 1970" for "the effective date of this Act" following "entered into prior to".

Cross References

Holding company systems, supplementation of this section, see § 222 of this title.

Library References

American Digest System
Insurance ⇐36, 57(1).
Encyclopedias
C.J.S. Insurance §§ 99 et seq., 110, 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3415. Borrowed capital funds

1. A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding, per annum, a rate of 5 percentage points in excess of the then current discount rate of the Federal Reserve Bank, Boston, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus as stipulated in the agreement. No commission or promotion expense may be paid in connection with any such loan, except that if sale is made of the loan securities through established securities brokers or by public offering, the insurer may pay the reasonable costs thereof approved by the superintendent.

2. Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement, or be the basis of any set-off or counterclaim; but until repaid, financial statements filed

or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

3. Any such loan shall be subject to the superintendent's approval. The insurer shall, in advance of the loan, file with the superintendent a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after date of such filing the insurer is notified of the superintendent's disapproval and the reasons therefor. The superintendent shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

4. Any such loan to an insurer or substantial portion thereof may be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such a loan, whether heretofore or hereafter outstanding shall be made, other than as provided in the loan agreement, unless approved in advance by the superintendent.

5. This section shall not apply to other kinds of loans obtained by the insurer in ordinary course of business, or to loans secured by pledge or mortgage of assets.

6. Loans authorized under this section may be made by domestic insurers as well as by other persons; but such a loan shall not constitute an asset in any determination of the financial condition of the lending insurer.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1969, c. 177, § 58, eff. Jan. 2, 1970; 1973, c. 585, § 12; 1983, c. 709, § 4.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1969 Amendment. Laws 1969, c. 177, § 58, in subsec. 4, substituted "an" for "a mutual" following "Any such loan to".

1983 Amendment. Laws 1983, c. 709, § 4, repealed and replaced subsec. 1, which formerly read:

"1. A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest not exceeding per annum a rate 2 percentage points in excess of the then current discount rate of the Federal Reserve Bank, Boston, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan, except that if sale is made of the loan securities through established securities brokers or by public offering the insurer may pay the reasonable costs thereof approved by the superintendent."

Library References

American Digest System
Insurance ⇐35, 57(1).
Encyclopedias
C.J.S. Insurance §§ 98, 110, 115 et seq.

WESTLAW Research
Insurance cases: 217k[add key number]

§ 3416. Dividends to stockholders

1. A domestic stock insurer shall not pay any cash dividend to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains.

2. A cash dividend otherwise lawful may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed or paid-in surplus.

3. A stock dividend may be paid out of any available surplus funds, other than "surplus" resulting from borrowed capital funds such as provided for under section 3415.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Historical and Statutory Notes

Derivation:
R.S.1954, c. 60, §§ 44, 76, 77, 78.
Laws 1969, c. 132, § 11.
Former §§ 516, 601 to 603 of title 24.

Library References

American Digest System
Insurance ⇐33.
Encyclopedias
C.J.S. Insurance §§ 96, 103.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3417. Participating policies

1. If provided for in its certificate of organization or charter, a stock insurer or mutual insurer may issue any or all of its policies or contracts with or without participation in profits, savings, unabsorbed portions of premiums or surplus; may classify policies issued and perils insured on a participating and nonparticipating basis, and may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination shall be reasonable, and shall not unfairly discriminate as between policies so classified.

2. A life insurer may issue both participating and nonparticipating policies or contracts if the right or absence of right to participate is reasonably related to the premium charged.

3. After the first policy year, no dividend, otherwise earned under a life or health insurance policy or annuity contract, shall be made contingent upon the payment of renewal premium on any such policy or contract; except that a participating life or health insurance policy providing for participation at the end of the first or second policy year may provide that the dividend or dividends will be paid subject to payment of premium for the next ensuing year.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐185.
Encyclopedias
C.J.S. Insurance § 343.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3418. Dividends to policyholders

1. The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its accumulated surplus funds which represents net realized savings, net realized earnings and net realized capital gains, all in excess of the surplus required by law to be maintained by the insurer.

2. A dividend otherwise proper may be payable out of such savings, earnings and gains even though the insurer's total surplus is then less than the aggregate of contributed surplus remaining unpaid by the insurer.

3. A domestic stock insurer may pay dividends to holders of its participating policies out of any available surplus funds.

4. No dividend shall be paid which is inequitable, or which unfairly discriminates as between classifications of policies or policies within the same classifications.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐33, 59.
Encyclopedias
C.J.S. Insurance §§ 96, 103, 114.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3419. Pension and other plans for employees and others

1. Pursuant to the terms of a pension plan or plans or any modification thereof, heretofore or hereafter adopted by the insurer's board of directors and approved by the superintendent, any domestic stock or mutual insurer may pay the whole or any part of the cost of retirement or disability pensions for such of its officers, employees or full-time insurance agents as are specified in such plan or plans or modifications thereof. If so specified in the plan or plans, in lieu of such pensions actuarially equivalent benefits may be paid to such officers, employees or full-time agents or to their designated beneficiaries.

2. The superintendent shall approve any such plan unless he finds the same not to be within the reasonable financial resources of the insurer or not fair and equitable as between the respective classifications of participants therein.

3. Nothing contained in this section or in section 3420 shall be deemed to prohibit profit-sharing, stock option or similar plans for an insurer's officers, employees or agents.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐36, 57(1).
Encyclopedias
C.J.S. Insurance §§ 99 et seq., 110, 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3420. Insurance benefits for employees and others

Pursuant to vote of its board of directors heretofore or hereafter made, any domestic stock or mutual insurer may provide for its officers, employees or full-time insurance agents a plan or plans of insurance, to be issued under group or individual policies. The insurer may pay the cost, in whole or in part, of such insurance; or, if duly authorized by its charter and bylaws, may itself provide such benefits directly as the insurer thereof, without requirement of placement through a licensed insurance agent, and in such case may adjust the premium rate for the insurance to reflect such savings in expense as the insurer may deem applicable.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Library References

American Digest System
Insurance ⇐36, 57(1).
Encyclopedias
C.J.S. Insurance §§ 99 et seq., 110, 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3421. Solicitation, insuring in other states

1. No domestic insurer shall knowingly solicit insurance business in any reciprocating state in which not then licensed as an authorized insurer. This subsection shall not prohibit advertising through publications and radio, television and other media originating outside such reciprocating state, if the insurer is licensed in the state in which the advertising originates and the advertising is not specifically directed to residents of such reciprocating state. This subsection shall not apply as to surplus lines insurance, or reinsurance, or prohibit insurance covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed, or insurance otherwise effectuated in accordance with the laws of the reciprocating state. A "reciprocating" state, as used herein, is one under the laws of which a similar prohibition is imposed upon and enforced against insurers domiciled in that state.

2. A domestic insurer duly authorized to transact insurance in another jurisdiction may frame and issue policies for delivery in such jurisdiction pursuant to applications for insurance solicited and obtained therein, in accordance

with the laws thereof, subject only to such restrictions, if any, as may be contained in the insurer's certificate of organization or bylaws; and subject, in the case of health insurers, to the provisions of section 2733 (policies issued for delivery in another state).

1969, c. 132, § 1, eff. Jan. 1, 1970; 1969, c. 177, § 59, eff. Jan. 2, 1970.

Historical and Statutory Notes

Amendments

1969 Amendment. Laws 1969, c. 177, § 59, in subsec. 2, substituted the reference to "section 2733" for "the provisions of section 2732" following "the case of health insurers, to".

Library References

American Digest System
Insurance ⇐11.
Encyclopedias
C.J.S. Insurance § 60 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3422. Purchase of own shares by stock insurer

A domestic stock insurer shall have the right to purchase or acquire shares of its own stock only as follows:

1. For elimination of fractional shares.

2. Incidental to the enforcement of rights of the insurer with respect to lawful transactions previously entered into in good faith for purposes other than the acquisition of such shares.

3. For the purposes of a general savings and investment plan for employees or agents of the insurer.

4. For mutualization of the insurer, as provided in section 3472.

5. For retirement or otherwise of the shares under a plan submitted to and approved in writing by the superintendent. The superintendent shall not approve a plan unless found by him to be reasonable, fair and equitable as to remaining stockholders of the insurer, and not materially adverse to the protection of the insurer's policyholders.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐35, 57(1).
Encyclopedias
C.J.S. Insurance §§ 98, 110, 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3423. Impairment of capital funds

1. If a domestic stock insurer's paid-in capital stock, as represented by the aggregate par value of its outstanding capital stock, becomes impaired, or the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of basic surplus required to be maintained by it under this Title for authority to transact the kinds of insurance being transacted, the superintendent shall at once determine the amount of deficiency and serve notice upon the insurer to cure the deficiency and file proof thereof with him within the period specified in the notice, which period shall be not less than 30 nor more than 90 days from the date of the notice. Such notice may be so served by delivery to the insurer, or by mailing to the insurer addressed to its registered office in this State.

2. The deficiency may be made good in cash or in assets eligible under chapter 13 (investments) for the investment of the insurer's funds or by amendment of the insurer's certificate of authority to cover only such kind or kinds of insurance thereafter for which the insurer has sufficient paid-in capital stock, if a stock insurer, or surplus, if a mutual insurer, under this Title; or, if a stock insurer, by reduction of the number of shares of the insurer's authorized capital stock or the par value thereof through amendment of its certificate of organization, to an amount of authorized and unimpaired paid-in capital stock not below the minimum required for the kinds of insurance thereafter to be transacted.

3. If the deficiency is not made good and proof thereof filed with the superintendent within the period required by the notice as specified in subsection 1, the insurer shall be deemed insolvent and the superintendent shall institute delinquency proceedings against it under chapter 57.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, § 69.
Laws 1967, c. 92, § 5.
Laws 1969, c. 132, § 11.
Former § 594 of title 24.

Library References

American Digest System
Insurance ⇐8.
Encyclopedias
C.J.S. Insurance §§ 72, 96.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3424. Restrictions during impairment; penalty

1. During the existence of impairment of the capital stock or surplus of an insurer, as referred to in section 3423, the superintendent shall require such restriction of, or arrangements as to, operations of the insurer while the

impairment exists as he deems advisable for protection of policyholders, the insurer or the public.

2. Any officer, director, representative or employee of the insurer who knowingly violates or fails to comply with any such restriction or requirement shall upon conviction thereof be subject to fine of not less than $500 or more than $5,000, or imprisonment for less than one year or to both such fine and imprisonment.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐27.
Encyclopedias
C.J.S. Insurance § 86.
WESTLAW Research
Insurance cases: 217k[add key number]

SUBCHAPTER IV

CONVERSION, AMALGAMATION, DISSOLUTION

Section

Library References

American Digest System
Insurance ⇐32, 52.
Encyclopedias
C.J.S. Insurance §§ 94 et seq., 104 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3471. Scope of subchapter

This subchapter applies as to domestic stock and mutual insurers whether heretofore or hereafter formed, including insurers chartered under special legislative Acts, notwithstanding any inconsistent provisions in the charters of the insurers.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1985, c. 399, § 2, eff. June 21, 1985.

Historical and Statutory Notes

Amendments

1985 Amendment. Laws 1985, c. 399, § 2, repealed and replaced this section, which, in effect, substituted provision making insurers chartered under special legislative Acts subject to this subchapter, notwithstanding any inconsistent charter provisions for former provision that made such insurers subject to this subchapter only where feasible and not in conflict with specific provisions of the special act.

Transition

Laws 1985, c. 399, § 9, provided: "Notwithstanding the terms of the Maine Revised Statutes, Title 1, section 302; Title 24-A, sections 10, 3471 and 3477, as amended by this Act, shall apply to any filing by a mutual insurer seeking the approval of the Superintendent of Insurance of its plan and procedure of demutualization, including any such filing which has been previously filed with and is currently pending hearing or decision by the Superintendent of Insurance upon the effective date of this Act."

§ 3472. Mutualization of stock insurer

1. A stock insurer other than a title insurer may become a mutual insurer, or a combination stock and mutual insurer, under such plan and procedure as may be approved by the superintendent after a hearing thereon.

2. The superintendent shall not approve any such plan, procedure or mutualization unless:

A. It is equitable to stockholders and policyholders;

B. It is subject to approval by the holders of not less than 2/3 of the insurer's outstanding capital stock having voting rights, and by not less than 2/3 of the insurer's policyholders who vote on such plan in person, by proxy or by mail pursuant to such notice and procedure as may be approved by the superintendent;

C. If a life insurer, the right to vote thereon is limited to holders of policies other than term or group policies, and whose policies have been in force for more than one year;

D. Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraisers;

E. The plan provides for the purchase of the shares of any nonconsenting stockholder in the same manner and subject to the same applicable conditions as provided by the general corporation law of the State as to rights of nonconsenting stockholders, with respect to consolidation or merger of private corporations;

F. The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and

G. The mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance, and for the kinds of insurance included in its certificates of authority in such states.

3. Any such combination stock and mutual insurer referred to in subsection 1 above must have and maintain separate paid-in capital stock and basic surplus in respective amounts as would be required under this Title of separate domestic stock and mutual insurers transacting the same kind or kinds of insurance.

4. No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their customary salaries or other regular compensation, for in any manner aiding, promoting or assisting in the mutualization, except as set forth in the plan of mutualization as approved by the superintendent.

5. This section shall not apply to mutualization under order of court pursuant to rehabilitation or reorganization of an insurer under chapter 57.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐32.1.
Encyclopedias
C.J.S. Insurance §§ 95, 105 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3473. Conversion of stock insurer to ordinary business corporation

1. A domestic stock insurer may convert to a Maine ordinary business corporation through the following procedures:

A. The insurer must give the superintendent written notice of its intent to convert to an ordinary business corporation;

B. The insurer must bulk reinsure all of its insurance, if any, in force, with another authorized insurer under a bulk reinsurance agreement approved by the superintendent as provided in section 3483. The agreement of bulk reinsurance may be made contingent upon approval of stockholders as provided in paragraph D;

C. The insurer must set aside funds in a special reserve in such amount and subject to such administration as may be found by the superintendent to be reasonable and adequate for the purpose, for payment of all obligations, if any, of the insurer incurred by it and remaining unpaid under its insurance contracts prior to the effective date of such bulk reinsurance, or make other reasonable disposition satisfactory to the superintendent for such payment;

D. The proposed conversion must be approved by affirmative vote of not less than 2/3 of each class of outstanding securities of the insurer having voting rights, at a special meeting of holders of such securities called for the purpose; and at such meeting and by a like vote the certificate of organization of the corporation must be amended to remove therefrom the power to transact an insurance business as an insurer, to provide for such new powers and purposes authorized by the general corporation laws of this State as may be consistent with the purposes for which the corporation is thereafter to exist, and to make such further alterations in the certificate of organization as may be required under such general corporation laws of an ordinary business corporation;

E. Security holders of the corporation who dissent from such proposed conversion shall have the same applicable rights as exist under such general corporation laws with respect to dissent from a proposed merger of the corporation; and

F. Upon compliance with paragraphs A to D, and upon filing of the amendment of the certificate of organization with the superintendent and otherwise as required by laws applicable to ordinary business corporations, the conversion shall thereupon become effective.

2. An insurer which has once converted to an ordinary business corporation shall not have power thereafter to convert to an insurer; and no ordinary business corporation shall have power to convert to an insurer.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐32.

Encyclopedias
C.J.S. Insurance § 94 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3474. Merger, consolidation of stock insurers

1. A domestic stock insurer may merge or consolidate with one or more domestic or foreign stock insurers, by complying with the applicable provisions of the statutes of this State governing the merger or consolidation of stock corporations formed for profit, but subject to subsections 2 and 3. A domestic stock insurer shall not merge or consolidate with any corporation not formed for the purpose of transacting insurance as an insurer.

2. No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the superintendent and approved in writing by him after a hearing thereon after notice to the stockholders of each insurer involved. The superintendent shall give such approval within a reasonable time after such filing unless he finds that the plan or agreement:

A. Is contrary to law; or

B. Is unfair or inequitable to the stockholders of any insurer involved; or

C. Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this State or elsewhere; or

D. Would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or

E. Is subject to other material and reasonable objections.

3. No director, officer, agent or employee of any insurer party to the merger or consolidation shall receive any fee, commission, compensation or other valuable consideration whatsoever for in any manner aiding, promoting or assisting therein except as set forth in the plan or agreement.

4. If the superintendent does not approve the plan or agreement, he shall so notify the insurer in writing specifying his reasons therefor.
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Cross References

Holding company systems, supplementation of these sections, see § 222 of this title.
Restrictions on mergers of insurance companies, see § 901 of title 13–A.

Library References

American Digest System
Insurance ⇐72.3.
Encyclopedias
C.J.S. Insurance § 115 et seq.

WESTLAW Research
Insurance cases: 217k[add key number]

§ 3475. Exchange of securities between insurers

1. Upon application of any domestic insurer, the superintendent is authorized to approve the fairness of the terms and conditions of the issuance by the insurer of any shares of its capital stock or of guaranty capital or bonds or its other securities or obligations in exchange for one or more bona fide outstanding securities, claims or property interest of any other insurer or corporation, domestic or foreign, or partly in such exchange and partly for cash; but only after a hearing has been held by the superintendent upon the fairness of such terms and conditions at which all persons to whom it is proposed to issue securities in such exchange shall have the right to appear and be heard.

2. Notice of such hearing and conduct thereof shall be as provided in chapter 3 (the insurance superintendent).
1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, § 4.
Laws 1969, c. 132, § 11.
Former § 54 of title 24.

Cross References

Holding company systems, supplementation of these sections, see § 222 of this title.

Library References

American Digest System
Insurance ⇐72.3.
Encyclopedias
C.J.S. Insurance § 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3476. Acquisition of controlling stock

1. Any person proposing to acquire the controlling capital stock or guaranty capital shares of any domestic stock insurer and thereby to change the control of the insurer, other than through merger or consolidation or affiliation as provided for in this chapter, shall first apply to the superintendent in writing for approval of such proposed change of control. The application shall state the names and addresses of the proposed new owners of the controlling stock or shares and contain such additional information as the superintendent may reasonably require.

2. The superintendent shall not approve the proposed change of control if he finds:

A. That the proposed new owners are not qualified by character, experience and financial responsibility to control and operate the insurer, or cause the insurer to be operated, in a lawful and proper manner; or

B. That as a result of the proposed change of control the insurer may not be qualified for a certificate of authority under section 407 (ownership, management); or

C. That the interests of the insurer or other stockholders of the insurer or policyholder would be impaired through the proposed change of control; or

D. That the proposed change of control would tend materially to lessen competition, or to create any monopoly, in a business of insurance in this State or elsewhere.

3. If the superintendent does not by affirmative action approve or disapprove the proposed change of control within 30 days after the date such application was so filed with the superintendent, the proposed change may be made without such approval. Except that if the superintendent gives notice to the parties of a hearing to be held by the superintendent with respect to the proposed change of control, and the hearing is held within such 30 days or on a date mutually acceptable to the superintendent and the parties, the superintendent shall have 30 days after the conclusion of the hearing within which to so approve or disapprove the proposed change; and if not so approved or disapproved, the change may thereafter be made without the superintendent's approval.

4. If the superintendent disapproves the proposed change he shall give written notice thereof to the parties, setting forth in detail the reasons for disapproval.

5. The superintendent shall file a complaint with the Administrative Court seeking to suspend or revoke the certificate of authority held by any insurer, the control of which has been changed in violation of this section.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12; 1977, c. 694, § 428, eff. July 1, 1978; 1989, c. 269, § 15.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1977 Amendment. Laws 1977, c. 694, § 428, repealed and replaced subsec. 5, which formerly read:

"5. The superintendent shall suspend or revoke the certificate of authority of any insurer the control of which has been changed in violation of this section."

1989 Amendment. Laws 1989, c. 269, § 15, in subsec. 3, made provisions gender neutral and increased from 10 to 30 days the period in which the superintendent may approve or disapprove a proposed change.

Cross References

Holding company systems, supplementation of this section, see § 222 of this title.

Library References

American Digest System
Insurance ⇐72.3.
Encyclopedias
C.J.S. Insurance § 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3477. Conversion of mutual to stock insurer

1. A mutual insurer may amend its charter pursuant to this section to become a stock insurer, or a combination stock and mutual insurer, under such reasonable plan and procedure as may be approved by the superintendent after a hearing thereon of which notice was given to the insurer, its directors or trustees, its officers, employees and its policyholders, all of whom shall have the right to appear and be heard at the hearing.

2. The superintendent shall not approve any such plan or procedure unless:

A. Its terms and conditions are fair and equitable;

B. It is subject to approval by vote of not less than 2/3 of the insurer's policyholders voting thereon in person, by proxy, or by mail at a meeting of policyholders called for the purpose pursuant to such reasonable notice and procedure as may be approved by the superintendent and each such policyholder shall be entitled to one vote, provided that only persons who were policyholders both at least one year prior to the submission of the insurer's plan to the superintendent and on a subsequent date, found reasonable by the superintendent, prior to the vote shall be entitled to vote; provided that as to life insurers chartered by special Act prior to January 1, 1970, the persons entitled to vote shall be further limited to owners of life insurance policies and contracts, and those persons shall be entitled to one vote and to an additional vote for each $1,000 of insurance above 1,000, except that in the case of any policy or contract of group life insurance or any group annuity contract providing life insurance, the employer or other person, firm, corporation or association, to whom or in whose name the master policy or contract shall have been issued or held, shall be deemed to be the owner within the meaning of this paragraph and shall be entitled to one vote for each such policy or contract of group life insurance or each such group annuity contract irrespective of the number of lives insured under that policy or contract;

C. The equity of each member in the insurer is determinable under a fair and reasonable formula approved by the superintendent, which such equity shall be based upon the insurer's entire surplus as shown by the insurer's financial statement filed with the superintendent, including all voluntary reserves but excluding contingently repayable funds and outstanding guaranty capital shares at the redemption value thereof, and without taking into account the value of nonadmitted assets or of insurance business in force;

D. The plan gives to each member of the insurer as specified in paragraph E, a preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer, or all of the stock of a proposed parent corporation of the insurer, within a designated reasonable period, as such part is determinable under the plan of conversion, and to apply upon the purchase thereof the amount of his equity in the insurer as determined under paragraph C, except that the plan may provide, subject to the approval of the superintendent, that such preemptive right will not apply to members who reside in jurisdictions in which the issuance of stock is

impossible, would involve unreasonable delay or would require the insurer to bear unreasonable costs, provided that any such member shall receive 100% of his equity share in the insurer in the form of a cash payment;

E. The members entitled to participate in the purchase of stock or distribution of assets shall include not less than all policyholders of the insurer as of the date the plan was submitted to the superintendent and each existing person who had been a policyholder of the insurer within 3 years prior to such date;

F. Shares are to be offered to members at a price not greater than to be thereafter offered under the plan to others;

G. The plan provides for payment to each member of his entire equity share in the insurer, with that payment to be made in cash or to be applied for or upon the purchase of stock to which the member is preemptively entitled, or both, provided that with respect to each member who is not given the option of receiving his entire equity share in cash, the plan shall provide that that member shall have the option to receive a reasonable portion of his equity share, as provided in the plan, but not in excess of 50% of his entire equity, in the form of a cash payment, which payment together with the amount applied to the purchase of stock shall constitute full payment and discharge of the member's equity or property interest in that mutual insurer; provided further that the superintendent may permit an insurer to forego the option of making a cash payment to members if he determines that it would be reasonable not to provide for the cash election, after taking into account all the facts and circumstances, including whether there is expected to be an active market for the stock to be received in the conversion;

H. The plan, when completed, would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital stock required of a new domestic stock insurer upon initial authorization to transact like kinds of insurance, together with expendable surplus funds in amount not less than 1/2 of such required capital stock; and

I. The superintendent finds that the insurer's management has not, through reduction in volume of new business written, or cancellation or through any other means sought to reduce, limit, or affect the number or identity of the insurer's members to be entitled to participate in such plan, or to secure for the individuals comprising management any unfair advantage through such plan.

3. Any such combination stock and mutual insurer referred to in subsection 1 must have and maintain separate paid-in capital stock and basic surplus in respective amounts as would be required under this Title of separate domestic stock and mutual insurers transacting the same kind or kinds of insurance.

4. Subsection 2 shall not be deemed to prohibit the inclusion in the conversion plan of provisions under which the individuals comprising the insurer's management and employee group shall be entitled to purchase for cash at the same price as offered to the insurer's members, shares of stock not taken by members on

the preemptive offering to members, in accordance with such reasonable classification of such individuals as may be included in the plan and approved by the superintendent.

5. No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their usual regular salaries and compensation, for in any manner aiding, promoting or assisting in such conversion except as set forth in the plan approved by the superintendent. This provision shall not be deemed to prohibit the payment of reasonable fees and compensation to attorneys at law, accountants and actuaries for services performed in the independent practice of their professions, even though also directors of the insurer.

6. **Costs.** For the purpose of determining whether a conversion plan meets the requirements of this section and any other relevant provisions of this Title, the superintendent may employ staff personnel and outside consultants. All reasonable costs related to the review of a plan of conversion, including those costs attributable to the use of staff personnel, shall be borne by the insurer or insurers making the filing.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12; 1985, c. 399, §§ 3 to 8, eff. June 21, 1985.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Amendments

1985 Amendment. Laws 1985, c. 399, § 3, in subsec. 1, inserted "amend its charter pursuant to this section to" and substituted "policyholders" for "members".

Laws 1985, c. 399, § 4, repealed and replaced subsec. 2, par. B, which formerly read:

"B. It is subject to approval by vote of not less than ⅔ of the insurer's current members entitled to vote and voting thereon in person, by proxy, or by mail at a meeting of members entitled to vote and called for the purpose pursuant to such reasonable notice and procedure as may be approved by the superintendent; if a life insurer, right to vote shall be limited to members who hold policies other than group policies or term policies for terms of less than 20 years, and whose policies have been in force for not less than one year;"

Laws 1985, c. 399, § 5, in subsec. 2, par. D, added ", except that the plan may provide, subject to the approval of the superintendent, that such preemptive right will not apply to members who reside in jurisdictions in which the issuance of stock is impossible, would involve unreasonable delay or would require the insurer to bear unreasonable costs, provided that any such member shall receive 100% of his equity share in the insurer in the form of a cash payment".

Laws 1985, c. 399, § 6, in subsec. 2, par. E, deleted "current" preceding "policyholders", inserted "as of the date the plan was submitted to the superintendent", substituted "such" for "the", and deleted "such plan was submitted to the superintendent" at end.

Laws 1985, c. 399, § 7, repealed and replaced subsec. 2, par. G, which formerly read:

"G. The plan provides for payment to each member, not electing to apply his equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in an amount found to be reasonable by the superintendent but not in excess of 50% of the amount of his equity not so used for the purchase of stock, and which cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the member's equity or property interest in such mutual insurer;"

Laws 1985, c. 399, § 8, added subsec. 6.

Transition

Laws 1985, c. 399, § 9, provided:

"Notwithstanding the terms of the Maine Revised Statutes, Title 1, section 302; Title 24–A, sections 10, 3471 and 3477, as amended by this Act, shall apply to any filing by a mutual insurer

seeking the approval of the Superintendent of Insurance of its plan and procedure of demutualization, including any such filing which has been previously filed with and is currently pending hearing or decision by the Superintendent of Insurance upon the effective date of this Act."

Library References

American Digest System
Insurance ⇐53.
Encyclopedias
C.J.S. Insurance § 106.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3478. Merger, consolidation of mutual insurers authorized

1. Any one or more mutual insurers existing under any of the laws of this State, may absorb by merger or consolidation, or be merged into or consolidate with, any one or more domestic or foreign mutual insurers either authorized to transact insurance in this State or qualified for such authority. The procedure for effectuation of such merger or consolidation shall be as set forth in sections 3479 to 3482.

2. Nothing in this section shall authorize the merger or consolidation of a mutual insurer with a stock insurer.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Historical and Statutory Notes

Derivation:

R.S.1954, c. 60, § 32.

Laws 1955, c. 219.
Laws 1969, c. 132, § 11.
Former § 504 of title 24.

Cross References

Holding company systems, merger or consolidation under this subchapter, see § 222 of this title.
Restrictions on mergers of insurance companies, see § 901 of title 13-A.

Library References

American Digest System
Insurance ⇐72.3.
Encyclopedias
C.J.S. Insurance § 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3479. Same—plan, agreement of merger, consolidation; approval by corporations

1. The plan and agreement for a merger or consolidation referred to in section 3478 shall be in writing signed by the duly authorized officers and under the corporate seals of the respective insurers; and shall be acknowledged to be the act, deed and agreement of the insurer by one of the executing officers of the respective insurers before an officer authorized by law to take acknowledgments of deeds. The plan and agreement shall be approved and authorized by vote of the majority of the directors of the respective insurers, and approved by vote of at least 2/3 of such policyholders of the respective insurers who are

entitled to vote and do vote thereon in person or by proxy at a special meeting of such members call [1] for the purpose.

2. Notice of such special meeting of members shall be given by publishing the same once weekly for 3 consecutive weeks in a newspaper circulated in each county of this State, the last such publication to be at least 7 days prior to such meeting. Notice to its members by a foreign insurer shall be in accordance with the laws of its domiciliary jurisdiction.

3. All of the members of the insurer shall be bound by the vote of policyholders as above provided for, and shall not have thereafter any right as to dissent or appraisal.

1969, c. 132, § 1, eff. Jan. 1, 1970.

[1] So in original. Probably should be "called".

Historical and Statutory Notes

Derivation:

R.S.1954, c. 60, § 32.

Laws 1955, c. 219.
Laws 1969, c. 132, § 11.
Former § 504 of title 24.

Cross References

Restrictions on mergers of insurance companies, see § 901 of title 13-A.

Library References

American Digest System
Insurance ⇐72.3.
Encyclopedias
C.J.S. Insurance § 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3480. Same—approval by superintendent

1. The plan and agreement referred to in section 3479 shall not be effectuated until filed with and approved by the superintendent in writing. The insurers shall furnish the superintendent such additional information in relation to the proposed merger or consolidation as the superintendent may reasonably require.

2. The superintendent shall approve the plan and agreement unless he finds that it:

A. Is contrary to law; or

B. Is inequitable to the policyholders of any domestic insurer involved; or

C. Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer; or

D. Would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or

E. Is subject to other material and reasonable objections.

3. If the superintendent does not approve the plan and agreement he shall so notify the insurers parties thereto in writing, specifying his reasons therefor. 1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, § 32.
Laws 1955, c. 219.
Laws 1969, c. 132, § 11.
Former § 504 of title 24.

Cross References

Restrictions on mergers of insurance companies, see § 901 of title 13–A.

Library References

American Digest System
Insurance ⇐4.2, 72.3.
Encyclopedias
C.J.S. Insurance §§ 57, 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3481. Same—review by Attorney General: filing with Secretary of State

1. Upon approval by the superintendent as provided in section 3480, the plan and agreement of merger or consolidation shall be submitted to the Attorney General and be examined by him. If the Attorney General finds the plan and agreement to be properly drawn and signed and otherwise in conformity with the Constitution and laws of this State, he shall so certify thereon in writing.

2. Within 60 days from date of approval by the superintendent, both an original and a copy of the plan and agreement showing thereon the certificate of the Attorney General, shall be delivered to the office of the Secretary of State. The Secretary of State shall file such copy and enter the date of filing on both the copy and the original, shall record the copy and return the original to the surviving merged or consolidated corporation.

3. From time of filing the copy of the plan and agreement in the office of the Secretary of State, the agreement shall be deemed to be the agreement and act of merger or consolidation of the insurers, and the original of such agreement or a certified copy thereof shall be evidence of the existence of such merged or consolidated corporation and of the performance of all acts and conditions necessary for the effectuation of such merger or consolidation.

4. If a domestic insurer is merged into or consolidated with a foreign insurer, the foreign insurer shall not transact insurance in this State until it has procured a certificate of authority from the superintendent therefor under this Title.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Derivation:

R.S.1954, c. 60, § 32.
Laws 1955, c. 219.
Laws 1969, c. 132, § 11.
Former § 504 of title 24.

Library References

American Digest System
Insurance ⇐72.3.
Encyclopedias
C.J.S. Insurance § 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3482. Same—effective date of merger, consolidation; effect as to assets, liabilities, rights and power

1. When the plan and agreement for merger or consolidation has been so signed, acknowledged, approved, authorized, certified, filed and recorded as provided in sections 3478 to 3481, then the separate existence of all of the constituent corporations other than the surviving corporation into which the other corporation or corporations parties have merged or consolidated shall cease.

2. The surviving corporation shall be the merged or consolidated corporation by the name provided for in the agreement; and shall thereby possess all the rights, privileges, powers, franchises and immunities as well of a public as of a private nature, and shall thereby be subject to all the liabilities, restrictions and duties, of each of the merged or consolidated corporations, and have all and singular the rights, privileges, powers, franchises and immunities of each of such corporations, together with all property, real, personal and mixed, wheresoever located, and all debts due to any of such constituent corporations on whatever account; and all other things in action of each of such corporations, are by virtue of such merger or consolidation automatically vested in such surviving corporation.

3. All such property, rights, privileges, powers, franchises and immunities and all and every other such interest shall be thereafter as effectually the property of the surviving corporation as they were of the respective constituent corporations; and title to any real estate, whether by deed or otherwise, under the laws of this State, vested in any of such constituent corporations shall not revert or be in any way impaired by reason of such merger or consolidation. All rights of creditors and all liens upon the property of any of such constituent corporations shall be preserved unimpaired, limited to the property affected by such liens at the time of the merger or consolidation; and all debts, liabilities and duties of the respective constituent corporations shall thenceforth attach to the surviving corporation and may be enforced against it to the same extent as if such debts, liabilities and duties had been incurred or contracted by it.

1969, c. 132, § 1, eff. Jan. 1, 1970.

Historical and Statutory Notes

Derivation:

R.S.1954, c. 60, § 32.

Laws 1955, c. 219.
Laws 1969, c. 132, § 11.
Former § 504 of title 24.

Library References

American Digest System
Insurance ⇐72.3.
American Digest System
C.J.S. Insurance § 115 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3483. Bulk reinsurance

1. A domestic insurer may reinsure, and thereby transfer its direct liability as the insurer with respect to, all or substantially all of its business in force, or all or substantially all of a major class thereof, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. No such agreement shall become effective unless filed with the superintendent, or if disapproved by him.

2. The superintendent shall disapprove such agreement within a reasonable time after filing if he finds:

A. That the plan and agreement are unfair and inequitable to any insurer or to policyholders involved; or

B. That the reinsurance, if effectuated, would substantially reduce the protection or service to the policyholders of any domestic insurer involved; or

C. That the agreement does not embody adequate provisions by which the reinsuring insurer becomes liable to the original insureds for any loss or damage occurring under the policies reinsured in accordance with the original terms of such policies; or

D. That the assuming reinsurer is not authorized to transact such insurance in this State, or is not qualified as for such authorization or will not appoint the superintendent and his successors as its irrevocable attorney for service of process, so long as any policy so reinsured or claim thereunder remains in force or outstanding; or

E. That such reinsurance would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or

F. That the proposed bulk reinsurance is not free of other reasonable objections.

3. If the superintendent disapproves the agreement, he shall forthwith notify in writing each insurer involved, specifying his reasons therefor.

4. If for reinsurance of all or substantially all of the business in force of an insurer at a time when the insurer's capital, if a stock insurer, or surplus, if a

mutual insurer, is not impaired, the plan and agreement of such reinsurance must be approved by a vote of not less than 2/3 of the insurer's outstanding stock having voting rights, if a stock insurer, or of members, if a mutual insurer, voting thereon, at a meeting of stockholders or members called for the purpose pursuant to such reasonable notice and procedure as is provided for in the agreement. If a mutual life insurer, right to vote may be limited to members otherwise entitled to vote and whose policies are other than term policies for terms of less than 20 years, or group policies, and have been in effect for more than one year.

5. No director, officer, agent or employee of any insurer party to such reinsurance, or any other person, shall receive any special compensation for arranging or with respect to, any such reinsurance except as is set forth in the reinsurance agreement filed with the superintendent.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Cross References

Cession of bulk reinsurance by domestic insurer subject to this section, see § 731 of this title.
Holding company systems, see § 222 of this title.

Library References

American Digest System
Insurance ⇐676.
Encyclopedias
C.J.S. Insurance §§ 1221, 1222.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3484. Voluntary dissolution

1. A solvent domestic stock or mutual insurer, which then is not the subject of a delinquency proceeding under chapter 57, may voluntarily dissolve under a plan therefor in writing authorized by its board of directors, approved or adopted by stockholders or members as hereinafter provided, and filed with and approved by the superintendent. The plan shall provide for the disposition, by bulk reinsurance or other lawful procedure, of all insurance in force in the insurer, for full discharge of all obligations of the insurer, and designate or provide for trustees to conduct and administer the settlement of the insurer's affairs.

2. The superintendent shall approve the plan unless found by him to be unlawful or unfair or inequitable or prejudicial to the interests of any stockholder, policyholder or creditor.

3. If a mutual insurer, the plan must have been approved by vote of not less than 2/3 of the policyholders voting thereon at a special meeting of such policyholders called and held for the purpose pursuant to such reasonable notice and information as the superintendent may have approved.

4. If a stock insurer, the plan must have been adopted by vote of not less than 2/3 of all outstanding voting securities of the insurer at a special meeting of such security holders called and held for the purpose.

5. Following approval of the dissolution and plan therefor by members or adopted thereof by stockholders as above provided, and approval by the superintendent, the trustees designated or provided for in the plan shall proceed to execute the plan. When all liabilities of the corporation have been discharged or otherwise adequately provided for, and all assets of the corporation have been liquidated and distributed in accordance with the plan, the trustees shall so certify in quadruplicate under oath in writing. The trustees shall deliver the original and the 3 copies of such certificate to the superintendent. The superintendent shall make such examination of the affairs of the corporation, and of the liquidation and distribution of its assets and discharge of or provision for its liabilities as he deems advisable. If upon such examination he finds that the facts set forth in the certificate of the trustees are true, he shall inscribe his approval on the certificate, file the original thereof so inscribed in the office of the Secretary of State, file a copy thereof in the bureau and return the remaining 2 copies to the trustees. The trustees shall file one of such copies for recording in the registry of deeds of the county in this State in which the corporation's principal place of business is located, and retain the fourth copy for the corporate files.

6. Upon filing the certificate of the trustees with the Secretary of State as provided in subsection 5, the Secretary of State shall issue to the trustees his certificate of dissolution, and the corporate existence of the corporation shall thereupon forever terminate. The Secretary of State shall charge and collect a fee of $25 for the filing of the trustee's certificate, and shall deposit the same with the Treasurer of State for credit to the General Fund.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Laws 1959, c. 152, § 1.
Laws 1961, c. 317, § 184.
Laws 1963, c. 414, § 60.
Laws 1969, c. 132, § 11.
Former § 63, 506 of title 24.

Derivation:

R.S.1954, c. 60, §§ 12–A, 34.

Library References

American Digest System
Insurance ⇐72.4.
Encyclopedias
C.J.S. Insurance § 124 et seq.
WESTLAW Research
Insurance cases: 217k[add key number]

Notes of Decisions

1. Disposal of assets

When a dissolution of a mutual insurance company has been decreed by the court, its assets remaining after paying all liabilities against the company vest in the State, as such a corporation has no stockholders, and its original corporators cannot be regarded as such. Titcomb v. Kennebunk Mut. Fire Ins. Co. (1887) 9 A. 732, 79 Me. 315.

§ 3485. Mutual member's share of assets on liquidation

1. Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, retirement of guaranty fund capital shares and payment of expenses of administration and of the dissolution and liquidation procedure, shall be distributed to currently existing persons who had been members of the insurer for at least a year and who were its members at any time within 36 months next preceding the date such liquidation was authorized or ordered, or date of last termination of the insurer's certificate of authority, whichever date is the earlier; except, that if the superintendent has reason to believe that those in charge of the insurer's management have caused or encouraged the reduction of the number of members of the insurer, or changed the identity thereof, in anticipation of liquidation and for the purpose of reducing or controlling thereby the number or identity of persons who may be entitled to share in distribution of the insurer's assets, he may enlarge the qualification period in such manner as he deems to be reasonable.

2. The insurer shall make a reasonable classification of its policies so held by such members, and a formula based upon such classification for determination of the equitable distributive share of each such member. Such classification and formula shall be subject to the approval of the superintendent, who shall approve the same except for reasonable cause.

1969, c. 132, § 1, eff. Jan. 1, 1970; 1973, c. 585, § 12.

Historical and Statutory Notes

Codification

Throughout this title, "commissioner" has been changed to "superintendent" and "department" has been changed to "bureau" pursuant to Laws 1973, c. 585, § 12, set out as a note under § 5 of this title.

Library References

American Digest System
Insurance ⇐72.5.
Encyclopedias
C.J.S. Insurance § 133.
WESTLAW Research
Insurance cases: 217k[add key number]

§ 3486. Plans for acquisition of minority interests in domestic stock insurance companies and appraisal of stock of dissenting shareholders

1. Any parent corporation directly or indirectly owning at least 95% of the aggregate issued and outstanding shares of all classes of voting stock of a domestic stock insurance company or any such domestic stock insurance compa-

ny whose voting stock is so owned may, pursuant to a plan for acquisition of minority interests in such subsidiary, acquire all of its remaining issued and outstanding shares of voting stock, by exchange of stock, other securities, cash, other consideration or any combination thereof.

2. The board of directors, trustees or other governing body of the parent corporation or the domestic stock insurance company may adopt a plan for the acquisition of minority interests in such subsidiary insurer. Every plan shall set forth:

A. The name of the company whose shares are to be acquired;

B. The total number of issued and outstanding shares of each class of voting stock of the company, the number of its shares owned by the parent corporation and, if either of the foregoing is subject to change prior to the effective date of acquisition, the manner in which any change may occur;

C. The terms and conditions of the plan, including the manner and basis of exchanging the shares to be acquired for shares or other securities of the parent corporation, for cash, other consideration, or any combination of the foregoing, the proposed effective date of acquisition and a statement clearly describing the rights of dissenting shareholders to demand appraisal;

D. If the parent corporation has adopted the plan and is neither a domestic corporation nor an authorized insurer, its agreement to be bound by this section with respect to the plan, its consent to the enforcement against it in this State of the rights of shareholders pursuant to the plan, and a designation of the superintendent as the agent upon whom process may be served against the parent corporation in the manner set forth in section 421 in any action or proceeding to enforce any such rights; and

E. Such other provisions with respect to the plan as the board of directors, trustees or other governing body deems necessary or desirable, or which the superintendent may prescribe.

3. Upon adoption of the plan, it shall be duly executed by the president and attested by the secretary, or the executive officers corresponding thereto, under the corporate seal of the parent corporation or the domestic stock insurance company which has adopted the plan, as the case may be. Thereupon, a certified copy of the plan, together with a certificate of its adoption subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of the parent corporation or the domestic stock insurance company, as the case may be, shall be submitted to the superintendent for his approval. The superintendent shall thereupon consider the plan and, if satisfied that it complies with this section, is fair and equitable and not inconsistent with law, he shall approve the plan. If the superintendent disapproves the plan, notification of his disapproval, assigning the reasons therefor, shall be given in writing by him to the parent corporation or domestic stock insurance company that submitted the plan. No plan shall take effect unless the approval of the superintendent has been obtained.

4. If the superintendent approves the plan, the parent corporation or the domestic stock insurance company which has adopted the plan shall deliver to

each person who, as of the date of delivery, is a holder of record of stock to be acquired pursuant to the plan, a copy of the plan, or a summary thereof approved by the superintendent, in person or by depositing the same in the post office, postage prepaid, addressed to the stockholder at his address of record. On or before the date of acquisition proposed in the plan, the parent corporation or the domestic stock insurance company which has adopted the plan shall file with the superintendent a certificate, executed by its president and attested by its secretary, or the executive officers corresponding thereto, and subscribed by such officers and affirmed by them as true under the penalties of perjury, and under the seal of the parent corporation or the domestic stock insurance company, as the case may be, attesting to compliance with this subsection.

5. Upon compliance with this section, ownership of the shares to be acquired pursuant to the plan shall vest in the parent corporation or the domestic stock insurance company which has adopted the plan on the date of acquisition proposed in the plan whether or not the certificates for such shares have been surrendered for exchange. If the plan was adopted by the parent corporation it shall be entitled to have new certificates registered in its name. If the plan was adopted by the domestic stock insurance company the shares shall be retired and the capital of the domestic company reduced by the par value of the retired shares. Shareholders whose shares have been so acquired shall thereafter retain only the right either to receive the consideration to be paid in exchange for their shares pursuant to the plan or to dissent to the plan and demand appraisal and receive payment of the fair value of their shares as hereinafter provided. The fair value of shares shall be determined as of the day prior to the date on which the plan was adopted, excluding any appreciation or depreciation of shares in anticipation of such corporate action. A shareholder may not dissent as to less than all of the shares registered in his name.

6. A dissenting shareholder shall file, within 20 days after the delivery to him of either a copy of the plan or a summary thereof pursuant to subsection 4, a written notice of his election to dissent from the plan and a demand for payment of the fair value of his shares. Such notice and demand shall be filed with the company which adopted the plan by personally delivering it, or by mailing it via certified or registered mail, to such company at its registered office within this State or to its principal place of business or to the address given to the Secretary of State pursuant to Title 13–A, section 906, subsection 4, paragraph B.

7. At the time of filing his notice and demand for the payment of the fair value of his shares, or within 20 days thereafter, a dissenting shareholder shall surrender the certificate or certificates representing his shares to the company which adopted the plan.

8. Within 10 days after the expiration of the period provided in subsection 6 for the shareholder to file his notice and demand, the company which adopted the plan shall make a written offer to each dissenting shareholder to pay for such shares at a specified price deemed by such company to be the fair value thereof. Such offer shall be made at the same price per share to all dissenting shareholders of the same class. The notice and offer shall be accompanied by a balance sheet of the corporation, the shares of which the dissenting shareholder holds, as

of the latest available date and not more than 12 months prior to the making of such offer and a profit and loss statement of such corporation, for the 12-months' period ended on the date of such balance sheet.

9. If, within 20 days after the date by which the company is required by the terms of subsection 8 to make a written offer to each dissenting shareholder to pay for his shares, the fair value of such shares is agreed upon between any dissenting shareholder and the company, payment therefor shall be made within 90 days after the date of delivery of the plan or a summary thereof as provided in subsection 4. Upon payment of the agreed value, the dissenting shareholder shall cease to have any interest in such shares.

10. If, within the additional 20-day period prescribed by subsection 9, one or more dissenting shareholders and the company have failed to agree as to the fair value of the shares, then Title 13–A, section 909, subsections 9, 11, 12 and 13, shall be applicable, except that:

A. The term "the corporation" as used therein shall be deemed to refer to the company which adopted a plan pursuant to subsection 2;

B. The reference in Title 13–A, section 909, subsection 9, paragraph G to the date on which a vote was taken on the proposed corporate action shall be deemed to refer to the date on which a plan was adopted pursuant to subsection 2;

C. The references in Title 13–A, section 909, subsection 11 to a shareholder's "objection" and "demand" and the reference in Title 13–A, section 909, subsection 13 to a shareholder's "demand for payment" shall be deemed to refer to a shareholder's notice and demand filed pursuant to subsection 6;

D. The references in Title 13–A, section 909, subsection 9 to "the date on which such corporate action was effected" shall be deemed to refer to the date of delivery of the plan or a summary thereof as provided in subsection 4;

E. The reference in Title 13–A, section 909, subsection 9, paragraph A to the county in the State where the registered office of the corporation is located shall be deemed, where the parent corporation which has adopted the plan is neither a domestic corporation nor an authorized insurer, to include the county where the registered office of the subsidiary domestic stock insurance company whose stock is being acquired is located;

F. The reference in Title 13–A, section 909, subsection 9, paragraph E to "this section" shall be deemed to include this section; and

G. The references in Title 13–A, section 909, subsection 9 to "subsection 8" shall be deemed to refer to subsection 9.

11. If no action to determine the fair value of the shares of the dissenting shareholder is commenced within the time specified in Title 13–A, section 909, subsection 9, paragraph C, then the dissenting shareholder shall receive the consideration which was specified as payment in exchange for his shares pursuant to the plan. Such consideration shall be paid by the company within 60 days after the time within which an action can be commenced as specified in Title

13–A, section 909, subsection 9, paragraph C. Upon payment of such consideration, the dissenting shareholder shall cease to have any interest in such shares.

12. If the court determines pursuant to Title 13–A, section 909, subsection 9, paragraph E that a shareholder is not entitled to receive payment of the fair value of his shares because of his failure to satisfy the requirements of Title 13–A, section 909 and of this section, then the shareholder shall receive the consideration which was specified as payment in exchange for his shares pursuant to the plan. Such payment shall not include the allowance for interest specified in Title 13–A, section 909, subsection 9, paragraph G.

13. Neither the right granted by this section nor the exercise thereof by a parent corporation or domestic stock insurance company shall preclude the exercise by it of any other rights it may have under this section.

14. The provisions of Title 13–A, section 525, regarding unclaimed dividends and other distributions to shareholders shall apply to any unclaimed payment to which a shareholder may be entitled under this section.

15. All laws and parts of laws of this State inconsistent with this section are superseded with respect to matters covered by this section.

1977, c. 377.

Library References

American Digest System
Insurance ⇐33.
Encyclopedias
C.J.S. Insurance §§ 96, 103.
WESTLAW Research
Insurance cases: 217k[add key number]

3. Notice to insureds. Every policy to which this section applies, either upon policy issuance or upon the first renewal after January 1, 1992, must be accompanied or supplemented by a notice, in a form prescribed or approved by the superintendent, advising the insured of the rental vehicle coverage provided pursuant to this section.

4. Application. This subchapter applies to all personal automobile policies issued for delivery in this State or renewed on or after January 1, 1992.

1991, c. 335.

Library References

Words and Phrases

Words and Phrases (Perm.Ed.)

CHAPTER 41

PROPERTY INSURANCE CONTRACTS

SUBCHAPTER I

STANDARD FIRE POLICY

§ 3007. Cancellation and nonrenewal

[See main volume for text of 1 to 7]

8. This notice does not apply to any insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time notice of cancellation is mailed or otherwise delivered, except as provided in subsection 1, paragraph A and subsection 5, paragraphs A and C. This section does not apply to any policy subject to the Maine Property Insurance Cancellation Control Act, subchapter V.[1] This section does not apply to any policy issued pursuant to any assigned risk plan. The superintendent may suspend, in whole or in part, the applicability of this section to any insurer if, in the superintendent's discretion, its application will endanger the ability of the insurer to fulfill its contractual obligation.

[See main volume for text of 9]

1991, c. 25, § 2.

[1] Section 3048 et seq. of this title.

Historical and Statutory Notes

Amendments

1991 Amendment. Laws 1991, c. 25, § 2, in subsec. 8, first sentence, added subsec. 1 exception, and made a gender-neutral language change.

SUBCHAPTER IV

GENERAL PROVISIONS

Section
3042. Loss information to be supplied.

§ 3042. Loss information to be supplied

1. Request for information. Every insurer shall provide loss information concerning an insurance policy to its insured within 30 calendar days of the receipt of a written request from the insured or an insurance agent or other authorized representative of the insured. An insurer may not cancel or refuse to renew an insurance policy for the nonpayment of premium during any period within which the insurer fails to provide the loss information requested under this section, unless the insured requests that information fewer than 45 calendar days prior to the expiration date of the insurance policy.

2. Transmittal of request. If an insured requests loss information from an insurance agent or an authorized representative of the insured, the representative or agent shall transmit the request for loss information to the insurer within 4 working days.

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section.

B. "Loss information" means the following items: the name of the insured, the date of the loss, the date the claim was received by the insurer, a description of the loss, any amount paid by the insurer on account of the loss, any amount reserved for the loss and whether the claim is open or closed.

1989, c. 696, § 2.

CHAPTER 47

ORGANIZATION, CORPORATE POWERS, PROCEDURES OF DOMESTIC LEGAL RESERVE STOCK AND MUTUAL INSURERS

SUBCHAPTER IV

CONVERSION, AMALGAMATION, DISSOLUTION

§ 3474. Merger, consolidation of stock insurers

1. Subject to the provisions of this section, a domestic stock insurer, whether or not authorized to transact insurance in this State, may merge or consolidate with one or more domestic or foreign stock corporations by complying with the applicable provisions of the laws of this State governing the merger or consolidation of stock corporations formed for profit.

A. A corporation merging or consolidating with a domestic stock insurer must be incorporated as an insurer in the manner provided by its state of incorporation, but the corporation need not be authorized or licensed to transact insurance by any state prior to the merger or consolidation.

B. A foreign or alien insurer may merge or consolidate pursuant to this section with a domestic insurer only if, at the time of the merger or consolidation:

(1) The domestic insurer is authorized to transact insurance in this State; o

(2) The foreign or alien insurer meets all requirements applicable to a domesti insurer set forth in this Title for initial authorization to transact in this State th kinds of insurance, as defined in chapter 9,[1] then transacted by that insurer i any jurisdiction.

C. A domestic insurer may not participate in a merger or consolidation that wi result in the surviving or new corporation being domiciled in a jurisdiction other tha this State unless the surviving or new insurer in the merger or consolidation obtai a Certificate of Authority in the jurisdiction in which it will be domiciled and in th State to transact the kinds of insurance for which any participating insurers we authorized at the time of the merger or consolidation and agrees to maintain th certificate of authority in this State until and unless the superintendent approves plan of withdrawal filed pursuant to section 415–A.

D. The following provisions apply to the authority of the surviving or new corpo tion to transact insurance in this State following the merger or consolidati

(1) If the surviving or new corporation is a domestic insurer and no participati corporation in the merger or consolidation was authorized or licensed to trans insurance in this State, the surviving or new domestic insurer shall meet applicable requirements of this Title for initial authorization to transact all kir of insurance, as defined in chapter 9, formerly transacted by any participat insurer or insurers in any jurisdiction.

(2) If the surviving or new corporation is a domestic insurer and seeks authority to transact kinds of insurance other than those for which the domestic insurer or insurers participating in the merger or consolidation were authorized at the time of the merger or consolidation, that corporation must meet the requirements set forth in this Title for initial authorization to transact those kinds of insurance.

(3) If the surviving or new corporation is a foreign or alien insurer that seeks to transact insurance in this State, that corporation shall meet all applicable requirements of this Title for initial authorization to transact all kinds of insurance, as defined in chapter 9, formerly transacted by any participating insurer or insurers as well as for any additional kinds of insurance for which authority is sought.

2. No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the superintendent and approved in writing by the superintendent after a hearing thereon after notice to the stockholders of each insurer involved. The superintendent shall give such approval within a reasonable time after such filing unless the superintendent finds that the plan or agreement:

A. Is contrary to law;

B. Is unfair or inequitable to the policyholders of any insurer involved;

C. Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this State or elsewhere;

D. Would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or

E. Is subject to other material and reasonable objections.

In making any determination required by paragraph C, the superintendent may consider, among other factors, whether the surplus of the surviving or new corporation satisfies the requirements of section 410.

[See main volume for text of 3, 4]

1989, c. 611, §§ 2, 3, eff. Feb. 14, 1990.

[1] Section 701 et seq. of this title.

Historical and Statutory Notes

Amendments

1989 Amendment. Laws 1989, c. 611, § 2, among other changes, in subsec. 1, opening par., deleted provision preventing a domestic stock insurer from merging or consolidating with any corporation not formed for the purpose of transacting insurance as an insurer; and added subsec. 1, pars. A to D.

Laws 1989, c. 611, § 3, in subsec. 2, opening par., made references to superintendent gender-neutral; in subsec. 2, par. B, substituted reference to policyholders for reference to stockholders; and added closing par. to subsec. 2, which allowed the superintendent to consider whether the requirements of § 410 of this title have been satisfied, when making a determination under subsec. 2, par. C.

Application

1989 Act. Laws 1989, c. 611, § 4, eff. Feb. 14, 1990, provided:

"Notwithstanding the terms of the Maine Revised Statutes, Title 1, section 302, this Act shall apply with respect to any filing by a domestic stock insurer seeking approval of the Superintendent of Insurance of its plan and agreement of merger, including any filing which has been previously filed with and which is currently pending hearing or decision by the Superintendent of Insurance on the effective date of this Act. [Feb. 14, 1990]."

§ 3483. Bulk reinsurance

[See main volume for text of 1 to 5]

6. The superintendent may adopt rules, subject to Title 5, chapter 375,[1] to effectuate this section.

1989, c. 846, § E-3.

[1] Section 8001 et seq. of title 5.

Historical and Statutory Notes

Amendments

1989 Amendment. Laws 1989, c. 846, § E-3, added subsec. 6.

CHAPTER 52

MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY

Historical and Statutory Notes

Codification

Laws 1991, c. 615, § D-1, enacted Chapter 52, Maine Employers' Mutual Insurance Company.

Application

1991 Act. Laws 1991, c. 615, § D-26, provided:

"Except as otherwise provided, this Act applies only to injuries occurring on or after the effective date of this Act."

§ 3701. Purpose

The Maine Employers' Mutual Insurance Company may be established for the purpose of providing workers' compensation insurance to employers of this State at the highest level of service and savings consistent with applicable actuarial standards and the sound financial integrity of the company.

1991, c. 615, § D-1.

Historical and Statutory Notes

Application

1991 Act. Laws 1991, c. 615, § D-26, provided:

"Except as otherwise provided, this Act applies only to injuries occurring on or after the effective date of this Act."

§ 3702. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Board.** "Board" means the Board of Directors of the Maine Employers' Mutual Insurance Company.

2. **Company.** "Company" means the Maine Employers' Mutual Insurance Company created in section 3703.

1991, c. 615, § D-1.

Historical and Statutory Notes

Application

1991 Act. Laws 1991, c. 615, § D-26, provided:

"Except as otherwise provided, this Act applies only to injuries occurring on or after the effective date of this Act."

Library References

Words and Phrases

Words and Phrases (Perm.Ed.)

§ 3703. Creation

The Maine Employers' Mutual Insurance Company may be established as a domestic mutual insurance company subject to all the requirements and standards of this Title except those from which it is specifically excepted. Notwithstanding any other law to the contrary, the company's authority to operate is limited as follows.

SUMMARY OF WORK SESSION OF JULY 1, 1992
(Lewis Checklist)

ISSUE: SECURING THE PAYMENT OF BENEFITS

still ?'s

Picker: Voluntary market
Mutual Fund
If have state competitive fund it must be completely separate from the state treasury - the fund should not be able to be a drain on the state treasury in any way nor should the state be able to borrow or use the fund's assets or credit - an impenetrable barrier must be set up.

Hathaway: ME law for self-insureds
Mutual fund - not run by state
New Mexico plan

Dalbeck: ME law plus competitive mutual fund (self-supporting)
Greater accountability
Role of Insurance Dept. same as with other types of insur.

Levesque: Greater monitoring of system
ER/EE participation, no one watchdog

ISSUE: ESTABLISHMENT OF WORKERS' COMPENSATION INSURANCE RATES

MI - comp. mkt.

Hathaway: MI law
Competitive market

Dalbeck: MI law
Possible ceiling on rates for approx. one year

Levesque: MI law
Competitive market is key
Ceiling on rates for 1 to 1 1/2 years

Picker: MI law?
Ceiling on rates could be disincentive to get insurance companies back in the market; consider file and use for those coming into market

ISSUE: COVERAGE OF EMPLOYERS AND EMPLOYEES

ME law
questn re MI posit'n
@ subs.

Dalbeck: ME law

Levesque: ME law

Picker: ME law

One problem - small companies disadvantaged in competing with those not included in the system; should extend safety to all ER's, not just those in the system

Hathaway: ME law
Need more input on MI position that contractors are responsible for subs if not providing their own insurance

ISSUE: COVERAGE OF INJURY AND DISEASE

ME law question re: predom. cause

Levesque: ME law
Need to educate medical profession
Medical profession should be able to be relied upon to determine underlying cause of diseases

Picker: Need to move workers' comp. back to its real purpose instead of using it as a substitute for a health care system
Predominant cause definition

Hathaway: ME law - clearer definitions
Not in favor of predominant cause - will only lead to more litigation

Dalbeck: ME law - better definitions, less confusing
Need more input regarding predominant cause

ISSUE: INDEMNITY BENEFITS

MI law - 80% net

TOTAL DISABILITY

Picker: ME or MI law - doesn't matter

Hathaway: MI law - more realistic

Dalbeck: Leaning toward MI law
Likes 80% net

Levesque: MI law
80% net should maybe be just a guideline

PARTIAL DISABILITY

impairment v. wage loss (Burtt report)

Hathaway: MI law
Need more testimony on impairment basis, but leaning against impairment and toward income basis

Dalbeck: Leaning towards MI law, except for lack of cap
Keep ME cap of 520 weeks

Need more input on impairment basis

Levesque: MI law with some adjustments

Picker: Wants to hear from Barth before making final decision

ISSUE: DEATH BENEFITS

Dalbeck: MI law

Levesque: MI law

Picker: Either

Hathaway: MI law

ISSUE: MEDICAL BENEFITS

Levesque: Need to bring costs in line with regular health care costs

Picker: Need good administration of medical system, doesn't matter so much what the law is
Need to bring costs in line with regular health care costs

Hathaway: Likes aspects of ME and MI systems
No decision right now

Dalbeck: Leaning toward MI, but likely a mixture of ME and MI
Likes fee schedule, utilization review, ER involvement in selection of doctor, expert IME's

Levesque: ME and MI both sound fair
Questions part of MI plan where ER chooses doctor but EE can choose own doctor within 10 days - questionable time frame

ISSUE: BENEFIT DELIVERY MI law

Picker:

Hathaway:

Dalbeck: MI law

Levesque: MI law - simplifies system

ISSUE: DISPUTE RESOLUTION further discussi

Hathaway: Likes aspects of ME and MI law
Postpone decision until further discussion

Dalbeck: Leaning towards MI law, but open to improvements in it
Likes informal stages of MI law, but there's a resource problem

Levesque: MI law - 40-50% of cases could be solved by mediation

Picker: Favors MI law at this point

ISSUE: ATTORNEYS' FEES MI

Dalbeck: MI law - consistent with what we are trying to accomplish

Levesque: MI law

Picker: MI law

Hathaway: MI law - likes fee schedule and fees out of EE's award

ISSUE: LUMP SUM SETTLEMENTS MI

Levesque: Some reservations as to lump sum settlements, but might be good in some areas
Need counseling as to how to use lump sum award properly

Picker: MI law

Hathaway: MI law
Need to monitor lump sums

Dalbeck: Concerns about lump sums, can't get rid of them completely but need to have more guidelines to make sure appropriate in particular cases
More regulation, control

ISSUE: ADMINISTRATIVE STRUCTURE like TX system

Picker: Need restructuring, MI good model but needs some changes
ER/EE committee is desirable, act as Board of Directors
Make it a separate agency
Fund system by contributions from all ER's, separate from state funds
Magistrate-types should be selected by ER/EE panels

Hathaway: Texas plan - run by 6 member ER/EE board with no public

member to break ties, must come to agreement or deadlock
Selection of ER's and EE's - labor groups (AFL-CIO) submit slate to governor, local chambers should submit slate to governor (unlike in TX where governor alone appoints)
Do not make it part of Department of Labor (unlike MI)
ER/EE commission should run the show - can set up depts., choose an executive director, etc.
Commissioners should be part-time and compensated on a per diem basis for any lost wages while serving
Role of Supt. of Insurance should be limited
Need to study area more

Dalbeck: Likes separate agency idea, except Dept. of Insurance should still play their normal role as they do with other types of insurance, especially with regard to competitive fund
Should not be part of Dept. of Labor
Likes idea of ER/EE commission - thinking of 8 members
Likes part-time, per diem basis idea
Chair of commission should rotate
Fund the same as now except put it all in separate, not general, fund
Should work with Dept. of Labor on safety programs

Levesque: Agrees with separate agency and ER/EE committee having complete supervision
Need one person to answer for entire system
MI law not ideal way to go
ER/EE commission should monitor safety programs of <u>all</u> ER's

Picker: Agrees with much of what has been said
Should also consider that the independent agency be involved in the appointment of IME's - ER's and EE's should agree on doctors
Also need to look at residual pool servicing

ISSUE: COORDINATION OF BENEFITS MI law

Hathaway: MI law - greater coordination of benefits

Dalbeck: MI law - cannot separate benefits and the coordination of benefits

Levesque: MI law

Picker: MI law

ISSUE: SPECIAL FUNDS

ME/MI mix questions re: pool

Dalbeck: Mix of ME and MI law
MI's second injury fund looks good but there's the dust disease, logging aspect
Need more data, especially regarding workplace health and safety fund

Levesque: Need to make sure special funds are used for what they were intended
Monitoring
Need incentives for ER to retrain

Picker: Maybe should leave special funds up to discretion of ER/EE commission - that way they can adjust to changes
Tell commission they have power to create special funds but focus should be on getting people reemployed

Hathaway: Some merit to Picker's suggestion, but should be careful about making too broad a delegation - should limit the number of funds they can create and create guidelines for them

ISSUE: VOCATIONAL REHABILITATION

MI law - K basis

Hathaway: MI law
Do not make it mandatory, some type of contract basis

Dalbeck: MI law - more informal approach
Get people back to work
Apply voc. rehab. where it will work

Levesque: MI law
Do not make it mandatory
Use of rehab. is good but must be selective

Picker: MI law - simple, informal

ISSUE: SAFETY

ME law further discussion

Dalbeck: ME law - way ahead of MI

Levesque: Reservations about MI law
Problem with ME law - no safety programs since advent of OSHA which can't properly supervise workplace safety
Dept. of Labor should do its fair share
Group self-insureds should teach one another safety

Picker: ME law better - leave it to federal regulation
MI having its own OSHA is not good

Need to enhance safety inspections by the state
Need to later discuss possibility of putting safety advice under Workers' Comp. Comm. but expecting it to be further reaching (applicable to all ER's) - better than putting safety under Dept. of Labor because ER's and EE's both have self-interest in safety

Hathaway: Have Workers' Comp. Comm. responsible for safety

AREAS IN WHICH ADDITIONAL INFORMATION IS NEEDED

✓ COVERAGE OF EMPLOYERS AND EMPLOYEES
(Hathaway/Levesque)

Under MI law - how are subcontractors treated and defined

COMPENSABILITY - July 14th, 15th
→ (Lewis)

More info regarding predominant cause definition

PERMANENT PARTIAL - wait for Lewis July 14th, 15th
(Barth)

Whether impairment approach is worth considering

✓ MEDICAL BENEFITS
(Picker)

More general info, including fee schedules

✓ DISPUTE RESOLUTION — type up detailed summary - give to Hathaway to review
(Hathaway/Jane Orbeton)

General info, including small claims area

✓ ADMINISTRATIVE STRUCTURE
(Dalbeck)

General info and fleshing out

✓ SPECIAL FUNDS
(Lewis/Levesque/Picker)

General info

OTHER AREAS THAT NEED TO BE STUDIED AND DISCUSSED

✓RESIDUAL POOLS

MONITORING OF THE SYSTEM — Lewis

HOW TO PHASE IN A NEW SYSTEM/WHAT TO DO ABOUT OLD SYSTEM

OMBUDSMAN — coding what do under ME law

CONFLICT OF INTEREST LAW

✓COMPETITIVE MUTUAL ~~COMPANY~~ FUND

7/5/92

To Bill, Dick, Emilien

From Harvey

Suggested Workers' Comp Medical System

Preface

The term "commissioner" or "commission" in this memo, is not used to denote dispute resolution officers as in the current Maine compensation system. Here the terms denote the chief policy making body and its members. The commission is comprised of an equal number of employers and employees, and has no other representative on it. The commissioners' duties and responsibilities are consistent with the concept we outlined in our 7/1/92 meeting.

I'll be glad to provide more details of the following system but rather than do it in this memo let me give you this general outline of the mechanism recommended.

Introduction

As Peter Barth pointed out in his excellent presentation, one doesn't normally expect to have to employ an attorney to collect social security benefits or medical expenses which are covered by an insurance policy. By the same token it ought to be possible to operate a worker's compensation system which will provide an injured worker good medical care with the benefits of case management.

The major thesis of the following concept is to keep the costs of worker's compensation medical care comparable to the cost of treating a similar case in the regular medical system, and to assure that worker's illnesses or injuries are managed so competently, objectively and authoritatively that the current level of disputes about the medical aspects of cases are sharply reduced.

The Medical Division

A division of the Worker's Compensation Commission is established that has the responsibility and authority to manage the medical aspects of worker's care in a manner consistent with the most efficient and effective systems currently in use for insured medical care.

Medical Advisory Board

The purpose of the Medical Advisory Board is to assist the commissioners by providing advice. All professional aspects of the medical division are monitored by it.

It's members are physicians (including a member who is a D.O. and a chiropractor). The medical advisory board reports to the commissioners on the quality of care workers receive, the efficiency with which that care is delivered, and the effectiveness of the medical division's staff.

The Medical Advisory Board is assisted by advisory committees comprised of appropriate health care professionals who serve or are knowedgeable in the various pertinent aspects of occupational health.

Quality and cost control

There are two major mechanisms used to asssure high quality health care for the worker and reasonable cost of operations for the system.

1. **A case management system** is created which the medical division uses to assist the injured worker find his way through the health care system, and to insure that the amount of care is consistent with good medical practise.

Protocols for case management of the more complex or expensive types of injury or illness are to be developed. These protocols will largely be based on the federally issued guidelines promulgated by the Agency for Health Care Policy and Research. They will cover not only the care given by physicians but also other health related aspects of a worker's treatment including care by other health care or occupational providers.

Protocols formulated by advisory panels will insure general agreement as to what constitutes normal practise in treating a given type of injury or illness, and therefore should largely eliminate one scource of friction between employers and employees. The protocols provide a standard for the person charged with deciding a dispute.

Utilisation review will be performed by a committee appointed that purpose. It will use the protocols as a standard, and will, when appropriate, recommend changes. The utilization review committee, by appropriate sampling techniques, will call to the attention of health professionals instances where their practise gives indication of possible overutilization.

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The term "independent medical examiner" no longer is used in its current confusing sense of either being an independent medical authority or a person whose selection by an insurance company raises questions of objectivity.

Independent Medical Examiners in the new system are completely independent of the factions in disputes. They are have been selected by the Compensation Commission for being especially qualified to evaluate occupational type problems. They are not only able to assess the degree of injury as a medical diagnostician, but are specifically qualified to asses the extent to which an injury limits ability to work at specific tasks. Their proficiency will be indicated by their having been board certified by organizations such as the American College of Occupational Medicine, or by some other appropriate selection system. The perception of IME's as objective is enhanced by the fact that they are paid by the Commission.

Independent Medical Examiners are not full time employees. They are members of a selective panel of no more than 25 MDs or DOs to be called upon by the mediator or hearing examiner in a dispute. They will also be called upon by the commission's medical division as experts to render advice in the early stages of the care of difficult cases to insure that a patient's treatment is appropriate to both the patient's welfare and in its cost.

On the IME panel will be representatives from various specialties that may be required from time to time to evaluate specialised types of disabilities.

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FILE

Federal Maritime Commission
Washington, D.C. 20573

Office of the Commissioner

NUMBER OF PAGES: 7 including cover DATE: July 6, 1992

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TO: Michelle Bushey for William D. Hathaway RECIPIENT'S TELEPHONE NUMBER: 207-780-4578

FAX MACHINE NUMBER: 207-780-4913

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FROM: Lori Becker SENDER'S TELEPHONE NUMBER: 202-523-5715

SENDER'S FAX NUMBER: (202) 523-0298

****

SPECIAL INSTRUCTIONS:

DATE July 6, 1992 TOTAL # OF PAGES $6

TO William Hathaway

FAX # 202-523-0298

TELEPHONE # _____

FROM: HARVEY PICKER
TELEPHONE # 207-236-8851
FAX # 207-236-3510

Dick + Bill

I've been told that the best people for information on the residual pool are Mitch Sommers or Bill Vieweg. Dick Johnson has their telephone numbers.

You probably know this already.

Regards,
Harv

7/6/92

Michelle,

Many thanks for your summary of the work session. It is most helpful.

During the discussion of a state competitive fund, I made a comment that I feel strongly enough about to ask that it be included:

If we are to have a state competitive fund it has to be devised so that it is impossible for it to become a drain on the state treasury in any way. It must also be impossible for the state to borrow, hypothecate, or in any other way to use the competitive fund's assets or credit. In other words, an impenetrable barrier has to be created between the state's funds and taxing ability on the one side, and the assets, credit, and fiscal soundness of the fund.

Harry Picker

cc Dick Dahlbeck
Bill Hathaway
Emilien Levesque

To: Bill. Emilion, and Harvey

From: Dick

Re; Phone call 7/9/92 from Steve Clarken (IP), John Melrose, and Roger Maller re some concerns of theirs.

Concerns expressed were:

1. Maintaining a cap on permanent partial. They feel this is the single most important change in recent years. I explained we were looking quite intensively at this, including input from M&R.

2. Changes made recently have reduced costs. They fear MI would put many of these back. An example is including benefits as part of the wages, especially as applied to lower paid workers. I did not comment one way or another. (I wonder how many of the low paid workers are covered by benefits.)

This led to a discussion which gave me some added insight into the community vs. statewide search for work. This mapparently ONLY pertains to workers who are partially disabled if they are to get <u>total</u> disability. They can still claim partial (e.g. 10% or whatever).

3. Liability for subcontractors. Steve sent us a letter on this. It is a huge issue in the wood products area. I did not commit but am very leary about extending coverage at this time which will increase cost, which we are trying to reduce.

4. Residual market deficit. They made three points:

a. The numbers need to be challenged. (The Ins. Bureau seems to feel the same.) I've asked M&R to look at the NCCI projections.

b. Make the 1991 law which is basically procedural changes (altho statewide search might not be considered all that procedural by some) retroactive.

c. Don't hit the self insured, who are taking care of their own responsibilities.

5. Market collapse. Need a mechanism that will assure a market opn Jan. 1st. They are interested in the Kany proposal. They like the idea of a system which applies peer pressure. They fear one big fund won't provide enough focus and could become too bureaucratic. They note the difference in size between N.M. (about $65MM) and ME ($250MM).

6. Compensibility. Don't want MI. Suggest we have made progress in ME. Suggest we look at the way Oregon proportions rather than using predominant cause.

7. A few misc. others:

a. The Loggers Fund simply has other industries subsidizing logging.

b. Don't try to cap competitive rates. That's what happened before.

c. They are leary of a 50-50 lab or management.

d. Don't let the use of MI law rule out ME's occupational disease law. That has verfy much iomproved our definitions.

e. We changed our seasonal worker approach in 1987 to one which better reflect earning capacity. MI could change it back.

f. Consider having a brief period during which the proposed statute can be commented on. It might eliminate some objections/oversights.

7/8/92
10

To Bill, Dick, Emilien

From Harvey

(Page 3 has been revised
Revision is underlined)

Suggested Workers' Comp Medical System

Preface

The term "commissioner" or "commission" in this memo, is not used to denote dispute resolution officers as in the current Maine compensation system. Here the terms denote the chief policy making body and its members. The commission is comprised of an equal number of employers and employees, and has no other representative on it. The commissioners' duties and responsibilities are consistent with the concept we outlined in our 7/1/92 meeting.

I'll be glad to provide more details of the following system but rather than do it in this memo let me give you this general outline of the mechanism recommended.

Introduction

As Peter Barth pointed out in his excellent presentation, one doesn't normally expect to have to employ an attorney to collect social security benefits or medical expenses which are covered by an insurance policy. By the same token it ought to be possible to operate a worker's compensation system which will provide an injured worker good medical care with the benefits of case management.

The major thesis of the following concept is to keep the costs of worker's compensation medical care comparable to the cost of treating a similar case in the regular medical system, and to assure that worker's illnesses or injuries are managed so competently, objectively and authoritatively that the current level of disputes about the medical aspects of cases are sharply reduced.

The Medical Division

A division of the Worker's Compensation Commission is established that has the responsibility and authority to manage the medical aspects of worker's care in a manner consistent with the most efficient and effective systems currently in use for insured medical care.

Medical Advisory Board

The purpose of the Medical Advisory Board is to assist the commissioners by providing advice. All professional aspects of the medical division are monitored by it.

It's members are physicians (including a member who is a D.O. and a chiropractor). The medical advisory board reports to the commissioners on the quality of care workers receive, the efficiency with which that care is delivered, and the effectiveness of the medical division's staff.

The Medical Advisory Board is assisted by advisory committees comprised of appropriate health care professionals who serve or are knowedgeable in the various pertinent aspects of occupational health.

Quality and cost control

There are two major mechanisms used to asssure high quality health care for the worker and reasonable cost of operations for the system.

1. **A case management system** is created which the medical division uses to assist the injured worker find his way through the health care system, and to insure that the amount of care is consistent with good medical practise.

Protocols for case management of the more complex or expensive types of injury or illness are to be developed. These protocols will largely be based on the federally issued guidelines promulgated by the Agency for Health Care Policy and Research. They will cover not only the care given by physicians but also other health related aspects of a worker's treatment including care by other health care or occupational providers.

Protocols formulated by advisory panels will insure general agreement as to what constitutes normal practise in treating a given type of injury or illness, and therefore should largely eliminate one scource of friction between employers and employees. The protocols provide a standard for the person charged with deciding a dispute.

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SUMMARY OF WORK SESSION OF JULY 10. 1992
(Further discussion of Lewis checklist)

ISSUE: COVERAGE OF EMPLOYERS AND EMPLOYEES

(Subcontractor problem)

Levesque: MI law would help subs to alleviate some of liability
Contractor must assume part of responsibility especially in hazardous industry
MI law would perhaps create more comfortable culture between contractor, subs and ee's
Correspondence has indicated that the industry couldn't absorb this, but other states have been able to do so
Limit this to logging area and keep present exemptions under ME law

Dalbeck: Wants more insight regarding rates - why are MI's rates higher in logging despite having a logging fund?
Additional liability on paper companies will only drive rates higher
Limit to logging area and keep present exemptions under ME law

Picker: If subs entirely responsible for Workers' Comp., there is an unfair advantage when competing for jobs to those who do not carry it
Compromise - at time sub is hired, hiring co. should have to require proof that sub has Workers' Comp. and should do an annual review to make sure they continue to have it - this would exempt hiring co. from any liability; if hiring co. fails to do this, it would be at risk
Such a compromise spreads costs and responsibility for safety.
If sub cannot afford workers' comp. then shouldn't be in business - just like if can't pay taxes or its ee's
Keep present ME exemptions

Hathaway: Keep present ME exemptions

ISSUE: INDEMNITY BENEFITS

(Permanent Partial - Barth memo)

Hathaway: Against impairment approach - only benefit is to give payor idea of costs from the outset, avoids paying

appropriate money to ee

Picker: Against impairment approach

Dalbeck: Leaning away from impairment approach, but wants more info from Lewis

Levesque: Wants more info from Lewis

ISSUE: MEDICAL BENEFITS

Picker: See Picker's typed outline
Highlights of outline:
- Creation of med. division in Workers' Comp. system
- Med. advisory board
- Case management system and development of protocols; in response to Dalbeck's concerns - more appropriate term may be monitor rather than manage, in protocols should determine which cases will be tracked and which will fall out of the system - no desire to see costly bureaucracy
- Utilization review - make sure no over-utilization
- Fee schedules - published and followed, based on fed. gov't. standards - RBRVS system
- Dr. selection at time of injury - MI system
- Require data collection for cost control and efficiency
- Panel of IME's - paid by Commission, about 25 IME's, <u>not</u> full time ee's, selected on basis of special qualific., medical opinion final, qualified to look at job person does and say whether they could con't to do such a job
- IME's chosen by judge in each case

Hathaway: Likes Picker's plan

Dalbeck: Likes plan but nervous about case mgt. and degree to which state agency involved as a medical case manager-costly-maybe need to define this area better

Levesque: Likes Picker's plan overall
- Concerned that there are only 3 medical professionals in ME trained in occupational injury
- Contract basis might be the best solution

ISSUE: DISPUTE RESOLUTION

Hathaway: Attitudes need to change, the system itself should not lend itself to litigation

Mandatory mediation - contract out for mediators; tight time frame, begin within 7-10 days and finish within 30 days; mediation on the premises if possible; informal; mediators must submit written report to Commission regarding outcome of mediation - if no settlement, issues can be narrowed for further proceedings

If mediation fails to bring about settlement, Commission would hear the case - either a specified number of Commissioners would hear the case or could contract out to an arbitrator; record of proceeding should be kept; state administrative procedure act will apply to hearings, in addition to other rules made by Comm.

Pre-trial procedures eliminated

Outcome of proceeding before Commission is <u>final</u> - appeals limited to claims of constitutional error which would include a claim that there are no facts to support a decision (due process claim) - there is constitutionally no need for an appeal mechanism unless there is a claim of constitutional error

Board could certify questions to the Law Court if they would like advice on a given issue

To avoid any abuse of the Board applying law, there should be an Office of General Counsel which can advise the Commission as to the law

IME's medical report is final - this will reduce litigat.

Review attorneys' fee limitation - might modify MI system; discuss this with Lewis

Picker: Hathaway's outline sounds great

There might be a lot of cases at first, but hopefully the caseload will drop sharply - should give safety valve to Commissioners to obtain outside help if caseload gets too heavy

Dalbeck: Outline needs clarification

Seems to change the concept of the labor-mgt. board to more of a judicial role - very large burden on them, might make it a <u>full</u>-time position

Levesque: Likes Hathaway's outline

ISSUE: ADMINISTRATIVE STRUCTURE

Dalbeck: See Dalbeck's typed outline

Picker: Outline good overall
Hesitant about having selection of labor-mgt board in sole hands of AFL-CIO and Chamber - should think of some other selection process, perhaps geographic

Levesque: Good outline
Leans towards 8 Commissioners because of the size of the state, especially if they do the hearings

Hathaway: Good outline
Need to make sure that labor and mgt. reps. are real representatives

ISSUE: SPECIAL FUNDS

(Safety as a special fund)

Levesque: Need special funds to take care of the residual market
Needs to be handled outside the political arena
Set up so that state cannot borrow from it
Safety should be a special fund
Need data to go by; the Bureau of Labor Standards has no statistics and no money to i.d. safety problems
Under one of the new rules 1/2 of a 5% surcharge on premiums goes into a safety/training fund, but no set policies on how to handle such a fund, no real monitoring in place - Commission could set up such a fund and monitor it, take this out of Dept. of Labor before it goes into effect and put it in the Workers' Comp. Commission

Picker: Barth warns against anything looking like sanctions in the safety area; education is okay, but enforcement runs into OSHA - one possibility is for the state to do safety inspections and publish a list of those who do not comply, has been effective in other states
Washington state requires joint health and safety committees in companies with over 11 ee's to investigate accidents and evaluate company safety programs - good idea
Maine needs to focus on accident prevention rather than on long-term health research (can get this from fed. gov't.)
Other special funds up to discretion of Commissioners
Disturbed with dividing safety; put it all in the Workers' Comp. Commission - labor and mgt. are the people most concerned about and affected by safety

Funds for safety should come out of workers' comp. assessment
Need funding immediately to start safety programs

Dalbeck: Need second injury fund, important to MI approach
In creating new Commission with new functions (e.g. responsibility for safety) wondering if dumping too much on 8 Commissioners
Might be premature to preempt the new safety rules, don't know how they'll work yet
Maybe task force should look at this later

Hathaway: Safety is the most important issue and needs to be dealt with now
Should discuss this with Lewis as the Blue Ribbon Comm. needs to come to some agreement on this issue

ISSUE: COMPETITIVE MUTUAL FUND

Dalbeck: See Dalbeck's typed outline

Picker: If initial financing from state, want to make sure state cannot default; make organizations jointly responsible to pay - look thru corporation to individuals
Should consider limits on Board members' terms - don't want it to become a fast group
Concerned that fund would have to accept any ER as policyholder - don't want to go back to old problems; maybe should accept everyone the first year, but at the end of 2 years any company not meeting reasonable standards needs to solve its own problems
Everyone can stay in the fund if can afford to pay their rate; should be no subsidies
Would almost eliminate high risk pool
Should also consider taking group of companies and putting them in the same pool; get like companies monitoring each other (mimic self-insureds); don't have one group subsidize another

Hathaway: Should leave the question of whether a company gets to stay in high risk pool to discretion of the Commission-what if company had a major accident with many injuries?

Levesque: Good outline
Mechanics of pool initially should have some leeway - give at least a second chance before kicking anyone out of the system (includes raising rates so high that a company cannot afford to pay them)

Revised 7/14

MAINE WORKERS COMPENSATION COMMISSION

A New Independant Agency

The Commission

* Eight (or six?) Commissioners
* Equally divided between :
    -Labor (i.e. no -management wage earners employed by a covered company)
    -Management (i.e. owners or management level people whose companies are insured or self insured under workers comp.)
*Representation
    -If eight, small (50 or less ees), medium (51-500) and large (500 plus) and one municipal representative.
    -Same breakdown for labor and management.
* Selection Process
    -Potential nominees would be submitted to the Governor by representative labor or management organizations (and, after the initial year, the Workers Compensation Commission itself). The Governor would appoint with normal legislative approval.
    -Ability and willingness to collaborate should be a major part of the selection criteria.
    -In the initial Commission, at least two of the labor and management members should come from the ad hoc labor management Workers Comp Group.
*Terms of Office
    -Four years, if eight. Three if six.
    -Staggered terms. Only one labor and management position open each year. Initial appointments should be for 4, 3, 2, and 1 year terms.
    -Vacancies due to resignation should be filled only for the remainder of the term.
* Chair
    -Rotate between labor and management every six months.

Accountability of the Commission

* Overall management of the Commission with and objective of assuring appropriate benefits at a cost which is competitive with the average state.

Responsibilities of the Commission

* Hires the Director of the Commission who is responsible for day-to-day management of the Commission.
* Approves and monitors the Commission's budget.
* Establishes policies and approves regulations by which the Commission operates.
* Appoints mediators, magistrates and any appeals board. Note that these may be either contract positions on Commission employees.

* Approves the appointment of other Commission senior staff.
* Reviews the performance of magistrates, appelate and senior staff.
*Creates and appoints Advisory Boards (see below).
* Communicates to labor and management throughout the state a culture which enhances an appropriate and expeditious handling of workers compensation claims and a fast return to work.
* Establishes safety programs and promotes a safe work environment.
* Assures that the Commission maintains an adequate data gathering and analysis activity and monitors the results of the Commission's efforts.
* Makes appropriate recommendations to the governor and legislature for changes in the workers compensation statutes.
* Reviews and advises on all W/C legislation proposed by the legislature or governor. This review is mandatory before any new legislation can be enacted.
* Initiates new programs which may be necessary to attain the Commissions goals.
* Approves experimental programs for the delivery of workers compensation benefits such as the integration of W/C with other benefits (e.g. 24 coverage, cafeteria, etc).

Compensation of the Commission

* Commissioners will be reimbursed for all expenses and for any lost wages due to Commission meetings, up to a maximum of $100 per day.

Advisory Boards

* The commission shall establish a Safety Board to provide input on safety matters and help in the promotion of workplace safety.
* The Commission shall establish a Medical Advisory Board to provide input on medical matters as well as assistance in the employment of expert Independant Medical Examiners.

Function and Structure of the Commission Staff

* The Commissioners, working with the Director, are responsible for the organization structure.
* That structure shall include the functions performed by the State of Michigan except that they will be combined into a single agency.
* The specific structure can deviate from that of Michigan. However, it will include a data gathering function and a Safety Bureau at a senior level.
* Compensation for all positions, including magistrates and appelate commissioners will be consistent with the job evaluation practices of the State Government in Maine.

Funding

* The commission's operations shall be funded by an assessment on insurers and self insured employers as currently practiced in Maine.
* The assessed money shall be placed in a special fund under the management of the Commissioners.
* This Process will not be instituted until after the current budget biennium, during which time the Commissioners will determine the needs of the Commission and its special funds. The eventual assessments will not exceed the current assessment rates.

Role of the Insurance Bureau

* The Insurence Bureau will exercise for workers comp its normal insurence functions consistent with other types of insurance coverage. These include:
    -Approval of insurence companies to do business in the State and to provide workers compensation insurance.
    -Filing and review of rates.
    -Self insurance approval.
    -Financial audit of companies (including the special workers comp state mutual company).
    -Etc.

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    -If eight, small (50 or less ees), medium (51-500) and large (500 plus) and one municipal representative.
    -Same breakdown for labor and managtement.
* Selection Process
    -Labor representatives nominated by Maine AFL/CIO and any other representative labor group.
    -Three Management representatives nominated by Maine Chamber of Commerce and Industry in consultation with local and regional chambers. One nominated by the Maine Municipal Association.
    -Three names nominated per open position. Names submitted to the governor who would appoint with legislative approval.
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    -Financial audit of companies (including the special workers comp state mutual company).
    -Etc.

Revised 7/14

MAINE MUTUAL WORKERS COMP COMPANY
(A Proposal)

The Charter

* Legislation would create an independant, non-profit corporation. It would be responsible for running a special competitive workers compensation fund. The charter would require it to become a mutual insurance company in the future, at such time that it could generate sufficient capital for that purpose. While it would establish its own sound underwriting practices and related rate structure, its priority, by law, is to serve ANY small or medium sized employer in the state seeking coverage, except as provided below for companies unable to control their risk.

* The company is NOT an agency of the State of Maine and is not to be supported in any way by the State's general fund. There are no State guarantees related to the fund or the Company's operation.

* Initial financing????

* The company will operate to the benefit of its policyholders utilizing the principals of equity normally practiced by mutual companies.(i.e. Each class of policyholders should be paying its own way.)

Board of Directors

* The Board will include twelve persons plus the President, who will also be the Chief Executive Officer.

* The Board will elect as Chairman one of its members other than the President.

* Nine of the twelve members will come from policyholder employers. They will be elected at the annual meeting of the company by vote of the policyholders (one vote per policyholder). They should serve staggered three year terms.

* The initial nine members will be nominated by a five person nominating committee consisting of current residual pool chief executive officers. Three of these nominating committee members will be selected by the employer representatives of the current residual pool, and one each by the Maine Chamber and Maine Merchants. These Board members will be elected at an organizational meeting of the policyholders to be held prior to October 31,1992. Nominations can also be made from the floor. This meeting will be convened by the Superintendant of Insurance.

* The other three directors will recognize the public interest objective of the company. They will include one each selected by the Governor, Senate President and Speaker of the House (with mutual approval?). They will have three year terms, initially staggered 3, 2, 1 respectively.

Policyholders

* Initial policyholders will be ALL companies presently participating in the residual pool.

* The company will be obligated by statute to accept any employer as a policyholder. The premium rates of each policyholder will reflect its risk and will not consider affordability.

Divisions

* Policyholders will be divided into appropriate sized industry and/or geographic groupings, called Divisions. Boards representing the companies in each Division will be appointed by the company Board (see above). They will be responsible for advising on rates to assure division profitability, advising on claims processing and helping to create and assure safety standards and safe and healthy work environments.

* The number and size of divisions will be detemined by the Board based on actuarial advice.

* A seperate division will be created for "high risks", to be defined by the Company Board. The Company Board will be the board for this division and will have as its objective improving practices in these companies so they can be returned to their normal division.

* To facilitate management and accountability of the divisions, the Board will establish, through internal accounting, operating statements fund balances for each division with normal actuarial principals. However, all assets of the Company will be comingled for investment purposes.

* If the Board deems a subsidy is necessary for the High Risk Division, it will recommend same to the Workers Compensation Commission which will have the final authority to decide the amount of subsidy, if any, and the method of assessment. Any such assessment will be made against the premiums (benefits for self insured) of all employers covered by workers compensation. Every effort should be made to avoid subsidies.

Management

* The Board will appoint the Chief Executive Officer of the Company and such other officers as it deems necessary.

* The Company will employ a Chief Actuary or hire a consulting actuary to act as same. If the latter, it will not be a firm involved in establishing rates for the industry. However, this does not preclude the use of advice or data from such a firm.

* The Company may utilize investment advisors to manage its funds, as approved by the Board.

* Third Party Administrators may be used to administer the claims handling functions of either the total Company or of divisions. In addition to cost considerations, selection should the ability to handle claims in an expeditious manner and work closely with claimants, including helping them return to work.

Products

* The Company would exclusively offer workers compensation insurance.

Duties of the Board

* Overall responsibility for the Company's operation and its financial integrety.

* Approval of the basic corporate structure.

* Approval of basic underwriting policies and rate structures consistent with the Charter of the Company.

* Approval of investment policies, the selection of investment manager(s) and any specific investments which are made outside the parameters it establishes.

* Appointment of any appropriate Advisory Boards.

Liabilities/Guarantees

MAINE MUTUAL WORKERS COMP COMPANY
(A Proposal)

The Charter

* Legislation would create a domestic mutual insurance company as a non-profit, independant public corporation. It would be charged to operate like any other insurance company, subject to the same rules, regulations, taxes and assessments. Further, while it would establish its own sound underwriting practices and related rate structure, its priority is to serve ANY small or medium sized employer in the state seeking coverage.

* The company is NOT an agency of the State of Maine and is not to be supported in any way by the State's general fund.

* Initial financing has not been determined, but may require some assistance from the State in the form of loans which would be paid back.

* As a mutual, the company will operate to the benefit of its policyholders utilizing the principals of equity normally practiced by mutual companies.(i.e. Each class of policyholders should be paying their own way.)

* A model for this approach is the New Mexico Mutual Casualty Company, established in 1990 by the New Mexico legislature. However, some of these recommendations do differ.

Board of Directors

* The Board will include twelve persons plus the President, who will also be the Chief Executive Officer.

* The Board will elect as Chairman one of its members other than the President.

* Nine of the twelve members will come from policyholder employers. They will be elected at the annual meeting of the company by vote of the policyholders (one vote per policyholder). They should serve staggered three year terms.

* The initial nine members will be nominated by a nominating committee consisting of the three employer representatives of the current residual pool, and elected at an organizational meeting of the policyholders to be held prior to October 31,1992.

* The other three directors will recognize the public interest objective of the company. They will include one each selected by the Governor, Senate President and Speaker of the House (with mutual approval?). They will have three year terms, initially staggered 3, 2, 1 respectively.

Policyholders

* Initial policyholders will be ALL companies presently participating in the residual pool.

* The company will be obligated by statute to accept any employer as a policyholder.

* Policyholders will be divided into appropriate sized industry and/or geographic groupings. Advisory Boards representing each group will be formed to both advise on rates and help promote safe and healthy work environments.

* To facilitate management and accountability of the above groupings, the Board is free to establish, through internal accounting, "funds" for each group consistent with the principals of actuarial equity. However, all assets of the Company will be comingled for investment purposes.

* It is recognized that no matter what, a certain small percentage will have excessively high rates. These would be placed in a seperate High Risk Pool, with a focus to change their practices and bring them into one of the regular employer groupings.

* If the Board deems a subsidy is necessary for the High Risk Pool, It will recommend same to the Workers Compensation Commission which will have the final authority to decide the amount of subsidy and the method of assessment. The assessment, if any, will be made against the premiums (benefits for self insured) of all employers covered by workers compensation.

Management

* The Board will appoint the Chief Executive Officer of the Company and such other officers as it deems necessary.

* The Company will employ a Chief Actuary or hire a consulting actuary to act as same. If the latter, it will not be a firm involved in establishing rates for the industry. However, this does not preclude the use of advice or data from such a firm.

* The Company may utilize investment advisors to manage its funds, as approved by the Board.

* Third Party Administrators may be used to administer the claims handling functions of either the total Company or od seperate groups. In addition to cost considerations, selection should the ability to handle claims in an expeditious manner and work closely with claimants, including helping them return to work.

Products

* The Company would exclusively offer workers compensation insurance.

Duties of the Board

* Overall responsibility for the Company's operation and its financial integrety.

* Approval of the basic corporate structure.

* Approval of basic underwriting policies and rate structures consistent with the Charter of the Company.

* Approval of investment policies, the selectio0n of investment manager(s) and any specific investments outside the parameters it may establish.

* Appointment of any appropriate Advisory Boards.

Whenever a dispute arises under this act the moving party shall notify the Commission and the Commission shall contract forth with for a mediator from the State Court Mediation Service to attempt to settle the dispute without delay. The mediator shall meet with the parties at a place convenient to them and shall proceed to gather whatever information it deems necessary to resolve the dispute and shall have compulsory process for the purpose of obtaining evidence. The mediator may resolve any issue of fact against a party who intentionally refuses to cooperate and shall so certify to the Commission which shall enter such resolve as if part of its decision as in a hearing.

Assistance to parties in filing required documents and other procedures shall be furnished by the Commission.

The statements made by the parties during the mediation conference are confidential and not admissible before the Commission or any court proceeding.

At the conclusion of the mediation process the mediator shall file a written report with the Commission which shall state the terms of the agreement if the dispute is resolved or the issues of fact agreed upon if the matter is not resolved.

If the matter is not resolved by mediation it shall be heard without delay by one or more of the Commissioners or by a person or persons designated by the Commission, which person shall be a person experienced in labor relations.

A record of such hearing shall be kept. The Commission or its designee shall file a concise written opinion stating its findings of fact, conclusions of law and its order. The order and opinion shall be part of the hearing record.

Appeals from such orders are limited to claims of Constitutional error and shall be made within 30 days of the order.

The hearing tribunal shall consult the general counsel on matters of law.

Hearings shall be governed by the State APA rules and such other rules of procedure not inconsistent with the APA as the Commission shall promulgate.

No interrogatives, depositions, etc.

APPROVED | CHAPTER
JUL 30 '91 | 615
BY GOVERNOR | PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

H.P. 1397 - L.D. 1981

An Act to Make Changes in the Workers' Compensation System

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 20-A MRSA §12704, sub-§1, as enacted by PL 1985, c. 695, §11, is amended to read:

1. Long-term and short-term training. Providing, in close cooperation with the private sector, both the long-term education and training required for certain vocational and technical occupations, including occupational health and safety aspects of those occupations, and the short-term training necessary to meet specific private sector and economic development needs;

Sec. A-2. 24-A MRSA §1853, as amended by PL 1989, c. 168, §§26 and 27, is further amended by adding at the end a new paragraph to read:

The superintendent shall adopt rules to establish the standards for performance of the duties of the adjuster. In addition to the causes provided in section 1539, the superintendent may suspend, revoke or refuse a license of an adjuster for failure to perform the duties of the adjuster in accordance with the standards.

Sec. A-3. 24-A MRSA §2362-A is enacted to read:

§2362-A. Disclosure of premium information

All policies issued to employers for workers' compensation insurance must disclose clearly to the employer as separate figures the base rate, the employer's experience modification

factor for each year included in the formula pursuant to section 2364, the medical, indemnity and administrative portions of the premium and the portion of the premium attributable to the workplace health and safety consultation services.

When a policy is issued to employers for workers' compensation insurance, it must be accompanied by a statement disclosing the percentages of premium expended during the previous year by the insurer for claims paid, loss control and other administrative costs, medical provider expenses, insurer and employee attorney's fees and private investigation costs.

Sec. A-4. 24-A MRSA §2362-B is enacted to read:

§2362-B. Workplace health and safety consultations

Workplace health and safety consultation services provided by workers' compensation insurance carriers to employers with an experience rating factor of one or more are subject to the following.

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

A. "Workplace health and safety consultations" means a service provided to an employer to advise and assist the employer in the identification, evaluation and control of existing and potential accident and occupational health problems.

2. **Standards for workplace health and safety consultations.** The superintendent shall adopt rules establishing the standards for approval of workplace health and safety consultations provided to employers by insurance carriers, including provision of adequate facilities, qualifications of persons providing the consultations, specialized techniques and professional services to be used and educational services to be offered to employers.

3. Required coverage and premium. All insurance carriers writing workers' compensation coverage in this State shall offer workplace health and safety consultations to each employer as part of the workers' compensation insurance policy. The premium for the workplace health and safety consultation must be identified as a separate amount that must be paid.

4. **Optional purchase from another provider.** An employer may elect to purchase workplace health and safety consultation services from a provider other than the insurer. Upon submission

by the employer of a certificate of completion of workplace health and safety consultation services from another approved provider, the insurance carrier must refund to the employer the portion of the premium attributable to the workplace health and safety consultation.

5. **Notification to employer; request for consultation services.** An insurance carrier writing workers' compensation insurance coverage shall notify each employer of the type of workplace health and safety consultation services available and the address or location where these services may be requested. The insurer shall respond within 30 days of receipt of a request for workplace health and safety consultation services.

6. **Reports to employers.** In any workplace health and safety consultation that includes an on-site visit, the insurer shall submit a report to the employer describing the purpose of the visit, a summary of the findings of the on-site visit and evaluation and the recommendations developed as a result of the evaluation. The insurer shall maintain for a period of 3 years a record of all requests for workplace health and safety consultations and a copy of the insurer's report to the employer.

7. **Safe workplace responsibility.** Workplace health and safety consultations provided by an insurer do not diminish or replace an employer's responsibility to provide a safe workplace. An insurance carrier or its agents or employees do not incur any liability for illness or injuries that result from any consultation or recommendation.

Sec. A-5. 24-A MRSA §2363, sub-§§1 and 2, as enacted by PL 1987, c. 559, Pt. A, §4, are amended to read:

1. Policies. Every insurance company or insurer issuing workers' compensation insurance policies covering the payment of compensation and benefits provided for in this subchapter ~~shall~~ must use only policy forms approved pursuant to section 2412.

2. Determination of rates. Every insurer issuing workers' compensation insurance policies shall file with the superintendent its classification of risks and maximum premium rates, which may not take effect until the superintendent has approved them. The superintendent shall apply the procedures and standards of this section in investigating, reviewing and determining just and reasonable rates. The superintendent may:

A. Require the filing of specific rates for workers' compensation insurance, including classification of risks, experience or any other rating information from insurance

companies carriers authorized to transact insurance in this State;

B. Make or cause to be made investigations as he deems the superintendent considers necessary to satisfy himself determine that the rates to be promulgated are just and reasonable; and

C. At any time, after public hearing, withdraw his the superintendent's approval of a previously approved rate filing.

Sec. A-6. 24-A MRSA §2363, sub-§4, ¶A, as repealed and replaced by PL 1989, c. 423, §1, is amended to read:

A. Maine premium, loss and loss adjustment experience. Maine premium, loss and loss adjustment experience shall must show:

(1) Data from all companies carriers writing workers' compensation insurance in this State. If a company is excluded from the rate level, trend, loss development, expense determination, classification differentials or investment income calculations, that company and its market share shall must be identified and an explanation provided for its exclusion;

(2) Premiums calculated at current rate level. Whenever on-level factors are used, their derivation shall must be shown. The derivation of the percentages of total premium written and earned at various rate levels shall must also be shown;

(3) The amount of premium collected from the expense constant. This premium shall must be provided in dollars and as a percentage of the standard earned premium and as a percentage of net earned premium. If the percentage of premium collected in this manner is expected to change, the extent of the change shall must be estimated and the details of this estimation provided;

(4) The amount of premium collected by the minimum premium. This premium shall must be provided in dollars and as a percentage of standard earned premium and as a percentage of earned premium. If the percentage of premium collected in this manner is expected to change, the extent of the change shall must be estimated and the details of this estimation provided;

(5) Earned premiums, which ~~shall~~ must include premium collected from the specific disease loading. If disease loadings have been excluded, a justification ~~shall~~ must be provided;

(6) The latest earned premiums and market shares for the 10 largest workers' compensation insurers, by group, in this State;

(7) The following information on ~~companies~~ carriers deviating from bureau workers' compensation rates for each of the last 3 years:

(a) A list of all deviating ~~companies~~ carriers;

(b) The total standard premium written at deviated rates;

(c) The percentage of the entire statewide standard premium written at deviated rates;

(d) The total amount of deviations in dollars;

(e) The average percentage deviation for deviating companies; and

(f) The average percentage deviation for all ~~companies~~ carriers;

(8) The following information on ~~company~~ carriers' workers' compensation dividend practices for each of the last 3 years:

(a) A list of all ~~companies~~ carriers issuing dividends;

(b) The total amount of dividends in dollars;

(c) The average percentage dividend issued by ~~companies~~ carriers issuing dividends; and

(d) The average percentage dividend issued by all ~~companies~~ carriers;

(9) All policy year and accident year incurred loss data used in the filing, provided in the aggregate and also separated into paid losses, case-incurred and incurred but not reported losses; and

(10) The related incurred losses for all incurred loss adjustment expense data contained in the filing;

Sec. A-7. 24-A MRSA §2363, sub-§4, ¶N, as enacted by PL 1989, c. 423, §1, is amended to read:

N. The level of capital and surplus needed. The following information relating to the level of capital and surplus ~~shall~~ must be provided:

(1) Aggregate premium to surplus ratios and reserve to surplus ratios for the latest 5 calendar years for all ~~companies~~ carriers writing workers' compensation insurance in this State; and

(2) Estimates of comparable ratios for the years during which the rates will be in effect; and

Sec. A-8. 24-A MRSA §2363, sub-§7, ¶B, as enacted by PL 1987, c. 559, Pt. A, §4, is amended to read:

B. In establishing just and reasonable rates, the superintendent shall consider:

(1) ~~The~~ When applicable, the reasonableness of any return on capital and surplus allocable to the coverage of risks in this State;

(2) The reasonableness of the amounts of capital and surplus allocable to the coverage of risks in this State;

(3) The reported investment income earned or realized from funds generated from business in this State;

(4) The reported loss reserves, including the methods and the interest rates used in determining the present value for reported reserves and the use of those reserves in the determination of the proposed rates;

(5) The reported annual losses and loss adjustment expenses;

(6) The measures taken to contain costs, including loss control, loss adjustment and employee safety engineering programs;

(7) The relationship of the aggregate amount of operating expenses reported by all ~~companies~~ carriers to the annual operating expenses reported in the filing

and the annual insurance expense exhibits filed by each ~~company~~ carrier with the superintendent;

(8) The impact of operating and management ~~efficiency~~ efficiency of the ~~companies~~ carriers on expense levels and the effect of variations in expense levels on rates; and

(9) Any premium surcharges or credits ordered by the superintendent pursuant to section 2367.

Sec. A-9. 24-A MRSA §2363, sub-§7-A, as enacted by PL 1989, c. 467, §2, is amended to read:

7-A. Fee for servicing residual market. In every rate filing in which a rating bureau requests a rate adjustment, the superintendent shall take evidence on the issue of whether the fee for servicing the residual market is reasonable. Concurrent with the decision on the rate adjustment, the superintendent shall issue a decision on whether the fee is reasonable, taking into account the rate adjustment approved. If the superintendent determines that the fee is not reasonable, the superintendent shall order an adjustment to the fee, as necessary, to ensure that the fee is reasonable. The superintendent shall adopt rules establishing standards for the performance of adjustment services and requiring that servicing fees for individual insurance carriers be separately reviewed.

Sec. A-10. 24-A MRSA §2364, sub-§4, ¶A, as enacted by PL 1987, c. 559, Pt. A, §4, is amended to read:

A. The uniform experience rating plan ~~shall~~ must be the exclusive means for providing prospective premium adjustments based upon the past claim experience of an individual insured. The experience rating plan must provide that the claims experience for the 3 most recent years for which data is available be considered on the following basis.

(1) The claims and exposure for the most recent year for which data is available must be given 40% weight.

(2) The claims and exposure for the 2nd most recent year for which data is available must be given 35% weight.

(3) The claims and exposure for the 3rd most recent year for which data is available must be given 25% weight.

If data is available for only 2 years of claims experience, the weighting must be 60% for the most recent year and 40% for the 2nd most recent year.

Sec. A-11. 24-A MRSA §2365-A is enacted to read:

§2365-A. Medical expense deductibles

Each insurer transacting or offering to transact workers' compensation insurance in this State shall offer deductibles for medical expenses as follows.

1. Optional deductible of $250. To employers who are not experience-rated, insurers shall offer a deductible of $250 per occurrence.

2. Optional deductible of $250 or $500. To employers whose premium is between 100% and 500% of the premium qualifying for experience rating and to all employers in the logging and lumbering industries, including employers of drivers, and sawmill industries, insurers shall offer a deductible of $250 or $500 per occurrence.

3. Mandatory deductible of $500. Except for employers that qualify under subsections 1 and 2, insurers shall provide a deductible of $500 per occurrence to employers of more than 10 employees whose premium is over 500% of the premium qualifying for experience rating.

Sec. A-12. 24-A MRSA §2366, sub-§1-A is enacted to read:

1-A. Rules. The superintendent shall adopt rules for the purpose of encouraging workers' compensation insurers to take workers' compensation policies out of the residual market by establishing credits applicable to any assessments that may be ordered under section 2367 or by any other means. The criteria for applying credits must include consideration for policies taken out of the residual market prior to as well as after the effective date of the rules.

Sec. A-13. 24-A MRSA §2366, sub-§2, ¶B, as enacted by PL 1987, c. 559, Pt. A, §4, is amended to read:

B. An employer is eligible for insurance from the Accident Prevention Account if:

(1) The employer has at least 2 lost-time claims over $10,000 and a loss ratio greater than 1.00 over the last 3 years for which data is available; and

(2) The employer has attempted to obtain insurance in the voluntary market and has been refused by at least 2 insurers ~~which~~ that write that insurance in this State. For the purpose of this section, an employer ~~shall be~~ is considered to have been refused if offered insurance only under a retrospective rating plan or plans.

Sec. A-14. 24-A MRSA §2366, sub-§3, ¶¶A and B, as enacted by PL 1987, c. 559, Pt. A, §4, are amended to read:

A. The Safety Pool is an insurance plan that provides for an alternative source of insurance for employers with good safety records ~~and is intended to operate within the framework of the voluntary insurance market~~.

B. An employer ~~shall be~~ is eligible for the Safety Pool if that employer:

(1) Has had no more than one lost-time claim in the last 3 years for which data is available, regardless of the resulting loss ratio;

(2) Has a loss ratio ~~which~~ that does not exceed 1.0 or has had no more than one lost-time claim over $10,000 over the last 3 years for which data is available; or

(3) Has been in business for less than 3 years, provided that the eligibility ~~shall terminate~~ terminates if ~~his~~ the employer's loss ratio exceeds 1.0 and the employer has at least 2 lost-time claims over $10,000 each at the end of any year.

Sec. A-15. 24-A MRSA §2366, sub-§4, ¶A-1 is enacted to read:

A-1. The plan must include a procedure to handle appeals filed pursuant to Title 39, section 106, subsection 2, paragraph B.

Sec. A-16. 24-A MRSA §2366, sub-§5, ¶C is enacted to read:

C. In a residual market rate proceeding, the superintendent may order payment of dividends to insureds in the Safety Pool to the extent that the pool's experience supports them. The superintendent may adopt rules establishing a dividend plan for the Safety Pool to provide an incentive for implementation of safety programs by insureds in the pool. The superintendent may employ outside consultants to assist in the development of these rules, the costs of which

must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

Sec. A-17. 24-A MRSA §2366, sub-§7-A is enacted to read:

7-A. Credits for qualifying safety programs. The superintendent shall adopt rules to establish dividend plans and premium credits between 5% and 15% of net annual premiums for policyholders that establish or maintain qualifying safety programs. The rules must identify the classifications by which policyholders are eligible for the credits and establish criteria for qualifying safety programs and procedures to be followed by servicing carriers in approving and auditing compliance with the safety programs. The superintendent may employ outside consultants to assist in the development of rules under this subsection, the costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

Sec. A-18. 26 MRSA §42-A, sub-§2, ¶E-1, as enacted by PL 1987, c. 782, §3, is amended to read:

E-1. The development and administration of programs to educate employers and employees regarding the Whistleblowers' Protection Act, chapter 7, subchapter V-B; and

Sec. A-19. 26 MRSA §42-A, sub-§2, ¶E-2 is enacted to read:

E-2. The support for the development of long-term strategies to improve occupational health and safety professional education and resources. The department may award contracts to public and private nonprofit organizations as seed money to develop programs that will serve this purpose and that will develop other funding sources in the future; and

Sec. A-20. 39 MRSA §2, sub-§2, ¶G is enacted to read:

G. "Average weekly wages, earnings or salary" does not include fringe benefits, including but not limited to employer payments for or contributions to a retirement, pension, health and welfare, life insurance, training, social security or other employee or dependent benefit plan for the employee's or dependent's benefit or any other employee's dependent entitlement.

Sec. A-21. 39 MRSA §5 is enacted to read:

§5. Predetermination of independent contractor status

1. Predetermination permitted. A worker, an employer or a workers' compensation insurance carrier, or any together, may apply to the Department of Labor 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 Department of Labor creates a rebuttable presumption that the determination is correct in any later claim for benefits under this Act.

B. Nothing in this section requires a worker, an employer or a workers' compensation insurance carrier to request predetermination.

2. Premium adjustment. If it is determined that a predetermination does not withstand commission 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.

3. Predetermination submission. A party may submit, on forms approved by the Department of Labor, a request for predetermination regarding the status of a person or job description as an employee or independent contractor. The status requested by a party is deemed to have been approved if the Department of Labor does not deny or take other appropriate action on the submission within 14 days.

4. Hearing. A hearing, if requested by a party within 10 days of the Department of Labor's decision on a petition, must be conducted under the Maine Administrative Procedure Act.

5. Certificate. The Department of Labor 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.

6. Rulemaking. The Commissioner of Labor 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 and independent contractor status.

Sec. A-22. 39 MRSA §21-A, sub-§4 is enacted to read:

4. 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.

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, shall provide a statistical evaluation of the employer's workplace health and safety experience and shall enclose a set of workplace health and safety options, including on-site consultation, education and training activities and technical assistance.

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 Maine technical college or the Department of Labor workplace health and safety training programs.

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. The superintendent shall assess a surcharge of 5% on that employer's workers' compensation insurance premium or the imputed premium for self-insurers, to be paid to the Treasurer of State who shall credit 1/2 of that amount to the Safety Education and Training Fund, as established by Title 26, section 61, and 1/2 to the Occupational Safety Loan Fund, as established by Title 26, section 62.

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.

Sec. A-23. 39 MRSA §23, sub-§1-A is enacted to read:

1-A. Pilot projects. Workers' compensation health benefits pilot projects are authorized under the following provisions.

A. The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with workers' compensation medical payments benefits through comprehensive health insurance that covers workplace injury and illness. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this Title. The superintendent shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.

B. The comprehensive health insurance may provide for health care by a health maintenance organization or a preferred provider organization. The premium must be paid entirely by the employer. The program may use deductibles, coinsurance and copayment by the employees not to exceed $5 per visit or $50 maximum per occurrence.

C. The superintendent shall report annually to the joint standing committees of the Legislature having jurisdiction over banking and insurance and labor matters by November 1st on the status of any pilot projects approved by the superintendent.

D. Unless continued or modified by law, this section is repealed on October 31, 1996.

Sec. A-24. 39 MRSA §23, sub-§2, as amended by PL 1989, c. 435, §2, is further amended to read:

2. Proof of solvency and financial ability to pay; trust. By furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and deposit cash, satisfactory securities or a surety bond, with the Workers' Compensation Commission, in such sum as the superintendent may determine pursuant to subsection 6; such bond to run to the Treasurer of State and the Treasurer of State's successor in office, and 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, the cash or securities ~~shall~~ 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 ~~shall~~ must be credited to the account

and ~~shall~~ may not be paid to the employer to the extent that the interest is required to support any present value discounting in the determination of the amount of the deposit. Any security deposit ~~shall~~ 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 the Act.

The superintendent shall prescribe the form of the surety bond ~~which~~ that may be used to satisfy, in whole or in part, the employer's responsibility under this section to post security. The bond ~~shall~~ must be continuous, ~~shall~~ be subject to nonrenewal only upon not less than 60 days' notice to the superintendent and ~~shall~~ cover payment of all present and future liabilities incurred under the Act while the bond is in force and cover payments ~~which~~ that become due while the bond is in force ~~which~~ that are attributable to injuries incurred in prior periods and ~~which are~~ otherwise unsecured by cash or acceptable securities. A bond ~~shall~~ must be held until all payments secured thereby have been made or until it has been replaced by a bond issued by a qualified successor surety ~~which~~ that covers all outstanding liabilities. Payments under the bond ~~shall be~~ are due within 30 days after notice has been given to the surety by ~~the chair of~~ the commission that the principal has failed to make a payment required under the terms of an award, agreement or governing law. A surety bond ~~shall~~ may not be used to fund a trust established to satisfy the requirements of this section.

As an alternative to the method described in the first paragraph of this subsection, an eligible employer may establish an actuarially 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, provided that the superintendent requires that the value of trust assets ~~shall~~ be at least equal to the present value of ultimate expected incurred claims and claims settlement costs. The present value of ultimate expected incurred claims and claims settlement costs for a group self-insurer may not be more than the amount actuarially determined considering the value of trust assets and excess insurance to satisfy a 90% confidence level. A group self-insurer may elect to fund at a higher confidence level through the use of cash, marketable securities, surety bonds or excess insurance. If a member of a group self-insurer terminates its membership in the group for any reason, then that member shall fund its 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 its proportionate share of the trust's exposure to the 95% level of confidence, then the remaining members of the group shall make such additional contribution no later than the anniversary date of the program as required to fund the departing member's exposure in accordance

with this provision. ~~The trust~~ Trust assets ~~shall~~ must consist of cash or marketable securities of a type and risk character as specified in subsection 7, and ~~shall~~ have a situs in the United States. The trustee shall submit a report to the superintendent not less frequently than quarterly ~~which~~ 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 ~~shall~~ must be established and maintained subject to the condition that trust assets ~~cannot~~ 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 pay out ~~shall~~, must be as approved by the superintendent; provided, that the value of the trust account ~~shall~~ 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. For purposes of this paragraph, an "eligible employer" is one who is found by the superintendent to be capable of paying compensation and benefits required by this Act and:

A. Has positive net earnings; or

B. Can demonstrate a level of working capital adequate in relation to its operating needs.

Notwithstanding any provision of this section or chapter, any bond or security deposit required of a public employer ~~which~~ that is a self-insurer ~~shall~~ may not exceed $50,000, provided that such public employer has 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 $25,000,000. If a county, city or town relies upon a bond rating, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value ~~shall~~ must be incorporated in the annual audit of the county, city or town together with disclosure of funds appropriated to discharge incurred claims expenses. "Public employer" includes the State, the University of Maine System, counties, cities and towns.

In consideration of a self-insuring entity's application for authorization to operate a plan of self-insurance, the superintendent may require or permit an applicant to employ valid risk transfer by the utilization of primary excess insurance, subject to the provisions of subsection 6. Standards respecting

the application of primary excess insurance ~~shall~~ must be contained in a regulation promulgated by the superintendent pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375. Primary excess insurance ~~shall~~ must be defined as insurance covering workers' compensation exposures in excess of risk retained by a self-insurer.

As a further alternative to the methods described in this subsection, an employer ~~shall--be~~ is 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 ~~which~~ 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. The guarantor shall provide quarterly financial statements, audited annual financial statements and such other information as the superintendent may require, and the employer shall provide a bond as otherwise required by this Act in an amount not less than $1,000,000. Any such guarantor ~~shall--be~~ is deemed to have submitted to the jurisdiction of the Workers' Compensation Commission and the courts of this State for purposes of enforcing any such guarantee. The guarantor, in all respects, ~~shall--be~~ 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, encumbered or are otherwise found to be inadequate to support the guarantee.

Sec. A-25. 39 MRSA §51-B, sub-§7, as amended by PL 1989, c. 502, Pt. D, §22, is further amended to read:

7. Notice of controversy. If the employer, prior to making payments under subsection 3, controverts the claim to compensation, the employer shall file with the commission, within 14 days after an event ~~which~~ that gives rise to an obligation to make payments under subsection 3, a notice of controversy in a form prescribed by the commission. If the employer, prior to making payments under subsection 4, controverts the claim to compensation, the employer shall file with the commission, within 75 or 90 days, as applicable, after an event ~~which~~ that gives rise to an obligation to make payments under subsection 4, a notice of controversy in a form prescribed by the commission. The notice ~~shall~~ must indicate the name of the claimant, name of the employer, date of the alleged injury or death and the grounds

upon which the claim to compensation is controverted. The employer shall promptly furnish the employee with a copy of the notice.

If, at the end of the 14-day period in subsection 3 or the 90-day or 75-day periods in subsection 4, the employer has not filed the notice required by this subsection, the employer shall begin payments as required under those subsections. In the case of compensation for incapacity under subsection 3, the employer may cease payments or continue payments as provided in subsection 8 and file with the commission a notice of controversy, only as provided in this subsection, no later than 44 60 days after an event ~~which~~ that gives rise to an obligation to make payments under subsection 3. Failure to file the required notice of controversy prior to the expiration of the ~~44-day~~ 60-day period, in the case of compensation under subsection 3, constitutes acceptance by the employer of the compensability of the injury or death. Failure to file the required notice of controversy does not constitute such an acceptance by the employer when it is shown that the failure was due to employee fraud or excusable neglect by the employer, except when payment has been made and a notice of controversy is not filed within 44 60 days of that payment. Failure to file the required notice of controversy prior to the expiration of the 90-day period under subsection 4 constitutes acceptance by the employer of the extent of impairment claimed. Failure to file the required notice of controversy prior to the expiration of the 75-day period under subsection 4 for compensation for medical expenses, aids or other services pursuant to section 52 constitutes acceptance by the employer of the reasonableness and propriety of the specific medical services for which compensation is claimed and requires payment for those services, but does not constitute acceptance of the compensability of the injury or death.

If, at the end of the ~~44-day~~ 60-day period the employer has not filed a notice of controversy, or if, pursuant to a proceeding before the commission, the employer is required to make payments, the payments may not be decreased or suspended, except as provided in section 100.

Sec. A-26. 39 MRSA §52-A, sub-§2, as enacted by PL 1981, c. 514, §2, is repealed and the following enacted in its place:

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

A. 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 employee's health care provider shall forward to the

employer and the employee a diagnostic medical report, on forms prescribed by the Medical Coordinator, 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 Medical Coordinator may assess penalties up to $500 per violation upon health care providers who fail to comply with the 5-day requirement of this subsection.

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 Medical Coordinator. An employer may request, at any time, medical information concerning an employee's condition pertaining to the condition for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request.

C. Any 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.

D. In the event that an employee changes physicians 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 physician upon request of the employee. When an employee is scheduled to be treated by a different physician or in a different facility, the employee shall request to have the records transferred.

E. The reporting requirements of paragraph A do not apply to claims for medical benefits only.

F. The provider may not charge the employer or carrier an amount in excess of the fees prescribed in section 52-B for the submission of reports prescribed by this section and for the submission of any additional records. An insurer or self-insurer may withhold payment of fees for the submission of reports of treatment required by this section to any provider who fails to submit the reports on the forms prescribed by the Medical Coordinator 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 commission to resolve the dispute.

Sec. A-27. 39 MRSA §52-B, as enacted by PL 1987, c. 559, Pt. B, §22, is amended by adding at the end a new paragraph to read:

In order to qualify for reimbursement for health care services provided to employees under this Title, health care providers providing individual health care services and courses of treatment may not charge more for the services or courses of treatment for employees than is charged to private 3rd-party payers for similar services or courses of treatment. An employer is not responsible for charges that are determined to be excessive or treatment determined to be inappropriate by an independent medical examiner pursuant to section 92-A.

Sec. A-28. 39 MRSA §52-C is enacted to read:

§52-C. Restriction on reimbursement for health care providers

To qualify for reimbursement for health care services provided after October 31, 1995, to employees under this Title, health care providers providing individual health care services and courses of treatment must have successfully completed the occupational health training program established in section 83-A.

Sec. A-29. 39 MRSA §53-C is enacted to read:

§53-C. Effect of volunteer service

An employee may serve in a volunteer capacity, if that capacity is consistent with any medical restrictions, for a public entity or nonprofit organization organized under the provisions of Title 13-B, subsection 405 or the Internal Revenue Code, section 501(C)(3) and the fact of that volunteer service has no effect on any determination of capacity to work under this Title.

Sec. A-30. 39 MRSA §57, as amended by PL 1985, c. 372, Pt. A, §22, is repealed.

Sec. A-31. 39 MRSA §57-B, sub-§13, as enacted by PL 1985, c. 372, Pt. A, §23, is amended to read:

13. Applicability. Reimbursement under this section is available solely with respect to employees who are injured and rehabilitated after the effective date of this section. If

reimbursement is available from the Employment Rehabilitation Fund under this section, reimbursement ~~shall~~ may not be available ~~from the Second Injury Fund~~ under section ~~57~~ 57-D.

Sec. A-32. 39 MRSA §57-C, sub-§3, as enacted by PL 1985, c. 372, Pt. A, §23, is amended to read:

3. Assessment waived. If, at the end of a calendar quarter, the amount of deposit in the Employment Rehabilitation Fund, in that portion attributable to this section, is equal to or exceeds the amount derived from the last assessment, the assessment for that quarter ~~shall~~ must be waived and not levied or imposed.

A. The Treasurer of State shall notify the State Tax Assessor on the day after the end of the calendar quarter, if the fund equals or exceeds that amount.

B. If so notified, the State Tax Assessor shall immediately notify each insurer that the assessment is waived for that quarter.

Sec. A-33. 39 MRSA §57-D is enacted to read:

§57-D. Permanent total incapacity due partly to prior injury

1. Payment for second injuries. If an employee who has a permanent impairment from any cause or origin that is, or is likely to be, a hindrance or obstacle to employment sustains a personal injury arising out of and in the course of employment that, in combination with the earlier preexisting impairment, results in total permanent incapacity, the employer or the employer's insurance carrier is liable for all compensation provided by this section. The employer or insurance carrier must be reimbursed from the Employment Rehabilitation Fund for compensation payments not attributable to the second injury.

2. Permanent impairment. As used in this section, "permanent impairment" means any permanent physical or mental condition, whether congenital or due to injury or disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee should become unemployed.

3. Employer knowledge. In order to qualify under this section for reimbursement from the Employment Rehabilitation Fund, the employer must establish that the employer had knowledge of the permanent impairment at the time that the employee was hired or at the time the employee was retained in employment after the employer acquired that knowledge.

4. Jurisdiction. The commission has jurisdiction over all claims brought by employers or insurance carriers against the Employment Rehabilitation Fund. The Employment Rehabilitation Fund may not be bound as to any question of law or fact by reason of any award or any adjudication to which it was not a party or in relation to which it was not notified, at least 3 weeks prior to the award or adjudication, that it might be subject to liability for the injury or death. An employer or its insurance carrier shall notify the commission of any possible claim against the Employment Rehabilitation Fund as soon as practicable, but in no event later than 3 years after the injury or death.

5. Legal representation. The Attorney General shall provide legal representation for any claim made under this section. The reasonable expenses of prosecution or defense by the Attorney General of claims against the Employment Rehabilitation Fund, subject to the approval of the Workers' Compensation Commission, are payable out of the Employment Rehabilitation Fund. The Attorney General may not defend the Employment Rehabilitation Fund against any claim brought by the State. The commission is authorized to hire, using funds from the Employment Rehabilitation Fund, private counsel to defend any claim brought against the Employment Rehabilitation Fund by the State.

6. Contributions to Employment Rehabilitation Fund. Until the chair of the commission determines that the Second Injury Fund is no longer required under section 57-E, 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 Employment Security Commission for benefit of the Second Injury Fund.

7. Transitional eligibility. Employers and insurance carriers that were eligible for or were receiving reimbursement under the Second Injury Fund are eligible for reimbursement under this section.

8. Applicability. This section does not apply to cases in which reimbursement is available from the Employment Rehabilitation Fund under section 57-B.

Sec. A-34. 39 MRSA §57-E is enacted to read:

§57-E. Contribution from employers; transfer from Second Injury Fund

After the chair determines that the Second Injury Fund is no longer required under this section, in every case of the death of an 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 Employment Security Commission for benefit of the Employment Rehabilitation Fund.

When the chair of the commission determines that the Second Injury Fund established pursuant to former section 57 is no longer required for payments to employers or insurance carriers, the chair shall direct that the Treasurer of State transfer the balance in the account to the Employment Rehabilitation Fund and the Treasurer of State shall deposit the balance to the Employment Rehabilitation Fund.

Sec. A-35. 39 MRSA §65, 2nd ¶, as repealed and replaced by PL 1965, c. 408, §8, is amended to read:

The commission or any commissioner may at any time after the injury appoint a competent and impartial physician or surgeon to act as medical examiner, the reasonable fees of whom ~~shall be~~ are fixed by the commission. Upon order of the commission or any commissioner, the fee for the examination must be paid by the employer. Such medical examiner, after being furnished with such information in regard to the matter as may be deemed essential for the purpose, shall thereupon and as often as the commission or the said commissioner may direct, examine such injured employee in order to determine the nature, extent and probable duration of the injury, or the percentage of permanent impairment. ~~He~~ The medical examiner shall file in the office of the commission a report of every such examination, and a copy thereof ~~shall~~ must be sent to each of the interested parties, who upon request therefor ~~shall~~ must be given the opportunity at a hearing, before decree is rendered, to question said impartial examiner as to any matter included in such report.

Sec. A-36. 39 MRSA §65, 4th ¶, as repealed and replaced by PL 1965, c. 408, §8, is amended to read:

If any employee refuses or neglects to submit ~~himself~~ to any reasonable examination provided for in this Act, or in any way obstructs any such examination, or if ~~he~~ the employee declines a service ~~which~~ that the employer is required to provide under this Act, then, upon the filing of a petition ~~of said~~ or of a notice of automatic discontinuance by the employer ~~and hearing before the commission~~ pursuant to section 100, such employee's rights to compensation ~~shall be~~ are forfeited during the period of said infractions if the commission finds that there is adequate cause to do so.

Sec. A-37. 39 MRSA §66-A, sub-§3, as amended by PL 1989, c. 388, is further amended to read:

3. Time period; discrimination prohibited. The employer's obligation to reinstate the employee continues until one year, or ~~2~~ 3 years if the employer has over ~~250~~ 200 employees, after the ~~employee has reached the stage of maximum medical improvement in the judgment of the commission~~ 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 111.

Sec. A-38. 39 MRSA §66-A, sub-§4, as enacted by PL 1987, c. 559, Pt. B, §35, is repealed.

Sec. A-39. 39 MRSA §66-B is enacted to read:

§66-B. Light-duty work pools

Employers may form light-duty work pools for the purpose of encouraging the return to work of injured employees.

Sec. A-40. 39 MRSA §72, as amended by PL 1981, c. 291, §1, is further amended to read:

§72. Interest on awards

Upon each award of the Workers' Compensation Commission, interest ~~shall~~ must be assessed from the date on which the petition is filed at a rate of 6% 8% per year, ~~provided~~ except that if the prevailing party at any time requests and obtains a continuance for a period in excess of 30 days interest will be suspended for the duration of the continuance. From and after the date of the decree, interest ~~shall be~~ is allowed at the rate of ~~10%~~ 15% per year. Payment of any interest allowed after the 10th day following the date of the decree is not an element of loss for the purpose of establishing rates for workers' compensation insurance. This section ~~shall~~ must be enforced by the Workers' Compensation Commission.

Sec. A-41. 39 MRSA §92, sub-§10 is enacted to read:

10. Information. The commission shall maintain a toll-free telephone number to enable employees and employers to obtain information from the commission.

Sec. A-42. 39 MRSA §94-A, sub-§1-A is enacted to read:

1-A. Notice to employer. The commission shall notify an employer when an informal conference 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.

Sec. A-43. 39 MRSA §94-B, sub-§3, as amended by PL 1983, c. 479, §19, is further amended by adding a new 2nd blocked paragraph to read:

The employer or representative of the employer or insurer who attends the informal conference must be familiar with the employee's claim and has full authority to make decisions regarding the claim. The commissioner may assess a penalty in the amount of $100 against any employer or representative of the employer or insurer who attends the conference without full authority to make decisions regarding the claim. If a representative of the employer attends the informal conference or any other proceeding of the commission, the representative shall notify the employer of all actions by the representative on behalf of the employer and any other actions at the proceeding.

Sec. A-44. 39 MRSA §95, as amended by PL 1989, c. 256, §4, is further amended to read:

§95. Time for filing petitions

Any employee's claim for compensation under this Act ~~shall~~ be is barred unless an agreement or a petition as provided in section 94 ~~shall be~~ is filed within 2 years after the date of the injury, or, if the employee is paid by the employer or the insurer, without the filing of any petition or agreement, within 2 years of any payment by such employer or insurer for benefits otherwise required by this Act. The 2-year period in which an employee may file a claim does not begin to run until the employee's employer, if the employer has actual knowledge of the injury, files a first report of injury as required by section 106 of the Act. Any time during which the employee is unable by reason of physical or mental incapacity to file the petition ~~shall~~ is not be included in the period provided in this section. If the employee fails to file the petition within that period because of mistake of fact as to the cause and nature of the injury, the employee may file the petition within a reasonable time. In case of the death of the employee, there ~~shall be~~ is allowed for filing said petition one year after that death. No petition of any kind may be filed more than ~~10~~ 6 years following the date of the latest payment made under this Act. For the

purposes of this section, payments of benefits made by an employer or insurer pursuant to section 51-B or 52 ~~shall be~~ are considered payments under a decision pursuant to a petition, unless a timely notice of controversy has been filed.

Sec. A-45. 39 MRSA §103-B, sub-§2-A, as enacted by PL 1989, c. 412, §§2 and 5, is amended to read:

2-A. Basis. There ~~shall~~ may be no appeal upon questions of fact found by the commission or by any commissioner, except to correct manifest error or injustice. Unless continued by law, this subsection is repealed June 30, 1993.

Sec. A-46. 39 MRSA §103-B, sub-§2-B is enacted to read:

2-B. Basis; effective date. There may be no appeal upon questions of fact found by the commission or any commissioner. This section takes effect June 30, 1993.

Sec. A-47. 39 MRSA §104-A, sub-§2-A, as enacted by PL 1987, c. 559, Pt. B, §45, is amended to read:

2-A. Failure to pay within time limits. An employer or insurance carrier who fails to pay compensation, as provided in this section, ~~shall~~ must be penalized as provided in this subsection.

A. Except as otherwise provided by section 51-B, subsection 9, if an employer or insurance carrier fails to pay compensation as provided in this section, the ~~commission~~ Superintendent of Insurance shall assess against the employer or insurance carrier a forfeiture of up to ~~$100~~ $200 for each day of noncompliance. If the ~~commission~~ Superintendent of Insurance finds that the employer or insurance carrier was prevented from complying with this section because of circumstances beyond their control, no forfeiture may be assessed.

(1) ~~One-half of the forfeiture shall be paid to the employee to whom compensation is due and 1/2 shall be paid~~ The forfeiture for each day of noncompliance must be divided as follows: Of each day's forfeiture amount, the first $50 must be paid to the employee to whom compensation is due and the remainder must be paid to the commission and be credited to the General Fund.

(2) If a forfeiture 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 fees, as determined by the ~~commission~~ Superintendent of Insurance, to the employee.

(3) Forfeitures assessed under this subsection may be enforced by the Superior Court in the same manner as provided in section 103-E.

B. Payment of any forfeiture assessed under this subsection ~~shall~~ is not ~~be~~ considered an element of loss for the purpose of establishing rates for workers' compensation insurance.

Sec. A-48. 39 MRSA §104-B, sub-§3, as enacted by PL 1981, c. 474, §4, is amended to read:

3. Subrogation. Any insurer determined to be liable for benefits under subsection 2 ~~shall~~ 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. Any such insurer may, in accordance with rules ~~prescribed~~ adopted by the ~~commission~~ Superintendent of Insurance, file a ~~petition for an~~ request for appointment of an arbitrator to determine apportionment of liability among the responsible insurers. ~~The commission has jurisdiction over all claims for apportionment under this section. In any proceeding for apportionment, no insurer is bound as to any finding of fact or conclusion of the law made in a prior proceeding in which it was not a party.~~ The arbitrator's decision is limited to a choice between the submissions of the parties and may not be calculated by averaging. Within 30 days of the request, the Superintendent of Insurance shall appoint a neutral arbitrator who shall decide, in accordance with the rules adopted by the Superintendent of Insurance, respective liability among or between insurers. Arbitration pursuant to this subsection will be the exclusive means for resolving apportionment disputes among insurers and the decision of the arbitrator is conclusive and binding among all parties involved. Apportionment decisions made under this subsection may not affect an employee's rights and benefits under this Act.

Sec. A-49. 39 MRSA §106, sub-§1, as repealed and replaced by PL 1987, c. 559, Pt. B, §46, is amended to read:

1. Injuries. Whenever any employee has reported to an employer under the Act any injury arising out of and in the course of ~~his~~ the employee's employment ~~which~~ that has caused the employee to lose a day's work ~~or has required the services of a physician~~, or whenever the employer has knowledge of any such injury, the employer shall report the injury to the commission

within 7 days after ~~he~~ the employer receives notice or has knowledge of the injury. The employer shall also report the average weekly wages or earnings of the employee, together with any other information required by the commission. The employer shall report whenever the injured employee resumes ~~his~~ the employee's employment and the amount of ~~his~~ 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 commission unless the injury later causes the employee to lose a day's work.

Sec. A-50. 39 MRSA §106, sub-§2, as repealed and replaced by PL 1987, c. 559, Pt. B, §46, is repealed and the following enacted in its place:

2. Settlements. Settlements are subject to this subsection as follows.

A. Whenever any settlement is made with an injured employee by the employer or insurance carrier for compensation covering any specific period under an approved agreement or a decree or covering any period of total or partial incapacity that has ended, the employer or carrier shall file with the commission a duplicate copy of the settlement receipt or agreement signed by the employee showing the total amount of money paid to the employee for that period or periods, but the settlement receipt or agreement is not binding without the commission's approval.

B. At least 14 days prior to submitting any residual market settlement agreement that is in excess of $10,000 to the commission for approval, the insurance carrier shall give notice of the settlement to the employer. If the employer objects to the settlement agreement, the employer shall give notice of the grounds for objection to the carrier within 7 days of receipt of the agreement. If an employer gives notice of objection under this paragraph, within 60 days of the commission approving a settlement the employer may appeal inclusion of all or part of the settlement payment in calculation of the experience modification factor to the Superintendent of Insurance. Within 30 days from the date notice of appeal was filed, both parties shall submit any relevant information to the superintendent and within 60 days from receipt of the appeal notice the superintendent shall issue a decision based upon the written submissions of the parties. Upon issuance of a decision by the

superintendent, either party may request a hearing before the superintendent pursuant to Title 24-A, section 229. The procedures set forth in Title 24-A, section 2320 do not apply to appeals pursuant to this section.

C. A settlement approved under paragraph A while the injured employee is participating in a rehabilitation plan does not affect the injured employee's rights to complete the plan.

Sec. A-51. 39 MRSA §106, sub-§3, as repealed and replaced by PL 1987, c. 559, Pt. B, §46, is amended to read:

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

Sec. A-52. 39 MRSA §106, sub-§4 is enacted to read:

4. 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 commission 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 commission by rule may require. Any employer requesting a quarterly report under this section must provide the employee with the prescribed form at least 15 days prior to the date on which it is due.

Sec. A-53. 39 MRSA §114 is enacted to read:

§114. 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 commission. Any person or entity found by the commission to have violated this section is subject to the remedy provision of the Maine Human Rights Act, Title 5, sections 4613 and 4614.

Sec. A-54. 39 MRSA §192, first ¶. as amended by PL 1977, c. 696, §415, is further amended to read:

On request of a party or on its own motion the commission may in occupational disease cases appoint one or more competent and impartial physicians~~,--their--reasonable-fees-and-expenses-to be--fixed--and--paid--by--the--commission.~~ Upon order of the commission, 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 ~~he~~ the employee has worked in order to determine the nature, extent and probable duration of ~~his~~ the occupational disease, the likelihood of its origin in the industry and the date of incapacity. Section 65 of the Workers' Compensation Act ~~shall apply~~ applies to the filing and subsequent proceedings on their report, and to examinations and treatments by the employer.

Sec. A-55. Report. The Director of the Maine Human Rights Commission and the Chair of the Workers' Compensation Commission shall consult and issue a joint report by October 1, 1992 to the Joint Standing Committee on Banking and Insurance and the Joint Standing Committee on Labor on unlawful discrimination against injured employees, the need for coordination between the Maine Human Rights Commission and the Workers' Compensation Commission and any legislation and agency rules needed to protect injured employees from unlawful discrimination.

Sec. A-56. Public advocate for insurance study. The Office of Policy and Legal Analysis shall study the establishment of a public advocate for insurance to represent the public interest in proceedings with regard to all lines of insurance. A report containing background information and options for legislative action must be presented to the Joint Standing Committee on Banking and Insurance for the Second Regular Session of the 115th Legislature no later than November 1, 1991.

Sec. A-57. Allocation. The following funds are allocated from the Safety Education and Training Fund to carry out the purposes of this Act.

	1991-92	**1992-93**
LABOR, DEPARTMENT OF		

Bureau of Labor Standards

All Other	$120,000	$100,000

Provides funds of $20,000 for fiscal year 1991-92 for workplace health and safety training programs in the Maine Technical College System. Provides funds of $50,000 for fiscal year 1991-92 and $50,000 for fiscal year 1992-93 for the Center for Occupational Health and Safety at the Central Maine Technical College. Provides funds of $50,000 for fiscal year 1991-92 and $50,000 for fiscal year 1992-93 to fund contracts to support the development of long-term strategies to improve occupational health and safety professional education and resources pursuant to the Maine Revised Statutes, Title 26, section 42-A, subsection 2, paragraph E-2.

PART B

Sec. B-1. Special Commission to Study the Workers' Compensation Commission. There is established the Special Commission to Study the Workers' Compensation Commission.

1. Membership. The commission consists of 13 members. Six members are appointed by the Governor, 3 members are appointed by the President of the Senate and 3 members are appointed by the Speaker of the House of Representatives. Appointments of the Governor, the President of the Senate and the Speaker of the House of Representatives must be made within 30 days of the effective date of this section. At the commission's first meeting, the members shall select the 13th member by majority vote and that member shall serve as the commission chair. The appointing authorities shall notify the Executive Director of the Legislative Council at the time appointments are made.

2. **Scope of study.** The Governor, the Joint Standing Committee on Labor, the Joint Standing Committee on Banking and Insurance and any other interested parties may each submit a list of proposed areas for investigation by the commission. All proposals submitted under this section must be submitted to the Executive Director of the Legislative Council no later than October 25, 1991. At its first meeting, the commission shall select, by majority vote, from proposals submitted those that it will review. The scope of the commission's study is limited to those selected proposals.

3. Chair; meetings. The Chair of the Legislative Council shall convene the first meeting of the commission no later than November 1, 1991. At the first meeting, the commission shall elect a chair as provided in section 1 and define its scope of study as provided in section 2. The commission shall meet as often as necessary to complete the study, but must meet at least once each month.

4. Report. The commission shall submit an interim report on the status of the study and any preliminary findings to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by December 1, 1991. A final report including findings, recommendations and any necessary implementing legislation must be submitted to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by March 1, 1992.

5. Staff. The commission may request staff assistance from the Legislative Council and from the Department of Professional and Financial Regulation.

6. Compensation. Legislative members are compensated as provided in the Maine Revised Statutes, Title 3, section 2. Nonlegislative members are compensated for any reasonable expenses.

Sec. B-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

1991-92

LEGISLATURE

Special Commission to Study the Workers' Compensation Commission

Personal Services	$2,860
All Other	6,700

Provides funds for the Special Commission to Study the Workers' Compensation Commission including per diem for legislative members, expenses for all members, printing costs and other miscellaneous expenses.

LEGISLATURE TOTAL	$9,560

Sec. B-3. Special Commission to Study the Regulation of the Insurance Industry. There is established the Special Commission to Study the Regulation of the Insurance Industry.

1. **Membership.** The commission consists of 13 members. Six members are appointed by the Governor, 3 members are appointed by the President of the Senate and 3 members are appointed by the Speaker of the House of Representatives. Appointments of the Governor, the President of the Senate and the Speaker of the House of Representatives must be made within 30 days of the effective date of this section. At the commission's first meeting, the members shall select the 13th member by majority vote and that member shall serve as the commission chair. The appointing authorities shall notify the Executive Director of the Legislative Council at the time appointments are made.

2. **Scope of study.** The Governor, the Joint Standing Committee on Labor, the Joint Standing Committee on Banking and Insurance and any other interested parties may each submit a list of proposed areas for investigation by the commission. All proposals submitted under this section must be submitted to the Executive Director of the Legislative Council no later than October 25, 1991. At its first meeting, the commission shall select, by majority vote, from proposals submitted those that it will review. The scope of the commission's study is limited to those selected proposals.

3. **Chair; meetings.** The Chair of the Legislative Council shall convene the first meeting of the commission no later than November 1, 1991. At the first meeting, the commission shall elect a chair as provided in section 1 and define its scope of study as provided in section 2. The commission shall meet as often as necessary to complete the study, but must meet at least once each month.

4. **Report.** The commission shall submit an interim report on the status of the study and any preliminary findings to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by December 1, 1991. A final report including findings, recommendations and any

necessary implementing legislation must be submitted to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by March 1, 1992.

5. **Staff.** The commission may request staff assistance from the Legislative Council and from the Department of Professional and Financial Regulation.

6. **Compensation.** Legislative members are compensated as provided in the Maine Revised Statutes, Title 3, section 2. Nonlegislative members are compensated for any reasonable expenses.

Sec. B-4. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92
LEGISLATURE	
Special Commission to Study the Regulation of the Insurance Industry	
Personal Services	$2,860
All Other	6,700
Provides funds for the Special Commission to Study the Regulation of the Insurance Industry including per diem for legislative members, expenses for all members, printing costs and other miscellaneous expenses.	
LEGISLATURE TOTAL	$9,560

PART C

Sec. C-1. 24-A MRSA §2364, sub-§4, ¶C-1 is enacted to read:

C-1. An experience or merit rating plan may not permit in the calculation of experience modification factors consideration of those lost-time cases attributable to work-related injuries that are aggravations of or that combine with any prior lost-time work-related injury to produce an incapacity. The superintendent shall adopt rules to protect employers from the impact of these subsequent injury claims and to equitably compensate insurers that provide coverage to these employers.

Sec. C-2. **24-A MRSA §2366, sub-§11** is enacted to read:

11. Producer fees. The servicing carrier in the residual market shall pay a fee to the producer designated by the employer on renewed policies upon payment of premium due. The fee must be 4% of the first $5,000 of renewal premium and 2.5% of renewal premium in excess of $5,000. The fee must be based on the state standard premium.

Sec. C-3. 39 MRSA §51-B, sub-§8, as amended by PL 1983, c. 682, §6, is further amended to read:

8. Effect of payment. If, within the ~~-44-day~~ 60-day period established in subsection 7 and after the payment of compensation for incapacity without an award, the employer elects to controvert the claim to compensation for incapacity, the payment of compensation ~~shall~~ may not be considered to be an acceptance of the claim or an admission of liability. Notwithstanding the provisions of section 99-C, the acceptance of compensation in any case, except by decision or agreement, by the injured employee or ~~his~~ the employee's dependents ~~shall~~ is not ~~be~~ considered an admission by the employee or ~~his~~ the employee's dependents as to the nature and scope of the employer's liability or a waiver of the right to question the amount of compensation or the duration of the same or the nature of the injury and its consequences.

The employer may continue the payment of compensation for incapacity under subsection 3 following the filing of a notice of controversy and up to the convening of the formal hearing if the notice of controversy was filed prior to the expiration of the 60-day period established in subsection 7. The continuation of payments under these circumstances is not an acceptance of the claim or an admission of liability on the part of the employer. When benefits paid under this paragraph are discontinued prior to a formal hearing but beyond the 60-day period established in subsection 7, the employer must give written notice to the employee at the time of discontinuing and the employee is entitled to an expedited hearing within 14 days after the employee requests a hearing.

Sec. C-4. 39 MRSA §52, first ¶, as amended by PL 1981, c. 93, is further amended to read:

An employee sustaining a personal injury arising out of and in the course of ~~his~~ that employee's employment or ~~is~~ disabled by occupational disease ~~shall--be~~ is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer. An injured employee ~~shall--have~~ has the right ~~to~~

~~make--his--own--selection--of~~ select a physician or surgeon authorized to practice as such under the laws of the State. Initially the employee may select the employee's own health care provider. Once an employee selects a health care provider, the employee may not change health care providers more than once without seeking approval from an independent medical examiner or the employer. This provision 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 an independent medical examiner or the employer.

Sec. C-5. 39 MRSA §52, as amended by PL 1989, c. 434, §8, is further amended by adding at the end 2 new paragraphs to read:

The Medical Coordinator, in consultation with the appropriate professional organization representing the health care specialty involved, shall propose rules establishing specific protocols pertaining to the extent and duration of treatment for specific injuries and illnesses, and the chair may adopt these rules.

An employee shall purchase generic drugs for the treatment of an injury or disease for which compensation is claimed if the prescribing physician indicates that generic drugs may be used and if generic drugs are available at the time and place of purchase. Providers shall prescribe generic drugs whenever medically advisable for the treatment of an injury or disease for which compensation is claimed. If an employee purchases a nongeneric drug when the prescribing physician 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 section, "generic drug" has the same meaning found in Title 32, section 13702, subsection 11.

Sec. C-6. 39 MRSA §52-A, sub-§1, as amended by PL 1989, c. 668, is repealed and the following enacted in its place:

1. Certificate of authorization. Authorization from the employee for release of medical information by health care providers to the employer is not required under the following circumstances:

A. The information pertains only to treatment of an injury or disease after the occurrence of an event that gives rise to an obligation to make payments under this Act; and

B. The information pertains only to the initial treatment in paragraph A and all treatments within 5 days of the initial treatment.

Sec. C-7. 39 MRSA §65, first ¶, as amended by PL 1965, c. 513, §81, is further amended to read:

Every employee shall after an injury, at all reasonable times during the continuance of ~~his~~ disability if so requested by ~~his~~ the employer, submit ~~himself~~ to an examination by a physician or surgeon authorized to practice as such under the laws of this State, to be selected and paid by the employer. 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 without prior approval from the independent medical examiner or the employee. 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 without prior approval from the independent medical examiner or the employee. The employee ~~shall have~~ has the right to have a physician or surgeon of ~~his~~ the employee's own selection present at such examination, whose costs ~~shall be~~ are paid by the employer. The employer shall give the employee notice of said right at the time ~~he~~ the employer requests such examination.

Sec. C-8. 39 MRSA §100-A, as amended by PL 1989, c. 580, §20, is repealed.

Sec. C-9. 39 MRSA §100-B is enacted to read:

§100-B. Trial work periods

An employee's return to any work, including work other than the employee's preinjury position or work with a different employer, is governed by this section. An employee's return to any work following the signing of an agreement to discontinue benefits is not governed by this section.

1. Trial work period. A trial work period is deemed to exist for the first 15 working days following an employee's return to any work, except that the employer and employee may agree to a longer trial work period. During this time and while the employee is receiving payment for the employment:

A. The employee's compensation may be reduced to reflect the wages, earnings or salary received from employment; and

B. All obligations under subchapter III-A are suspended.

The employee must provide to the employer a memorandum from the employee's treating health care provider stating that the employee is able to return to work.

2. Restoration of benefits. Any reduction in the employee's weekly compensation must cease and compensation must be restored immediately to the amount being paid before the commencement of the trial work period under the following circumstances:

A. The employee's employment was involuntarily terminated or suspended without good cause; or

B. The employee attempted a trial work period and was unable to adequately perform during the period due to the effects of the employee's prior compensable injury and has submitted to the employer, within 14 days of leaving employment, a memorandum from the same health care provider that furnished the memorandum under subsection 1. The health care provider shall include in the memorandum the provider's opinion that the employee was unable to adequately perform during the period due to the effects of the employee's prior compensable injury and the provider's opinion as to the employee's capacity for other work.

If the employee supplies a memorandum from the employee's health care provider after leaving the employment but in a timely fashion under paragraph B, the employer shall restore benefits retroactively to the date the employee left employment. If the employee does not supply a memorandum from the employee's health care provider in a timely fashion under paragraph B, the employer need not automatically restore benefits and the employee must file a petition for restoration of compensation under section 100.

PART D

Sec. D-1. 24-A MRSA c. 52 is enacted to read:

CHAPTER 52

MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY

§3701. Purpose

The Maine Employers' Mutual Insurance Company may be established for the purpose of providing workers' compensation insurance to employers of this State at the highest level of

service and savings consistent with applicable actuarial standards and the sound financial integrity of the company.

§3702. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Board. "Board" means the Board of Directors of the Maine Employers' Mutual Insurance Company.

2. Company. "Company" means the Maine Employers' Mutual Insurance Company created in section 3703.

§3703. Creation

The Maine Employers' Mutual Insurance Company may be established as a domestic mutual insurance company subject to all the requirements and standards of this Title except those from which it is specifically excepted. Notwithstanding any other law to the contrary, the company's authority to operate is limited as follows.

1. Workers' compensation. The company shall provide workers' compensation insurance. The company may not write other lines of insurance.

2. Exclusion from guaranty funds. The company and its policyholders are exempt from participation and may not join or contribute financially to, nor be entitled to the protection of, any plan, pool, association or guaranty or insolvency fund authorized or required by this Title.

3. Initial board of directors. The Governor shall appoint the initial board of directors of the company upon notification by the superintendent that sufficient funds have been collected in accordance with section 3704. Upon appointment, the board shall establish its charter consistent with this chapter and pursue the company's authorization as a domestic mutual insurance company of this State.

The board shall establish appropriate underwriting criteria for the acceptance of risks to ensure the sound financial integrity of the company.

§3704. Prerequisites to operations

1. Prerequisites to operations. As of July 1, 1994, if the premium volume of the voluntary market is less than 20% of the total statewide premium volume, or if, by December 31, 1995, the

premium volume of the voluntary market is less than 25% of the total statewide premium volume, the operations of the company may be initiated as provided in this section.

For the purpose of this section, the imputed premium of any policyholder that is granted initial authority to self-insure after the effective date of this section is considered to be voluntary market premium.

The determinations required under this section must be made within 8 months after the dates prescribed in the first paragraph.

If the superintendent determines that the voluntary market premiums fail to meet those thresholds, the superintendent shall notify the Governor and the Legislature.

2. Company becomes operational upon appropriation. The company becomes operational only upon the receipt of funds provided by appropriation of the Legislature of no more than $20,000,000. The appropriation must be repaid by the company, plus interest at market interest rate calculated from the time that the company accepts the appropriation. The appropriation repayments must be amortized by the Treasurer of State over a 10-year period and must be repaid by the company to the General Fund in equal installments at the end of each fiscal year. The repayment must begin once there exists sufficient earned surplus to comply with state law.

3. Application for certificate of authority. The Governor shall appoint the initial board of directors, as provided in section 3703, subsection 3, which shall as soon as practicable apply for a certificate of authority. If the application complies with the standards prescribed in this Title, the superintendent shall issue a certificate of authority.

§3705. Nonstate agency

The company is not considered a state agency or instrumentality of the State for any purpose.

§3706. Reports and information

1. Annual report. The board shall submit an annual report to the Governor and Legislature indicating the business done by the company during the previous year and containing a statement of the resources and liabilities of the fund and any other information considered appropriate by the board.

2. Statistical and actuarial data. The company must compile and maintain statistical and actuarial data related to

the determination of proper premium rate levels, the incidence of work-related injuries, costs related to those injuries and any other data that the company considers desirable. The company must provide this data to the Superintendent of Insurance, the Chair of the Workers' Compensation Commission and the Department of Labor annually and upon request.

Sec. D-2. 39 MRSA §2, sub-§3-B is enacted to read:

3-B. 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.

Sec. D-3. 39 MRSA §51, sub-§4 is enacted to read:

4. 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.

Sec. D-4. 39 MRSA §52-B, as enacted by PL 1987, c. 559, Pt. B, §22, is amended to read:

§52-B. Medical fees; reimbursement levels

In order to ensure appropriate limitations on the cost of health care services, the ~~commission~~ Medical Coordinator shall propose to the chair and the chair may adopt or amend rules under Title 5, chapter 375, that establish:

1. Maximum charges. Standards, schedules or scales of maximum charges for individual services, procedures of courses of treatment. The maximum charges ~~shall~~ may not be less than the usual, customary and reasonable charge paid by private 3rd-party payors for similar services provided by Maine health care providers. In establishing these standards, schedules or scales, the commission shall consult with organizations representing health care providers and other appropriate groups. The standards ~~shall~~ must be adjusted annually to reflect any appropriate changes in levels of reimbursement. The standards shall ~~not~~ apply to hospital costs and health care providers and must be in effect no later than January 1, 1992; and

2. Depositions or hearings. Various fees for preparation of materials, including reports of treatment required in section 52-A, subsection 2, or attendance at depositions or hearings as may be required under this Act.

Sec. D-5. 39 MRSA §52-D is enacted to read:

§52-D. Medical utilization review and case management

1. Purpose. To ensure quality treatment for injured employees and to provide reasonable and proper health care services, the Medical Coordinator shall develop and implement a medical utilization review and case management program consistent with the requirements of this section. The Medical Coordinator shall utilize independent medical examiners from the lists maintained pursuant to section 92-A to perform the medical utilization review and case management.

2. Medical utilization review. A commissioner, employee, employer or insurer may request a medical utilization review of services rendered by a health care provider as follows.

A. The following issues relating to the treatment or proposed treatment of an employee may be presented to an independent medical examiner:

(1) Whether treatment or proposed treatment is excessive, unreasonable or improper;

(2) Whether the services rendered are inadequate with respect to either the level or quality of care;

(3) Whether fees charged by a provider are in excess of the medical fee schedule under section 52-B;

(4) Whether a provider charged more for services provided to an employee under this Act than charged for services to a private 3rd-party payor in violation of section 52-B; or

(5) Whether a proposed surgical procedure is reasonable and necessary to the proper treatment of an employee.

The issues that may be presented to the independent medical examiner may be expanded through rulemaking by the chair, as proposed to the chair by the Medical Coordinator.

B. An employee, employer or insurer may initiate the medical utilization review process by submitting to the Medical Coordinator, the other parties and the provider whose treatment will be reviewed, a request on forms prescribed by the Medical Coordinator.

Within 15 days after a request for medical utilization review has been submitted, the Medical Coordinator shall appoint an independent medical examiner to perform the review and notify the parties and the provider whose treatment will be reviewed of the appointment. The independent medical examiner must be from the same health care field as the provider whose services are being reviewed. The independent medical examiner may not have any prior knowledge of the case or have examined the employee at an earlier time in connection with the case.

C. All parties shall, when notified that an independent medical examiner has been appointed, supply immediately copies of any medical reports or statements relating to the treatment under review to the independent medical examiner. Upon request of the independent medical examiner, the provider shall submit any additional medical records or information within 3 working days of the examiner's request. The independent medical examiner shall review medical information and records regarding the services that are the subject of the review. The independent medical examiner may interview and examine the employee or order the performance of additional medical tests if necessary.

D. If determined necessary by the independent medical examiner, the employee shall submit to an examination at any reasonable time during the review process. The rights of an employee with respect to examinations and penalties as described in section 65 are applicable to this section.

E. The independent medical examiner shall submit the examiner's findings and recommendations to the parties, the provider and the commission within 30 days from the appointment of the examiner. The independent medical examiner may make recommendations appropriate to the issue that is the subject of the review, including but not limited to:

(1) That a provider be paid or not be paid for services that were inappropriate, unreasonable or excessive;

(2) That a provider be partially paid for services charged in excess of the medical fee schedule;

(3) That a provider be partially paid for services provided to an employee under this Act that exceeded the provider's charge for services to a private 3rd-party payor in violation of section 52-B;

(4) That a provider reimburse an employer or insurer for services that were paid for and are found to be inappropriate, unreasonable or excessive; or

(5) That a proposed surgical procedure is not reasonable and necessary to the proper treatment of an employee.

F. Any employee, employer, insurer or provider that seeks to implement the recommendations of the independent medical examiner or that seeks resolution of a dispute related to the treatment under review may file a petition with the commission. The commissioner shall adopt the medical findings of the independent medical examiner unless there is substantial evidence in the record that does not support the medical findings. "Substantial evidence" means at least a preponderance of evidence. "Substantial evidence" does not include medical evidence not considered by the independent medical examiner. The commissioner must state in writing the reasons for not accepting the medical findings of the independent medical examiner.

G. The party requesting the review shall pay the costs of the review. The Medical Coordinator shall establish a reasonable per diem to be paid to the independent medical examiner and set a maximum charge for other expenses the Medical Coordinator finds necessary for the review process.

3. Case management program. The Medical Coordinator shall create a case management program for cases involving unusually lengthy or expensive medical services, or cases involving chronic conditions that are unresponsive to standard medical treatment. The program must use independent medical examiners acting as case managers. The program must include at least the following elements:

A. The guidelines for the types of cases that may be reviewed by a case manager;

B. The process by which a party or a commissioner may request that an independent medical examiner may be appointed to act as a case manager;

C. The treatment issues that may be addressed by the case manager; and

D. The method by which the recommendations of the case manager may be enforced.

4. **Penalties.** If the Medical Coordinator finds from a review of the findings of independent medical examiners that a provider has demonstrated a pattern of overcharging for services or of rendering services that are inappropriate, unreasonable or excessive, or has submitted false testimony or a false report in connection with any claim, the Medical Coordinator shall provide the licensing board of the provider with full documentation of this determination. The Medical Coordinator may also order an appropriate remedy including, but not limited to, an order barring the provider from receiving any payment under this Act for services rendered for a period not to exceed one year in the first instance and 3 years in the 2nd instance. The Medical Coordinator may permanently bar a provider from eligibility for payment of services under the Act for subsequent instances. The provider may appeal any order of the Medical Coordinator to the chair.

5. **Rules.** The Medical Coordinator may propose to the chair rules to carry out the purposes of this section and the chair may adopt those rules. In proposing these rules, the Medical Coordinator shall consult with organizations knowledgeable about health care utilization and cost containment, including health care providers and insurers that have implemented utilization review and case management.

Sec. D-6. 39 MRSA §54-B, sub-§2, as enacted by PL 1987,c. 559, Pt. B, §27, is amended to read:

2. **Limitation.** Any employee who ~~has--reached--maximum medical improvement and~~ 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 ~~his~~ that employee's community, is not eligible for compensation under this section, but may be eligible for compensation under section 55-B. Reasonable moving and relocation expenses for employees who are retrained or rehabilitated under this Act are available as provided in section 87, subsection 2.

Sec. D-7. 39 MRSA §55-B, as amended by PL 1989, c. 575, is repealed and the following enacted in its place:

§55-B. Compensation for partial incapacity

While the incapacity for work is partial, the employer shall pay the injured employee a weekly compensation equal to 2/3 the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefit under section 53-B. An employee is not eligible to receive

compensation under this section after the employee has received 520 weeks of compensation under section 54-B, this section or both sections.

1. **Evaluation standards.** This subsection governs the determination of an injured employee's degree of incapacity under this section.

A. During the first 40 weeks from the date of the injury, the commission shall consider the availability of work that the employee is able to perform in and around the employee's community and the employee's ability to obtain such work considering the effects of the employee's work-related injury. If no such work is available in and around the employee's community or if the employee is unable to obtain such work in and around the employee's community due to the effects of a work-related injury, the employee's degree of incapacity under this section is 100%. The employee has the burden of production and proof on the availability of work.

B. After the first 40 weeks from the date of injury, the employer has the burden of production regarding the employee's capacity to perform work and the burden of producing a list of suitable and available job positions within the State. The employee has the burden of production regarding a good-faith exploration of the positions on the list. The employee bears the ultimate burden of proof to show that the employee was not hired for one of the positions. The employer shall pay all reasonable expenses incurred by the employee in conducting the exploration of the positions on the list provided by the employer.

2. **Relocation expenses.** If an employee is hired for a permanent position obtained from the list of positions provided by the employer under subsection 1, paragraph B, and that position requires the employee to move and the employee changes residence to take the position, the employer must pay the employee up to $1,000 for actual moving expenses.

Sec. D-8. 39 MRSA §56-B, sub-§1, as enacted by PL 1987, c. 559, Pt. B, §33, is amended to read:

1. Weekly benefit. In the case of permanent impairment, the employer shall pay the injured employee a weekly benefit equal to 2/3 of the state average weekly wage, as computed by the Bureau of Employment Security, for the number of weeks shown in the following schedule:

A. One week for each percent of permanent impairment to the body as a whole from 0 to 14%;

B. Three weeks for each percent of permanent impairment to the body as a whole from 15% to 50%;

C. Four and 1/2 weeks for each percent of permanent impairment to the body as a whole from 51% to 85%; and

D. Eight weeks for each percent of permanent impairment to the body as a whole greater than 85%.

Compensation under this section is ~~in addition to~~ reduced by any compensation under section 54-B or 55-B received by the employee.

Sec. D-9. 39 MRSA §82, sub-§3, ¶D, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

D. The administrator shall assist the ~~chairman~~ chair in developing rules under section 92, subsection 1, regarding rehabilitation, including, but not limited to, rules governing minimum standards for providers of rehabilitation services, the types of services each category of provider is qualified to provide and procedures for rehabilitation cases.

The minimum standards for approved providers of rehabilitation services must include a combination of medical and employment rehabilitation education and experience and are governed by the following requirements.

(1) The standards must separately consider the providers of the following 3 employment rehabilitation services:

(a) Evaluations of suitability for employment rehabilitation;

(b) Development of a plan for employment rehabilitation; and

(c) Implementation of the employment rehabilitation plan.

(2) The standards must include minimum levels of success in the completion by the employee of the rehabilitation plan in placement in suitable employment as similar as possible to the employee's regular employment at a wage as close as possible to the employee's wage at the time of injury.

(3) The standards must state that providers of evaluations of suitability may not perform employment

rehabilitation development or implementation services or be employed by or have an ownership interest in any firm or organization that provides rehabilitation plan development or implementation services.

Sec. D-10. 39 MRSA §82, sub-§3, ¶F, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

F. The administrator shall develop fee schedules for providers of rehabilitation services, listing the maximum allowable fees for testing, evaluations of suitability, development of rehabilitation plans and other rehabilitation services.

(1) In setting a fee, the administrator shall take into account the usual fee charged to provide that service in the State and the reasonable and necessary costs of providing the service.

(2) The administrator may grant prior approval of a fee higher than the maximum in the rate schedule in exceptional circumstances.

(3) Fee schedules developed under this paragraph do not apply to services provided by in-house providers of rehabilitation services.

(4) The fee schedule for the provider of a rehabilitation plan must include a maximum amount for administrative services and costs, not to exceed 30% of the total cost of a plan.

Sec. D-11. 39 MRSA §83, sub-§1, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

1. Reports. Within 120 days following an injury ~~which~~ that gives rise to a claim under this Act, or within 120 days following the first day of a subsequent period of incapacity due to that injury, ~~where~~ when an employee has not returned to ~~his~~ the employee's previous employment, the employer shall submit a report to the administrator to assist in the early identification of those employees who may need rehabilitation to achieve job placement.

A. The report ~~shall~~ must be in the form prescribed by rule of the commission and ~~shall~~ include information to the best of the employer's knowledge on whether the employee is likely to return to ~~his~~ the employee's previous employment and any other information required by the rule.

B. The report ~~shall~~ must be forwarded to the administrator and a copy provided to the employee.

C. If the employer is unable to determine whether the employee is likely to return to ~~his~~ the employee's previous employment, the employer shall include in the report a date by which ~~he~~ the employer expects this determination to be made and the basis for selecting that date.

D. If the employer reports that the employee is likely to return to ~~his~~ the employee's previous employment, the employer shall include in the report the date by which ~~he~~ the employer expects the employee to return to work and the basis for selecting that date.

E. ~~In--either--instance,--the~~ The employer shall file a supplemental report under this subsection on or before ~~that~~ the date selected in paragraph C or D unless the administrator requires otherwise.

Sec. D-12. 39 MRSA §83, sub-§3, ¶D is enacted to read:

D. The plan must consider the relative costs of proposed services to the employer. In no case may a plan last longer than 2 years nor cost more than $5,000 without demonstration of special and unusual circumstances in that case.

Sec. D-13. 39 MRSA §83-A is enacted to read:

§83-A. Early evaluation screening

The administrator shall adopt rules establishing criteria for early evaluation screening to identify disabilities appropriate for early screening and early entry into employment rehabilitation. In developing the rules and in reviewing them periodically, the administrator shall convene a temporary panel of medical, vocational and rehabilitation experts.

The temporary panel of medical, vocational and rehabilitation experts shall also do the following:

1. Occupational health training program. Develop a short-term occupational health training program that concentrates on workplace evaluation and modification to be provided by physicians who are board certified in occupational medicine; and

2. Medical management services. Identify those occupational illnesses and injuries that would benefit from provision of medical management services by an approved

rehabilitation provider prior to beginning employment rehabilitation under this Title.

Sec. D-14. 39 MRSA §84, sub-§1, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

1. Applicability. This section applies to all employers in the State ~~which~~ that maintain~~, on January 1, 1986,~~ a certified rehabilitation counselor on premises to provide rehabilitation services that meet the requirements of this subchapter. These services ~~must~~ may be provided only to their own employees.

Sec. D-15. 39 MRSA §85, sub-§1, as amended by PL 1989, c. 580, §11, is further amended to read:

1. Order of evaluation. When a compensable injury exists and the employee has requested employment rehabilitation upon referral by the treating health care provider or occupational health center, when the employee meets the screening criteria for early evaluation for employment rehabilitation or when the report required under section 83, subsection 1, indicates that the employee is not likely to return to the employee's previous employment, the administrator shall order an evaluation of the suitability of rehabilitation for the employee. If the parties agree to an evaluation, the order is deemed to have been made by the administrator unless notice to the contrary is received by the parties within 14 days after written notice of the agreement is sent to the administrator.

Sec. D-16. 39 MRSA §85, sub-§2-A, ¶F, as enacted by PL 1989, c. 580, §11, is repealed.

Sec. D-17. 39 MRSA §85, sub-§4-A, ¶B is enacted to read:

B. The settlement of a claim between an employee and an employer does not affect the employer's obligation to the fund under this section or under section 57-B, subsection 6, paragraph B, subparagraph (2).

Sec. D-18. 39 MRSA §90, sub-§4 is enacted to read:

4. Repeal. Upon receipt of the report required under subsection 3, the effectiveness of this subchapter must be reviewed by the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. Unless continued by law, this subchapter is repealed September 1, 1993.

Sec. D-19. 39 MRSA §92-A is enacted to read:

§92-A. Independent medical examiners

1. Examiner system. The Medical Coordinator shall develop and implement an independent medical examiner system consistent with the requirements of this section. As part of this system, the Medical Coordinator shall create and maintain a list of health care providers experienced and competent in the treatment of work-related injuries to serve as independent medical examiners from each of the health care fields that the Medical Coordinator finds most commonly used by injured employees. The Medical Coordinator shall propose to the chair rules establishing fees for services rendered by independent medical examiners and any rules considered necessary to effectuate the purposes of this section and the chair may adopt those rules.

2. Duties. The independent medical examiners shall render medical findings on the medical condition of the employee and related issues as specified under this section. The physician or other provider appointed as 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 benefits are being paid. Nothing in this subsection precludes the selection of providers authorized to receive reimbursement under section 52 to serve in the capacity of an independent medical examiner. A physician who has examined an employee at the request of an insurance company or employer in accordance with section 65 during the previous 52 weeks is not eligible to serve as an independent medical examiner.

3. Appointment. The commissioner may select 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 disputes that involve the following:

A. Incapacity for work under sections 54-B and 55-B;

B. Determination of maximum medical improvement and degree of impairment under section 56-B;

C. Determination of the proper cost of medical services or aids under section 52 or 52-B;

D. Evaluation of the employee's ability to return to work including physical limitations on ability to commute; and

E. Review of medical services under section 52, 52-B, 52-C or 52-D.

If the commissioner fails to act within 5 days of receipt of a request for an independent medical examination review or report,

the Medical Coordinator may select an independent medical examiner.

4. Procedure. The Medical Coordinator shall propose to the chair 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 and the chair may adopt those rules. 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.

5. **Medical findings; fees.** The independent medical examiner must submit a written report to the commissioner, 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.

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 commissioner and the parties at least 3 days prior to the hearing.

7. **Weight.** The commissioner shall adopt the medical findings of the independent medical examiner unless there is substantial evidence in the record that does not support the medical findings. "Substantial evidence" means at least a preponderance of evidence. "Substantial evidence" does not include medical evidence not considered by the independent medical examiner. The commissioner must state in writing the reasons for not accepting the medical findings of the independent medical examiner.

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

commission or for assisting in the origination, investigation or preparation of the report or other information so provided.

9. Annual review. The Medical Coordinator 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 providers approved to serve as independent medical examiners.

Sec. D-20. 39 MRSA §98, as repealed and replaced by PL 1983, c. 479, §21, is amended by adding at the end a new paragraph to read:

The commission shall provide for an expedited process for the scheduling and hearing of petitions for review of automatic discontinuances or reductions under section 100, subsections 4-A and 4-B upon the request of either party. Insofar as practicable, expedited cases must be set for a single hearing and take precedence over all other pending cases for scheduling purposes.

Sec. D-21. 39 MRSA §100, as amended by PL 1987, c. 559, Pt. B, §§41 and 42, is further amended to read:

§100. Petitions for review; automatic discontinuance or reduction of benefits

1. Relief available. Upon the petition of either party, a single commissioner shall review any automatic discontinuance or reduction by an employer pursuant to subsection 4-A or any compensation payment scheme required by this Act for the purposes of ordering the following relief, as the justice of the case may require:

A. Increase, decrease, restoration or discontinuance of compensation.

2. Standard for review. The basis for granting relief under this section is as follows.

A. On the first petition for review brought by a party to an action, the commissioner shall determine the appropriate relief, if any, under this section by determining the employee's present degree of incapacity.

B. Once a party has sought and obtained a determination under this section, it is the burden of that party in all proceedings on ~~his~~ subsequent petitions under this section to prove that the employee's earning incapacity attributable to the work-related injury has changed since that determination.

C. When an order has been issued pursuant to subsection 4-A denying the employee's petition for reinstatement of benefits, the commissioner may not reinstate benefits after a hearing if any of the conditions in subsection 4-A are met.

3. Petition procedure. Sections 96-A to 99 apply to petitions brought under this section.

~~3-A. Petitions during rehabilitation. A petition may not be brought during the development or implementation of a rehabilitation plan under section 83, subsection 3 or 4, except in the event of substantial change in the employee's medical condition.~~

~~4. Payments pending hearing and decision. If the employee is receiving payments at the time of the petition, the payments may not be decreased or suspended pending the hearing and final decision upon the petition, except in the following circumstances:~~

~~A. The employer and the employee file an agreement with the commission;~~

~~B. The employer or his insurance carrier files a certificate with the commission stating that:~~

~~(1) The employee has left the State for reasons other than returning to his permanent residence at the time of injury;~~

~~(2) The employee's whereabouts are unknown; or~~

~~(3) The employee has resumed work;~~

~~C. The employer or his insurance carrier files a certificate with the commission stating that the employee refuses to submit to an examination; or~~

~~D. The employee refuses an offer of reinstatement to a position which is suitable to his physical condition or the employee is able to return to work and there is work available, in or near the community in which he resides, which is suitable to his physical condition.~~

~~(1) If the employee refuses an offer of reinstatement or fails to return to available suitable work, his benefits shall be reduced in an amount equal to the difference between the employee's weekly benefit and the benefits he would have been entitled to receive if he had accepted reinstatement or returned to available suitable work.~~

~~(2) Benefits shall not be suspended or reduced pending hearing under this paragraph unless the employer has provided the employee with written notice that benefits may be suspended or reduced together with any information relied on by the employer to support the proposed suspension or reduction. The employee has 20 days, after receiving that notice, to submit to the commission any additional information relating to his continued entitlement to benefits.~~

~~(3) Benefits shall not be suspended or reduced pending hearing under this paragraph if the employee shows that, despite a good faith work search, the employee is unable to obtain suitable work.~~

~~(4) Within 30 days after notice to the employee under subparagraph (2), the commission shall enter a provisional order providing for the suspension, reduction or continuation of benefits pending a hearing on the petition. The order shall be based upon the information submitted by both the employer and the employee under this section.~~

~~(5) If benefits are suspended or reduced under this paragraph and the commission, after hearing, reverses the provisional order, either in whole or in part, the commission shall order a lump sum payment of all benefits withheld together with interest at the rate of 6% a year. The employer shall pay this lump sum within 10 days of the order.~~

4-A. Automatic discontinuance or reduction. The employer may discontinue or reduce benefits by sending a certificate by certified mail to the employee and to the commission, together with any information on which the employer relied to support the discontinuance or reduction. The employer may discontinue or reduce benefits under paragraphs A and B no earlier than 21 days from the date that the certificate was mailed to the employee. 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 commission, including the employee's appeal rights. The employer may discontinue or reduce benefits pursuant to this section under the following circumstances only:

A. If the employee refuses an offer of reinstatement to a position that is suitable to the employee's medical condition, age, education, skills and prior work experience and the employee's physician or an independent medical

examiner has determined that the employee is medically able to perform the employment being offered;

B. If the employee's physician or the independent medical examiner determines that the employee is able to perform actually available employment and;

(1) There is employment suitable to the employee's medical condition, age, education, skills and prior work experience actually available within the community; or

(2) After 40 weeks from the date of the injury, within the State, if the employer demonstrates by affidavit that the position is actually available for the employee by required age, education, skills and prior work experience. If the employee demonstrates by affidavit that the employee applied for up to 3 of the identified positions within 10 days of being notified of availability and, through no fault of the employee, was not employed, the employee must be automatically reinstated;

C. If the employee returns to work other than during a trial work period under section 100-B, or if the employee continues to work following a trial work period;

D. If the employee refuses to submit to a medical examination pursuant to subsection 5;

E. If the employer and the employee file an agreement with the commission;

F. If the employee has left the State for reasons other than returning to the employee's permanent residence at the time of injury and the employer has given notice to the employee by certified mail as evidenced by a signed return receipt or has completed a diligent search;

G. If the employee's whereabouts are unknown and the employer has completed a diligent search for the employee; or

H. If the employee's treating physician or the independent medical examiner determines that the employee is able to return to work without any medical restrictions due to the injury.

The work search standards and burdens of proof described in section 55-B, subsections 1 and 2, are applicable to all hearings under paragraph B.

The report of the independent medical examiner under paragraph H may be dated no earlier than 30 days before the filing of the employer's certificate under this subsection.

If the employee refuses an offer of reinstatement or fails to return to available suitable work, benefits must be reduced in an amount equal to the difference between the employee's weekly benefit and the benefits the employee would have been entitled to receive if the employee had accepted reinstatement or returned to available suitable work.

4-B. Employee's right to hearing. The employee may file a petition for review, contesting the employer's discontinuance or reduction under subsection 4-A. 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 the employer's certificate.

A. The commissioner, within 21 days after the employee files 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 and the employee under this section.

B. The commissioner shall adopt the medical findings of the independent medical examiner unless there is substantial evidence in the record that the medical findings are in error. "Substantial evidence" means at least a preponderance of evidence. "Substantial evidence" does not include medical evidence not considered by the independent medical examiner. The commissioner shall state in writing the reasons for not accepting the medical findings of the independent medical examiner.

C. If either party disagrees with the order of the commissioner under paragraph A, that party may request an expedited hearing on the pending petition pursuant to section 98.

D. If an order is not issued under paragraph A and the commissioner, after hearing, reverses that decision, either in whole or in part, the commissioner 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.

E. Except as provided in subsection 4-A, paragraph B, the employer has the burden of proof in any hearing under this section.

5. Medical examination. Upon the request of the ~~petitioner, the commission shall order~~ employer or the independent medical examiner, the employee ~~to~~ shall submit to examination by ~~an impartial physician or surgeon designated by the commission from the geographical area where the employee resides~~ the independent medical examiner. The fee for the examination ~~shall~~ must be paid by the employer. ~~Payment of compensation may be decreased or suspended by the commissioner pending final decision on the petition if:~~

~~A. The physician or surgeon certifies to the commission after examination that in his opinion the employee is able to resume work; or~~

~~B. The employee refuses to submit to an examination.~~

6. Recovery of overpayments. ~~Compensation~~ Any compensation paid ~~by the employer after the employee has resumed work may be recovered~~ to an employee from the date the employee is not qualified for compensation to the date the employer automatically discontinued or reduced benefits pursuant to subsection 4-A is recoverable from the employee ~~in a legal action brought by the employer~~ if: the employer discontinued compensation pursuant to subsection 4-A, paragraphs C to G.

~~A. At the time of his filing a petition under this section, the employer also filed a certificate that the employee had resumed work; and~~

~~B. After the hearing the commissioner finds that the petition was properly filed and decrees that compensation cease.~~

7. Report. The chair of the commission shall provide a report to the joint standing committee of the Legislature having jurisdiction over labor matters by December 1, 1992, regarding automatic suspension and reduction of benefits under this section. The report must include:

A. The number of cases in which employers automatically suspended or reduced benefits under subsection 4-A, paragraphs A to H;

B. The number of cases in which employees requested a hearing pursuant to subsection 4-B;

C. The number of cases in which a commissioner entered an order under subsection 4-B, paragraph A and the number of cases in which the order was entered within 21 days;

D. The number of cases in which a commissioner upheld an employer's automatic suspension or reduction of benefits after hearing; and

E. Any other information that the chair considers useful.

Sec. D-22. 39 MRSA §110, sub-§3 is enacted to read:

3. Attorney's fees. Attorney's fees for lump-sum settlements are limited as follows. The employer may be assessed an attorney's fee based on a lump-sum settlement for services on behalf of the employee. The fee may not exceed:

A. Ten percent of the first $50,000 of the settlement;

B. Nine percent of the first $10,000 over $50,000 of the settlement;

C. Eight percent of the next $10,000 over $50,000 of the settlement;

D. Seven percent of the next $10,000 over $50,000 of the settlement;

E. Six percent of the next $10,000 over $50,000 of the settlement; and

F. Five percent of any amount over $100,000 of the settlement.

Sec. D-23. 39 MRSA c. 1, sub-c. V is enacted to read:

SUBCHAPTER V

MEDICAL COORDINATION

§121. Office of Medical Coordination established

The Office of Medical Coordination is established to coordinate medical and occupational health services to injured employees to ensure the delivery of appropriate medical and occupational health services and to implement the medical examiner system and administer and supervise independent medical examiners, medical utilization review and case management under this Title.

§122. Medical Coordinator

1. Appointment. The Medical Coordinator shall direct the Office of Medical Coordination. The Medical Coordinator is referred to in this subchapter as the "coordinator." At any time the position of Medical Coordinator is vacant, the chair of the commission, after consultation with the Commissioner of Human Services and the Commissioner of Professional and Financial Regulation shall submit the names of 3 candidates for the position of Medical Coordinator to the Governor. The Governor may appoint one of the candidates as Medical Coordinator, or may, at the Governor's discretion, reject all candidates and request another list of candidates from the chair. The Medical Coordinator serves for a term of 5 years or until a successor is appointed and qualified.

2. Qualifications. The coordinator must be qualified by training, professional experience or education in employment rehabilitation, medical treatment and occupational health and safety and must be familiar with the workers' compensation system.

3. Powers and duties. In addition to any other provisions in this subchapter, the coordinator has the following powers and duties.

A. The coordinator is responsible for the receipt of reports and other information required under this Title and may require supplementary information needed to fulfill the purposes of this subchapter.

B. The coordinator shall propose rules to the chair and the chair may adopt those rules pursuant to Title 5, chapter 375 to carry out the purposes of this subchapter including, but not limited to the following:

(1) Rules required to create and maintain a list of health care providers experienced and competent in the treatment of work-related injuries to serve as independent medical examiners from each of the health care fields that the coordinator finds most commonly used by injured employees;

(2) Rules required to develop and implement an independent medical examiner system for resolution of disputes by independent medical examiners, including procedures before the independent medical examiner and the parties' ability to propound questions relating to the medical condition of the employee to be submitted to the independent medical examiner;

(3) Rules required to develop and implement a medical utilization and case management program consistent with the requirements of section 52-D. In establishing these rules, the coordinator shall consult with organizations knowledgeable about health care utilization and cost containment, including health care providers and insurers that have implemented utilization review and case management; and

(4) Rules establishing specific protocols pertaining to the extent and duration of treatment for specific injuries and illnesses, and the chair may adopt these rules.

In adopting rules, the chair shall distinguish among and respect the different types of health care providers and health care services.

C. The coordinator shall:

(1) Monitor medical and occupational health services provided to injured workers under this Title;

(2) Encourage agreement and attempt to conciliate differences on medical and occupational health services issues;

(3) Provide leadership in the development of occupational health centers;

(4) Review and make recommendations on the fee schedule established in section 52-B;

(5) Oversee medical utilization review pursuant to section 52-D; and

(6) Together with the chair establish and maintain the fee schedule pursuant to section 52-B.

D. The coordinator may not provide direct medical services. Medical services under this subchapter must be provided by private and public medical professionals and occupational health centers.

E. The coordinator shall make efforts to educate and disseminate information to all persons interested in medical and occupational health services as those services relate to injured workers.

4. Access to records. Except for purposes directly connected with the administration of the Office of Medical Coordination, a person may not solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of any list of, or names of, or any information concerning individuals applying for or receiving medical coordination services, directly or indirectly derived from the records, papers, files or communications of the Office of Medical Coordination or acquired in the course of the performance of official duties. This subsection does not prevent any employee or that person's employer from obtaining or viewing information relating to the medical coordination services provided to the employee under this subchapter.

Sec. D-24. Implementation of rate reductions. The Superintendent of Insurance shall, in the workers' compensation proceeding authorized pursuant to Private and Special Law 1991, chapter 16 and subsequent rate proceedings, order appropriate reductions in workers' compensation rates to reflect the impact of this Act. The superintendent shall report to the Legislature whether the percentage reductions attested to by the Bureau of Insurance actuary as a result of this Act is adequately reflected in the reductions in these proceedings.

Sec. D-25. Application; retroactivity; average weekly wages, earnings or salary. That section of this Act that enacts the Maine Revised Statutes, Title 39, section 2, subsection 2, paragraph G applies to employees injured on or after the effective date of this Act and retroactively to employees injured before the effective date of this Act except those employees awarded compensation consistent with the holding in Ashby vs. Rust Engineering, 559 A.2d 774 (Me. 1989).

Sec. D-26. Applications. Except as otherwise provided, this Act applies only to injuries occurring on or after the effective date of this Act.

Sec. D-27. Effective date. The following sections take effect January 1, 1992:

1. Those sections in Part A enacting the Maine Revised Statutes:

Title 24-A, section 2362-A;
Title 24-A, section 2362-B;
Title 24-A, section 2365-A;
Title 24-A, section 2366, subsection 5, paragraph C; and
Title 24-A, section 2366, subsection 7-A;

2. Those sections in Part A amending:

Title 24-A, section 2364, subsection 4, paragraph A;
Title 24-A, section 2366, subsection 2, paragraph B;
Title 24-A, section 2366, subsection 3, paragraphs A and B; and
Title 39, section 72; and

3. Those sections in Part C enacting:

Title 24-A, section 2364, subsection 4, paragraph C-1; and
Title 24-A, section 2366, subsection 11.

PART E

Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92	1992-93
WORKERS' COMPENSATION COMMISSION		
Workers' Compensation Commission		
All Other	$35,000	$39,450
Provides funds to establish and operate an "800" telephone number and to provide written notification to employees of workers' compensation actions.		
Office of Medical Coordination		
Positions	(2.0)	(2.0)
Personal Services	$51,677	$77,483
All Other	12,948	17,198
Capital Expenditures	3,500	
TOTAL	$68,125	$94,681
Provides funds to establish the Office of Medical Coordination to include one Medical Coordinator position and one Secretary position with related operating		

expenses and capital expenditure funds for computer equipment.		
WORKERS' COMPENSATION COMMISSION TOTAL	$103,125	$134,131
PART E TOTAL APPROPRIATIONS	$103,125	$134,131

115th MAINE LEGISLATURE

SECOND REGULAR SESSION-1992

Legislative Document **No. 2423**

H.P. 1735 House of Representatives, March 17, 1992

Reference to the Committee on Banking and Insurance suggested and ordered printed.

EDWIN H. PERT, Clerk

Presented by Representative LIPMAN of Augusta. (GOVERNOR'S BILL)
Cosponsored by Senator CARPENTER of York, Representative HASTINGS of Fryeburg and Representative CARLETON of Wells.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-TWO

An Act to Reform the Workers' Compensation System.

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 24-A MRSA §2362, as enacted by PL 1987, c. 559, Pt. A, §4, is repealed and the following enacted in its place:

§2362. Workers' compensation rates

1. Prior approval. Workers' compensation rates and classifications must be approved, modified or disapproved by the superintendent subject to this chapter. Rates determined by the superintendent are maximum rates except as provided in subsection 2. Premium rates less than those approved may be used if filed with the superintendent within 5 days after commencing use. If the superintendent has reason to believe that the filing produces rates that are inadequate or unfairly discriminatory, the superintendent may disapprove them under chapter 23 and chapter 25, subchapter I.

2. Upward deviation permitted. Rates up to 20% above the rates established by the superintendent may be used by an insurer in the voluntary market on a risk-by-risk basis. An offer of insurance using rates in excess of the rates established by the superintendent may not be used to deny eligibility to the safety pool of the residual market mechanism.

Sec. A-2. 39 MRSA §2, sub-§2, ¶B-1, as amended by PL 1989, c. 511, is further amended to read:

B-1. Notwithstanding paragraphs A and B, the average weekly wage of a seasonal worker ~~shall be~~ is determined by dividing the employee's total wages, earnings or salary for the ~~prior calendar~~ immediately preceding 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.

Sec. A-3. 39 MRSA §51, sub-§1, as enacted by PL 1981, c. 200, is amended to read:

1. Entitlement. If an employee who has not given notice of ~~his~~ the employee's claim of common law or statutory rights of

action, or who has given the notice and has waived the same, as provided in section ~~28~~ 28-A receives a personal injury arising out of and in the course of ~~his~~ employment or is disabled by occupational disease, ~~he--shall~~ the employee must be paid compensation and furnished medical and other services by the employer who has assented to become subject to this Act. Entitlement for any personal injury or occupational disease must be established by objective medical evidence.

Sec. A-4. 39 MRSA §51, sub-§5 is enacted to read:

5. Apportionment between work-related and nonwork-related injuries or conditions. When, as determined by the independent medical examiner, one or more work-related injuries or conditions combine with, aggravate or are aggravated by one or more nonwork-related injuries or conditions to produce an incapacity, a change in incapacity or a need for medical treatment, the liability of the employer is governed by this subsection. Liability for the incapacity or condition must be apportioned on the basis of an independent medical examiner's medical determination of the relative contribution of each injury or condition on a percentage basis, and the employer is liable only for that portion of incapacity or treatment caused by the work-related injury.

Sec. A-5. 39 MRSA §51-B, sub-§8, as amended by PL 1991, c. 615, Pt. C, §3, is further amended to read:

8. Effect of payment. If, within the 60-day period established in subsection 7 and after the payment of compensation for incapacity without an award, the employer elects to controvert the claim to compensation for incapacity, the payment of compensation may not be considered to be an acceptance of the claim or an admission of liability. Notwithstanding the provisions of section 99-C, the acceptance of compensation in any case, except by decision or agreement, by the injured employee or the employee's dependents is not considered an admission by the employee or the employee's dependents as to the nature and scope of the employer's liability or a waiver of the right to question the amount of compensation or the duration of the same or the nature of the injury and its consequences.

The employer may continue the payment of compensation for incapacity under subsection 3 following the filing of a notice of controversy and up to the ~~convening--of--the~~ commissioner's decision following a formal hearing if the notice of controversy was filed prior to the expiration of the 60-day period established in subsection 7. The continuation of payments under these circumstances is not an acceptance of the claim or an admission of liability on the part of the employer. When benefits paid under this paragraph are discontinued or reduced prior to the commissioner's determination following a formal

hearing but beyond the 60-day period established in subsection 7, the employer must give written notice to the employee at the time of discontinuing or reducing and the employee is entitled to an expedited hearing within 14 days after the employee requests a hearing.

Sec. A-6. 39 MRSA §52-B, sub-§1, as amended by PL 1991, c. 615, Pt. D, §4, is further amended to read:

1. Maximum charges. Standards, schedules or scales of maximum charges for individual services, procedures of courses of treatment. The maximum charges may not be less than the usual, customary and reasonable charge paid by private 3rd-party payors for similar services provided by Maine health care providers. In establishing these standards, schedules or scales, the commission shall consult with organizations representing health care providers and other appropriate groups. The standards must be adjusted annually to reflect any appropriate changes in levels of reimbursement. The standards ~~shall~~ must apply to hospital costs and health care providers and must be in effect no later than January 1, 1992. Notwithstanding this section or any other provision of law, the standards, schedules or scales for 1993 are the same as those in effect on January 1, 1992; and

Sec. A-7. 39 MRSA §53, as amended by PL 1973, c. 557, §1, is further amended to read:

§53. Waiting period; when compensation payable

No compensation for incapacity to work ~~shall be~~ is payable for the first 3 days of incapacity, except that ~~firemen shall~~ firefighters receive compensation from the date of incapacity. In case incapacity continues for more than 14 days, compensation ~~shall be~~ is allowed from the date of incapacity.

Sec. A-8. 39 MRSA §54-B, as amended by PL 1991, c. 615, Pt. D, §6, is repealed.

Sec. A-9. 39 MRSA §§54-C and 54-D are enacted to read:

§54-C. Compensation for temporary total incapacity

1. Temporary total benefits. While an injured employee's incapacity for work is total, the employer shall pay that employee a weekly compensation equal to 60% of that employee's average gross weekly wages, earnings or salary, but not more than the maximum benefit under section 53-B or less than $25 weekly. The total number of weeks of compensation due the employee under this section may not exceed 156 weeks from the date of injury.

2. Limitation Any employee who is able to perform full-time remunerative work in the ordinary competitive labor

market, regardless of the availability of that work in and around the employees community is not eligible for compensation under this section, but may be eligible for compensation under section 55-B. Reasonable moving and relocation expenses for employees who are retrained or rehabilitated under this Act are available as provided in section 87, subsection 2.

3. Applicability. This section applies only to employees injured on or after the effective date of this section.

§54-D. Compensation for total permanent incapacity

1. Permanent total benefits. While the incapacity for work resulting from the injury is total, the employer shall pay the injured employee a weekly compensation equal to 60% of that employee's average gross weekly wages, earnings or salary but not more than the maximum benefit under section 53-B nor less than $25 weekly.

2. Annual adjustment. Beginning on the 3rd anniversary of the injury, weekly compensation under this section must be adjusted annually. The adjustment must be equal to the lesser of the actual percentage increase or decrease in the state average weekly wages, as computed by the Bureau of Employment Security, for the previous year or 5%, whichever is less.

The annual adjustment must be made on the 3rd and each succeeding anniversary date of the injury, except that, when the effect of the maximum under section 53-B is to reduce the amount of compensation to which the claimant would otherwise be entitled, the adjustment must be made annually on July 1st.

3. Presumption. For the purposes of this Act, in the following cases, it is conclusively presumed 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:

A. The total and irrevocable loss of sight in both eyes;

B. The loss of both hands at or above the wrist;

C. The loss of both feet at or above the ankle;

D. The loss of one hand and one foot;

E. An injury to the spine resulting in permanent and complete paralysis of the arms or legs; or

F. An injury to the skull resulting in incurable imbecility or insanity.

4. Limitation. 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 that work in and around that employee's community, is not eligible for compensation under this section, but may be eligible for compensation under section 55-B. This limitation does not apply to cases described under subsection 3. Reasonable moving and relocation expenses for employees who are retrained or rehabilitated under this Act are available as provided in section 87, subsection 2.

5. Applicability. This section applies only to employees injured on or after the effective date of this section.

Sec. A-10. 39 MRSA §55-B, as repealed and replaced by PL 1991, c. 615, Pt. D, §7, is repealed and the following enacted in its place:

§55-B. Compensation for partial incapacity

1. Benefit and duration. While the injured employee's incapacity for work is partial, the employer shall pay the injured employee a weekly compensation equal to 60% of the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefit under section 53-B. An employee is not eligible to receive more than 260 weeks of compensation under this section or more than 364 weeks under a combination of this section and section 54-C, except that, this number may be extended to 520 weeks if an employer agrees or a commissioner finds that the employee is, as a result of personal injury under this Title, incapacitated due to a permanent loss of 75% or more of any of the following bodily functions or senses:

A. One eye;

B. One hand;

C. One arm;

D. One foot; or

E. One leg.

The degree of loss under this section must be determined using the schedules prescribed by the commission under section 56-B.

2. Evaluation standards. This subsection governs the determination of an injured employee's degree of incapacity under this section.

A. During the first 40 weeks from the date of the injury, the commission shall consider the availability of work that the employee is able to perform in and around the employee's community and the employee's ability to obtain such work considering the effects of the employee's work-related injury. If no such work is available in and around the employee's community or if the employee is unable to obtain such work in and around the employee's community due to the effects of a work-related injury, the employee's degree of incapacity under this section is 100%. The employee has the burden of production and proof on the availability of work.

B. After the first 40 weeks from the date of injury, the employer has the burden of production regarding the employee's capacity to perform work and the burden of producing a list of suitable and available job positions within the State. The employee has the burden of production regarding a good-faith exploration of the positions on the list. The employee bears the ultimate burden of proof to show that the employee was not hired for one of the positions. The employer shall pay all reasonable expenses incurred by the employee in conducting the exploration of the positions on the list provided by the employer.

3. Applicability. This section applies only to employees injured on or after the effective date of this section.

Sec. A-11. 39 MRSA §56-B, sub-§1, as amended by PL 1991, c. 615, Pt. D, §8, is further amended to read:

1. Weekly benefit. In the case of permanent impairment, the employer shall pay the injured employee a weekly benefit equal to ~~2/3~~ 60% of the state average weekly wage, as computed by the Bureau of Employment Security, for the number of weeks shown in the following schedule:

A. One week for each percent of permanent impairment to the body as a whole from 0 to 14%;

B. Three weeks for each percent of permanent impairment to the body as a whole from 15% to 50%;

C. Four and 1/2 weeks for each percent of permanent impairment to the body as a whole from 51% to 85%; and

D. Eight weeks for each percent of permanent impairment to the body as a whole greater than 85%.

Compensation under this section is reduced by any compensation to be received by the employee under section 54-B or 55-B ~~received by the employee~~.

Sec. A-12. 39 MRSA §65-A is enacted to read:

§65-A. Applicability

Section 65 governs any actions, dispositions or proceedings under this Act after the effective date of this section.

Sec. A-13. 39 MRSA §71-A, sub-§§4 and 5 are enacted to read:

4. Offsets. If a settlement is approved and the employee suffers another injury for which compensation is payable under this Act, the benefits payable for the subsequent injury must be reduced by an amount not to exceed the amount of the settlement to the extent necessary to avoid duplicative payment of benefits for any period of incapacity. All settlement agreements must expressly allocate amounts payable as compensation for wage loss, medical services, permanent impairment or other benefits agreed to by the parties, subject to a determination by the commissioner that the settlement is fair and reasonable.

5. Disapproval; disqualification of commissioner. A commissioner who disapproves or otherwise fails to approve a proposed lump-sum settlement must be disqualified from presiding at any subsequent formal hearing in that case.

Sec. A-14. 39 MRSA §92-B, sub-§2, as enacted by PL 1991, c. 615, Pt. D, §19, is amended to read:

2. Duties. The independent medical examiners shall render medical findings on the medical condition of the employee and related issues as specified under this section. The physician or other provider appointed as 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 benefits are being paid. Nothing in this subsection precludes the selection of providers authorized to receive reimbursement under section 52 to serve in the capacity of an independent medical examiner. A physician who has examined an the employee at the request of an insurance company or employer in accordance with section 65 during the previous 52 weeks is not eligible to serve as an independent medical examiner with respect to the injury for which benefits are being claimed.

Sec. A-15. 39 MRSA §92-B, sub-§3, ¶B, as enacted by PL 1991, c. 615, Pt. D, §19, is amended to read:

B. Determination of degree of impairment under section 55-B and of maximum medical improvement and degree of impairment under section 56-B;

Sec. A-16. 39 MRSA §92-B, sub-§10 is enacted to read:

10. Applicability. This section governs any actions, dispositions or proceedings under this Act after the effective date of this subsection.

Sec. A-17. 39 MRSA §95, as amended by PL 1991, c. 615, Pt. A, §44, is further amended to read:

§95. Time for filing petitions

Any employee's claim for compensation under this Act is barred unless an agreement or a petition as provided in section 94 is filed within 2 years after the date of the injury, or, if the employee is paid by the employer or the insurer, without the filing of any petition or agreement, within 2 years of any payment by such employer or insurer for benefits otherwise required by this Act. ~~The 2-year period in which an employee may file a claim does not begin to run until the employee's employer, if the employer has actual knowledge of the injury, files a first report of injury as required by section 106 of the Act.~~ With respect to those injuries for which section 106 requires the filing of a first report of injury, the 2-year period in which an employee may file a claim does not begin to run until the employee's employer, if the employer has actual knowledge of the injury, files a first report. Any time during which the employee is unable by reason of physical or mental incapacity to file the petition is not included in the period provided in this section. If the employee fails to file the petition within that period because of mistake of fact as to the cause and nature of the injury, the employee may file the petition within a reasonable time. In case of the death of the employee, there is allowed for filing said petition one year after that death. No petition of any kind may be filed more than 6 years following the date of the latest payment made under this Act. For the purposes of this section, payments of benefits made by an employer or insurer pursuant to section 51-B or 52 are considered payments under a decision pursuant to a petition, unless a timely notice of controversy has been filed.

Sec. A-18. 39 MRSA §96-A, sub-§3 is enacted to read:

3. Effect of previous settlement. A petition or claim for benefits of any type available under this Act is not allowed on account of an injury that has been previously resolved by a lump-sum settlement or by any other final settlement process pursuant to the laws of any other jurisdiction.

Sec. A-19. 39 MRSA §100, sub-§4-B, ¶C, as enacted by PL 1991, c. 615, Pt. D, §21, is amended to read:

C. If either party disagrees with the order of the commissioner under paragraph A, that party may request an

expedited hearing on the pending petition pursuant to section 98. If an employee petitions for review of a discontinuance or a reduction in benefits made under subsection 4-A more than 21 days after the discontinuance or reduction and either party disagrees with the order of the commissioner under paragraph A, that party may request a hearing, but is not entitled to a hearing on an expedited basis pursuant to section 98.

Sec. A-20. 39 MRSA §100, sub-§8 is enacted to read:

8. Applicability. This section governs any actions, dispositions or proceedings under this Act after the effective date of this subsection.

Sec. A-21. 39 MRSA §110, sub-§3, ¶E, as enacted by PL 1991, c. 615, Pt. D, §22, is amended to read:

E. Six percent of the next ~~$10,000~~ $20,000 over $50,000 of the settlement; and

Sec. A-22. 39 MRSA §111, first ¶, as amended by PL 1985, c. 118, is further amended to read:

No employee ~~shall~~ may 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 ~~shall~~ must be referred to a commissioner for a formal hearing under section 98, but any commissioner who has previously rendered any decision concerning the claim must be excluded. If the employee prevails at this hearing, the commissioner may award the employee reinstatement to ~~his~~ the employee's previous job, payment of back wages, reestablishment of employee benefits and reasonable ~~attorneys'~~ attorney's fees.

PART B

Sec. B-1. 4 MRSA c. 35 is enacted to read:

CHAPTER 35

WORKERS' COMPENSATION COMMISSION

§1641. Commission established

The Workers' Compensation Commission is established within the Judicial Department.

§1642. Workers' Compensation Commission

1. Membership; term. The Workers' Compensation Commission, as established in this section, consists of 11 members who must be persons learned in the law and members of good standing of the bar of this State. The members must be appointed by the Governor within 60 days after a vacancy occurs or a new commissioner is authorized, subject to review by the joint standing committee of the Legislature having jurisdiction over judiciary matters and to confirmation by the Legislature. One of the commissioners, to be designated by the Governor as chair, must be appointed for the term of 7 years from the date of the chair's appointment and the other commissioners for a term of 6 years each from the date of their respective appointments.

2. Vacancies; removal. Commissioners hold office for the terms provided in subsection 1, unless removed, and until their successors are appointed and qualified, but not beyond 6 months after the expiration of their terms. They must be sworn and for inefficiency, willful neglect of duty or for malfeasance in office may be removed by the Governor, only with the review and concurrence of the joint standing committee of the Legislature having jurisdiction over judiciary matters upon hearing in executive session, or by impeachment. Before removing a commissioner, the Governor must notify the President of the Senate and the Speaker of the House of Representatives of the removal and the reasons for the removal. In case the office of chair becomes vacant, the senior appointed commissioner acts as chair until the Governor makes an appointment to fill the vacancy.

3. Salary; expenses; retirement. Salaries of commissioners are as provided in Title 2, section 7, subsection 2. Members of the commission are entitled to receive their actual, necessary, cash expenses while away from their offices on official business of the commission. Commissioners who elect to join the Maine State Retirement System receive credit for their creditable service as a member of the Maine State Retirement System prior to July 1, 1983 and for any service as a commissioner from July 1, 1983 to November 30, 1984 without further contribution.

4. Practice. Each commissioner and chair shall devote full time to the duties of the office and may not hold any other public office or public employment. A commissioner may not practice law during the term of office, nor may the commissioner during that term be the partner or associate of any person in the practice of law.

5. Headquarters; regional offices. The commission shall have its central office in Augusta, and 4 district offices to be located in Androscoggin, Aroostook, Cumberland and Penobscot Counties. The commission may hold sessions at any place within the State.

6. Seal. The commission shall have a seal bearing the words "Workers' Compensation Commission of Maine."

§1643. Jurisdiction

The Workers' Compensation Commission has jurisdiction over actions brought pursuant to the Workers' Compensation Act.

§1644. Authority of chair; administration

1. Rules. The chair of the commission has general supervision over the administration of the Workers' Compensation Act, and responsibility for the efficient and effective management of the commission and its employees. Subject to any applicable requirements of the Maine Administrative Procedure Act after obtaining the advice of the commissioners, the chair shall make rules, prescribe forms and make suitable orders as to procedure adopted to ensure a speedy, efficient and inexpensive disposition of all proceedings.

2. Employees. The chair shall appoint an assistant to the chair, who shall serve at the chair's pleasure. Subject to the Civil Service Law, the chair shall appoint a Director of Administrative Services, full-time or part-time reporters and such legal, professional and clerical assistants as may be necessary.

3. Data system; reports. The chair is responsible for development and administration of the commission data system. The chair shall report quarterly to the Governor, the President of the Senate and the Speaker of the House of Representatives on each commissioner's caseload and progress, and the number of instances in which each commissioner has exceeded the 30-day rule contained in Title 39, section 99-B.

4. Booklets; information. To ensure that both employers and employees are fully informed as to their rights and responsibilities under the Workers' Compensation Act, the chair shall prepare, publish and distribute an illustrated booklet explaining, in informal and readily understandable language, those rights and responsibilities. The chair is responsible for periodic revision of the booklet.

5. Active retired commissioners. Any commissioner having retired from the commission is eligible for appointment as an active retired commissioner. The Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over judiciary matters and to confirmation by the Legislature, may, upon being notified of the retirement of a commissioner, appoint that commissioner to be an active retired commissioner for a term of 4 years, unless sooner removed, and subject to reappointment. An active retired commissioner has the

same powers as before retirement, except that the active retired commissioner shall act only in those cases and at times and places as directed by the chair, and except that an active retired commissioner may not be a member of a panel of the appellate division.

An active retired commissioner who performs the services of a commissioner at the direction and assignment of the chair is entitled to compensation at a rate established by the chair, as long as the total per diem compensation and retirement pension received by an active retired commissioner does not exceed the annual salary of a regular commissioner. In addition, the active retired commissioner is entitled to reimbursement for expenses actually and reasonably incurred in the performance of the active retired commissioner's duties.

6. Abuse investigation unit. The chair shall provide adequate funding for a unit of abuse investigation.

A. The chair shall, subject to the Civil Service Law, appoint at least 2 abuse investigators for the unit of abuse investigation. Investigators must be qualified to perform their duties by experience and training.

B. The unit of abuse investigation, at the direction of the chair, shall investigate all complaints or allegations of fraud, illegal or improper conduct or violation of the Workers' Compensation Act or rules of the commission related 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 the Workers' Compensation Act or rules of the commission and all records, correspondence and reports of criminal prosecution or civil action are confidential. The confidential nature of any record, correspondence or report does not limit or affect the use of those materials in any prosecution or action.

C. Each employer or employee, and each state, county, municipal or quasi-governmental agency shall cooperate fully with the unit of abuse investigation and provide any information requested by it.

D. The unit of abuse investigation shall report all its findings to the chair.

E. Whenever the chair determines that a fraud, attempted fraud or violation of the Workers' Compensation Act or rules may have occurred, the chair shall report in writing all information concerning the fraud, attempted fraud or violation to the Attorney General or a delegate for

appropriate action, including a civil action for recovery of funds and criminal prosecution by the Attorney General.

7. Information. The commission shall maintain a toll-free telephone number to enable employees and employers to obtain information from the commission.

§1645. Investigations; subpoenas; depositions

1. Investigators. Any commissioner, when the interests of any of the parties or when the administration of the Workers' Compensation Act demand, may appoint a person to make a full investigation of the circumstances surrounding any industrial injury or any matter connected with that injury, and report the circumstances without delay to the office of the commission.

2. Subpoenas. Any commissioner may administer oaths and any commissioner, notary public or clerk of any Superior Court may issue subpoenas for witnesses and subpoenas duces tecum to compel the production of books, papers and photographs related to any questions in dispute before the commission or to any matters involved in a hearing. Witness fees in all proceedings under the Workers' Compensation Act must be the same as for witnesses before the Superior Court. When a witness subpoenaed and obliged to attend before the commission or any member of the commission fails to do so without reasonable excuse, the Superior Court or any Justice of the Superior Court, on application of the Attorney General made at the written request of a member of the commission, may 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 that court.

3. Proceedings before Workers' Compensation Commission. In all proceedings before the Workers' Compensation Commission, discovery is available to any of the parties in the proceedings as the chair, by rule adopted under section 1644, may prescribe to ensure that hearings may be held within the time periods prescribed by the Workers' Compensation Act. A commissioner shall rule on all objections and may enforce this subsection in the same manner and to the same extent as a Superior Court Justice may enforce compliance with the Maine Rules of Civil Procedure, as amended, with regard to discovery, except that the commissioner does not have the power of contempt.

Signed statements by a medical doctor or osteopathic physician related to medical questions, by a psychologist related to psychological questions or by a chiropractor related to chiropractic questions are admissible in workers' compensation hearings before the Workers' Compensation Commission, providing that notice of that 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, subpoenas or cross-examination of health care practitioners is permitted only if the commissioner finds that the testimony is sufficiently important to outweigh the delay in the proceeding.

4. Witnesses. Upon agreement of the parties, a witness may be heard by a commissioner other than the one to whom the matter was originally referred and a transcript of the witness' testimony must be furnished to the original commissioner. This testimony has the same force and effect as if taken by deposition or heard by the original commissioner.

5. Contempt before Workers' Compensation Commission. A person, in proceedings before the Workers' Compensation Commission or a single commissioner, may not disobey or resist any lawful order, process or writ; misbehave during a hearing or so near the place of the 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 a person commits any acts forbidden in this subsection, the commission or commissioner shall immediately certify the facts to a Superior Court Justice in the county where the alleged offense occurred and may serve or cause to be served upon that person an order requiring that person to appear before the Superior Court Justice on a day certain to show cause why that person should not be adjudged in contempt by reason of the facts so certified. The justice then, in a summary manner, shall hear the evidence as to the acts complained of and, if the evidence warrants, the justice shall punish that person in the same manner and to the same extent as for a contempt committed before that justice, or commit that person on the same conditions as if the forbidden act had occurred with reference to the process of the Superior Court or in the presence of the justice.

6. Case administration. The commission shall assume an active and forceful role in the administration of the Workers' Compensation Act to ensure that the system operates efficiently and with maximum benefit to both employers and employees. The commission shall continually monitor individual compensation cases to ensure that injured employees or their dependents receive the full amount of compensation to which they are entitled under the Workers' Compensation Act.

§1646. Appellate division created

1. Composition. The Appellate Division of the Workers' Compensation Commission is created and known and cited in this chapter as the "division." The division consists of at least one Appellate Judge appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over judiciary matters and to confirmation by the Legislature.

2. Rules. Subject to the power of the Supreme Judicial Court to make and amend rules, the division shall establish uniform rules of procedure calculated to provide a prompt and inexpensive review of a decision by the commission.

§1647. Appeal from commission decision

1. Procedure. An appeal must be taken from the commission decision by filing a copy of the decision, order or agreement with the division within 20 days after receipt of notice of the filing of the decision by the commission or commissioner.

Any party in interest may present copies of any order, decision or agreement to the clerk of the division.

The failure of an appellant, who timely notifies the division of the appellant's desire to appeal, to provide a copy of the decision, order or agreement appealed from does not affect the jurisdiction of the division to determine the appeal on its merits unless the appellee shows substantial prejudice from that failure.

2. Basis; effective date. An appeal may not be made on questions of fact found by the commission or any commissioner.

3. Action. The division, after due consideration, may reverse or modify any decree of the commission and shall issue a written decision. The written decision of the division must be filed with the commission and mailed to the parties or their counsel.

4. Costs. If the employee prevails, costs of appeal must be allowed, including the record, and including reasonable attorney's fees as provided for under Title 39, section 110. An attorney who represents an employee who prevails in an appeal before the division may not recover any fee from that client for that representation. Any attorney who violates this paragraph loses that fee and is liable in a court suit to pay damages to the client equal to 2 times the fee charged that client.

5. Publication of decisions. The division shall biennially publish its significant decisions and make them available to the public at such cost as is required to pay for suitable publication. Copies of all written decisions must be distributed

to the Law and Legislative Reference Library and the county law libraries.

§1648. Appeal from a decision of the division

1. Procedures. Any party in interest may present a copy of the decision of the division to the clerk of the Law Court within 20 days after receipt of notice of the filing of the decision by the division. Within 20 days after the copy is filed with the Law Court, the party seeking review by the Law Court must file a petition seeking appellate review with the Law Court, setting forth a brief statement of the facts, the error or errors of law that are alleged to exist and legal authority supporting the position of the appellant.

2. Rules. The Law Court shall establish and publish procedures for the review of petitions for appellate review of decisions of the division.

3. Discretionary appeal; action. Upon the approval of 3 or more members of a panel consisting of no less 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 division 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. The Law Court, after due consideration, may reverse, modify or affirm any decision of the division.

4. Costs. In all cases of appeal to the Law Court in which the employee prevails, the Law Court may order a reasonable allowance to be paid to the employee by the employer for expenses incurred in the proceedings of the appeal, including the record, but not including expenses incurred in other proceedings in the case. Reasonable attorney's fees must be allowed as provided for under Title 39, section 110. An attorney who represents an employee who prevails in an appeal before the court may not recover any fee from that client for that representation. Any attorney who violates this paragraph loses that attorney's fee and is liable in a court suit to pay damages to the client equal to 2 times the fee charged that client.

§1649. Report to the Law Court

Decisions of the commission may be reported directly to the Law Court pursuant to the Maine Rules of Civil Procedure, Rule 72.

§1650. Enforcement of division

Any decision of the commissioners or the division is enforceable by the Superior Court by any suitable process including execution against the goods, chattel and real estate and including proceedings for contempt for willful failure or neglect to obey the orders or decrees of that court, or in any other manner that decrees for equitable relief may be enforced. Any party in interest may present copies, certified by the clerk of the commission or of the division, of any order or decision of the commission or of the division, or of any memorandum of agreement approved by the commission 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 the County of Kennebec. Whereupon any Justice of the Superior Court shall render a pro forma decision in accordance therewith and cause all interested parties to be notified. The decision and all proceedings related to the decision have the same effect as if rendered in an action in which equitable relief is sought, duly heard and determined by that court. The decision must be for enforcement of a commission decision, order or agreement. Appeals from a commission decision, order or agreement must be in accordance with section 1647.

Sec. B-2. 26 MRSA §52 is enacted to read:

§52. Office of Employee Assistants

The Office of Employee Assistants is created within the bureau and known and cited in this section as the "office." The purpose of this office is to assist employees in proceedings before the Workers' Compensation Commission under Title 39. The director shall provide adequate funding for the office and, subject to the Civil Service Law, shall appoint the assistants. Assistants are not attorneys, but must demonstrate a level of expertise roughly equivalent to that of insurance claims' analysts. The assistants shall provide advice and assistance to employees under the Workers' Compensation Act particularly in preparing for and assisting in informal conferences under Title 39, section 94-B. In addition, if an employer appeals a decision of the Workers' Compensation Commission or institutes any proceeding against an employee under the Workers' Compensation Act, the office, upon request, shall advise an employee how to best prepare for and proceed with the case.

An employee of the office may not represent before the commission any insurer, self-insurer, group self-insurer, adjusting company or self-insurance company for a period of 2 years after terminating employment with the office.

The director shall appoint 6 employee assistants and a supervisor of employee assistants. After January 1, 1993, the director may

appoint up to 5 additional assistants if, in the director's judgment, the additional assistants are necessary to effectuate the purposes of this subsection.

Sec. B-3. 39 MRSA §91, as amended by PL 1989, c. 483, Pt. A, §§57 and 58, is repealed.

Sec. B-4. 39 MRSA §92, sub-§6, as amended by PL 1987, c. 877, §1, is repealed.

Sec. B-5. 39 MRSA §92, sub-§7, as amended by PL 1991, c. 591, Pt. AA, §2, is repealed.

Sec. B-6. 39 MRSA §92, sub-§8, as amended by PL 1985, c. 785, Pt. B, §180, is repealed.

Sec. B-7. Effective date. This Part takes effect January 1, 1993.

STATEMENT OF FACT

The purpose of this bill is to:

1. Encourage the placement of policies in the voluntary market and to allow an employer to contract with an insurer that may charge a higher rate, but provide a potential dividend and better service than that available to the employer through the residual market mechanism. An offer of voluntary market insurance at rates in excess of those established by the superintendent is not an acceptable reason for denial of eligibility for the safety pool of the residual market mechanism; and

2. Eliminate a possible interpretation of current law that allows the greater of earnings in the 12 months immediately preceding injury or earnings in the last full January to December period prior to injury to be utilized in the calculation of average weekly wage of seasonal workers.

The bill also:

1. Requires objective medical evidence of an injury before an employee is entitled to workers' compensation;

2. Limits compensation in combined effects cases in which compensation is provided only for that portion of an incapacity or treatment caused by a work-related injury;

3. Clarifies the ability of employers to pay workers' compensation benefits in contested cases without prejudice by allowing for payments to be continued without prejudice until a

commissioner of the Workers' Compensation Commission's decision following a hearing. Current law allows payment without prejudice only until the convening of the hearing;

4. Clarifies that notice requirements in the event of a discontinuance prior to a commissioner's determination after a hearing relate to reductions in benefits as well as total discontinuances;

5. Replaces a reference to "firemen" with the gender-neutral term "firefighters";

6. Amends current law by creating a new distinction between temporary total and permanent total incapacities. Temporary total benefits are payable for a maximum of 3 years, after which an injured worker who is not permanently and totally incapacitated, but who continues to have a compensable incapacity, is compensated for the partial incapacity under the Maine Revised Statutes, Title 39, section 54-C for the duration specified in that section. Employers must pay 60% of that employee's gross weekly wages under Title 39, section 54-C and section 54-D. Permanently and totally incapacitated workers receive ongoing compensation under the new section 54-D, which is substantively the same as the current total incapacity in section 54-B;

7. Establishes new durational limits with respect to partial incapacity benefits. Employers must pay 60% of that employee's gross weekly wages. Total benefit duration for specified severe injuries remain at 520 weeks from the date of injury. Other partial incapacity cases are limited to a duration of 260 weeks or, if the partial incapacity follows a temporary total incapacity, to a maximum of 364 weeks from the date of injury;

8. Provides that, if an injured worker who has received a lump-sum settlement receives a subsequent injury, the benefits for the 2nd injury must be reduced to the extent necessary to avoid duplicative payment of benefits for a period of disability. All settlement agreements must expressly allocate wage loss, medical services, permanent impairment or other benefits;

9. Provides that a commissioner who disapproves a proposed lump-sum settlement of a case must be excluded from subsequent formal hearings in the case;

10. Clarifies the eligibility of a health care provider to serve as an independent medical examiner in a case;

11. Clarifies the effective date of certain provisions of this bill;

12. Addresses the issue of when the 2-year period for the filing of a claim by an employee begins in cases in which a first report of injury is not required. Under current law, the 2-year period begins when a first report of injury is filed by the employer. Public Law 1991, chapter 615 provided that first reports are not required in so-called "medical only" cases, but the time for filing petitions in those cases was not addressed. This bill provides that the 2-year period begins on the later of the date of the injury or the date of the payment by the employer of any benefits otherwise required under the Act;

13. Prevents persons from filing claims for workers' compensation benefits in this State for injuries for which they have received a final settlement in another jurisdiction;

14. Provides that, in instances in which an employer discontinues benefits based on an employee's return to work, the employee files a petition for review, and the commissioner issues a provisional order, and either party wishes to appeal that order, a hearing is not required to be held on an expedited basis. This change eliminates the potential for a situation in which an employee could file a petition for review months or years after a discontinuance based on a return to work and become entitled to an expedited hearing;

15. Provides for an attorney's fee with respect to that portion of a settlement of 6%. Current law does not specify attorney's fees for lump-sum settlements of between $90,000 and $100,000;

16. Clarifies the provision of law that applies when an employee files a discrimination claim against an employer against whom the employee has testified or asserted a workers' compensation claim. Currently a hearing is scheduled by the commission concerning the discrimination claim, but any commissioner who has previously rendered any decision in the matter is excluded from presiding. This has the effect of requiring pending cases to be transferred to other commissioners. The bill allows the original commissioner to remain involved in pending cases and contemplates that the underlying case and the discrimination issue can be considered together;

17. Moves the Workers' Compensation Commission to the Judicial Department. Membership of the commission has been reduced to 11 members through elimination of a vacant position;

18. Provides for appeals to an Appellate Division Judge, rather than to an appellate panel of workers' compensation commissioners; and

19. Moves the Office of Employee Assistants into the Department of Labor.

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State Government's

W O R K E R S' C O M P. S Y S T E M

costly
inefficient
discriminatory

[an unfinished, preliminary report]
January, 1991

Reviewer's comment:

The systemic problems with the state's management of WC claims are numerous and complex. In order to fully understand the issues, many months of effort by experts in a variety of fields -- not two and a half months of review by a non-expert -- is required. This review, even if it had continued for as long as originally planned, could not have sufficiently analyzed all of the relevant issues. That this review is ending sooner than intended, simply results in it being that much less sufficient.

The next phase of this current effort would have been the distribution of this first draft to key commentators for their reactions and corrections. A final draft would then have been written.

Much of the statistical data needed for this review was unavailable -- a problem with the current data collection system and/or with the management of WC claims in general. The "findings" of this review are, therefore, primarily supported by the information gained from individual commentators and other technical reviews.

In spite of its inadequacies, it is hoped that this review contains some useful "talking points".

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PREFACE

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Background

Originally, the focus of this report was to be the computer system(s) involved with the processing of Workers' Compensation (WC) claims. The principle issue was whether current computer systems were meeting the data collection, processing and analysis needs of all parties involved with WC claims management and related issues such as safety, prevention, risk management, human resources, etc.

After some initial discussions with individuals directly involved in various aspects of the WC "system", it became clear that before it would be possible to determine the system's computer needs, some critical questions regarding a variety of other issues would first have to be answered.

For example, will WC expenses be handled by each department/agency as is now the case, or will such expenses be handled by the new, centralized (yet still unfunded) Workers' Compensation Management Fund? The answer to this question is critical to a decision regarding what type of computer system is needed. If a central fund will be handling "all expenses related to the resolution of Workers' Compensation claims including: records and information management, investigation, medical review; representation; rehabilitation; payment of compensation; appropriate medical expenses and other payments...settlement of cases; and other necessary expenses" [Sec., 5 MRSA ss1833: "Workers' Compensation Management Fund"], then it would appear that only the administrators of such a fund -- and not each department/agency -- would need a computer system designed to handle the technical, fiscal details associated with processing WC claims. On the other hand, if the responsibility will remain with the departments/ agencies, they will each need direct access to such a computer system.

In the process of exploring this and related questions, it became obvious that almost no WC issue could be adequately understood, nor addressed, if it were viewed in isolation of other WC, as well as non-WC but inter-related, issues. When exploring the "central" vs. "department/agency" funding issue, for instance, critical questions regarding such other issues as re-employment philosophies, safety/prevention practices, "care management" programs, and legal concerns were revealed as elements that are inexorably related to the funding format issue as well as elements that are related to each other.

However, the one single issue that relates to all of the other issues and that is of primary concern in light of the state's current budget crisis is the overall excessively high

costs associated with the WC system in general.

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Consequently, it seemed not only reasonable but necessary to pursue at least a general review of the factors contributing to the high WC costs while also exploring the other critical, inter-related issues which appear to impact on the functioning of the WC system. Such a review, to be truly thorough, would take months of analysis by individuals with expertise in the various fields most closely associated with the state's WC system (claims management, human resources, data management, fiscal issues, etc.). The following review is not a technically thorough review, but, rather, is simply a general review of some of the basic issues.

Other Studies

Since 1987, at least four different reviews have been conducted involving the management of WC claims.

1. Tillinghast: DRAFT "General Liability, Automobile and Workers' Compensation Claim Administrative Review", April, 1990
2. Advanced Risk Management Techniques (ARMTECH) : DRAFT "Risk Management Study", November, 1987
3. Bureau of Human Resources: "Workers' Compensation in Maine State Government" (internal review of WC claims management issues), 1988
4. Bureau of Employee Health: (Untitled outline of goals, objectives, and methods related to improving aspects of state's WC system), 1990(?)

The first two reviews in the above list were conducted by private consultants (Tillinghurst and ARMTECH) and included assessments of other programs in addition to WC. The last two reports listed were internal reviews conducted by different bureaus within state government and were limited to WC issues. All of these reviews assessed the weaknesses/strengths of the WC claims management system and recommended ways to improve the system.

All of the studies appear to have reached similar conclusions about the existence of a number of weaknesses of the WC system:

-- need for the WC Division to be located in a bureau other than the Bureau of Employee Relations
-- need for a different fiscal system for paying/budgeting for WC claims
-- lack of case reserving mechanism
-- lack of qualified WC claims investigators/managers

-- lack of appropriate computer services
-- need for attitudinal changes regarding the handling of claims and regarding the responsibilities of the WC claims management staff

Even though there was agreement among all of the reviews regarding some general problem areas and some recommended solutions, and even though some of those recommendations have since been implemented, many of the problematic issues still remain.

In some ways, this current review is just one more study of the same, remaining issues. However, this review differs from the prior reviews in at least two ways: (1) whereas the scope of the prior reviews was primarily limited to the technical activities associated with processing WC claims, this review expands the scope to include non-technical, but inexorably involved, issues; (2) since the expanded scope of this review includes some of the activities of other programs/agencies, some of the recommendations of this review also involve modifications of the policies of other programs/agencies.

Methods

The information contained in this report is from a variety of sources:

-- the principle sources of information were 32 individual "commentators" who agreed to discuss their experiences with, and recommendations regarding the state's WC system;
-- other sources of information included the four (known) most recent technical reviews regarding the WC claims management system;
-- another source of information was a limited, general overview of the state's WC laws/regulations and relevant civil rights laws.

The 32 commentators represented a variety of different types of involvement in, and/or experience with issues related to the WC system/process. While some individuals asked that their identities not be disclosed, most commentators agreed to be identified. They include:

Tim Smith	Risk Management
Roger Willette	Workers' Comp. Division
John Rioux	Labor
Bill Blaine	Defense and Veteran Services

Tom Meiser	Corrections
Isabella Tighe	Administration
Barbara McGee	Conservation
John Nichols	Transportation
Richard Paradis	Human Resources
Ed Karass	Administration
Jane Gilbert	Transportation
Laurie Shippee	Human Resources
Mel Gleason	Rehabilitation
Frank Johnson	Employee Health
Joyce Oreskavitch	Human Rights Commission
Earle Pease	Workers' Comp Division
Susan Brown	MOICCA
Linda Harvell	Human Resources
Craig Davis	Labor Standards
Bill Chenoweth	Workers' Comp. Commission
Sandra Cavanaugh	Labor
John Marvin	MSEA rep.
David Fitts	Risk Management
Bill Bellanger	Defense

[Five current/previous WC claimants]
[Attorneys involved in WC litigation/issues]
[Staff and clients of private rehab. companies]

As has been noted earlier, the previous reviews regarding WC issues that were sources of information for this report are:

* Tillinghast's, April, 1990
* ARMTECH's, November,1987
* Bureau of Human Resources, 1988
* Bureau of Employee Health, 1990(?)

The laws and regulations that were quickly reviewed for this report include:

* 39 MSRA ss1-195: Maine Workers' Compensation Act and Occupational Disease Law (as amended at the close of the first session of the 114th Legislature which adjourned July 1, 1989)
* 5 MRSA, Sec 16, ss1833: "Workers' Compensation Management Fund" (as enacted during the first regular session, 1989)
* Maine Workers' Compensation Commission Rules and Regulations, effective November 1, 1989
* 5 MRSA: "Maine Human Rights Act"

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SUMMARY of FINDINGS/CONCLUSIONS

This review found that the State's WC costs are unnecessarily high and that there are four principle reasons for such excessively high cost:

(1) WC claimants who were out of work for over one year represented 87% of the total WC costs in fiscal year 1989-1990. Contrary to the common belief that WC claimants remain out of work simply because they really don't want to work, this review found that most claimants are able and very willing to resume employment when that reemployment is suitable, productive and meaningful. It appears that the unemployment of the claimants is principally a result of the State's reluctance/refusal to reinstate WC claimants in their original positions (with any necessary reasonable accommodations) or reemploy them in other suitable positions. Prejudiced attitudes toward WC claimants, and the (conspicuous) lack of policies requiring reinstatement or reemployment of claimants appear to be the primary factors which are preventing claimants from returning to work.

(2) Some of the high costs associated with WC claims are a result of inappropriate and ineffective management of WC claims. Untrained department/agency personnel ineptly perform some claims management functions, and the understaffed WCD often fails to competently perform the remainder of the functions in a timely manner.

(3) Compensable medical costs are higher than necessary. The lack of effective review of medical claims, the use of expensive and often ineffective private rehabilitation firms, and the lack of policies regarding the use of "preferred providers" are among the primary reasons medical costs are excessively high.

(4) The lack of, and lack of enforcement of, safety and prevention policies significantly contributes to the high number of work-related injuries. The unchecked "macho" attitudes of some workers and supervisors, the lack of incentives to comply with safety rules, and the virtual absence of meaningful enforcement efforts all contribute to compensable injuries/disease.

SUMMARY of RECOMMENDATIONS

(1): Reemployment

(1)a. Utilize WC reinstatement/reemployment "teams" that are separate from the WC claims management staff. These teams of professionals would consist of a Care Manager (as opposed to a "case" manager), rehabilitation/occupational therapist, a medical professional, a human resources staff person, and other professionals as may be needed. Members of these teams -- instead of untrained and possibly unsympathetic, and even hostile supervisors -- would be responsible for maintaining contact with and facilitating the return to work of injured employees.

(1)b. Develop specific policies requiring the reinstatement of WC claimants in their original positions, or reemployment in suitable, comparable other positions within state government. Eliminate the practice of placing claimants in generic, humiliating "light duty" jobs.

(1)d. Develop human resources policies that would give WC claimants a priority on job registers, and develop policies that would require that job descriptions be articulated in a manner that facilitates effective assessments by rehabilitation professionals regarding the "suitability" of different positions for individual WC claimants.

(1)e. Develop policies and provide training regarding "reasonable accommodations" of job requirements for WC claimants.

(1)f. Eliminate all unlawful, discriminatory practices related to reinstatement/reemployment of WC claimants with disabilities, and develop policies that prohibit inquiries regarding whether job applicants (including WC claimants who are seeking reemployment elsewhere in their department and/or elsewhere in state government) have ever filed WC claims.

(1)f. Develop policies regarding the State's lawful prerogative to reduce the WC benefits of any WC claimant who refuses suitable employment. Inform all employees -- as part of job orientation or during the annual review, but in any event prior to a work related injury/disease -- that, to the maximum extent possible, all injured employees will either be offered reinstatement in their original positions or will be offered suitable comparable employment, and that if employees refuse to accept such offers, the state will exercise its right to reduce WC benefits accordingly.

(2): Claims Management

(2)a. Capitalize the "central" Workers' Compensation Management Fund as directed in the recently passed law [Sec. 16., 5 MRSA, ss 1833: "Workers' Compensation Management Fund"]. And staff the Fund with professional, objective adjusters and trained legal staff.

(2)b. Do not renew the contract with Sedgewick James. If all WC activities will be centralized in the Workers' Compensation Management Fund, the Fund should have its own computer system commensurate with its operational, data collection and data analysis needs (as well as the data needs of the various agencies involved with such issues as safety, health, human resources, civil rights, etc.). Such a system, or the potential for such a system, may already exist with other computer systems currently operating within state government.

(2)c. Utilize professional Care Management services in the management of WC claims.

(2)d. Provide objective education and training to all employees about the WC claims management system, the process for filing a claim, the state's policies regarding claims management, reemployment, litigation, etc. Treat injured employees as customers/clients -- not adversaries.

(2)e. Develop policies that require that all information regarding a WC claim be kept confidential, except for technical reviews such as by the WC Management Fund staff, reviews by government auditors, or reviews ordered by a court of law.

(3): Medical Costs

(3)a. Shift the responsibility for monitoring WC medical costs from untrained department/agency personnel and/or understaffed WC claims adjusters to the trained personnel of the central WC Management Fund (working with the Re-employment Team, if necessary).

(3)b. Minimize or even eliminate the use of private rehabilitation companies/consultants as isolated, independent providers. Instead, encourage all rehabilitation professionals to become a cooperative member of a "Recovery/Reemployment Team" of professionals.

(3)c. Develop a list of "preferred" medical service providers who offer quality services at reasonable prices, and encourage WC claimants to utilize those providers.

(4) Safety/Prevention

(4)a. Design comprehensive, realistic safety/prevention programs. Involve the various affected parties including the employees and unions.

(4)b. Enforce safety/prevention regulations by means of both "incentive" and "punitive" programs/policies.

(4)c. Incorporate safety performance evaluations into the annual job performance review. Require a workplace "safety orientation" for all new employees and periodic reviews for existing employees.

(4)d. Create a "safety hotline" (or utilize the existing hotline system at the Bureau of Labor Standards) where callers may anonymously report suspected safety violations and/or unsafe activities of state employees.

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D I S C U S S I O N
of
Findings and Recommendations

(1): Non-Reemployment of WC claimants

"The cost of long term claims (claims where the employee has been out of work over one year) represents 87% of the total costs in fiscal year 1989-1990."
from a WCD data analysis report 12/14/90

At the end of the 1989-90 fiscal year, 473 WC claimants had not been reinstated/reemployed. Over 5 million dollars will be needed in fiscal year 1990-91 just to pay compensation to those employees. Clearly, if WC costs are to be reduced, the reasons for WC claimants remaining out of work must be understood and, where possible, addressed.

Given the medical, rehabilitative, and technological advances/equipment available, even the most severely disabled individuals are usually able to overcome the barriers which otherwise restrict their ability to successfully perform many different types of jobs. Therefore, in most cases, it is not the severity of the WC claimants' injuries which is preventing their reemployment. Most issues associated with the lack of reemployment of WC claimants fall within two general categories: prejudiced attitudes, and the conspicuous lack of meaningful reemployment policies/practices.

A. Prejudiced Attitudes

The prevalent perception among supervisors, management, and co-workers is that most individuals who have filed WC claims and have not returned to work, really don't want to work. Those who have such a perception believe that WC claimants remain out of work -- not because of any actual or serious injury/disease -- but because they are faking or exaggerating medical problems, and are simply lazy and intent on getting a "free ride". Therefore, according to the general perception, non-medical WC costs associated with the claimants' unemployment/lost time are primarily due to the dishonesty and slothfulness of the WC claimants.

This review found that such a perception is inaccurate. Although there probably are now, and always will be, a small percentage of individuals who will attempt to abuse the system, it appears that the majority of individuals who are injured on the job want to return to work. According to current and recent

WC claimants, they have applied (or have tried to apply) for a variety of positions within state government but they have consistently been rejected.

The claimants report they have been told by those involved in the application process or hiring decision that -- because they are WC claimants -- they are presumed to be a "risk" for future re-injury (and consequently, for increased WC costs for the department/agency) and therefore are "ineligible" for the positions they have sought. This practice is apparently widespread, despite the fact that such action appears to clearly constitute a violation of WC law [39 MRSA ss111 "Discrimination"].

This review found that the primary factor responsible for most WC claimants remaining out of work appears not to be the employees, but rather appears to be the employer: state government.

The hostile attitudes of supervisors, co-workers, and managers, and the policies -- or lack of policies -- regarding reinstatement, reemployment, and reasonable accommodations actually have the effect of discouraging and even preventing claimants from returning to work.

Employees who are injured on the job are often considered by management, personnel staff, and by their own supervisors and co-workers, to be "headaches", "deadheads", "impostors", and "sure bets to be repeat WC claimants". In most cases, neither supervisors, personnel/fiscal staff, nor co-workers want WC claimants to return to their original jobs, and other departments don't want to hire them into other positions.

Supervisors don't want claimants back because, in some cases, the supervisors feel the employees are being dishonest about the validity/seriousness of their injuries, and in other cases, because supervisors don't want employees who are physically or emotionally "not 100%". In nearly all cases, supervisors are fearful that the claimants will constantly be complaining that they are unable to perform one or another job responsibility, and fearful that they will request all sorts of special accommodations.

Personnel and fiscal staff in both the claimants' original department and in any new department don't want claimants because of fears that the claimants will re-injure themselves and file more WC claims. And co-workers are fearful about being burdened with whatever duties the claimants are restricted from performing.

Such an "attitudinal atmosphere" which a WC claimant must face in order to pursue reinstatement/reemployment is daunting.

Claimants are aware that their supervisors and co-workers don't want them to return (if the claimants aren't told outright, they learn of it indirectly or recall how other claimants in their agency were treated). In fact, claimants suffering from the emotional effects of disability often go through a phase where they, themselves, believe that they are "worthless", that they wouldn't be able to "hold their own", and that they would be a burden to others in the workplace.

Despite statistical and anecdotal evidence that indicates that all such fears are unfounded, these derogatory and harmful attitudes persist and profoundly influence reemployment issues.

In light of the prevalence of such attitudes among supervisory and personnel staff, current policies and procedures regarding reinstatement/reemployment of WC claimants appear, at best, counterproductive.

B. Lack of Reemployment Policies and Practices

It is common policy to place the responsibility with the employee's supervisor for encouraging an injured employee to return to work. Given the likelihood that the supervisor does not want the injured employee to return to work and/or the likelihood that the supervisor lacks the training and information which are necessary to assist an employee's return, such a policy is, at best, ineffective (and, often, counterproductive). Also, given the fact that an injury/illness often affects many other aspects of the claimant's personal life, to designate the supervisor (who the employee may not even like, and who is unlikely to be trained in disability issues) as the "critical link" appears to be a simplistic, paternalistic, inappropriate, and -- by most accounts -- totally ineffective policy.

Since many injured workers don't, or don't quickly, return to their original jobs, other employees recognize this as the norm and expect the same result if they or their co-workers are injured. Therefore, the employees as well as their supervisors neither expect, encourage, nor facilitate the return of injured workers to their original jobs.

In those relatively unusual situations where a claimant who has lost a significant amount of time from work is offered reemployment, the position is usually what is referred to as a "light duty" position. Such positions are generally of less "status", less responsibility, and more of a "make work" nature than the position that was held by the employee at the time of injury. Frequently, the jobs are temporary, minor projects that are soon completed by the claimant and consequently the claimant often is continually moved from one type of "make work" activity

to another.

The fact that there is such a generic "light duty" category of jobs reflects an attitude that individuals who have physical limitations are, "generically", considered less capable, less responsible, and less able to play a critical role in the operation of the department/agency. When claimants decline to accept such positions, or express dissatisfaction with such humiliating, demeaning "light duty" work, such "refusals to work" are incorrectly cited as evidence that WC claimants "really don't want to work".

In many cases, simple reasonable accommodations of the claimant's original job requirements, or accommodations of requirements of a different suitable job, would permit the claimant to return to regular employment. However, there is general uncomfortableness on the part of many supervisors and personnel staff regarding the issue of "reasonable accommodations" (for both WC claimants and other individuals with disabilities.) The concept of "reasonable accommodation" is generally not clearly understood, and therefore the bizarre, seemingly limitless possibilities that are imagined by uninformed personnel/supervisory staff are threatening. Consequently, "re-employees" are rarely informed of their right to request reasonable modifications of job requirements that constitute obstacles to particular positions -- including obstacles to their original positions.

Because of the general lack of awareness of WC claimants right to request job accommodations, and a similar lack of awareness of the state's legal responsibility to provide such accommodations, many WC claimants unnecessarily remain "un-reemployed".

But even if the injured employees were aware of their rights, it would often be difficult for them, as well as their rehabilitation and medical professionals, to know what accommodations for any given job might be necessary. Many job descriptions often lack sufficient information regarding specific responsibilities of the job. Many also lack clearly articulated, nondiscriminatory, bona fide occupational qualifications. Without such clearly specified, objective requirements, an applicant for a job does not know what, if any, accommodations to request. The result is missed employment opportunities for the claimants, and higher WC costs for the state.

Also compounding reemployment efforts is the lack of confidentiality about an individual's WC claimant status. In their efforts to find reemployment or "light duty" jobs for claimants, personnel staff and WC claims management staff have informed prospective supervisors of the fact that the individual is a WC claimant "but is qualified for the open position". If

the individual is qualified, what does the fact that he/she is a WC claimant have to do with the reemployment activity?

The majority of commentators who were asked such a question responded with an answer essentially equivalent to the following: No department wants to hire individuals who have filed a WC claim. Supervisors believe that such individuals are "headaches" and are likely to file other claims against them. Most employers -- not only state government -- ask if job applicants have ever filed WC claims. Therefore, those who are trying to find reemployment for the claimant reveal the employee's WC status: (1) because the prospective department will find out anyway, and (2) because it is that "claimant" status --rather than anything about the claimant's qualifications -- that is most important to those doing the hiring."

Despite the fact that any such refusal to hire an individual because s/he is a WC claimant violates civil right's law [Title 5, section 4572, subsection 1, paragraph A], commentators indicated that such refusals and similar adverse action against individuals because they are WC claimants occur daily. In fact, commentators report that they themselves have actually participated (either as claimants or as agency personnel attempting to facilitate reemployment) in "negotiations" with other departments where offers of "special deals" were made to those departments to "compensate" for the fact that the applicant was a claimant. Such deals included offers to pay the first year's worth of wages, offers to pay all costs associated with any injury related to the individual's original WC injury, and offers to have a special "trial" employment period.

Clearly, state government's lack of policies requiring confidentiality about individuals' status as WC claimants significantly contributes to the discrimination and adverse reactions claimants confront in their efforts to be reinstated/reemployed. Even though WC law requires such confidentiality only with regard to any rehabilitation activity the claimant is participating in, the state could expand that protection to the unnecessary revelation of any information associated with a WC claim.

In addition to the lack of policies that would <u>positively</u> facilitate reinstatement/reemployment and thereby reduce WC-related costs, state government also appears to lack <u>punitive</u> policies that are allowed by WC law as another method for limiting WC costs.

The WC law [Maine Workers' Compensation Act, Subchapter III, section 66-A.6] allows an employer to reduce a WC claimant's benefits if the claimant refuses to accept an offer of suitable

employment. This review was unable to identify any state policy requiring all departments/agencies to first offer suitable employment to all WC claimants and then, if the claimants refused such offers, to reduce their WC benefits accordingly.

The apparent lack of such a cost-saving policy is quite conspicuous. What could the state possibly lose by such a policy? The state would save money either by having the claimant back performing work which the state would, otherwise, have to pay someone else to do, or the state would save money by reducing the WC benefits of those claimants who refused the offers of work. All the state has to do in order to exercise its legal right to reduce benefits is to offer claimants jobs.

The lack of such a policy raises the suspicion that the state chooses not to utilize its prerogative to reduce benefits because it fears that the claimants will actually accept the job offers. It appears that, as an employer, the state doesn't want to re-employ WC claimants.

In summary, it appears that because of biased attitudes, and policies or the lack of policies resulting from such biases, that the state is discouraging -- and, in fact, preventing -- reinstatement/reemployment of WC claimants.

Since 87% of WC costs are related to long-term claims where individuals remain un-reemployed, it appears that any meaningful effort to reduce WC costs must include actions to address such biases and ensure claimants' reemployment.

The following are some general recommendations regarding how the issues related to the lack of reinstatement/reemployment of WC claimants might be addressed.

(1): RECOMMENDATIONS re REINSTATEMENT/REEMPLOYMENT

* Develop WC reemployment teams that are separate from the WC claims management staff. Such teams would consist of: a care (not "case") manager who would coordinate whatever care/services are needed by the injured employee; a rehabilitation/occupational therapist; a medical professional; a human resources staff person; and other professionals as may be needed. Members of these teams -- instead of untrained, possibly unsympathetic and even hostile supervisors -- would be responsible for maintaining contact with and facilitating the return to work of injured employees. These teams could be coordinated by the Bureau of Employee Health, the Bureau of Human Resources, or another appropriate agency.

* Develop specific policies requiring the reinstatement of WC claimants in their original positions, or reemployment in suitable, comparable other positions within state government.

* Develop policies, and educate all employees about "reasonable accommodations" of job requirements.

* Eliminate the practice of placing claimants in generic "light duty" jobs. Instead, professionally assess each claimant's abilities, skills and interests, and then -- based on that assessment -- identify and offer each claimant employment that is personally "suitable" to her/him. Such "suitable" employment might be temporary, "make work" type of activities for some individuals, and might be a full time, regular position with some accommodations for other individuals. The critical point is that whatever work is offered to the claimant will be individually suited to the claimant's skills/abilities, and not work which has been pre-ordained as generically "light duty" for all WC claimants -- regardless of the nature of their injury and regardless of their other unaffected abilities and potential.

* Develop human resources policies that would give WC claimants a priority on job registers. Such a priority should not necessarily supersede other current priorities (e.g. layoff status) but should be designed as one of a number of preferences to facilitate claimants' chances for interviews and, ultimately, reemployment. [Because of the biased attitudes of many supervisors toward WC claimants, the reason for the applicant's position on a register (i.e. WC claimant) should not be indicated on the register and should be kept confidential by the Bureau of Human Resources.)

* Develop policies that would require that job descriptions be articulated in a manner that specifies the minimum [lawful] physical and emotional qualifications of the job. Such descriptions would facilitate effective assessments by rehabilitation professionals regarding the "suitability" of different positions for individual WC claimants.

* Develop policies regarding the State's lawful prerogative to reduce the WC benefits of any WC claimant who refuses suitable employment. Inform all employees -- as part of job orientation or during the annual review, but in any event prior to a work related injury/disease -- that, to the maximum extent possible, all injured employees will either be offered reinstatement in their original positions or will be offered suitable comparable employment, and that if employees refuse to accept such offers, the state will exercise its right to reduce WC benefits accordingly.

* Eliminate all unlawful, discriminatory practices related to reinstatement/reemployment of WC claimants with disabilities.

* Develop policies which prohibit inquiries regarding whether job applicants (including WC claimants who are seeking reemployment elsewhere in their department and/or elsewhere in state government) have ever filed WC claims. Develop policies that prohibit the revelation of the nature of a claimant's injury to prospective employers, or the revelation of the particulars of an employee's injury to a supervisor when that information is not necessary to the employee's reinstatement nor job performance. Such information serves no purpose other than to potentially prejudice the recipients of such information against the claimant. As with other "protected" information about an employee, particulars related to the employee's WC claim should be available to certain professionals who need such information for authorized purposes, but should otherwise be treated as confidential in order to protect the individual from unfair treatment.

(2): WC CLAIMS MANAGEMENT

Some of the high costs associated with long term WC claims are a result of inappropriate and ineffective management of WC claims. Such issues have been explored by a number of reviewers in the recent past (see list of reviews in "Preface" of this report), and therefore are only briefly summarized below.

A. Unsound Fiscal Policies

The current method of paying for WC claims is fiscally unsound. Since each department/agency is responsible for paying for its own WC claims, yet each is prevented by the budgeting process from requesting any amount in excess of the equivalent of existing, weekly compensation costs, the departments/agencies are nearly always prevented from negotiating and utilizing less expensive methods of settling WC claims (such as one-time, "lump sum" settlements).

Also, since the staff who are involved in the management of WC claims at the departmental/agency level are rarely trained as insurance adjusters, the claims cannot be professionally, effectively managed.

B. Lack of efficient, unbiased claim management

WC procedures, workloads, and organizational structure are impeding effective claim management. Adjusters have lost touch with injured employees because of higher caseloads and the increasing complexity of the WC system. In smaller agencies, WC claim management is one of several responsibilities added to traditional personnel work. Those responsible usually lack sufficient training and support.

Case reserving methods and practices are not performed effectively. Even though an explicit WC case reserving philosophy and methodology has been formulated for use by the State's WC claim personnel, it is not being uniformly implemented.

Investigation and evaluation activities are not conducted in an assertive, diligent manner in part because current caseload levels of WCD claim adjusters are excessive, and in part because of lack of effective management.

Current computer services provided by the S. James company are inadequate. The third-party administrator functions performed by James often provides inaccurate, outdated information. The current system does not allow direct input, nor access by departments/agencies involved with processing WC claims.

James only handles information/data regarding WC injuries/claims, and does not meet the state's need for a system

to record all -- not just WC -- injuries, accidents, etc. so that broad trends can be identified and so that such information can be used to design safety/prevention programs.

Finally, the attitudes of those involved in the management of WC claims toward claimants affects the processing of claims. Often, it appears that the main focus of claims management is fraud. The time and effort expended in (usually) unsuccessful attempts to develop defenses or "talking points" based upon investigative or medical information results in unacceptable delays and unnecessary costs related to claim management.

C. Lack of Professional "Care" Management

"Care" management differs from "case" management in that "care" refers to the needs of the injured employee, while "case" refers to the technical (ultimately fiscal) concerns of the employer relative to resolving a WC claim. Although some individuals involved in WC case management also dabble in some care management, the current WC system does not provide professional care management services to claimants.

An injured employee often must deal with a variety of issues in addition to the medical concerns. Some of the other issues include emotional, financial, legal, insurance, rehabilitation, and other concerns such as the coordination of services/benefits, as well as questions about the process of filing a WC claim and questions about the prospects of future reinstatement or reemployment. Injuries/illnesses also often affect many non-employment, personal aspects of an employee's life, which in turn ultimately affect the employee's recovery.

The current WC 'system' does not appear to recognize the need to fully assess/address all of the issues impacting on the claimant's recovery, and therefore it is not surprising that the WC system fails to have a professional care management component.

D. Lack of Confidentiality of Information

Since, as has been noted in the "reemployment" section and elsewhere in this report, the biased attitudes of individuals toward WC claimants account for many of the problems associated with the high WC costs, a contributor to the magnitude of the problems is the lack of confidentiality about an employee's status as a WC claimant.

There appear to be numerous situations where information about an employee's WC status is unnecessarily provided to individuals who do not need -- and, arguably, should not have -- any information regarding the fact that the employee has filed a WC complaint. Although current laws do not seem to prevent the revelation of some WC-related information, in many cases, doing so seems to serve no positive purpose and only results in adverse

action against the claimant -- simply because she/he has filed a WC claim. The state's lack of policies protecting WC-related information ultimately contributes to the discrimination which prevents the claimants from reassimilating into the workforce.

The following are general recommendations regarding ways that some of the issues related to the management of WC claims might be addressed.

(2): RECOMMENDATIONS RE WC CLAIMS MANAGEMENT

* Capitalize the "central" Workers' Compensation Management Fund as directed in the recently passed law [Sec. 16. 5 MRSA ss 1833, passed in the First Regular Session, 1989]. Shifting the management of claims from each department or agency to professional adjusters, and pooling funds in a central payment mechanism will allow for a range of cost-saving management activities including "lump-sum" settlement options.

* Staff the WC Management Fund with professional, objective adjusters and trained legal staff. Such a staff would effectively, consistently review cases; would understand that fraud is not the central focus of claims management, but would be able to identify those cases that are clearly not compensable and aggressively challenge them; and would implement appropriate management activities such as case reserving, timely payment of claims, equitable settlements, etc.

* Do not renew the "Third Party Administrator" computer services contract with Sedgewick James Company. If all WC activities will be centralized in the Workers' Compensation Management Fund, the Fund should have its own computer system commensurate with its operational, data collection, and data analysis needs. Some computer experts within state government believe that certain computer software that is already available in, or could be readily obtained for, existing computer systems would be appropriate for the needs of the Fund (as well as appropriate for the data analysis needs of the various agencies involved with related policy issues such as safety, health, human resources, civil rights, etc.).

* Utilize professional care management services in the management of WC claims. Such activities should be separate from the case management activities because of the need for confidentiality and trust. Care managers should be part of a team of professionals (including rehabilitation professionals, medical personnel, human resources staff,

etc.) whose responsibility is to facilitate WC claimants' return to work.

* Provide objective education and training to all employees about the WC claims management system, the process for filing a claim, the state's policies regarding claims management, reemployment, litigation, etc. Treat injured employees as customers/clients -- not adversaries.

* Develop policies that require that all information regarding a WC claim be kept confidential, except for technical reviews such as by the WC Management Fund staff, reviews by government auditors, or reviews ordered by a court of law. Stop unnecessary revelation of medical information about claimants -- such as the production and circulation of computer print-outs of the names and nature of claims and/or medical expenses of WC claimants.

(3) HIGH MEDICAL COSTS

Although non-medical costs appear to represent the bulk of WC expenses, there is a significant percentage of the overall WC costs related to medical expenses that are unnecessarily high. Such excessive medical costs appear to be a result of the lack of effective claim review, lack of policies regarding preferred providers, and lack of control of cost/use of medical treatment.

The other recent reviews of the state's WC system, in particular Tillinghurst's and the Bureau of Employee Health's, identify the medical expense issues and recommendations related to reducing such costs. Therefore, only a brief review has been included here.

A. Lack of effective, consistent monitoring of medical costs

Due to the understaffing, poor management, and lack of training issues mentioned earlier, department/agency personnel and WCD staff are unable to consistently and effectively monitor the medical expense components of WC claims. Cases are not reviewed promptly, problems aren't identified early, and treatment and/or rehabilitation options aren't explored.

Consequently, otherwise controllable costs aren't controlled simply because they are not identified early enough, or at all.

B. Lack of policies re "preferred providers"

Although it isn't possible to control which providers a claimant chooses for medical services, the fact that the state lacks any list of "preferred providers" eliminates even the possibility of the state recommending to claimants certain providers who have been predetermined by the state offer quality services at reasonable rates. The lack of such a network of approved, "preferred" providers of medical services leaves claims adjusters without meaningful -- potentially cost saving -- recommendations for claimants.

One area where the identification of "preferred providers" is especially needed is with regard to private rehabilitation consultants. Anecdotal evidence appears to indicate that these private providers are often ineffective and excessively costly.

The following are general recommendations related to the resolution of some of the issues associated with excessively high WC medical costs.

(3): RECOMMENDATIONS re MEDICAL COSTS

* Shift the responsibility for monitoring WC medical costs from untrained department/agency personnel and/or the understaffed WC claims division to the trained personnel of a central WC Management Fund (working with the Re-employment Team, when appropriate).

* Minimize or even eliminate the need for private rehabilitation companies/consultants -- who often have little or no incentive to expedite the recovery/reemployment process. Utilize rehabilitation professionals who are either employed or contracted with by the state and who are required to become a cooperative member of the "Recovery/Reemployment Team" of professionals whose responsibility it is to facilitate the reassimilation of WC claimants back into the workforce, and who will be a natural "check" on each others efficiency and effectiveness.

* Develop a list of "preferred" medical service providers who offer quality services at reasonable prices, and encourage WC claimants to utilize those providers.

(4): SAFETY/PREVENTION

Ultimately, one of the most effective means of controlling medical costs is to reduce the incidence of work-related injuries/disease in the first place. A number of factors appear to contribute to the occurrence of compensable injuries: "macho" attitudes of supervisors and co-workers; lack of incentives and training regarding safety issues; lack of enforcement of safety regulations; lack of collection/analysis of relevant data necessary to identify precipitous trends and establish meaningful prevention strategies.

A. Macho attitudes

In a number of types of jobs that involve extensive physical activity, the "macho" attitudes of the supervisors and workers significantly contribute to unsafe work practices. Macho attitudes include those that consider anyone who insists on observing safety precautions as a "wimp", that anyone who is (permanently) unable to perform certain tasks in order to prevent exacerbation of an injury is a "wimp", and anyone who asks for help with a physical task is a "wimp". Such attitudes ultimately lead to injuries, disease, or re-injury, (and prevent the reinstatement/reemployment of claimants whose activities are restricted). Such attitudes also are an added deterrent to workers who might otherwise report suspected unsafe activities of either supervisors or coworkers, but who do not report such activities out of fear of being discovered and harassed as the "wimp" who squealed.

B. Lack of incentives/training

There is a general lack of safety orientation, training, review, and incentives. Although meaningful data is not now collected regarding whether a claimant had any prior safety training related to the activity involved in an injury or illness, anecdotal evidence seems to indicate that, in most cases, employees did not receive adequate safety orientation/training prior to compensable injuries/illnesses.

In addition to safety orientation and training, there appears to be a general lack of meaningful incentives to behave in compliance with whatever safety measures have been established. One incentive which is lacking is a routine "safety evaluation" as part of an employee's annual job performance review. Other incentives, including punitive actions, appear to have not been identified.

C. Lack of enforcement

If 'safety officers' are suppose to assist in enforcement of

prevention/safety regulations, they, as a group, appear to not be accomplishing that objective -- and neither is anyone else. Most safety officers have other full time job responsibilities (often unrelated to "safety") and in their capacities as "safety officers" do little more than complete paperwork after injuries have occurred. Such "post-injury" activity reflects and reinforces an attitude that safety/prevention issues are of low priority and that the state's involvement (as an employer) is "reactive" only.

There is a general lack of other tools which could contribute to the enforcement of safety regulations. Employees are not routinely evaluated on their knowledge of safety regulations, nor are they routinely penalized for violations of such regulation or rewarded for good safety records.

Another enforcement tool which may be lacking is a central location to anonymously report: all hazards at the worksite, any dangerous or reckless behavior by state employees during work time; violation of safety rules by supervisors and/or co-workers; etc.

D. Lack of collection/analysis of relevant data

The current computer/data system does not allow for the collection of data useful for identifying "controllable" contributing factors to injuries/illnesses (e.g. clothing worn at time of accident; distractions; attitudes; prior safety training related to the activities being performed at time of accident; etc.). Such data would facilitate the identification of precipitous "trends" and could be useful in the development of safety/prevention programs.

(4): RECOMMENDATIONS RE SAFETY/PREVENTION

(4)a. Design comprehensive, realistic safety/prevention programs. Involve the various affected parties including the employees and unions.

(4)b. Enforce safety/prevention regulations by means of both "incentive" and "punitive" programs/policies.

(4)c. Incorporate safety performance evaluations into the annual job performance review. Require a workplace "safety orientation" for all new employees and periodic reviews for existing employees.

(4)d. Create a "safety hotline" (or utilize the existing hotline system at the Bureau of Labor Standards) where callers may anonymously report suspected safety violations and/or unsafe activities of state employees.

CURRENT RESIDUAL MARKET RATES

		Maine	Michigan	% Difference
2003	Bakeries	8.92	6.36	- 29
2702	Logging/lumbering	36.97	50.43	+ 36
2841	Woodenware Mfg. NOC	13.34	10.87	- 19
3724	Millwright work NOC	23.07	13.87	- 40
5183	Plumbing NOC	12.63	8.76	- 31
5190	Electrical wiring in bldgs.	10.10	7.23	- 28
5403	Carpentry NOC	40.68	17.60	- 57
6217	Excavation	13.66	15.75	+ 15
7219	Truckmen	16.79	19.50	+ 16
7539	Electric light/power companies	4.62	3.81	- 18
8008	Clothing Store	1.57	1.82	+ 16
8017	Retail Store	2.00	2.36	+ 18
8033	Meat/combined grocery	4.02	4.73	+ 18
8058	Lumberyard (new materials) store	6.01	4.41	- 27
8350	Gas/Oil Dealers	8.24	12.91	+ 57
8742	Salespersons	1.18	.92	- 22
8810	Clerical Office	.48	.43	- 10
8829	Convalescent/Nursing Home	6.53	8.43	+ 29
8833	Hospital, prof. EE	1.94	2.15	+ 11
9040	Hospital all other employees	6.79	5.62	- 17
9101	Colleges/schools nonprof.	5.43	4.94	- 9

Labor Management Discussion Group on Workers' Compensation

The Administration of State Workers' Compensation Programs

Introduction

The Labor/Management Discussion Group on Workers' Compensation is a group led by representatives of employers and workers which has been meeting for some time to discuss concerns about workers' compensation. A list of the membership is attached. The group has adopted the following recommendations concerning state workers' compensation programs.

It should be the goal of a state workers' compensation system to provide benefits in a timely manner, to avoid disputes wherever possible, and to resolve expeditiously those disputes that do arise.

1. Administrative Agency

   States should utilize an effective workers' compensation agency to fulfill the administrative and adjudicatory obligations of a modern workers' compensation program. These agencies may sometimes be referred to as "courts," but that agency, not the state's courts of general jurisdiction, should be the principal locus of dispute resolution.

2. Funding

   It is essential that there be adequate funding for the state workers' compensation agency. An advisory committee, as mentioned below, might be employed to oversee the budget of the state workers' compensation agency and to advocate for sufficient resources when appropriate.

3. Education

   Workers' compensation will function most efficiently if all the parties understand their rights and responsibilities. A state workers' compensation agency should design and actively pursue programs for educating and informing all the parties involved in the system.

   At a minimum the agency should provide pamphlets explaining the law in

simple language (and in language other than English where that is appropriate) and a toll free number where more information can be obtained.

State agencies are encouraged to use public service announcements on radio and television and any other means available in order to inform the public about workers' compensation programs. Where possible, it would be desirable to have public service announcements sponsored jointly by labor and business groups. States are also encouraged to have well informed professionals available to provide information to workers and employers.

A state educational program should include efforts to inform the parties about the importance of prompt reporting of injuries by workers to employers, by insured employers to their insurance carriers, by self-insured employers and insurers to the state agency, and by medical providers to other appropriate parties.

4. Enforcement

Each state agency has a duty to enforce the requirements of the state's workers' compensation act.

This includes the requirement that insurers and self-insured employers pay benefits in accordance with the statute and in a timely manner. Each state should have some method of insuring that this is done. Each state should compile and publish data which lists the on time payment record of self-insured employers and insurers.

The appropriate state agency must also enforce those provisions of the act that apply to employers, including provisions that require employers to provide security for compensation and to fairly and honestly represent their operations when securing compensation insurance.

The state agency must also take steps to insure that workers use the system in the manner that it was intended.

Finally, the state agency should monitor the conduct of attorneys, medical providers, vocational rehabilitation providers, insurance agents, brokers, third party administrators and others to ensure that they perform in accordance with the requirements of the act.

5. Dispute Resolution

While education and other steps may reduce the frequency of disputes, it is recognized that a formal dispute resolution procedure must be available.

When there is a dispute, there should be some form of informal dispute resolution procedure which is offered to parties as early as possible. The parties should be able to effectively participate in this procedure without being represented by attorneys.

When formal disputes occur, efforts should be made as early as possible to identify the issues in dispute and to exchange information between the parties. There should be some procedure in place to ensure this.

It is desirable that disputes be resolved as promptly as possible. Each state should establish standards for the resolution of disputes. Such standards might include as a desired level of achievement a requirement that a certain percentage of all cases be resolved within a specified period of time.

Each state should gather and publish data which indicates how long it takes to resolve disputes in that jurisdiction.

Steps should be taken in each jurisdiction to insure that hearing officers and commission members work productively and efficiently and that they decide cases in an unbiased manner. Each state should initiate some procedure to achieve these goals. This might include the appointment of a bipartite review committee, the publishing of data concerning the productivity of hearing officers, and/or establishing standards by which judges would be examined concerning their knowledge of the law and processes. A procedure similar to that used by bar associations in screening judicial appointments might be considered.

In disputed cases the parties are entitled to a full and fair hearing on the record of the factual issues involved in the dispute. In the past some jurisdictions have allowed a retrial of factual issues at an appellate level. It is recommended that the system be design to resolve **factual issues** at the first formal hearing. The review of factual issues by an appeal board or commission should be limited. Such an appellate body should of course review legal issues. There should be a further appeal from the commission to the state courts. That appeal should also be limited to legal issues.

6. Data Collection

A number of organizations are reviewing issues concerning the collection of data related to workplace disability. It is essential that labor and management be involved in this process.

State workers' compensation agencies should gather data which will allow them to evaluate and manage the state's workers' compensation system. In order to collect and analyze this data, it is essential that state agencies computerize their operations. There are important advantages to be gained

for all concerned, if states comply with the recommendations of their national associations and gather data that is similar and comparable, and if they allow the submission of data in formats that are standardized.

7. Disputes Over Medical Issues

Many disputes in workers' compensation cases involve issues that are medical in nature (for example, the extent of impairment or the utilization of medical services). Each state should maintain a panel of medical experts from various fields who would be available at the request of the state agency to offer an impartial opinion on the disputed issues.

8. Advisory Councils

It is recognized that states frequently find a need to revise their workers' compensation statute and/or regulations. Each state should have an advisory council or committee which allows for continuing input to the state agency and the legislature concerning the workers' compensation system of that state. The voting members of the committee should be an equal number of representatives of labor and management. Other parties, such as insurers, medical providers, attorneys, and others, may be included as non-voting members.

The existence of such a committee does not necessarily guarantee success in amending or improving a state's workers' compensation act. If individuals who understand the state's workers' compensation system, who have a genuine interest in that system, and who can speak for their respective interest groups are actively involved in monitoring the system, rational improvements are more likely.

9. Mandatory Coverage

Coverage under workers' compensation should be mandatory. Neither employers nor employees should be allowed to "opt out" of workers' compensation.

Labor/Management Discussion Group on Workers' Compensation
Membership List

Labor

Dept. of Occupational Safety
and Health
AFL-CIO
815 16th Street, N.W.
Washington, DC 20006
(202) 637-5000

Building & Construction Trades Dept.
AFL-CIO
815 16th Street, N.W.
Washington, DC 20006
(202) 347-1461

Industrial Union Department
AFL-CIO
815 16th Street, N.W.
Washington, DC 20006
(202) 842-7842

Food & Allied Service Trades Dept.
AFL-CIO
815 16th Street, N.W.
Washington, DC 20006
(202) 737-7200

Occupational Health Foundation
815 16th Street, N.W.
Washington, DC 20006
(202) 842-7840

Business

National Assoc. of Manufacturers
1331 Pennsylvania Ave, N.W.
1500 North Lobby
Washington, DC 20004
(202) 637-3127

U.S. Chamber of Commerce
1615 H St., N.W.
Washington, DC 20062

National Federation of Independent
Business
600 Maryland Avenue, N.W., Suite 400
Washington, DC 20024
(202) 554-9000

Council of State Chambers of
Commerce
122 C Street, N.W., Suite 330
Washington, DC 20001
(202) 484-8103

National Council of Self-Insurers
One Marriott Dr., Dept. 924.36
Washington, DC 20058

State Associations Group
National Assoc. of Manufacturers
1331 Pennsylvania Ave., N.W.
Suite 1500 North Lobby
Washington, DC 20004
(202) 637-3054

UBA
600 Maryland Ave., S.W.
Suite 603
Washington, DC 20024
(202) 484-3344

Others

Alliance of American Insurers
1501 Woodfield Road, Suite 400W
Schaumburg, IL 60173-4980
(708) 330-8500

American Insurance Association
1130 Connecticut Ave., N.W.
Suite 1000
Washington, DC 20036
(202) 828-7100

Liberty Mutual Insurance Co.
175 Berkeley Street
Boston, MA 02117
(617) 574-5679

American Medical Association
Dept. of State Legislation
515 N. State
Chicago, IL 60610
(312) 464-4773

Data Collection

I will attempt here to list a few of the issues related to data collection. Please understand that this is a first attempt to pull these issues together and is subject to revision.

THE INITIATIVE

There has been discussion lately, both within the Labor/Management group and in general, concerning the collection of data relative to workers' compensation. This has resulted from a number of factors including:

1) Proposal by the U.S. Department of Labor to change its data gathering procedures.
2) Requests from various parties to analyze the costs of workers' compensation.
3) A model regulation promulgated by the National Association of Insurance Commissioners (NAIC).
4) Revising of the Basic Administrative Information System (BAIS) by the International Association of Industrial Accident Boards and Commissions (IAIABC).

Everyone wants to know how well workers' compensation systems are functioning in each jurisdiction. Many players are quite concerned about data which can be used to prevent injuries in the future. Some parties, however, express concern about the costs of data gathering, while others are concerned about the confidentiality of this information.

As these various events come together, it seems an appropriate time to consider what changes, if any, should be made in the way the various parties gather data about workplace disability.

REASONS FOR COLLECTING DATA

There are several reasons for gathering data:

1) To prevent future injuries and occupational disease. For this purpose, as much information as possible should be gathered concerning the incidence, cause, and nature of disabilities.

2) To administer a state workers' compensation system. This requires gathering data about what payments have been made, when, and by whom, as well as other information about the performance of the state system.

3) To analyze the performance of a state workers' compensation system. This requires information about where the money is going, what are the problems, and what is the likely result of proposed changes.

4) To set workers' compensation premium rates. This requires information about the losses in each job classification, as well as information about the trends and expenses.

5) To experience-rate employers. This requires gathering information about the experience of each individual employer, as well as information about all employers in each classification.

PLAYERS

There are various organizations that are playing a role in the current discussion of workers' compensation. Many of them are already gathering data concerning this topic.

State Workers' Compensation Agencies

Every state workers' compensation agency currently gathers some data about the injuries that occur within its jurisdiction. At a minimum, this includes the fact that an injury occurred, when benefits started, when benefits stopped, and the amount of benefits paid. Some states gather considerably more information about the nature of the injury. Some gather information about medical payments, while others do not. There is a great variation among the states as to how this information is maintained. In some cases, it is stored in computers in a manner that makes it available for retrieval and analysis. There are rumors that in other jurisdictions the forms are "put in cardboard cartons and stored in the basement."

U.S. Department of Labor

Information about workplace injuries has been gathered by the U.S. Department of Labor since the passage of the Occupational Safety and Health Act (OSHA). Until recently, this information has been gathered by the Bureau of Labor Statistics (BLS). Recently, however, a decision has been made that data collection will be governed by the Occupational Safety and Health Administration (OSHA), and the analysis of the data will be done by BLS.

There are also proposals to change the form in which data is collected by the federal government. Until the present, certain information has been recorded on the "OSHA Log." A summary of this data is reported to the federal government. More detailed information about time loss injuries is reported to OSHA on a "first report of injury" form. In many states the same form is used for OSHA and for the state workers' compensation agency.

A number of proposals for changing this have been discussed and experiments have been carried out. It now appears most likely that OSHA will adopt a procedure whereby all injuries will be reported on a form similar to the first report of injury. This form could potentially be used for both OSHA and state workers' compensation agencies.

OSHA has initiated a dialogue with the insurance industry concerning this topic. There have been a couple of joint meetings between OSHA and various representatives of the insurance industry. This group does not include self-insured employers.

National Council on Compensation Insurance (NCCI)

For many years NCCI has gathered data about losses which it uses when acting as an advocate for the insurance industry before the various commissions or individuals who set workers' compensation insurance premium rates. NCCI also gathers data which is used to establish experience modifications for individual employers. NCCI gathers this data for a majority of the states and assists in the analysis of the data in a number of additional states.

From time to time, NCCI has also used its database to analyze the workers' compensation systems in various jurisdictions and to provide estimates of the costs of proposed legislative changes.

For a number of years, NCCI has conducted a call for Detailed Claims Information (DCI). At first this was conducted in only 13 states. It was later expanded to include a few more states. Recently, NCCI has announced that it will gather this information in all the jurisdictions where it is involved. The DCI is a ten percent sample and gathers detailed information about each claim in the sample. It only covers injuries occurring with insured employers. It does not cover injuries with self-insured employers.

BAIS and the NAIC Model Regulation

Over 10 years ago, the International Association of Industrial Accident Boards and Commissions (IAIABC) adopted a Basic Administrative Information System (BAIS). This was designed to be a model that state workers' compensation

agencies could use in constructing an information system which was designed primarily to administer the state agency. Beginning in the late 80's, the IAIABC initiated a project to update BAIS. The new BAIS is an expanded system. It includes data needed to evaluate a state's workers' compensation program, as well as management information.

At about the same time that the BAIS project was taking place, the National Association of Insurance Commissioners (NAIC) adopted a model regulation under which states would gather information which could be used to analyze the operation of a state's workers' compensation system. As the BAIS and NAIC projects were being completed, the two organizations formed a joint task force, and as a result, the finished product of both projects are quite similar.

The Accord Form

There is a form published by a company known as Accord which has been endorsed by the IAIABC as a model form to be used for the first report of injury. While it has been recommended by the IAIABC, it has actually been fully adopted in only a very few states.

CONCERNS

While almost everyone agrees that we need more and better data, there are a number of concerns about the various approaches being taken.

Sufficiency of Data

Some groups express concerns that not enough data will be gathered to form the analysis required or that it will not be gathered in a way that allows for the proper analysis.

Cost

While everyone agrees that it is good to have data, some parties are concerned that the cost of gathering and analyzing the data will be excessive.

Duplication

All parties agree that duplication should be avoided whenever possible. Businesses feel that duplication will add to the cost. Organized labor is willing to cooperate with business and reduce cost, so long as the necessary information can be gathered. There is, however, a nagging concern that duplication may result, because this data gathering can be mandated by various agencies which are

completely independent of one another.

Confidentiality

Most people would agree that the names of individual injured workers should be kept confidential. At the other extreme, most would also agree that aggregate data about workers' compensation systems should be made public. There is a difference of opinion, however, concerning whether detailed information about individual employers should be kept confidential.

Compatibility of Data Systems

We are hopefully moving into an era where much of this information can be gathered and exchanged efficiently and at lower cost through electronic means. Efficiency, however, depends on the extent of the compatibility of the various data systems. If each state and the U.S. Department of Labor has vastly different requirements, much of the efficiency will be lost. At the same time, it has been felt by many over the years that state workers' compensation agencies should be completely autonomous. The IAIABC has recently formed a committee to study issues related to the electronic gathering of data.

The Unique Role of NCCI

NCCI currently gathers a great deal of information which is useful in analyzing state workers' compensation systems. Its expanded DCI will provide another rich source of information and analysis. It has been suggested by some that this could, to some extent, substitute for the gathering of data by state workers' compensation agencies.

Many people are concerned, however, that this would not be possible. First of all, NCCI has for many years been an advocate for the insurance industry in the setting of workers' compensation insurance premium rates. Secondly, the data for the DCI is gathered by insurance company employees reviewing insurance company files. Third, the access to the database is controlled by NCCI. It is not yet clear to what extent this database would be made available to outside parties. Would the NCCI allow outside parties to access the database and perform analyses? Would it charge for this? Would it control priorities? Would the NCCI maintain the database itself and simply produce its own analysis of the data from time to time?

While it is clear that the DCI is a valuable source of information, it is difficult to understand how it could substitute for the gathering of data by state agencies if access to it is controlled by the NCCI.

The Role of the NAIC and the IAIABC

The National Association of Insurance Commissioners and the International Association of Industrial Accident Boards and Commissions are voluntary associations comprised primarily of the administrators in each jurisdiction who have responsibility for insurance and workers' compensation, respectively. The fact that they adopt a regulation does not, in itself, have any effect whatsoever. The model regulations that they adopt only have effect if they are eventually adopted by the individual states.

Practical Limitations

The BAIS and NAIC model regulations describe comprehensive data gathering systems. To date, only one state has even attempted to implement the NAIC model and none claim to have fully implemented the new BAIS system. It would be ideal if all states were to gather this information and make it available for analysis. The practical considerations, including the cost, make it seem rather unlikely that this will occur in the near future.

BRINGING IT ALL TOGETHER

It seems quite clear that the various state workers' compensation agencies will continue to gather information about each injury that occurs within their jurisdiction. It seems likely that as time goes by, this and the NAIC model regulation will have some influence on the decisions they make in structuring their databases. It also seems quite clear that OSHA will adopt some new scheme for gathering data about occupational injuries and diseases. It would seem that to the extent these efforts can be coordinated, the systems will be improved for the benefit of all parties involved. It would also seem that, if good comprehensive data were readily available, we could prevent future injuries.

There appears to be some conflict among the parties concerning cost, confidentiality, and the amount of data to be gathered. There may also be some "turf" battles among the various agencies. At the same time, this topic has the potential of being one area within workers' compensation where all the parties could come to an agreement.

Doc. 4212

National Conference of State Legislatures
303-830-2200
Brenda Trolin
Can supply consultant to guide Commission through a 50 state survey, plus few other jurisdictions, NZ and Europe.
Also tracking 24-hour coverage proposals in other states.
Available anytime except July 25-30. Can cover costs.
NCSL has a Blue Ribbon Commission, task force to advise it is broad based, each has offered to assist states, most will pay own expenses.
Suggests office of Insurance Commissioner Garamindi in California and NAIC.
Says Council of State Governments and National Governors' Association have done very little in WC.

National Association of Insurance Commissioners
816-842-3600
Eric Nordman
Putting together study of WC marketplace, can share data, will be ready in fall. Suggests Commission look at Oregon and Michigan, which did broad based reforms recently.
Suggests study of examination report of NCCI. Can provide information, work with commission.

Workers' Compensation Research Institute
(617) 494-1240
Richard Victor, Exec. Director
An independent research organization providing data on the performance of various WC systems and effects of reforms.
Published a comprehensive study of Maine's system in late 1990.
Published numerous studies in past 10 years on various Workers' Compensation issues.
Can provide presentions comparing Maine's system to other states, or on specific subjects such as others experience in reducing litigation, controlling medical costs, etc.
May be difficult to arrange presentation before June.
Costs range from nothing to expenses.

Other sources suggested by WCRI
Academics: John Burton, Rutgers; Peter Barth, U Conn,
Alan Hunt, Upjohn Institute for Employment Research
Consultants: John Lewis, (Florida)

American Legislative Exchange Conference
(202) 547-4646, Washington, DC
Provides model legislation to interested legislators.
Working on comprehensive model legislation for Workers' compensation, but not yet completed.