Government Evaluation Act
Program Evaluation Report

Maine Workers' Compensation Board

November 1, 2025

Maine Workers' Compensation Board
BOARD MEMBERS

BOARD CHAIR

John C. Rohde, Esq., Executive Director/Chair

MANAGEMENT REPRESENTATIVES

Penny Picard
Term Expires: 02-01-2027

Lynne Gaudette
Term Expires: 02-01-2028

Paul Gendreau
Term Expires: 02-01-2029

LABOR REPRESENTATIVES

Glenn Burroughs
Term Expires: 02-01-2027

Serina DeWolfe
Term Expires: 02-01-2028

Ron Green
Term Expires: 02-01-2029

TITLE 3 §956. PROGRAM EVALUATION REPORT

§956. PROGRAM EVALUATION REPORT

1. **Report required.** Each agency and independent agency shall prepare and submit to the Legislature, through the committee of jurisdiction, a program evaluation report by a date specified by the committee.

[1995, c. 488, §2 (NEW) .]

2. **Program evaluation report; contents.** Each report must include the following information in a concise but complete manner:

A. Enabling or authorizing law or other relevant mandate, including any federal mandates; [1995, c. 488, §2 (NEW).]

B. A description of each program administered by the agency or independent agency, including the following for each program:

(1) Established priorities, including the goals and objectives in meeting each priority;

(2) Performance measures or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and

(3) An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance measures. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives; [2013, c. 307, §2 (AMD).]

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility; [1995, c. 488, §2 (NEW).]

D. [2013, c. 307, §3 (RP).]

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years; [1995, c. 488, §2 (NEW).]

F. [2013, c. 307, §4 (RP).]

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements; [1999, c. 661, §1 (AMD).]

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes; [1995, c. 488, §2 (NEW).]

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives; [1995, c. 488, §2 (NEW).]

J. Identification of emerging issues for the agency or program in the coming years; [1999, c. 661, §1 (AMD).]

K. Any other information specifically requested by the committee of jurisdiction; [2001, c. 321, Pt. A, §1 (AMD).]

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; [2001, c. 495, §1 (AMD).]

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement; [2013, c. 110, §2 (AMD); 2013, c. 307, §5 (AMD).]

N. A list of reports, applications and other similar paperwork required to be filed with the agency by the public. The list must include:

(1) The statutory authority for each filing requirement;

(2) The date each filing requirement was adopted or last amended by the agency;

(3) The frequency that filing is required;

(4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and

(5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication; [2013, c. 588, Pt. A, §1 (RPR).]

O. A list of reports required by the Legislature to be prepared or submitted by the agency or independent agency; [2013, c. 1, §4 (COR).]

(Paragraph O as enacted by PL 2013, c. 110, §4 is REALLOCATED TO TITLE 3, SECTION 956, SUBSECTION 2, PARAGRAPH Q)

P. A copy of the single-page list of organizational units and programs within each organizational unit required pursuant to section 955, subsection 1, placed at the front of the report; and [2013, c. 1, §4 (COR).]

Q. (REALLOCATED FROM T. 3, §956, sub-§2, ¶O) Identification of provisions contained in the agency's or independent agency's enabling or authorizing statutes that may require legislative review to determine the necessity of amendment to align the statutes with federal law, other state law or decisions of the United States Supreme Court or the Supreme Judicial Court. [2013, c. 1, §3 (RAL).]

[2013, c. 588, Pt. A, §1 (AMD) .]

SECTION HISTORY
1995, c. 488, §2 (NEW). 1999, c. 661, §§1,2 (AMD). 2001, c. 321, §§A1-3 (AMD). 2001, c. 495, §§1-3 (AMD). RR 2013, c. 1, §§3, 4 (COR). 2013, c. 110, §§2-4 (AMD). 2013, c. 307, §§2-7 (AMD). 2013, c. 588, Pt. A, §1 (AMD).

Table of Contents

Executive Summary

One of the major successes of the current Board of Directors is the progress they have made in realizing the original goals of the Board. In 1992, a Blue Ribbon Commission ("BRC") submitted a report to the Legislature detailing suggested changes to Maine's workers' compensation system. One recommendation, later enacted, was the creation of the Workers' Compensation Board. In recommending the enactment of the 1992 Act, the BRC stated:

> The plan that is being offered places control of the system in the hands of a new labor-management board, which will have virtually total control over the operation of the system. The Board will have the ability and the responsibility to see to it that the system operates as intended, and that any problems that arise can be quickly and accurately identified and dealt with.

Report of the Blue Ribbon Commission to Examine Alternatives to the Workers' Compensation System and to Make Recommendations Concerning Replacement of the Present System ["BRC Report"], August 31, 1992, p. 2.

The original board of directors was composed of 8 members, 4 representing labor and 4 representing management. During the late 1990s, the board deadlocked on some important issues. In 1997, in effort to encourage cooperation, the Board's mission statement was enacted:

> The board's mission is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.

39-A M.R.S.A. § 151-A.

In 2004, continued gridlock resulted in a change to the composition of the Board. Specifically, the legislature changed the board to its current 7-member configuration; 3 members represent labor, 3 represent management and the 7th is the Executive Director who is appointed by, and serves at the pleasure of, the Governor. Even after this, conflict was no stranger to the workers' compensation system.

In 2019, Governor Mills set an expectation that stakeholders work in good faith with the goal of reaching consensus on issues in the workers' compensation system. Since that standard was set, the directors have evolved into a board that is fulfilling its original purpose. The directors are dedicated, they work hard, they collaborate and, as envisioned by the Board's mission statement, they are "fostering labor-management cooperation." 39-A M.R.S.A. § 151-A.

The agency has made progress in other areas as well. For example, the average time a case is pending before an Administrative Law Judge and the Appellate Division has been significantly

reduced. Troubleshooters and mediators have been able to allocate time to training and education in an effort to increase compliance with the Workers' Compensation Act's requirements.

The Board is working to expand the scope of its compliance reports. To date, compliance reports have measured the timeliness of initial filings of First Reports of Injury, Notices of Controversy, Memoranda of Payment, Wage Statements, Fringe Benefit Worksheets and the timeliness of initial payments. To make these reports more meaningful, the Board is working to implement a process that will measure the accuracy of mandatory filings.

The Board of Directors has also increased its oversight of the Independent Medical Examiner (IME) system. This has resulted in a decrease in the amount of time it takes for IMEs to issue their reports which reduces delays in the dispute resolution process.

The Claims Management and Insurance Coverage Units continue to process thousands of forms each month. This ensures that the Board has timely and accurate data. The work of the Insurance Coverage Unit directly supports the Abuse Investigation Unit's effort to ensure that employers have, if required, workers' compensation coverage for their employees.

The Office of Medical and Rehabilitation Services keeps the Board's Medical Fee Schedule up-to-date and acts as a resource for health care providers and claim administrators to promote compliance and "ensure appropriate limitations on the cost of health care services while maintaining broad access for employees to health care providers in the State . . ." 39-A M.R.S.A. § 209-A. The Worker Advocate Division continues to play a necessary role in ensuring that injured workers are represented in proceedings before the Board.

Areas of continued focus for the Board include: Expanding the amount of data that is received via computer-to-computer transmission as opposed to forms that must be entered manually; gaining further insight into employment rehabilitation efforts; and, continuing to foster a collaborative environment for the Board of Directors.

Organizational Units and Programs

The Workers' Compensation Board (Department 90C) has the following units and programs:

Administration (unit 2001)
Represented as a single unit and program

A single unit that encompasses central administration for the agency and central services including the Insurance Coverage Unit, the Office of Medical and Rehabilitation Services, the Abuse Investigation Unit and the Legal Department.

Information Management (unit 2002)
Represented as a single unit and program

A single unit that provides services including the Claims Management Unit as well as support for the Board's technology resources.

Dispute Resolution (unit 2003)
Represented as a single unit and program

A single unit with four tiers of dispute resolution: Troubleshooting, mediation, formal hearings and appellate review.

Advocate Division (unit 2004)
Represented as a single unit and program

A single unit that provides assistance to eligible injured workers who have not retained the services of a private attorney.

Monitoring, Audit & Enforcement Division (unit 2005)
Represented as a single unit and program

A single unit that monitors compliance by insurers, self-insurers and employers with the requirements of the Workers' Compensation Act.

Enabling Legislation and History of Maine Workers' Compensation

Enabling Legislation

39-A M.R.S. § 101, et seq. (Maine Workers' Compensation Act of 1992)
On January 1, 1993, Title 39, which contained the Workers' Compensation Act of 1991 and all prior workers' compensation acts, was repealed and replaced with Title 39-A, the Workers' Compensation Act of 1992.

Revisions to Enabling Legislation

The following are some of the revisions made to the Act since 1993.

- **§102(4).** Clarified that, for injuries on and after January 1, 2020, fringe benefits that do not continue during incapacity must be included in the average weekly wage to the extent that the inclusion does not result in a weekly benefit amount greater than 2/3 of 125% of the state average weekly wage at the time of injury. Previously, the benefit cap was 2/3 of the state average weekly wage at the time of injury.
- **§102(11)(B-1).** Tightened the criteria for wood harvesters to obtain a predetermination of independent contractor status.
- **§102(13-A).** Tightened definition of independent contractor and made it the same as the definition used by Department of Labor.
- **§104-A.** Allows injured workers to bring civil actions against coworkers, supervisors, officers and directors for sexual harassment, sexual assault, intentional torts related to sexual harassment or sexual assault. Employing entities remain immune from civil suits.
- **§105.** Creates self-declaration process for employers to establish independent contractor status. Hiring entities can independently determine if predetermination has been granted by reviewing list of independent contractors on Board's website.
- **§113.** Permits reciprocal agreements to exempt certain nonresident employees from coverage under the Act.
- **§151-A.** Added the Board's mission statement.
- **§§151, Sub-§1.** Established the Executive Director as a gubernatorial appointment and member and Chair of the Board of Directors. Changed the composition of the Board from eight to seven members.
- **§153(9).** Established the monitoring, audit & enforcement (MAE) program.

- **§153-A.** Established the worker advocate program.
- **§154(6)** Provides that the Board may not raise more revenue in assessments than is sufficient to fund expenditures allocated by the Legislature for that given year, and to maintain a reserve of up to 1/4 of the board's annual budget.
- **§201 (3-A) (B)** Established a PTSD presumption of work relatedness for emergency first responders, corrections officers and 9-1-1 emergency dispatchers. In 2025 a sunset provision (which would have repealed the presumption) was removed.
- **§201(6).** Clarified rights and benefits in cases which post-1993 work injuries aggravate, accelerate, or combine with work-injuries that occurred prior to January 1, 1993.
- **§205(2).** If a notice of controversy is not filed within 14 days of when an employer has notice that a work-related injury occurred, then payments must begin. But if the insurer's failure to pay is due to a factual mistake, act of God or unavoidable circumstances, then the insurer is excused from paying a penalty for failing to pay within that 14-day period. If a notice of controversy is not filed within 45 days of notice of the occurrence of the injury, then benefits may only be stopped pursuant to the 21-day discontinuance process in §205 (9) (B) (1) unless the failure to file a notice of controversy was due to an act of God.
- **§209-A (4).** Provides that existing reimbursement rates for medical services remain in effect if an annual update of the medical fee schedule is not completed.
- **§211.** Sets the maximum weekly benefit level at 125% of the state average weekly wage for injuries occurring on and after January 1, 2020. For injuries on and after January 1, 2013, and before January 1, 2020, the weekly maximum is 100% of the state average weekly wage. For injuries before January 1, 2013, the weekly maximum is 90% of the state average weekly wage.
- **§§212 and 213.** Changed benefit determination to 2/3 of gross average weekly wages from 80% of after-tax wages for dates of injury on and after January 1, 2013.
- **§212 (4).** Provides cost-of-living adjustments after 5 years of total benefits paid under §212 for injuries on and after January 1, 2020.
- **§213.** Eliminates the permanent impairment threshold for dates of injury on and after January 1, 2013 and establishes 520 weeks as the maximum duration for partial incapacity benefits with certain exceptions.
- **§213(1)**. Establishes 624 weeks as the maximum duration for partial incapacity benefits for dates of injury on and after January 1, 2020.
- **§213(1-A).** Defines "permanent impairment" for the purpose of determining entitlement to partial incapacity benefits.
- **§213(1-B).** Clarifies that the 18% whole person impairment test for receipt of long-term partial incapacity benefits effective January 1, 2013 does not apply to injury dates on and after January 1, 2020. Partial incapacity benefits for injuries on and

after January 1, 2020, will be payable for 12 years without regard to the amount of a claimant's impairment.

- **§215 (1-B).** Grants the 500-week death benefit to parents of deceased employees who leave no dependents and whose injuries occur or and after January 1, 2020. Previously, payments were made to the Employment Rehabilitation Fund.
- **§217(9).** Establishes that an injured worker participating in employment rehabilitation is protected from having his/her case reviewed except under limited circumstances involving either a return to work or because the employee reached the durational limitation for partial incapacity benefits.
- **§221 (1) (B)** states that as a general rule, the coordination of benefits section applies to retirement and disability income, wage continuation payments, and paid time off (PTO).
- **§221 (2) (A) (2).** Sets forth the formula for calculating offset for old-age insurance benefits and payments under employee benefit plans for injuries on and after January 1, 2013.
- **§221 (3) (A) (2)** provides that workers' compensation benefits should be reduced by the after-tax value of PTO income received by claimants during periods of incapacity.
- **§221 (3) (H)** creates an exception and disallows reduction in workers' compensation benefits for PTO benefit payments if mandated by employer or paid to employee upon separation from employment.
- **§224** Clarified annual adjustments made pursuant to former Title 39, §§55 and 55-A.
- **§301** For injuries before January 1, 2013, deadline for notice of injury was 90 days. For injuries on and after January 1, 2013, but before January 1, 2020, deadline for notice of injury was 30 days. Notice deadline was changed to 60 days for injuries on and after January 1, 2020.
- **§§321-A & 321-B** Reestablished the Appellate Division within the Board.
- **§325 (6)** sets the maximum attorney's fees at 10% in lump-sum settlements for cases with injuries that occurred on or after January 1, 2020.
- **§328.** Creates rebuttable presumption that firefighter's cardiovascular or pulmonary condition is work-related if it occurs within 6 months of participating in firefighting or firefighting training.
- **§328-A** Creates rebuttable presumption that certain communicable diseases contracted by emergency rescue and public safety workers are work-related.
- **§328-B** Creates rebuttable presumption that specified cancers suffered by firefighters and certain employees of the State Fire Marshall's Office and the forest protection unit of the Department of Agriculture are work-related.

- **§328-C** Creates rebuttable presumption that heart disease or hypertension contracted by a state worker who is required to care for, supervise, or exercise custody over incarcerated people is work related.
- **§328-D.** Creates rebuttable presumption that a law enforcement officer's cardiovascular or pulmonary condition is work-related if it occurs within 6 months of work or training.
- **§§355-A, 355-B, 355-C, and 356.** Created the Supplemental Benefits Oversight Committee.
- **§360 (1).** Allows insurers to recover penalties from employers that are imposed for late-filed forms if employer's late notice to insurer caused the late filing.
- **§401 (4-A).** Sets forth process for wood harvesters and landowners to file forms with the Board to establish independent contractor status.

STATE AGENCY HISTORY

The original agency, the Industrial Accident Board, began operations on January 1, 1916. In 1978, it became the Workers' Compensation Commission. In 1993, it became the Workers' Compensation Board.

The Early Years of Workers' Compensation

A transition from the common law tort claim system into the statutory structure we know today occurred on January 1, 1916. Under our common law tort system, an injured worker had to sue his/her employer and prove negligence to obtain a remedy. Workers' compensation was conceived as an alternative to the tort system for those injured at work and because of their work. Instead of litigating negligence, under this "new" system, injured workers would receive statutorily mandated benefits for lost wages and medical treatment. Employers correspondingly lost legal defenses such as assumption of risk or contributory negligence. Injured workers gave up remedies beyond lost wages and medical treatment such as pain and suffering and punitive damages. This "grand bargain," as it has come to be known in the national literature, remains a fundamental feature of today's workers' compensation system. Perhaps as a sign of the times, in Maine financing and administration of benefit payments remained in the private sector, either through insurance policies or self-insurance. Workers' compensation disputes still arise in this no-fault system. For example, disputes address whether an employee's incapacity is related to work; the amount of weekly benefits due the injured worker; and what, if any, earning capacity has been lost. Maine, like most other states, established an agency to process these disputes and perform other administrative responsibilities. Disputes under this system became simpler. Injured workers rarely had lawyers. Expensive, long term, and medically complicated claims, such as cumulative trauma and chemical exposures, were decades away.

Adjudicators as Fact Finders

In 1929, the Maine Federation of Labor and an early employer group, "Associated Industries," opposed a commissioner's renomination. Testimony from both groups referred to decision reversals by the Maine Supreme Court. This early feature of Maine's system, review of decisions by the Supreme Court, still exists, although today these appeals are discretionary. The Supreme Court decides legal issues; it does not conduct de novo hearings. In Maine, our state agency adjudicators are Administrative Law Judges (ALJ's). ALJ's are the final fact finders.

In the 1980s, Commissioners became full time, and an informal conference process was introduced in an attempt to resolve disputes early in the claim cycle, before the need for a formal hearing. Additionally, the agency expanded its physical presence, opening regional offices in Caribou, Bangor, Augusta, Lewiston, and Portland. These regional offices are supported by a central administrative office in Augusta. In 1987, three full-time Commissioners were added, bringing the total from 8 to 11, in addition to a Chair. In recent years, the Board has reduced the number of staff hearing claims to eight, from a high of 11.

Until 1993, Commissioners, (those who now are ALJs), were gubernatorial appointments, subject to confirmation by the Legislature's judiciary committee. The need for independence of

its quasi-judicial function was one of the reasons why the agency was established as an independent, free-standing institution, rather than as a part of a larger administrative department within the executive branch. The small scale of state government in 1916 no doubt also played a role in this structural decision.

Transition to the Modern Era

During the 1970s, Maine, along with several other states, made changes to their workers' compensation laws in an effort to ensure that the laws were functioning equitably. These changes included: making coverage compulsory for most employers; increasing the maximum weekly benefit; removing durational limitations for total and partial benefits; and, making it easier for injured workers to secure legal services.

Statutory changes and evolving medical knowledge also brought a new type of claim into the system. The law no longer required an injury to happen "by accident." Doctors began to connect repetitive overuse conditions to claimants' work and thus brought these conditions within the workers' compensation coverage. Gradual, overuse injuries frequently heal more slowly. This requires benefit payments for longer periods than many accidental injuries. These claims were more likely to involve litigation. Over the course of time, rising costs transformed the workers' compensation system into a contentious political topic in the 1980s and early 1990s.

The political environment of the 1980s and early 1990s was extraordinary for Maine's workers' compensation system. Contentious legislative sessions directly related to workers' compensation occurred in 1982, 1985, 1987, 1991, and 1992. In 1991, the governor tied a veto of the state budget to changes in the Workers' Compensation Act. The consequence of this action was a three-week state government shutdown.

In 1992, the Legislature created a Blue Ribbon Commission ("BRC") to examine our system and recommend changes. The Commission's report made a series of proposals that were ultimately enacted. These changes included creation of the Workers' Compensation Board. The BRC's recommendation with respect to the Board

> Places control of the system in the hands of a new labor-management board, which will have the ability and the responsibility to see to it that the system operates as intended, and that any problems that arise can be quickly and accurately identified and dealt with.

Report of the Blue Ribbon Commission to Examine Alternatives to the Workers' Compensation System and to Make Recommendations Concerning Replacement of the Present System ["BRC Report"], August 31, 1992, p. 2.

The original board of directors was composed of 8 members, 4 representing labor and 4 representing management. During the late 1990s, the board deadlocked on some important issues. As a result, in 2004, the legislature changed the board to its current 7-member configuration. Despite this change, there was still conflict within the workers' compensation system.

In 2019 Governor Mills set an expectation that stakeholders work in good faith with the goal of reaching consensus on issues in the workers' compensation system. Since that standard was set, the directors have evolved into a board that is fulfilling its original purpose. They are engaged, involved, and working with each other.

Also enacted were changes that set the maximum weekly benefit at 90% of the state average weekly wage and a limit of 260 weeks of benefits for partial incapacity. These changes represented benefit reductions for injured workers, particularly those with long term incapacity. Additionally, the provision of the statute concerning access to legal representation was changed. This made it exceedingly difficult for injured workers to secure legal representation.

The agency was criticized in the late 1980s and early 90s for not doing more with its data gathering. The Board installed a relational database in 1996, with modern programming language; the result was an improvement in data collection. Subsequently, the Board mandated electronic filing of First Reports of Injury, Notices of Controversy and Proof of Coverage. Since 2019, the Board has focused on ensuring that the data it collects is timely, accurate and can be used by the Board to monitor how Maine's workers' compensation system is functioning.

Program Descriptions

Introduction

The mission of the Workers' Compensation Board "is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation." 39-A M.R.S.A. §151-A.

To achieve this mission, the Board is specifically tasked with resolving disputes, ensuring compliance with the requirements of the Act and the Board's rules, regulating medical costs, and providing representation to injured workers who are unable to obtain the services of private attorneys. The Board must accomplish its objectives without exceeding its allocated revenue. The Board is not a General Fund agency. It is financed through an assessment on employers directly, or if insured, through their insurers as provided in the Act. 39-A M.R.S.A. §154.

Each of these, and other related, areas are discussed in detail in the various sections of this report. A brief summary of the main functions is provided here.

In order to ensure compliance with the Act, employers and insurers are required to file information with the Board. The Board monitors the information that is filed to ensure it is accurate, complete, and timely. The goal is to identify and resolve cases at the first available level. When this is not possible, the cases move on to the next level of dispute resolution. This information also provides a foundation for the Monitoring and Audit Divisions. Specifically, monitoring and auditing staff take a more in-depth look at an entity's compliance and payment accuracy.

The Board also uses this information to ensure employers have workers' compensation coverage for their employees. A critical aspect of this effort is to prevent employers from misclassifying employees as independent contractors. Employers that misclassify employees not only place these employees at risk of not having any recourse if injured on the job, they also gain an unfair competitive advantage vis-a-vis employers that properly classify their workforce.

When employers and employees cannot agree on whether an injury is work-related or whether certain costs are related to a work injury, the Board provides a forum to resolve these issues. Dispute resolution starts with troubleshooting and progresses through mediation and if necessary, on to formal hearing. Since August 2012, parties can also appeal formal hearing decisions to the Board's Appellate Division.

The Advocate Division was established in 1997 to provide representation to employees who cannot obtain the services of private attorneys. The Advocate Division has grown significantly

over the years. It continues to provide services to many employees who might otherwise have to represent themselves – a nearly impossible task for most injured workers.

Finally, in accordance with 39-A M.R.S.A. §209-A the Board maintains a medical fee schedule that regulates medical costs within the workers' compensation system while ensuring access to care for injured employees. The medical fee schedule is updated annually, and a comprehensive review of the medical fee schedule is performed every three years. The Board completed the most recent comprehensive review in 2023. The Board did not make any adjustments to the conversion factors and baserates that are used to determine maximum allowable reimbursements. The Board is monitoring whether maximum reimbursements in its medical fee schedule are falling behind commercial third party payor rates.

Dispute Resolution

INTRODUCTION

The Workers' Compensation Board has five regional offices throughout the state that manage and process disputed claims. The regional offices are responsible for troubleshooting, mediations and formal hearings. Regional offices are located in Augusta, Bangor, Caribou, Lewiston and Portland.

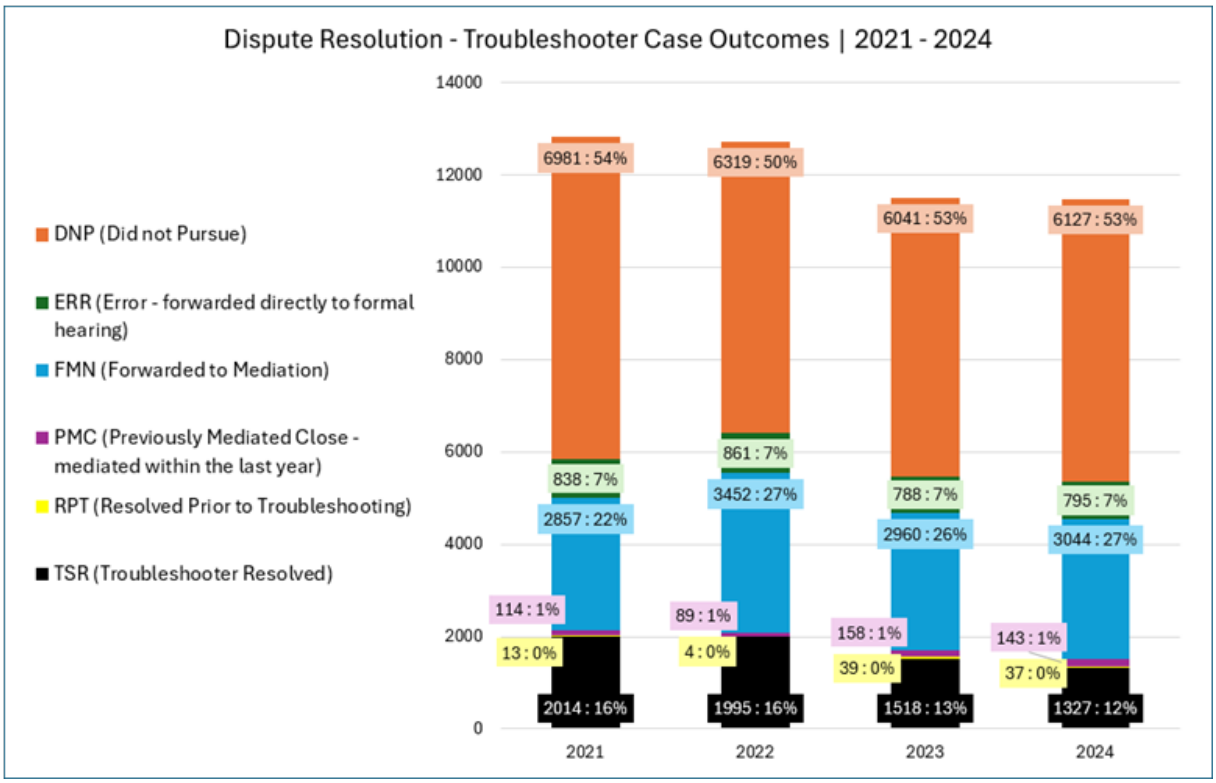
FOUR TIERS OF DISPUTE RESOLUTION

Title 39-A, the Maine Workers' Compensation Act, establishes a four-tiered dispute resolution process: troubleshooting, mediation, formal hearing, and an appellate division.

Troubleshooting

When the Board is notified of a dispute (which can include the filing of a Notice of Controversy, a petition or a phone call from an injured worker indicating there is an unresolved issue) the dispute resolution process at the Board begins. Troubleshooting is the first stage of this process. Troubleshooters function as neutral parties who attempt to informally resolve controversies by contacting the employee and the claim administrator responsible for adjusting the claim. Troubleshooters often assist parties with the gathering of additional information, including medical reports, in order to facilitate a resolution.

The following chart shows the number of filings assigned to the Troubleshooters for calendar years 2021 through 2024 and the disposition of those filings.



The goal for Troubleshooters is to move cases through this level within 30 days. The following chart shows that the Troubleshooters are meeting this objective.

Average Days Pending					
2024	2023	2022	2021	2020	2019
28	19	19	21	25	22

If the dispute is not closed after troubleshooting, the claim is referred to the next step in the dispute resolution process, mediation. Cases may have multiple filings. For example, multiple notices of controversy may have been filed with respect to a claim. Troubleshooters work to ensure that filings are consolidated into single cases for purposes of mediation.

Troubleshooters also provide another important service to the workers' compensation system. They are often the first point of contact at the Board for members of the public. Troubleshooters answer questions and provide assistance and information to these callers. In so doing, they can prevent some disputes from arising and can also ensure, when necessary, that claims are opened in the dispute resolution process. More recently, Troubleshooters have begun to provide training to insurers, employers, and employees.

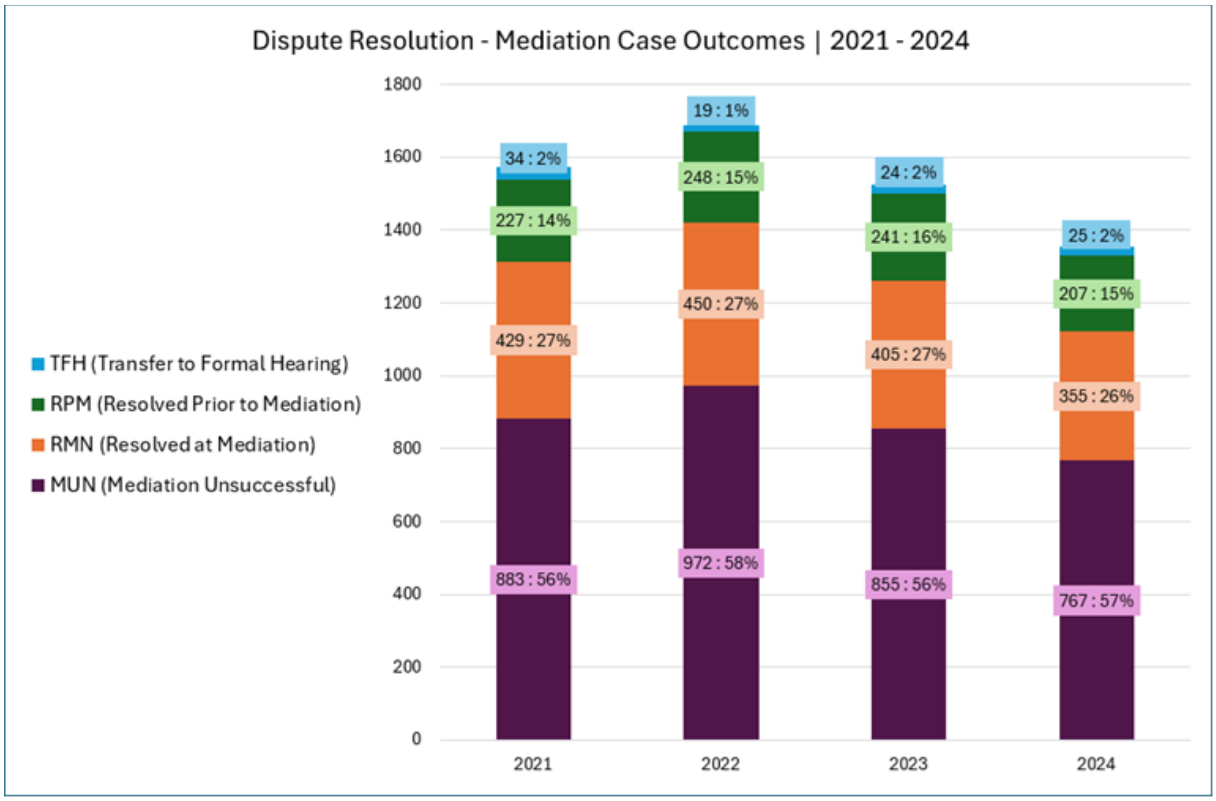
Mediation

Cases referred to mediation by the Troubleshooters are assigned to one of the Board's mediators. Mediators schedule and conduct mediation with the parties. Mediation is a mandatory step in the dispute resolution process. While participation is mandatory, resolutions are entirely voluntary. Mediation gives parties the opportunity to resolve disputed issues. In the typical case, a mediator requests that the party seeking benefits provide an explanation and rationale for the benefits being sought. The mediator then requests that the other parties explain their concerns and identify what benefits they are willing to pay and/or why they are not prepared to pay benefits. The mediator seeks resolution proposals from the parties, and the mediator may propose resolutions in an attempt to find an acceptable compromise.

Historically, mediation was held in-person at the regional offices. However, there had been an increasing demand for telephonic mediations as an alternative. The COVID-19 pandemic forced a shift to teleconferencing. Since the pandemic, the primary mode of mediation has remained teleconferencing. Most stakeholders appreciate the efficiencies gained by telephonic mediations. The shift has not affected the percentage of cases resolved at this stage. The Board continues to evaluate remote options for mediation, including the possibility of videoconferencing. In the event a party wants in-person mediation, it can still be scheduled at a regional office.

Agreements reached during mediation have the same effect as decrees issued after a contested hearing. The terms of the agreement are binding on those involved. Parties can resolve some, but not all, issues. In cases where agreement cannot be achieved, mediation still provides an opportunity to narrow the issues that are in dispute.

The following chart shows the number of cases mediated during calendar years 2021 through 2024 along with the disposition of the cases.



Many years ago, the Board set a goal of moving cases through mediation in 45 days. As the following chart shows, that goal has not been attained in recent years. One frequently cited reason for the delays is the length of time it takes to receive medical records. The Board will be considering whether the 45-day goal should be changed.

Average Days Pending					
2024	2023	2022	2021	2020	2019
75	68	70	65	72	66

Finally, as is the case with Troubleshooters, mediators have begun to provide training for insurers, employers and employees.

Formal Hearing

When mediation does not resolve the dispute and at least one party has filed a formal petition, the case is assigned to one of the Board's regional administrative law judges (ALJs). The ALJs are appointed, and reappointed, by the Board of Directors. During the late 1990s, the board deadlocked on some important issues, including employment of administrative law judges (then called hearing officers). As a result, in 2004, the legislature changed the board to its current 7 member configuration.

Decisions made by the board after the 2004 change were by simple majority – 4 out of 7 members. Pursuant to a 2019 amendment, employment decisions regarding administrative law judges now must be made with the support of 5 of 7 members. Because of the work done by the

Board of Directors to foster labor-management cooperation, the Board has hired five ALJs since the amendment took effect. All were hired with the unanimous support of the Board.

After an unsuccessful mediation or the filing of a petition, the parties, now usually represented by attorneys, file a joint scheduling memorandum requesting hearing time with the ALJ. Board staff then schedules a hearing. Since the COVID-19 pandemic, the primary mode of conducting hearings is through videoconferencing though requests for in person hearings are frequently granted.

At a hearing, witnesses for both sides testify and other, usually documentary, evidence is submitted. In most cases, the parties are represented either by an attorney or a worker advocate. Following the hearing, position papers are submitted, and the administrative law judge thereafter issues a final written decision. Other possible outcomes are dismissal or a lump-sum settlement.

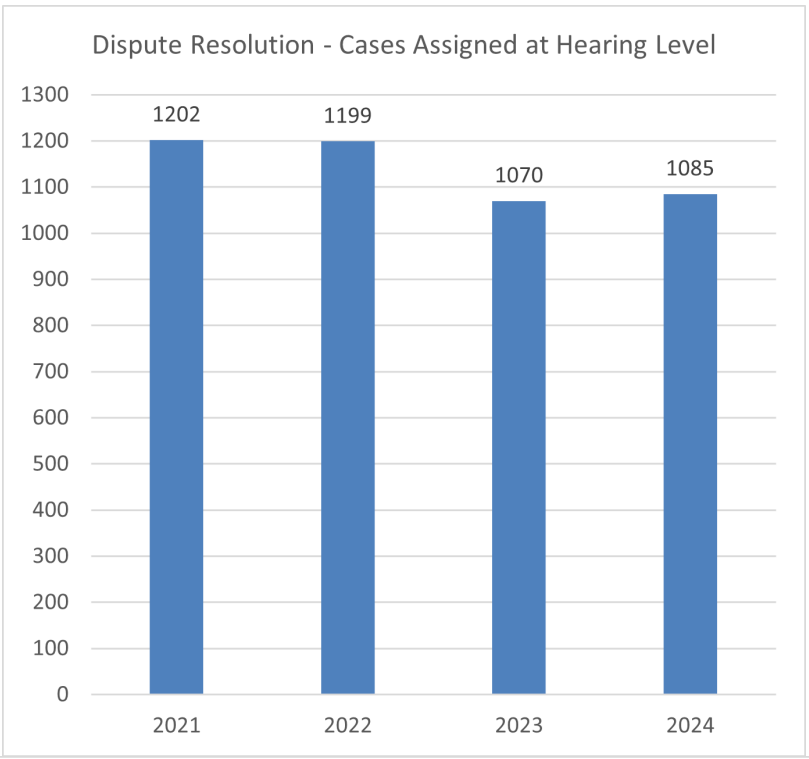
At the formal hearing stage, the Board endeavors to ensure cases are processed efficiently while still ensuring that parties have sufficient time to develop and present relevant evidence. In 2012, cases were pending at formal hearing for an average of 12 months. The goal has been to keep that number at or below 12 months. As the following chart shows, cases are moving through the formal hearing stage quickly.

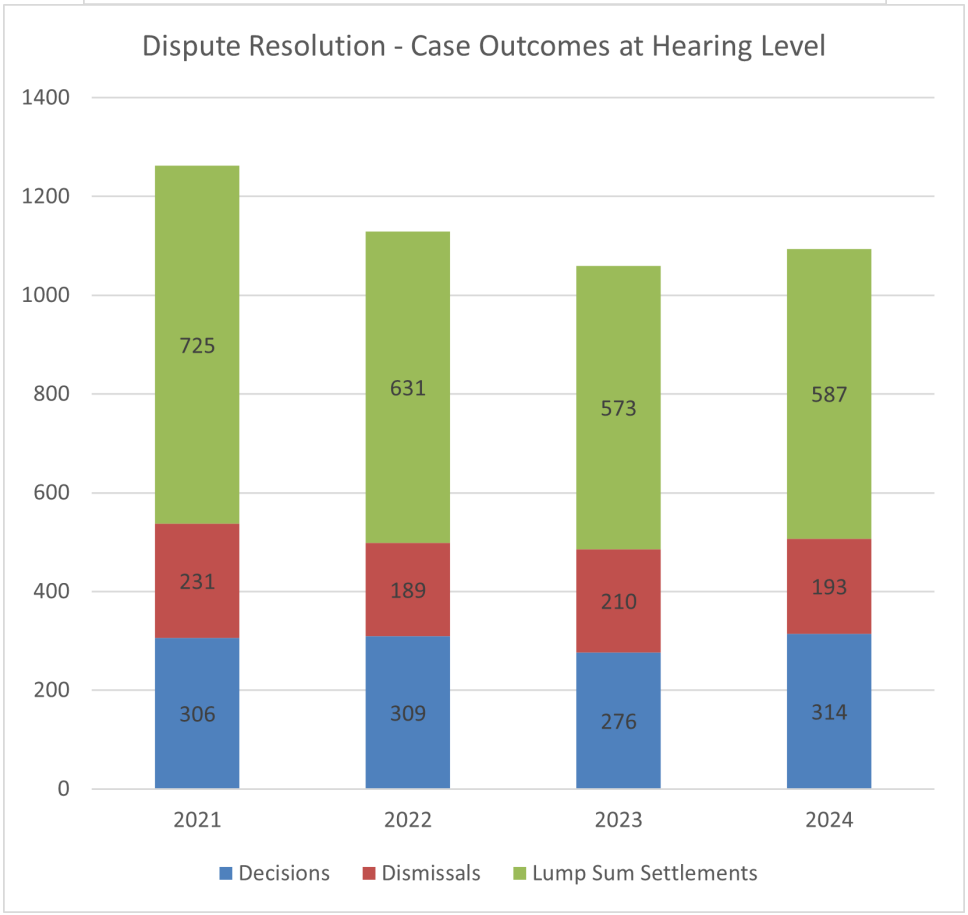
Average Months Pending					
2024	2023	2022	2021	2020	2019
7	7	8	8	9	10

In an individual case, the goal is for a decision to be issued within 60 days after the evidence closes and the case is ready to be decided. The average amongst the ALJs is significantly below that expectation.

Average Days from Ready for Decision to Decree					
2024	2023	2022	2021	2020	2019
35	28	31	24	36	42

The following charts contain information regarding the number of cases and outcomes at the formal hearing level from 2021 through 2024.


Dispute Resolution - Cases Assigned at Hearing Level
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
1202
1199
1070
1085
2021
2022
2023
2024


Dispute Resolution - Case Outcomes at Hearing Level
1400
1200
1000
800
600
400
200
0
725
631
573
587
231
189
210
193
306
309
276
314
2021
2022
2023
2024
Decisions
Dismissals
Lump Sum Settlements

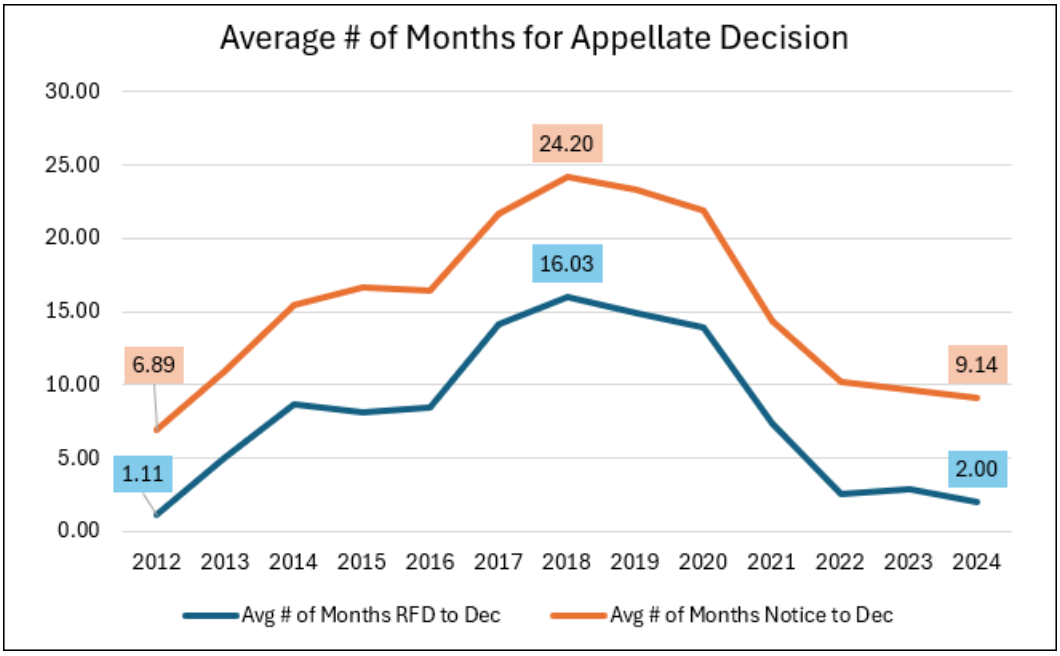
Appellate Division

Parties who have progressed through the formal hearing process and have received a decision from an administrative law judge may appeal that decision to the Appellate Division, where a panel of three administrative law judges will undertake careful review of that decision for errors of law. The panel can affirm, vacate, modify, or remand the decision for additional proceedings. Since its revival by the Legislature in 2012, the Appellate Division has reviewed and issued written decisions in over 400 cases.

The appellate process is governed by rules which set time deadlines for filing an appeal and briefing a case. Once the briefing process is complete, the case is set for either oral argument or a conference before the three-judge panel. At that point, the case is ready for decision.

The period from the initiation of the appeal to the completion of the briefing schedule is controlled by agency rules. The rules allow for liberal extensions of time to file briefs, therefore the parties are partly in control of the timing during that stage of the process. Once the briefing schedule is complete, the Appellate Division strives to issue a decision in a timely manner.

As seen in the Chart below, the average time a case was pending in the appellate division peaked in 2018. The Division has worked hard to eliminate its backlog and decrease the time a case is pending before the Division. Thanks to this hard work, the average time a case is pending in the Division has decreased dramatically; from 16 months in 2016 to 2 months in 2024.



Parties may seek review of an Appellate Division decision to the Maine Supreme Judicial Court, but that review is discretionary and is infrequently granted. The Appellate Division essentially provides the last stage of the Board's dispute resolution process.

Office of Monitoring, Audit, and Enforcement

HISTORY

The Maine Legislature, in 1997, established the Office of Monitoring, Audit and Enforcement (MAE). The multiple goals of this office are: (1) monitoring and auditing payments and filings; (2) providing timely and reliable data to policymakers; and (3) identifying those insurers, self-administered employers, and third-party administrators (collectively "insurers") who are not in compliance with minimum standards established under our Act.

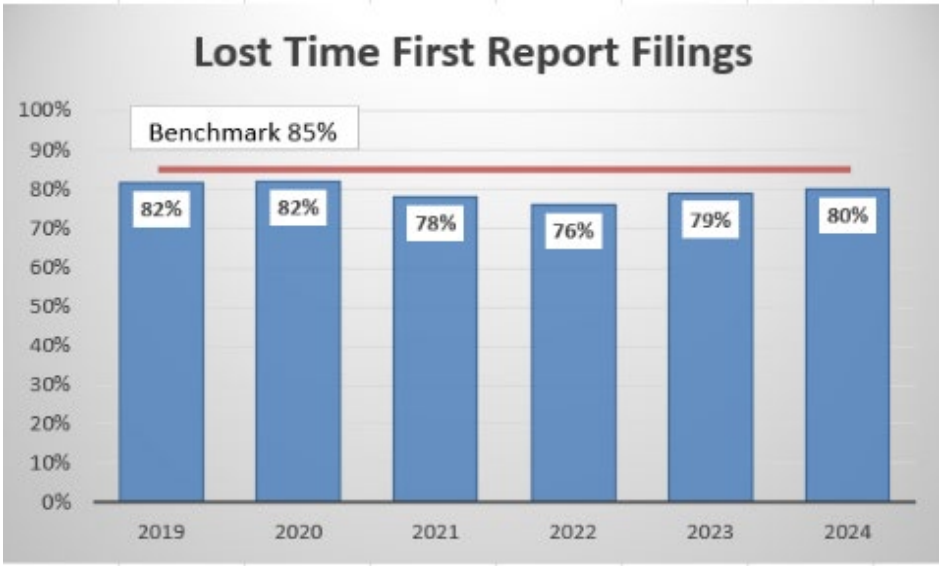
MONITORING

The Monitoring Unit ("Monitoring") is an integral part of the Board's effort to ensure that Maine's workers' compensation system operates as intended; namely, that legally due benefits are paid promptly and accurately and that the system functions fairly and expeditiously. Monitoring measures and reports on compliance by insurers and self-insurers with benchmarks established by the Board. Monitoring works with insurers and employers to ensure that data is accurate before it produces its reports are generated. Specifically, Monitoring produces Quarterly and Annual Compliance reports. Once approved by the Board, Monitoring's reports are posted to the Board's website. These reports provide a means of assessing the performance of insurers and self-insurers both individually and for the industry as a whole. Monitoring does not simply report on performance, it also actively participates in training activities and proactive outreach efforts with insurers and self-insurers to help identify, cure and prevent potential compliance issues.

Ultimately, the goal is to ensure that benchmarks are being met. This sometimes requires the use of additional strategies. For example, as the charts below show, compliance trends (other than the filing of Notices of Controversy) moved in a negative direction after 2019. In addition to outreach efforts, the Board also implemented, or, in the case of First Reports of Injury, continued, procedures to issue penalties in a small percentage of cases if compliance fell below the established benchmark. The charts below illustrate the improvement in compliance after the penalty process was added to the training and outreach efforts.

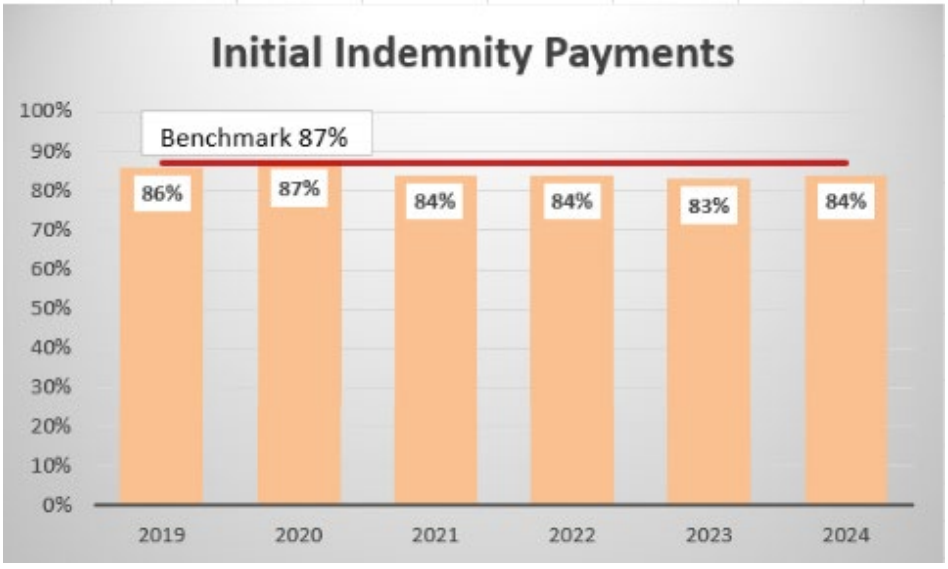
Lost Time First Report Filings

- There is compliance with the lost time first report filing obligation when a lost time first report is filed (accepted Electronic Data Interchange (EDI) transaction, with or without errors) within 7 days of the employer receiving notice or knowledge of an injury causing an employee to lose a day's work.
- When a medical-only first report is received and later the claim is converted to a lost time first report, if the date received minus the date of the employer's notice or knowledge of incapacity is less than zero, the filing is considered compliant.
- The Board's benchmark for lost time first report (FROI) filings within seven days is 85%.



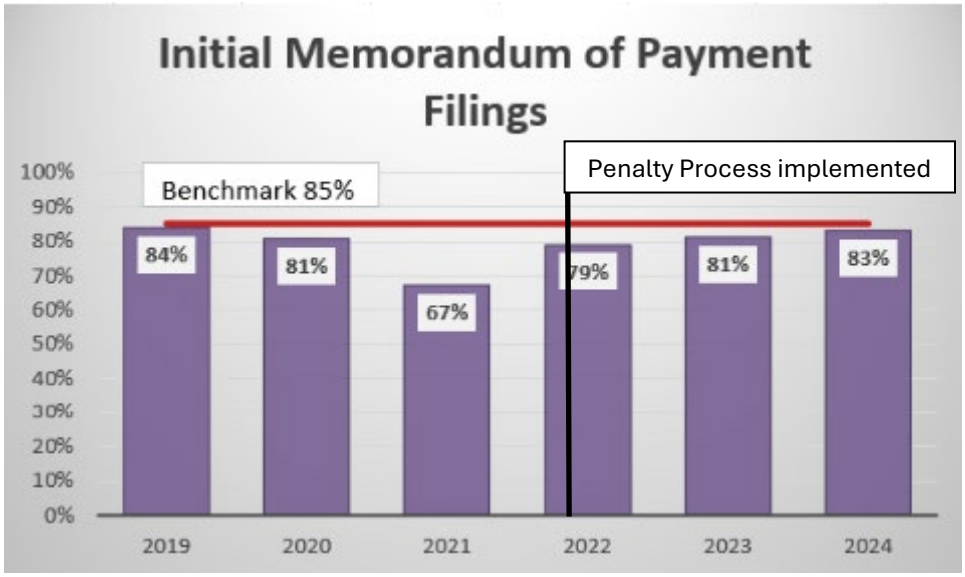
Initial Indemnity Payments

- Compliance with the Initial Indemnity Payment obligation occurs when an indemnity check is mailed within the later of: (a) 14 days after the employer's notice or knowledge of incapacity, or (b) the first day of compensability plus six days.
- The Board's benchmark for initial indemnity payments within 14 days is 87%.



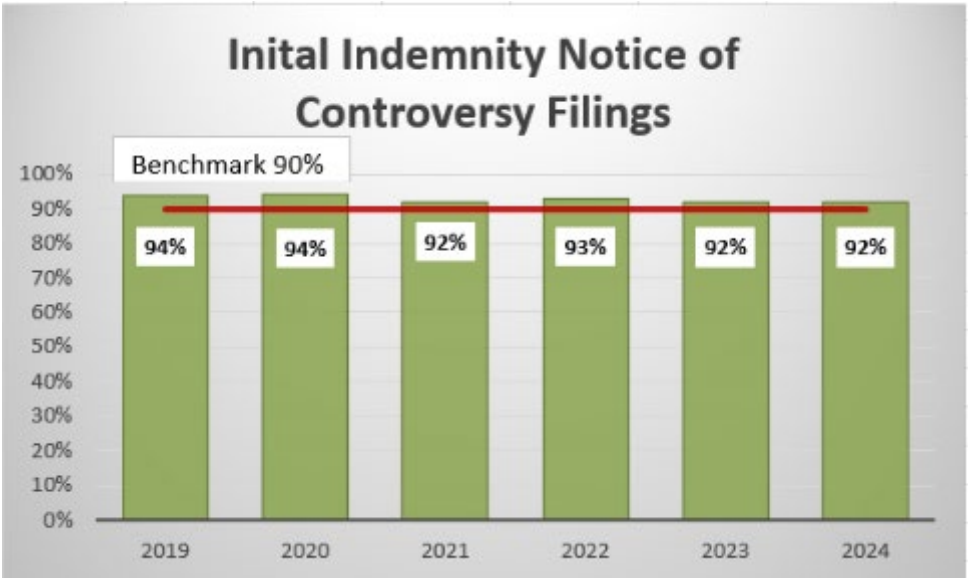
Initial Memorandum of Payment Filings

- Compliance with the Initial Memorandum of Payment (MOP) filing obligation occurs when the MOP is received within 17 days of the employer's notice or knowledge of incapacity.
- The Board's benchmark for Initial Memorandum of Payment filings within 17 days is 85%.



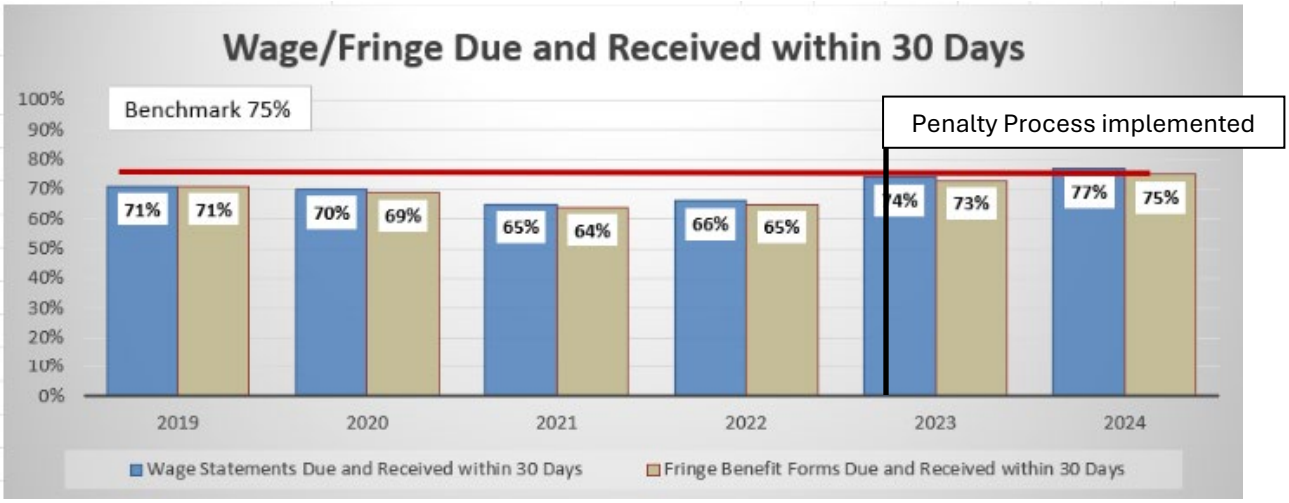
Initial Indemnity Notice of Controversy Filings

- Measurement excludes filings submitted with full denial reason codes 3A-3H (No Coverage).
- Compliance with the Initial Indemnity Notice of Controversy filing obligation occurs when the NOC is filed (accepted EDI transaction, with or without errors) within 14 days of the employer receiving notice or knowledge of the incapacity or death.
- The Board's benchmark for initial indemnity Notice of Controversy (NOC) filings within 14 days is 90%.



Wage Information

- Compliance with wage statements and fringe benefit worksheets is 30 days within notice/knowledge of a claim for compensation.
- The Board adopted a benchmark of 75% for these filings in latter 2019.



The work done by Monitoring, along with other departments at the Board, helps ensure that the Board has timely and accurate data. Monitoring is currently working to expand its program. First, instead of increasing or changing existing benchmarks, Monitoring is working on a process that will allow it to report upon accuracy and completeness of form filings, not just timeliness. Monitoring is also working to implement processes to track subsequent form filings. At this point in time, the Monitoring Unit only has the capacity to track initial required filings. The unit is looking at staffing as well as technological resources to assess when it will be able to implement these changes.

AUDIT

The Board conducts compliance audits of insurers, self-insurers and third-party administrators to ensure all obligations under the Workers' Compensation Act are met. The functions of the audit program include but are not limited to: ensuring that all Board reporting requirements are met, auditing the timeliness of benefit payments, auditing the accuracy of indemnity payments, evaluating claims-handling techniques, and determining whether claims are unreasonably contested. The Audit Division has historically conducted training events for insurers and employers, however due to staffing challenges those functions have moved over to Dispute Resolution Team (Troubleshooters and Mediators.)

The main effort of the Audit Division is conducting compliance audits. These audits are scheduled in advance and consist of a single Auditor from the Board conducting a desk audit of a random sample of claims. The Auditor then generates a report summarizing the findings of the examination and identifies any penalty exposure.

The priority of Audit is to conduct audits of as many claims as possible in order to foster a culture of compliance. The Audit Division currently only has three full-time staff members and this is following a significant period of time when it only had one. In the face of the staffing challenges encountered over past number of years, Audit has looked critically at its scheduling and sampling techniques to ensure that the highest number of claims are evaluated in the most efficient way possible. It has implemented three strategies during this period of transition:

The first is close cooperation with the Claims Management Unit to ensure that cases flagged for inaccuracies when filed are looked at quickly, rather than waiting for a random audit cycle.

The second is the creation of an audit schedule based on the number of claims each insurer adjusts in Maine. Formerly, the insurers all had a schedule that intended for every insurer to be audited every five years. Maine has large amount of insurance companies adjusting in Maine, many of whom only have one or two claims a year. Audit now looks at the insurers adjusting over 100 claims per year in Maine and seeks to audit those entities every three years, with the smaller market participants are still every five years.

The audit program also has a complaint process. When a formal complaint is received, the Board conducts an investigation to determine if the insurer, self-administered employer or third-party administrator violated 39-A M.R.S.A. §359 by engaging in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims and/or has violated §360(2) by committing a willful violation of the Act, committing fraud, or making intentional misrepresentations. The complainant also asks that the Board assess all applicable penalties. The incidence of these complaints has risen over the past ten years. In the past, it was common to get 10 complaints a year. Now, it is not unusual to receive that many in a month. Audit has also implemented procedures to track complaints for audit over time and evaluate possible claims handling issues from insurers that may warrant a deeper analysis from the Division.

ENFORCEMENT

The Board's Abuse Investigation Unit handles enforcement of the Workers' Compensation Act. The report of the Abuse Investigation Unit is discussed in a separate section of this report.

Office of Medical/Rehabilitation Services

Medical Fee Schedule

The goal of the Board's medical fee schedule is "to ensure appropriate limitations on the cost of health care services while maintaining broad access for employees to health care providers in the State." 39-A M.R.S.A. § 209-A(2).

To meet this goal, the fee schedule establishes maximum reimbursement levels for medical and ancillary services. Maximum reimbursement levels are determined based on a process that reflects the methodologies underlying the federal Centers for Medicare and Medicaid Services' ("CMS") inpatient, outpatient and professional services payment systems. In particular, the fee schedule uses procedure codes, relative weights or values (together "relative weights") and conversion factors or base rates (together "conversion factors") to establish maximum reimbursements.

The Act requires the Executive Director to annually update the fee schedule to ensure that procedure codes and relative weights are kept up-to-date. More comprehensive updates occur every three years. During this process, the Board considers whether or not the conversion factors need to be adjusted. No changes were made to the conversion factors when the last review was undertaken.

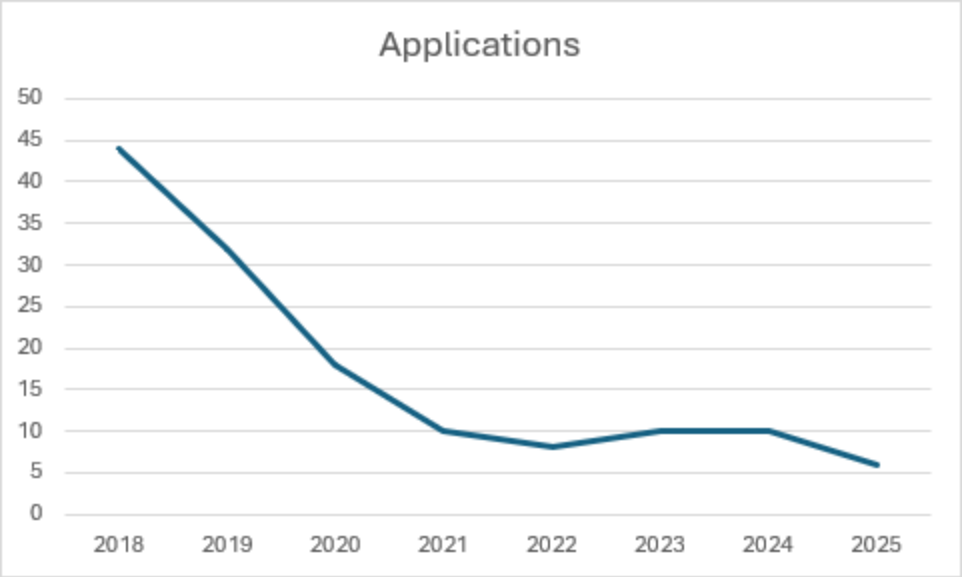
Medical Utilization Review

The Board does not currently have approved treatment guidelines.

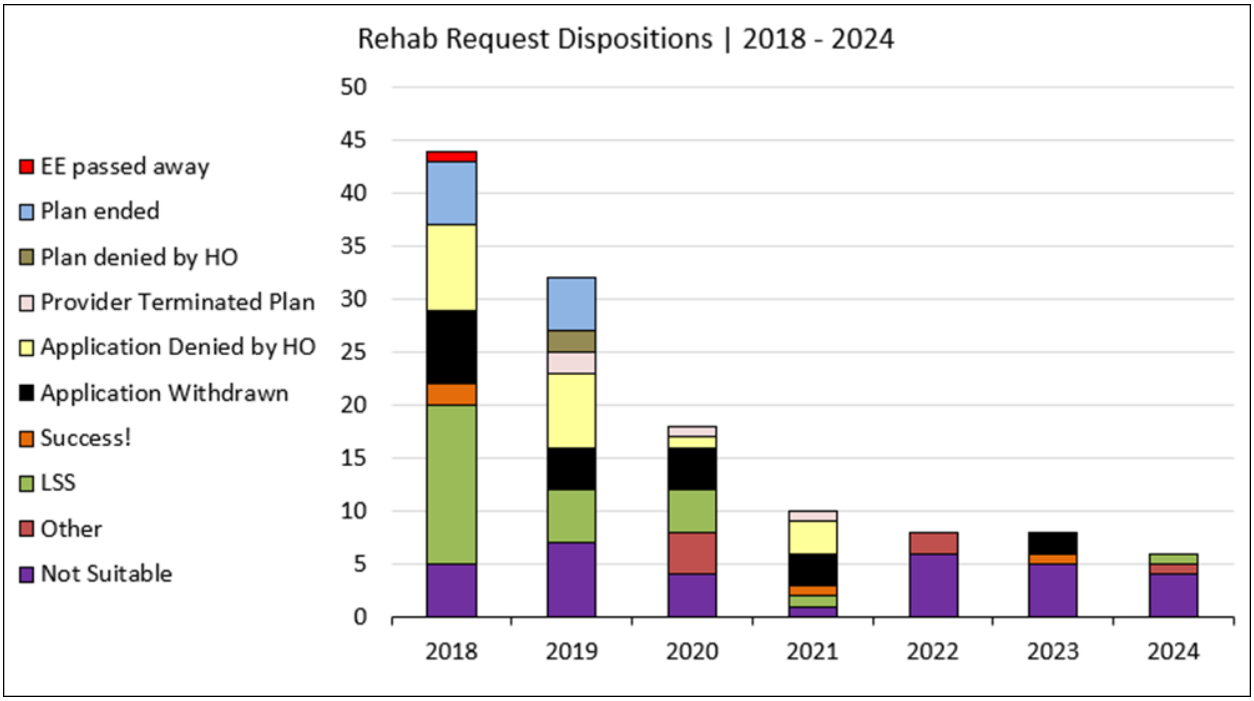
Employment Rehabilitation

At present, the Board has 2 approved employment rehabilitation providers pursuant to Title 39-A M.R.S.A. §217 and Board Rules Chapter 6. These rehabilitation professionals provide employment rehabilitation services, including retraining and job placement as reasonably necessary to restore the employee to suitable employment.

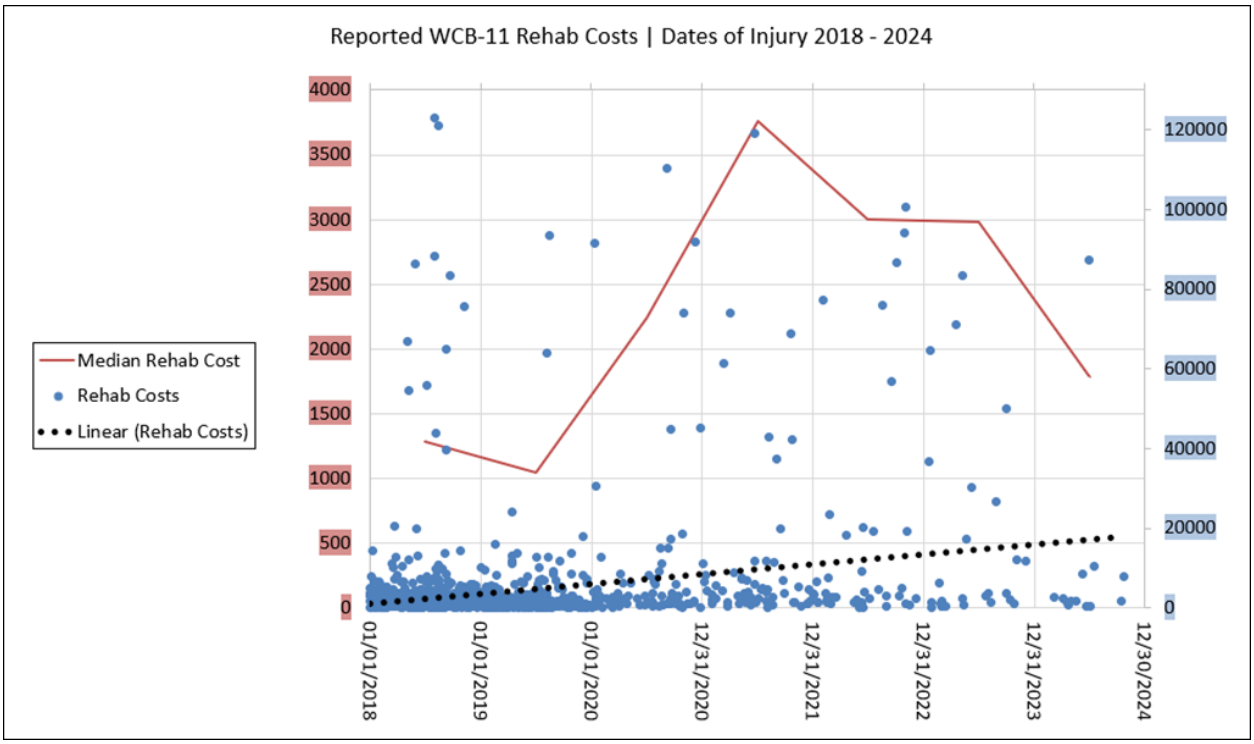
Over the last several years, the number of applications has steadily declined. In the last 3 years, the Board has received an average of 10 applications per year.



The following graph shows the disposition of employment rehabilitation applications broken down by year:



Statement of Compensation Paid forms filed by claim administrators include a field for rehabilitation costs. The following graph shows those reported costs over time:



In this graph,

The blue dots each represent the reported rehabilitation cost for a specific claim. There is a large grouping with small costs toward the beginning of the data (2018 to mid 2020) before the data became a little more dispersed. The dispersion means there is a lot of variation in the rehab costs, so, to determine a measure of central tendency, we must rely on the median.

The median is represented by the red line – Median rehabilitation costs rose sharply between 2020 and into 2023, where there was another sharp decrease. The fact that the median did not return to its 2018 level is an indication that costs, before adjusting for inflation, are increasing over time and not just fluctuating.

The dotted black line represents the "trend" of the blue dots, and is another indicator that costs are increasing over time. This trend must be viewed with caution because the data is highly distributed and there is a major skew in the data (meaning that there is a more data on one side of the "distribution").

INDEPENDENT MEDICAL EXAMINERS

At present, the Board has 12 independent medical examiners ("IMEs") appointed pursuant to Title 39-A M.R.S.A. §312 and Board Rules Chapter 4. IMEs render medical findings on the medical condition of an employee and related issues. Their reports carry a tremendous amount of weight; they are binding absent clear and convincing evidence to the contrary.

The following two charts show length of time it takes from the filing of a request for an IME to be appointed to the examination and how long it takes from the date of the examination for the report to be filed with the Board. By rule (Ch. 5, § 3(5)) reports are required to be filed within 14 days after completion of the exam. In 2021, the Board of Directors took a more active role in managing the IMEs and, as a result, timeliness of report submissions improved.

The following charts have data from calendar year 2023:

2023 Time from Request to Exam				
0-60 Days	**61-90 Days**	**91-120 Days**	**> 120 Days**	**TOTAL**
20	**55**	**64**	**88**	**227**
9%	**24%**	**28%**	**39%**	

2023 Time from Exam to Report					
0-14 Days	**15-21 Days**	**22-28 Days**	**29-60 Days**	**61+ Days**	**Total**
173	**22**	**10**	**9**	**13**	**227**
76%	**10%**	**4%**	**4%**	**6%**	

These charts have data from calendar year 2024:

2024 Time from Request to Exam				
0-60 Days	61-90 Days	91-120 Days	> 120 Days	Total
26	64	58	48	196
13%	33%	30%	24%	

2024 Time from Exam to Report					
0-14 Days	15-21 Days	22-28 Days	29-60 Days	61+ Days	Total
144	23	12	12	5	196
73%	12%	6%	6%	3%	

The current list of medical examiners can be found on the Board's website at the following address: https://www.maine.gov/wcb/Departments/omrs/ime.html.

Worker Advocate Program

INTRODUCTION

The Worker Advocate Program provides legal representation without cost to injured workers who pursue claims before the Workers' Compensation Board. In order for an injured worker to qualify for Advocate representation, the injury must have occurred on or after January 1, 1993; the worker must have participated in the Board's troubleshooter program; the worker must not have informally resolved the dispute; and, the worker must not have retained private legal counsel.

Traditional legal representation is the core of the program which has broad responsibilities to injured workers. Advocates attend mediations and hearings; conduct negotiations; act as information resources; advocate for and assist workers to return to work and obtain rehabilitation services; and communicate with insurers, employers and health care providers on behalf of injured workers.

HISTORY

As noted earlier, in 1992 the Maine Legislature re-wrote our Workers' Compensation Act (the "Act"). They repealed Title 39 and enacted Title 39-A. One of the most significant changes impacting injured workers was the elimination of the attorney fee "prevail" standard. Under Title 39, attorneys who represented injured workers were entitled to Board ordered fees from employers/insurers if they obtained benefits for their client greater than any offered by the employer, i.e., if they "prevailed." Now, under Title 39-A (effective for dates of injury on and after January 1, 1993), employers/insurers are no longer liable for legal fees. In addition, fees paid by injured workers to their attorneys are limited to a maximum of 30% of accrued benefits with settlement fees capped at 10% of the settlement amount.

These changes made it difficult in many instances for injured workers to obtain legal counsel unless they had serious injuries with substantial accrued benefits or a high average weekly wages. A significant number of injured workers did not have legal representation after this statutory change was enacted. This presented dramatic challenges for the administration of the workers' compensation system. In 1995, the scope of the problem prompted the Workers' Compensation Board of Directors to establish a pilot "Worker Advocate" program.

The pilot program was staffed by one non-attorney Advocate and was limited to the representation of injured workers through the mediation stage. Based on the pilot program's success, the Board expanded the program to five non-attorney Advocates, one for each regional office; however, representation remained limited to mediations. Ultimately, in recognition of both the difficulties facing unrepresented workers and the success of the pilot program, the Legislature in 1997 amended Title 39-A and formally created the Worker Advocate Program.

The 1997 legislation resulted in a substantial expansion of the existing operation. Most significantly, the new program required Advocates to provide representation at mediation and formal hearings. The additional responsibilities associated with this representation require greater skill and more work than previously required. Advocate responsibilities include, but are not limited to: depositions, representation at hearings, filing joint scheduling memorandums, filing motions, filing post-hearing position papers, working with complex medical reports, conducting settlement negotiations, and analyzing and understanding the Act, Board rules, and relevant case law.

THE CURRENT WORKER ADVOCATE PROGRAM

At present, the advocate program is staffed by 30 employees working in five regional offices. The program is required to represent all qualified employees who apply to the program. This contrasts with private attorneys who can choose their clients. The statute provides limited exceptions to this requirement. In addition to the case management authority outlined in the Act, the Board adopted a rule allowing advocates to cease representation in cases where injured workers refuse to respond to requests for meetings, and refuse to authorize relevant information be provided to opposing counsel and the Board. While not frequently used, in the situations when it does apply, it helps advocates better manage their caseloads and spend time more productively with employees who need assistance, and less time chasing uncooperative clients.

When the Board is notified of a dispute, a Claims Resolution Specialist (commonly referred to as a "troubleshooter") works to facilitate a voluntary resolution. If troubleshooting is unsuccessful, the Board determines if the employee qualifies for the assistance of the Advocate Program, and if so, a referral is made. As reported in the dispute resolution section of this report, if troubleshooting is unsuccessful, cases are forwarded to mediation. Prior to mediation, a meeting is held with the injured worker to explore the claim and review issues. The program also gathers information from health care providers and others. Representation of injured employees requires an explanation of the legal process and related issues such as the importance of medical evidence, work restrictions and the obligations to search for work in appropriate cases.

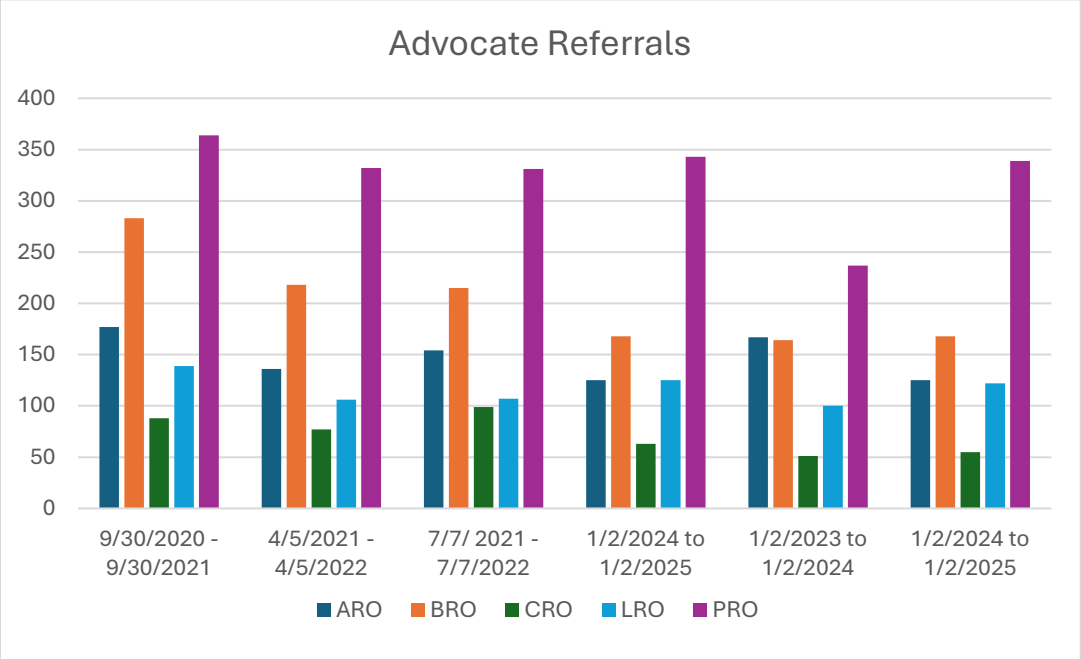
Cases not resolved at mediation can involve factually and/or legally complex disputes. These claims usually concern circumstances where facts are unclear or there are differing interpretations of the Act and case law. If a voluntary resolution of the dispute fails at the mediation stage, formal hearing is the next step in the process.

The hearing process is initiated when a petition is filed. Before a hearing, the parties exchange information through voluntary requests and formal discovery. Preparation for hearing involves filing and responding to motions, preparing the employee and other witnesses, preparation of exhibits, analysis of applicable law and review of medical and other evidence. At a hearing, Advocates, like any lawyer, must elicit direct and cross examination testimony from the witnesses, introduce exhibits, make objections and motions, and, at the conclusion of the evidence, file position papers that summarize the facts and credibly argue the law in the way most favorable to the injured worker. Along the way, the Advocates attend depositions of medical providers, private investigators, and labor market experts. Eventually, a decision is

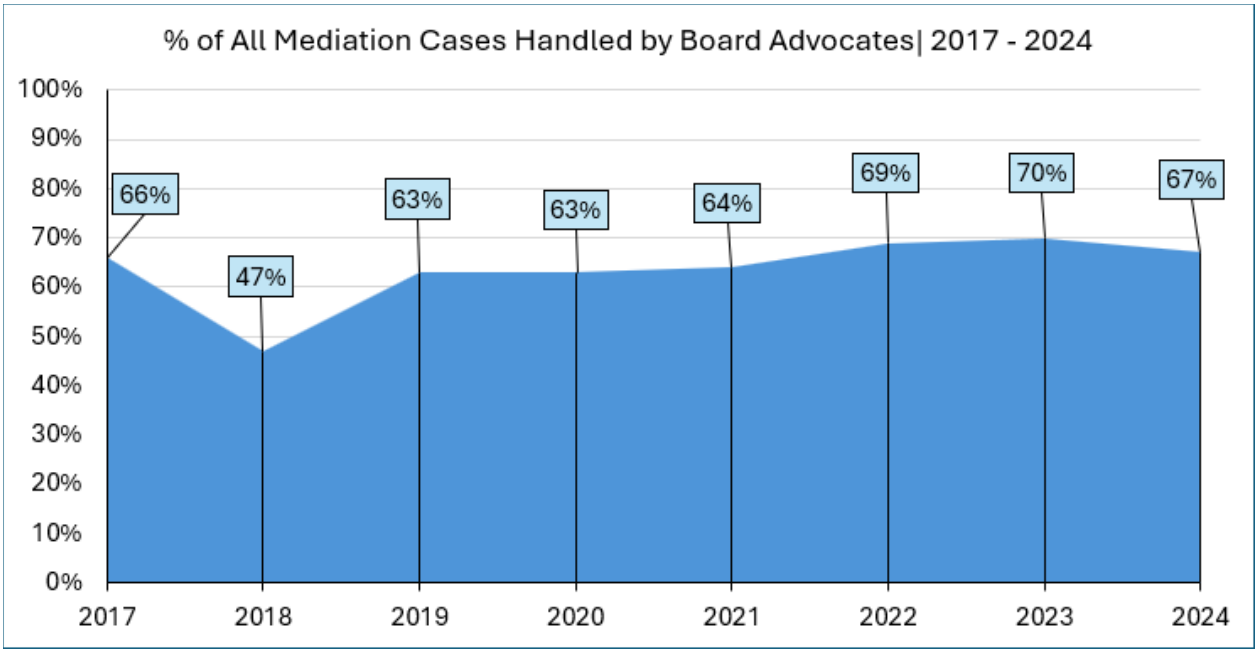
issued, or the parties agree on either a voluntary resolution of the issues or a final lump sum settlement.

CASELOAD STATISTICS

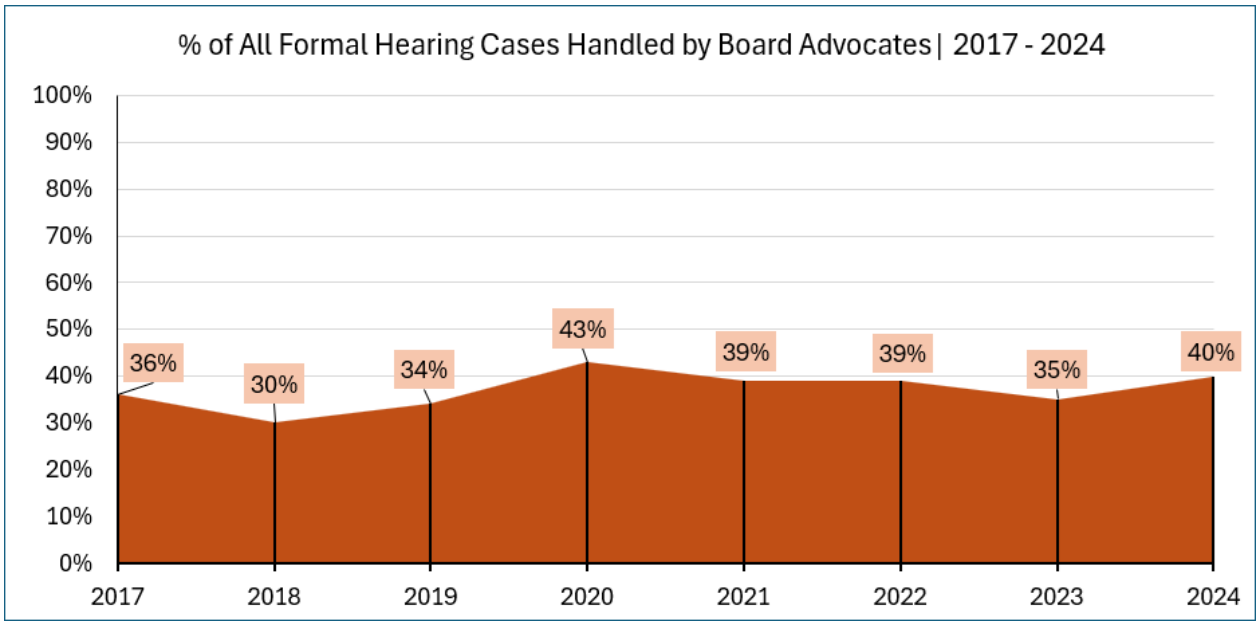
Injured workers in Maine make substantial use of the Advocate Program. The following chart shows referrals per regional office from September, 2020 through January, 2025.



Advocates represented injured workers at approximately 67% of the mediations held in 2024. The following table reflects the number of Advocate cases mediated from 2015 through 2024.



The Advocate Program represented injured workers in approximately 40% of all Board formal hearings in 2024. The following table shows the percentage of cases handled by Advocates at formal hearing from 2017 through 2024.



SUMMARY

The Advocate Program was created to meet a significant need in the administration of the workers' compensation system. Over the years, the Program has provided much-needed assistance to Maine's injured workers with limited resources. These services are provided to people in unfamiliar and sometimes desperate circumstances. In the years since its inception, the size of the plaintiff bar has shrunk. The Board is monitoring this situation because the Advocate Division is not equipped to absorb cases currently handled by private attorneys.

Recently, the program has struggled with challenges related to recruitment and retention. Turnover results in vacancies, of course, but even after newly hired advocates and paralegals are hired, months of training are required before they can independently maintain their own caseloads. This has contributed to significant backlogs of claims in some of our offices. The program is focused on eliminating this backlog.

Information Management

Introduction and Program Description

The Board's Information Management (IM) Department is the agency's technology backbone. The IM Department is responsible for ensuring data integrity, system availability, legislative compliance, and operational efficiency across all divisions. The department is staffed by a Deputy Director who oversees day-to-day operations and serves as the primary liaison with the Maine Office of Information Technology (MaineIT). The Deputy Director also directs the work of two management analysts employed by the Board as well as two full-time MaineIT programmers dedicated exclusively to the Board.

The IM Department has five core areas of responsibility:

1. **Electronic Data Interchange (EDI) Oversight:** The IM Department manages the EDI process for receiving First Reports of Injury (FROI), Notices of Controversy (NOC) and Proof of Coverage (POC) transactions. This includes ensuring all data edits are up-to-date and functioning correctly to ensure data integrity, maintaining updated trading partner profiles, conducting testing with new EDI senders, and promptly responding to all EDI-related inquiries.

2. **Agency Liaison with MaineIT:** The IM Department is the conduit between the Board and MaineIT for essential IT support services. These include: New, transferring, and departing user requests (computer deployment/collection, Active Directory account creation/deletion); management of Voice over Internet Protocol (VoIP) telephones; and, processing of general software and hardware requests. The department also spearheads troubleshooting efforts and ensures compliance with state-mandated security expectations.

3. **System Modernization and Maintenance:** The department facilitates smooth transitions during significant technology upgrades, such as the agency-wide deployment of Windows 11 and ongoing server migrations.

4. **Reporting and Data Analysis:** The IM Department produces a wide range of essential reports. Some of these reports are essential for the work of the Board of Directors as it monitors how Maine's workers' compensation system is functioning. Other reports are used by managers who receive either weekly or monthly management reports. The department also helps fulfill Freedom of Access Act (FOAA) requests and provides analysis, summaries, charts, and graphs for all data sets as needed.

5. **Software Administration & Development:** The department administers the primary software applications utilized by the Board:

    - ***Progress***: The main application that houses all claim information, insurance coverage data, the employer database, abuse investigation unit cases, and assessment data. Programmers are continuously tasked with improving its functionality, conducting routine database administration tasks (security patches, software upgrades, server

migration), and ensuring ADA compliance. The department currently manages a backlog of approximately 130 user-requested programming enhancements and fixes for this system.

- ***Practice Master***: The case management software utilized specifically by the agency's Advocate Division.

- **Other Products:** Administration extends to tools such as Microsoft Office, dtSearch, CorVu, Adobe Acrobat, Adobe Dreamweaver, and Visio.

Established Priorities, Goals, and Objectives

Since 2019, the IM Department has made great strides in improving the Board's data collection processes. The department established five key priorities with measurable goals and objectives designed to support the Board's mission of efficient and accurate administration.

Priority	Goal	Objectives in Meeting Goal
1. EDI Filings	Ensure the smooth, accurate, and timely electronic processing of all incoming data transactions.	Every transaction received through the EDI system must be date-stamped on the same day it is received. Maintain 24/7 monitoring of the secure file transfer protocol (FTP) program (MoveIT) to prevent system failures.
2. Hardware & IT Support	Ensure all technology needs of agency staff are met promptly and consistently.	Establish and enforce Standard Operating Procedures (SOPs) for managers and IM staff to ensure prompt delivery of hardware and software for all staff. Secure timely return of equipment from departing staff.
3. Software & Security	Ensure all agency software needs are met, kept updated, and in compliance with MaineIT security requirements.	Provide staff with all necessary software tools within one week of their start date. Complete all MaineIT-required software updates within their established deadlines. Research and assess replacement or upgraded software, implementing within one month of receiving necessary licenses.
4. Reports & Data Integrity	Provide comprehensive, accurate, and timely data reports for the Board and managers.	Rerun of existing reports should be completed and returned within 24 hours of due date. Newly created, non-complex reports should be delivered

		within 48 hours. Newly created complex reports should be delivered within one week.
5. Programming & Development	Work with departments to analyze, processes and implement programming changes that ensure work is performed as efficiently as possible and complies with new laws/rules.	Organize, manage, and prioritize programming requests. Ensure application servers meet MaineIT standards. Perform security patching within 30 days of patch release. Complete at least 50 user-submitted programming requests per year.

Performance Measures and Benchmarks

The WCB utilized specific quantitative and qualitative benchmarks to measure the IM Department's progress against its established goals:

- **EDI Filings:** The benchmark is a 100% same-day date stamp rate for all received transactions. The secondary benchmark is rapid response and resolution for any FTP system issues.

- **Hardware:** The primary measure is the successful implementation of new electronic communication procedures to minimize delays. The quantitative benchmark is maintaining tracking sheets to monitor timely equipment delivery (within one week of start date) and collection.

- **Software:** The key benchmark is **a 100% compliance rate** on MaineIT-mandated update deadlines. A secondary benchmark is the one-week deadline for provisioning software to new staff.

- **Reports:** Defined benchmarks for report delivery: 24 hours (reruns), 48 hours (new non-complex), and 7 days (new complex).

- **Programming:** The benchmark is completing a minimum of 50 user-submitted programming requests (tickets) annually. Other measures include 100% adherence to server standards and a 30-day window for applying security patches.

Assessment of Goal Achievement

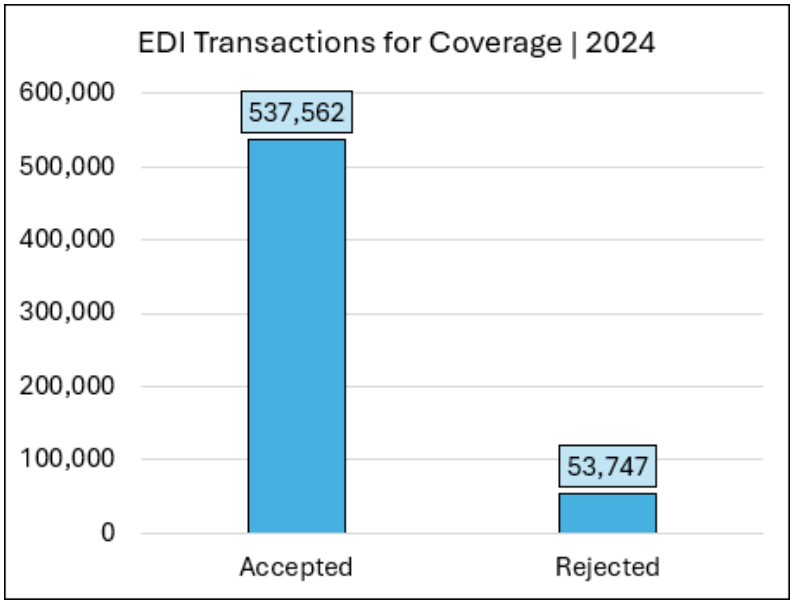
The Information Management Department has made tremendous progress since 2019. The following sections provide more detail and point out one area where progress did not meet our goals.

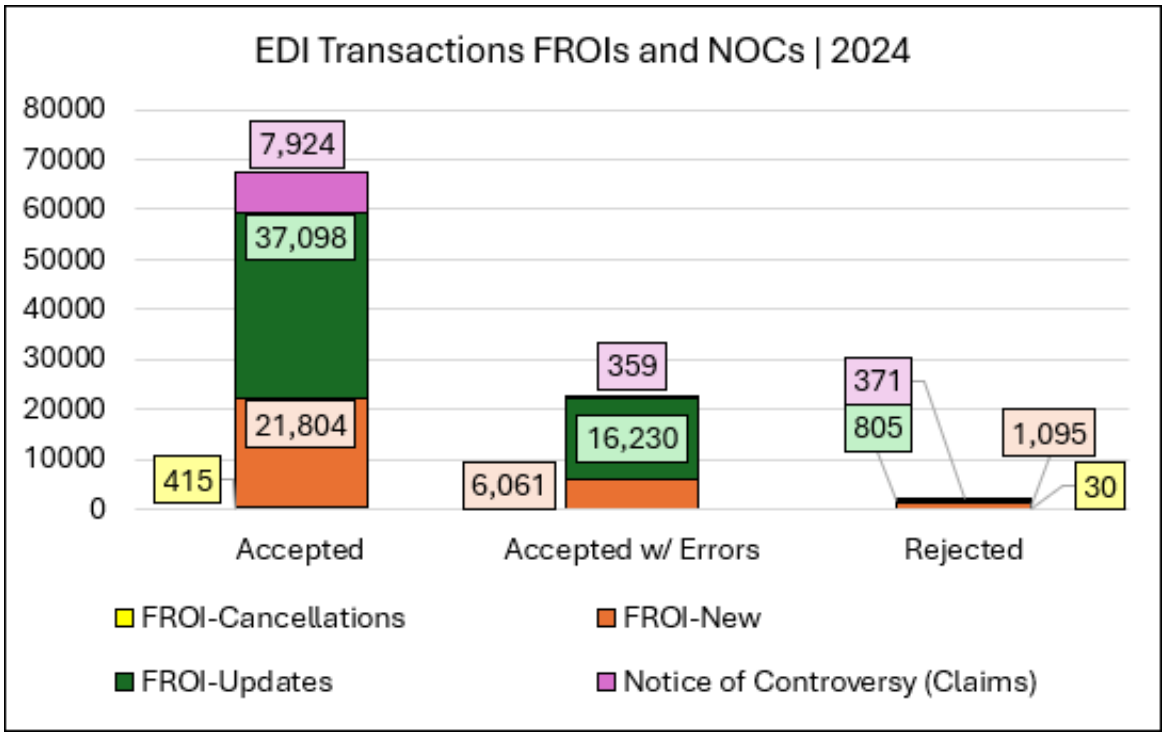
EDI Filings

The department successfully achieved its goal for the timely processing of electronic data. 100% of all EDI transactions received were date-stamped on the day they were received. This critical

metric demonstrates the robustness of the system and the effectiveness of the 24/7 monitoring protocol. While a handful of incidents involving the FTP site occurred, they were all addressed and fixed within the same day of occurrence, preventing any reporting delays.

The volume of transactions processed in 2024 is detailed below:





Hardware and Software

The department met its goals for hardware provisioning and software compliance through enhanced process management:

- **Hardware:** The implementation of electronic forms and a PowerApps-based flow for communicating information about new, transferring, or departing employees greatly improved internal communication and timeliness. The tracking sheet system proved effective, enabling the IM team to process requests for 11 new/transferring employees, 16 departing employees, and 14 computer returns/replacements efficiently.

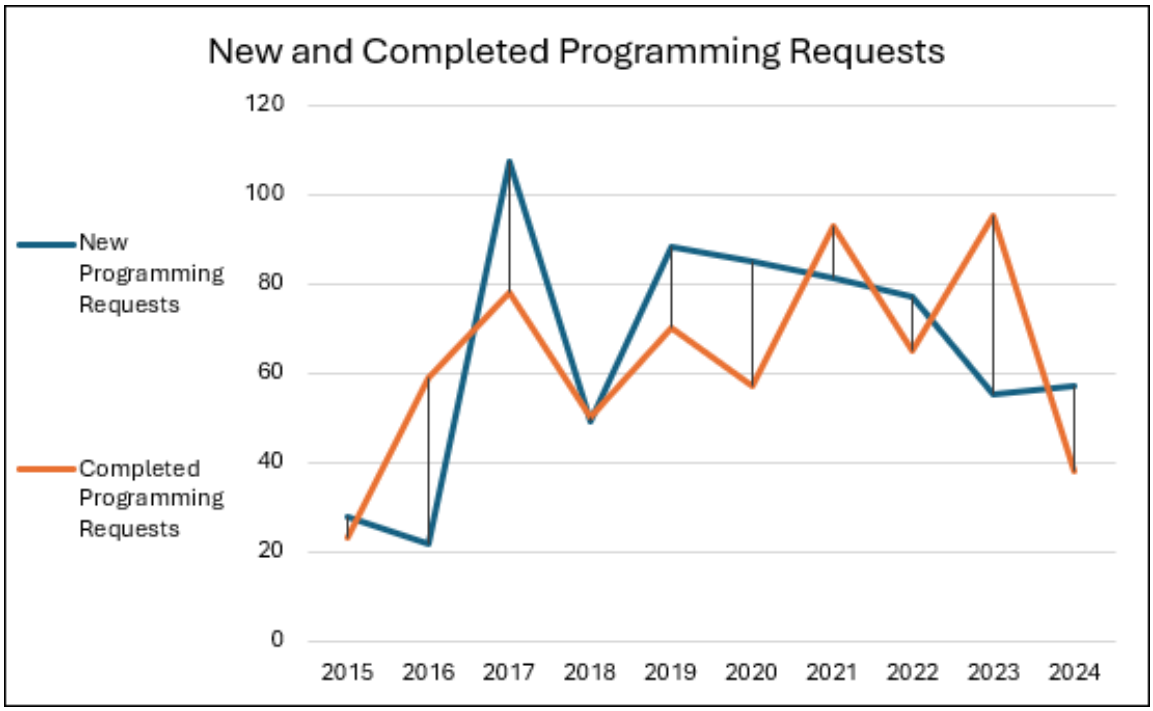
- **Software:** New staff were consistently provided with necessary software tools within the one-week benchmark. The department also maintained a 100% compliance rate for completing all MaineIT-required updates within specified timeframes, thereby meeting all security and maintenance objectives. A significant modernization achievement was the upgrade of the hearing recording software and equipment, which now allows for hybrid hearings and video recordings. The move of recording storage to a SharePoint site has streamlined the sharing process with transcriptionists and external requestors, replacing a previously time-consuming method.

Reports

The department met its reporting goals, consistently providing accurate and timely data essential for agency operations and legislative support. The department regularly runs 21 weekly, 36 monthly, and 7 quarterly reports, in addition to successfully fulfilling numerous new ad-hoc requests each month, adhering to the established 24-hour, 48-hour, and one-week benchmarks based on report complexity.

Programming and Development

The programming goal of completing at least 50 user-submitted programming requests per year was not met in 2024. Only 38 tickets were completed, missing the annual benchmark.



The primary reason for missing the 50-ticket benchmark was the mandatory RHEL9 server upgrade for the Board's main application, Progress, required by MaineIT. This project demanded the full-time attention of one of the two dedicated programmers for a significant portion of the year due to the tight security protocols required by MaineIT. This necessary, compliance-driven modernization project took priority over routine user-requested enhancements, effectively reducing the available development workforce by 50%. Despite this constraint, the one available programmer continued to complete complex and impactful projects, including several key upgrades to payment data entry screens.

Projects completed in prior years include a multi-year effort that reconstructed the employer database, creation of a file purge process for both abuse and injured worker claims, and enabling direct employer record creation from proof of coverage transactions.

The corrective measure is a renewed focus on user-submitted requests now that the server migration is complete. The IM Department will prioritize the reduction of the existing backlog of approximately 130 user requests while maintaining its commitment to security patching and essential system maintenance.

Conclusion

The Information Management Department is an integral part of the Board's operations. The IM Department ensures that the Board's employees have a secure, stable, and functioning technology infrastructure. The Department's employees have been especially successful with respect to improving the Board's data collection and management practices. Their work enables the Board to understand how Maine's workers' compensation system is operating. In addition,

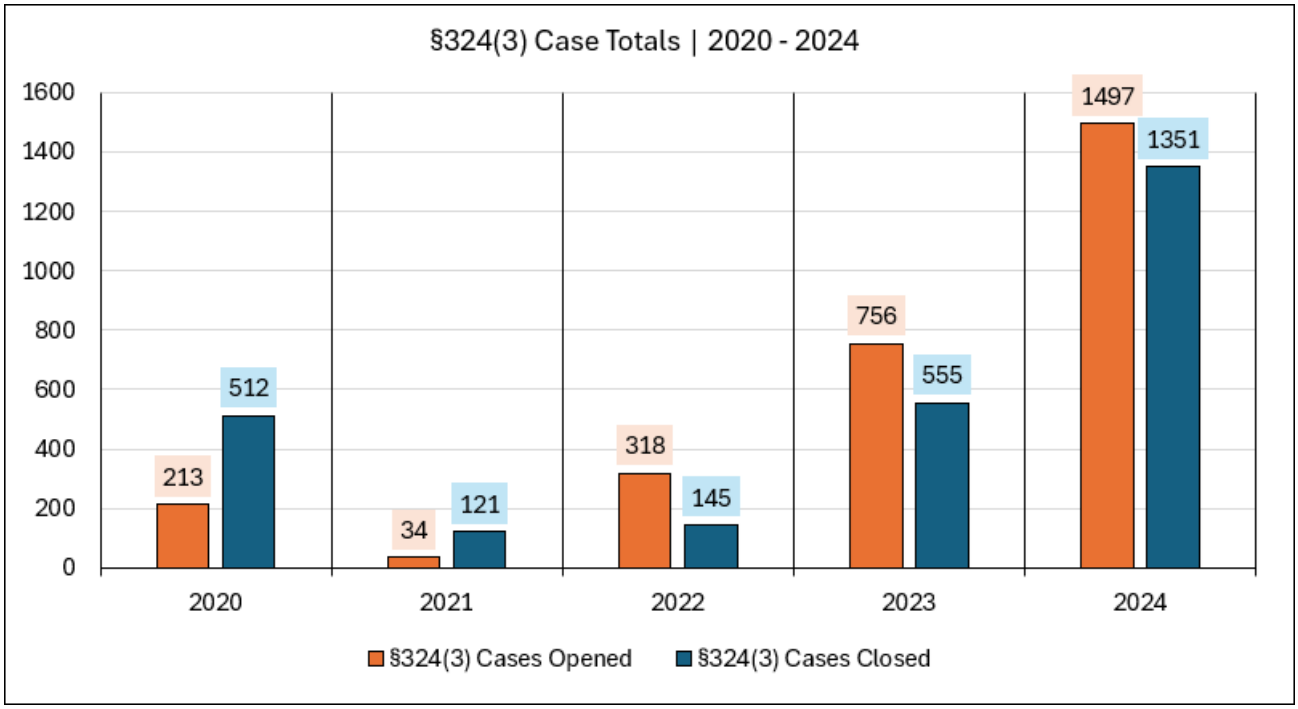
the Board's managers can more efficiently do their jobs because of the management reports created and produced by the IM Department.

Abuse Investigation Unit

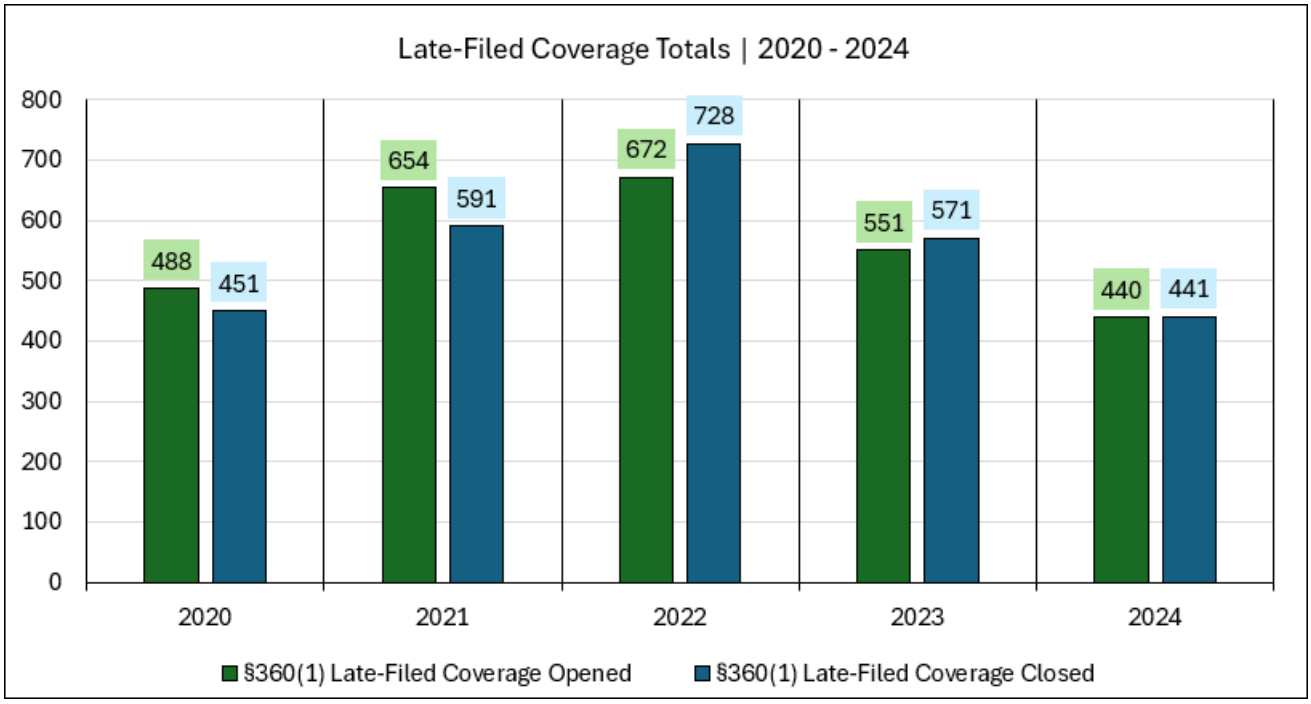
The Abuse Investigation Unit (AIU) is responsible for enforcing the administrative penalty provisions of the Workers' Compensation Act (Act). The AIU investigates allegations of fraud, illegal or improper conduct, and violations associated with mandatory filings, payments and insurance coverage. The Unit has six (6) professional staff and is supervised by the Board's Deputy General Counsel. AIU personnel conduct investigations, file complaints and petitions, represent the Board at administrative penalty hearings, and decide penalty cases.

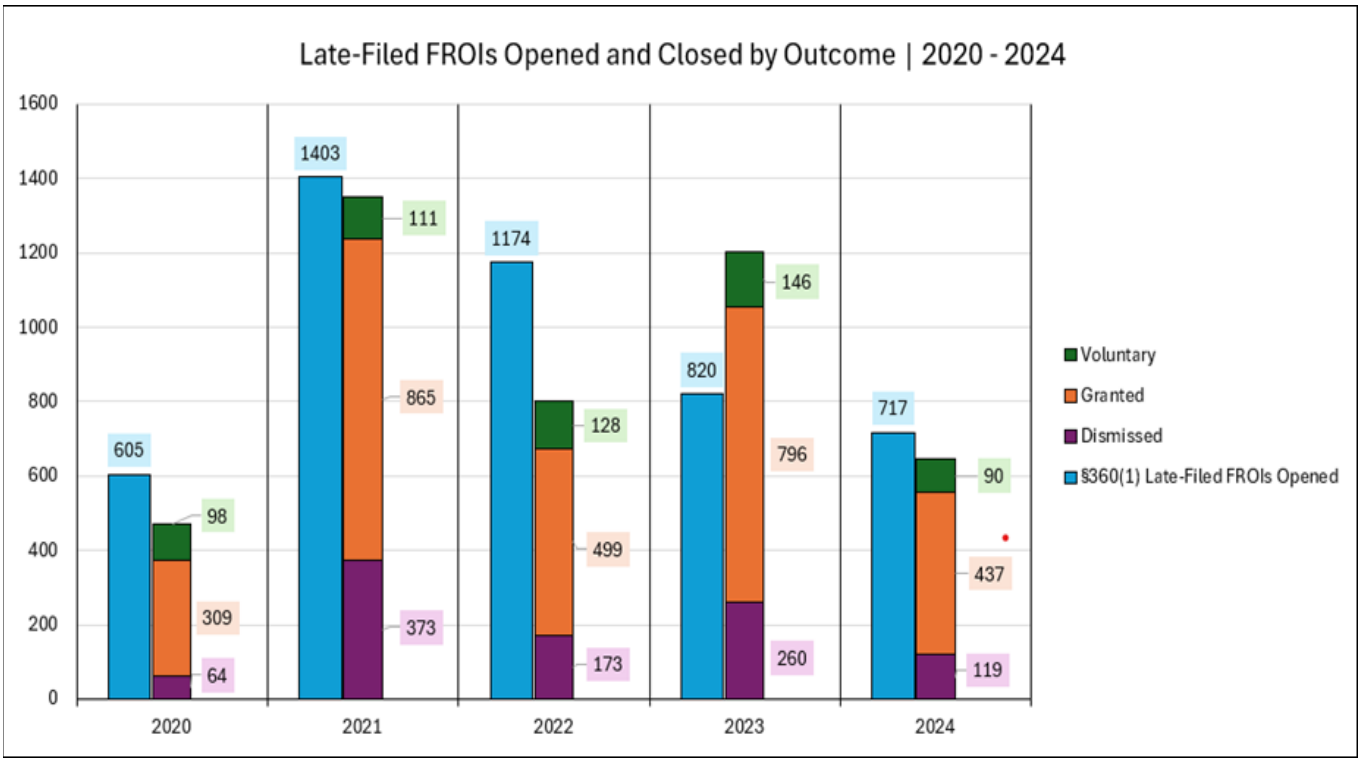
AIU staff are also responsible for managing billing and penalty payments, and for initiating collection with Maine Revenue Services and the Attorney General's office through civil and criminal actions. As part of this work, the AIU is responsible for complying with requirements established by the Department of Administrative and Financial Services, and the Office of the State Controller.

Pursuant to Section 324(3), the AIU investigates and pursues legal actions against employers that fail to procure statutorily required workers' compensation insurance for their employees. Members of the AIU staff represent the Unit in administrative penalty hearings and, when possible, negotiate consent agreements that resolve alleged violations. The Unit is also responsible for defending appeals of "coverage" penalty decisions to the Board's Appellate Division.



The AIU also pursues penalties for failing to provide timely proof of coverage and for failing to timely file First Reports of Injury.


Late-Filed Coverage Totals | 2020 - 2024
800
700
600
500
400
300
200
100
0
488
451
654
591
672
728
551
571
440
441
2020
2021
2022
2023
2024
§360(1) Late-Filed Coverage Opened
§360(1) Late-Filed Coverage Closed


Late-Filed FROIs Opened and Closed by Outcome | 2020 - 2024
1600
1400
1200
1000
800
600
400
200
0
605
98
309
64
1403
111
865
373
1174
128
499
173
820
146
796
260
717
90
437
119
2020
2021
2022
2023
2024
Voluntary
Granted
Dismissed
§360(1) Late-Filed FROIs Opened

The AIU coordinates its work with the Board's Coverage Unit and with the Monitoring, Audit and Enforcement Program (MAE). The AIU represents the Audit department to collect penalties for contested claims violations that are identified in audits. It coordinates with the Monitoring Unit to collect penalties charged to insurers for late-filed Wage Statements and Memorandum of Payments. AIU staff also assist the Board's Claims Management Unit by investigating improperly filed forms and filing penalty actions against insurers to curb filing violations. The AIU works with the Attorney General's office to enforce subpoenas, and to identify and refer cases for criminal prosecutions against employees and employers who have committed egregious or repeated violations of the Workers' Compensation Act. The AIU also collaborates with OSHA to ensure that employers within OSHA's jurisdiction have proper workers' compensation insurance coverage.

Ensuring sure that employers secure required workers' compensation coverage for their employees is a fundamental to the mission of serving employees and employers fairly and expeditiously. In addition to the work described above, the AIU also evaluates provisions in other jurisdictions, such as contractor-under liability and programs/funds for uninsured employees, to see if there are other strategies that will help achieve the goal of ensuring employees are eligible to receive workers' compensation benefits to which they are entitled.

Claims Management Unit

Introduction

The Claims Management Unit's ("CMU") work supports all of the Board's operations. The CMU processes and enters information in individual cases. The unit's primary responsibilities include maintaining a physical file room containing approximately 100,000 claim files and processing all incoming claims filings. CMU's employees file new documents, pull files for regional offices, purge files pursuant to the Board's records retention policy, and create new files when initial Notices of Controversy (NOCs), payment forms, and/or petitions are received. Claims filings include: First Reports of Injury (FROIs) which are received via Electronic Data Interchange (EDI). Manual intervention is only required when data discrepancies arise. NOCs are also received via EDI. These filings require CMU staff to pull or create physical files so they can be sent to regional offices where dispute resolution takes place. Payment documents are not received via EDI. Instead, they are, largely, received via e-mail. Information from these forms must be manually entered into the Board's database by CMU staff. These forms must also be printed so they can be added to the Board's physical files. Finally, staff enter into the database petitions and answers to petitions before sending the physical file to a regional office for dispute resolution.

Goals and Objectives

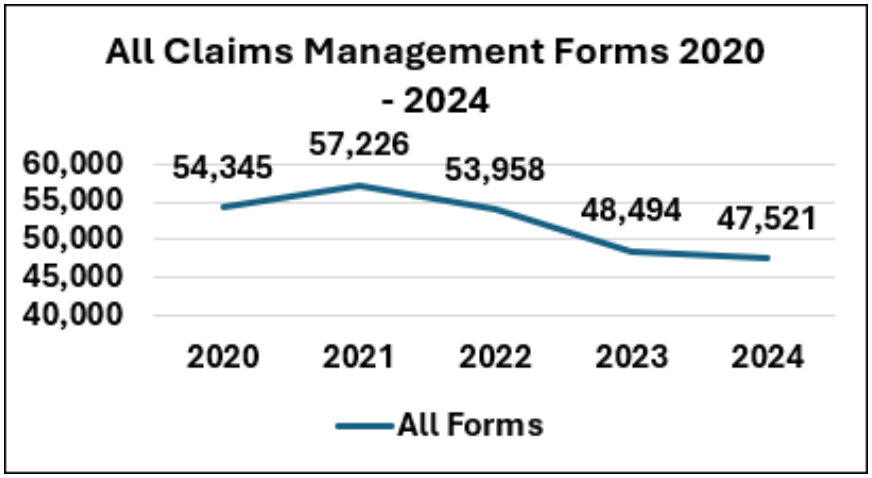
The unit's key objectives are centered on efficiency, accuracy, and communication.

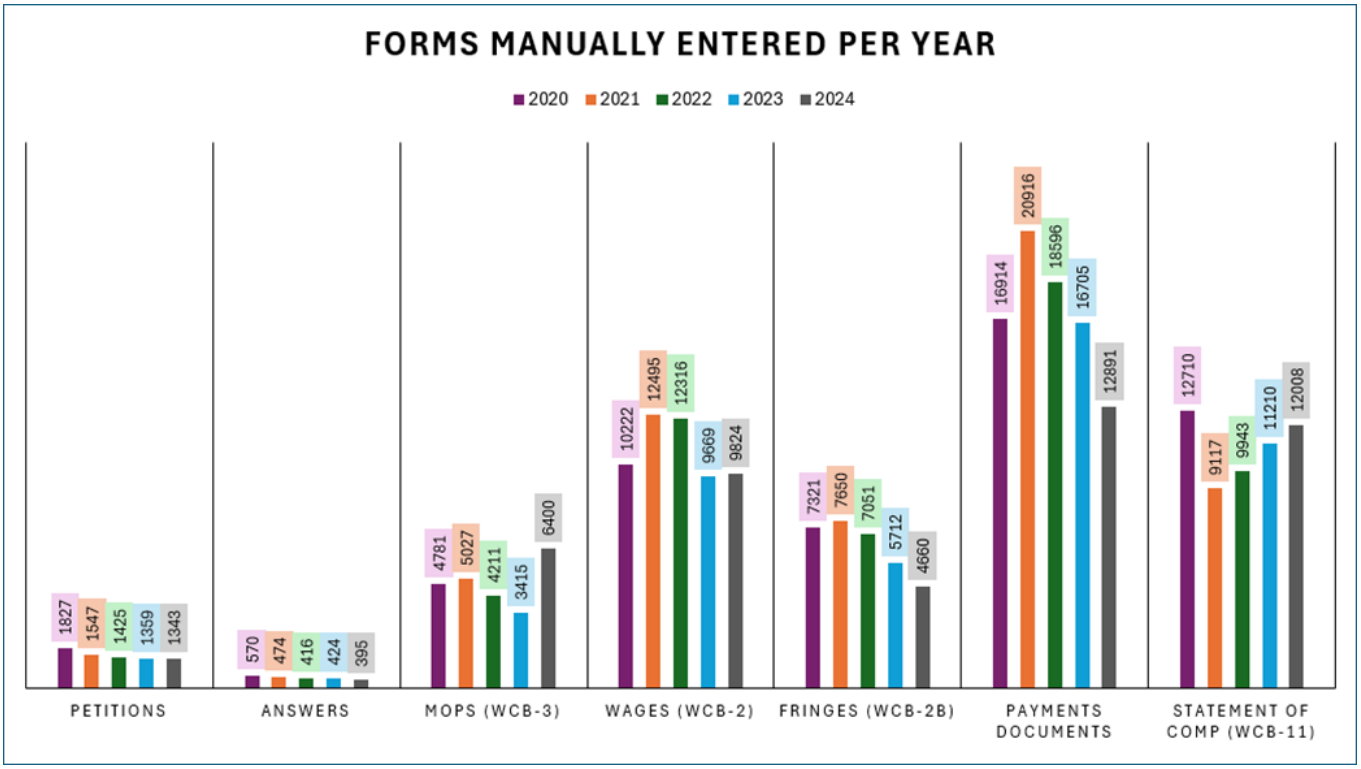
- **Timely Processing:** The unit strives to process all forms and data entry within one week of receipt to prevent backlogs.
- **Thorough Analysis:** Staff are expected to thoroughly analyze all incoming information to ensure compliance with Workers' Compensation Board (WCB) rules and laws.
- **Timely Feedback:** The unit aims to provide feedback on erroneous forms to claim administrators no more than one month after the form is received.
- **Timely Revisions:** The unit expects claim administrators to submit revisions on corrected forms within 14 days of receiving an error report.

Performance Measures and Benchmarks

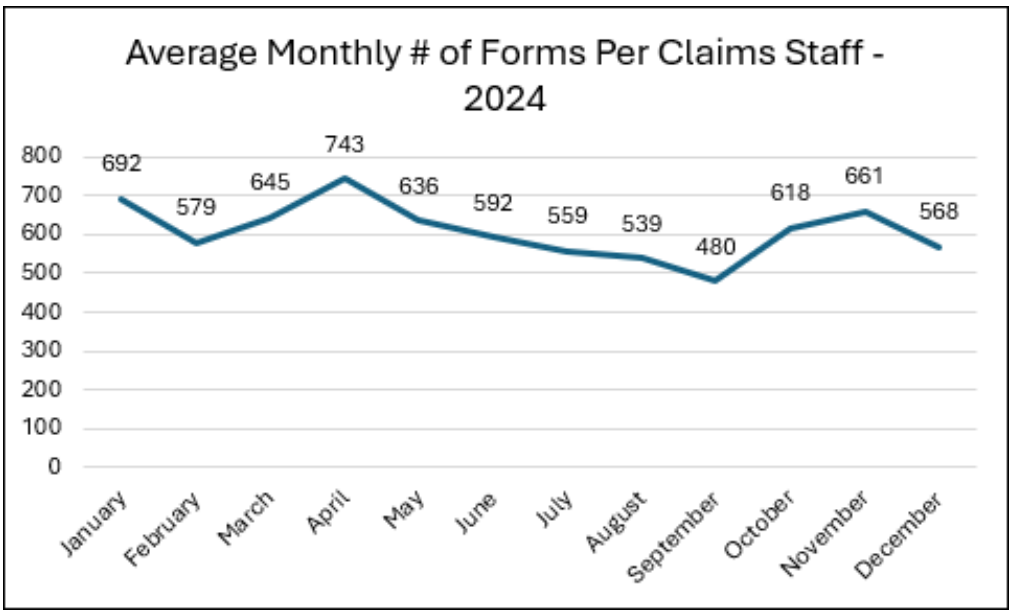
Establishing clear performance benchmarks for the unit's data entry is complex due to the varied nature of the work. The time required for data entry fluctuates based on the type of form and whether it requires error checking, research, or cross-referencing with other filings. Staff experience is a significant factor, with seasoned employees entering a significantly higher volume of forms than new hires.

The following charts show how many new and revised forms were manually entered each year from 2020-2024, with the second chart showing a breakdown by form type.





To further illustrate the workload, the following chart shows the average number of forms each staff person would be expected to enter each month in 2024, if it was possible to distribute the workload evenly.



To monitor progress, the unit's manager reviews weekly reports detailing the number of forms entered by each staff member. Staff also provide a monthly report on the number of unentered forms they possess and their current backlog. Based on this information, workloads are rebalanced as needed.

Due to the sheer volume of work, a formal measurement for the thoroughness of form analysis does not exist. Instead, management conducts weekly spot-checks of staff work and provides feedback as required. Standard operating procedures (SOPs) are frequently updated to reflect new scenarios, but continuous training and spot-checking remain the primary methods for ensuring quality. Timely feedback to claim administrators is now managed through reports sent on a rotating four-week schedule, a new process that began in July 2025. This replaced the previous time-consuming method of emailing administrators for each error.

Data Clean-up Project

In addition to the above, the CMU continued work on a large data clean up project in 2025. This on-going project is necessary to ensure that data in the Board's system is consistent from year-to-year.

Assessment of Goal Achievement

The Claims Management Unit has implemented several major changes to improve efficiency. These include revising board forms to reduce confusion, updating the database to match paper forms, programming new functionality for coding form quality, rewriting SOPs, and adding a new position to facilitate error reports. A key priority is also improving staff retention, as

turnover significantly hinders the unit's operations and productivity. Historically, the unit has not been able to function without assistance from staff in other departments to help with data entry and form work, and this remains the case today.

While significant progress has been made, the unit has not yet fully achieved all of its goals:

- **Timely Processing:** While the goal of processing forms within one week is being approached, a backlog remains. Data entry is currently closer to a two-week turnaround as the unit works through outstanding issues.
- **Thorough Analysis:** This remains a work in progress. Management continues to review and improve SOPs while providing regular training and weekly spot-checks to reinforce quality.
- **Timely Feedback:** The new reporting system for providing feedback to claim administrators is successfully achieving its goal.
- **Timely Revisions:** It is still too early to measure the responsiveness of claim administrators to the new reporting system. However, initial feedback and cooperation have been prompt, with administrators working diligently to clear their error reports.

Conclusion

The Claims Management Unit is actively using its available resources to improve efficiency and workflow. However, the unit is ultimately limited by its reliance on paper files and manual processes. The most impactful changes would involve a broader modernization effort, such as migrating to a paperless system and implementing an electronic process for payment forms, contingent on available funding,

Insurance Coverage Unit

The Workers' Compensation Act and Board rules require insurance companies to file, on behalf of employers (their insureds), proof of coverage. Coverage information is submitted to the Board electronically. The Insurance Coverage Unit is responsible for ensuring that filings are accurate and up-to-date. While the majority of filings submitted electronically are accurate when submitted, approximately 10% of these filings have errors that require staff in the Unit to make corrections and/or contact the insurance company for more information. This creates a considerable amount of work in light of the volume of filings received at the Board, as the next chart shows:

Coverage	2024 Avg	2023 Avg	2022 Avg	2021 Avg	2020 Avg	2019 Avg
POC EDI Transactions	**61,200**	**59,830**	**56,900**	**55,151**	**51,701**	**50,532**
Independent Contractor Statements submitted	**6,661**	**5,269**	**5,224**	**5,169**	**5,087**	**5,856**
Waivers Added	**564**	**558**	**522**	**587**	**797**	**1,080**
Immunities Added	**745**	**295**	**90**	**12**	**451**	**1,584**
No Coverage letters sent	**4,781**	**2,010**	**1,111**	**0**	**1,229**	**5,904**

The Insurance Coverage Unit also contacts employers that appear to have had a lapse in coverage. As the above chart shows, in 2024, 4,781 letters were sent to employers that the Board's records indicated did not have required coverage. (Letters were sent in 2021 due to the pandemic.) In response to these letters, the Unit receives and responds to phone calls and, when possible, resolves any issues.
Recent changes to the Unit's processes have brought a more concentrated focus on the reason an employer no longer has coverage. This has resulted in the Unit reaching more employers who are not properly insuring their employees and fewer employers who dropped their coverage for appropriate legal reasons.

The Unit also processes applications to waive the workers' compensation coverage requirement. Individuals who can waive coverage include owners of 20% of a corporation's outstanding voting stock, along with certain family members and family members of sole proprietors, partners and members of limited liability corporations. (Different provisions apply to the wood harvesting industry.) This process includes maintaining waiver records and rescinding waivers when applicants no longer meet the statutory requirements.

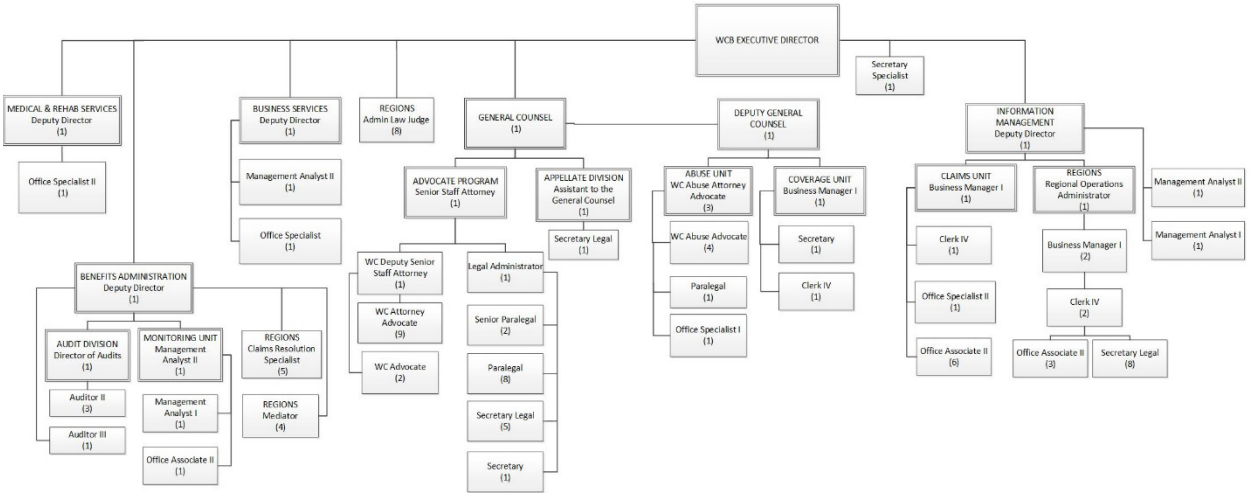
The Unit provides information to insurers, employers, insurance adjusters and the public on insurance coverage requirements. Staff matches insurance coverage to employers, updates employer records, and researches the history of an employer's insurance coverage when there is a question as to which insurer is liable for paying benefits.

The Coverage staff works closely with the Abuse Investigation Unit (AIU) on problems associated with coverage enforcement. The Units meet regularly which makes it easier to spot

developing trends and issues. The Unit also coordinates with the MAE program to identify carriers and self-insureds who consistently fail to file required information in a timely manner. They also assist the Bureau of Labor Standards in maintaining an accurate, up-to-date employer database utilized by both agencies.

Organizational Structure, Position Count, Job Classifications

The Workers' Compensation Board's position count was 122.5 in 2000. It is currently 107. The Board's organizational structure and job classifications are detailed on the next page.



Budget and Assessment
(Ten-Year Financial Summary)

The Workers' Compensation Board has three accounts: Administration (0183), Workers Compensation Board (0751), and the Employment Rehabilitation Program (0195). The Administrative Fund (0183) pays the operating expenses of the agency including personal services and all other costs. The Board account (0751) funds the per diem and travel expenses of the labor and management directors of the Board. The Employment Rehabilitation Fund (0195) is primarily designed to pay costs of employment rehabilitation plans that are implemented by order of the Board and not voluntarily implemented by claim administrators.

ADMINISTRATIVE FUND

The Workers' Compensation Board is a quasi-independent agency with an independent funding source. The Board does not receive any General Fund money; instead, the Board's operations are funded by an assessment on workers' compensation insurance and self-insured employers. The Board's largest expenses are personnel costs.

The process for issuing and collecting the annual assessment is set forth in the Workers' Compensation Act. 39-A M.R.S.A. § 154. The statute requires the Board to divide the assessment between self-insured employers and insured employers. The division is based on the pro rata share of disabling cases reported by each category of employer. 39-A M.R.S.A. § 154(5). Once the distribution of disabling cases is determined, the Board must then determine an assessment amount for each employer category. The Board has reduced its annual assessment in each of the last ten fiscal years (2016-2026).

The procedure for assessing self-insured employers is straight-forward. Each self-insured employer is assessed a specific dollar amount based on the aggregate benefits paid by each during the previous calendar year. If, for example, a self-insured employer paid 10% of the total aggregate benefits paid by self-insured employers in the previous calendar year, that self-insured employer is assessed 10% of the total self-insured assessment. Each self-insured employer must pay its assessment for the upcoming fiscal year on or before each June 1.

The procedure for calculating and collecting the assessment from insured employers is more complicated. Insured employers do not pay a specific dollar amount. Instead, a rate, calculated by the Board with assistance from the Bureau of Insurance, is applied to each workers' compensation policy. Insurers collect the money from their insured employers and then remit payment to the Board on a quarterly basis. Due to audits, reconciliations, and the method of collection, the Board's books for a fiscal year do not close at the end of the fiscal year. Money attributable to prior fiscal years can be received for several years after the fiscal year ends.

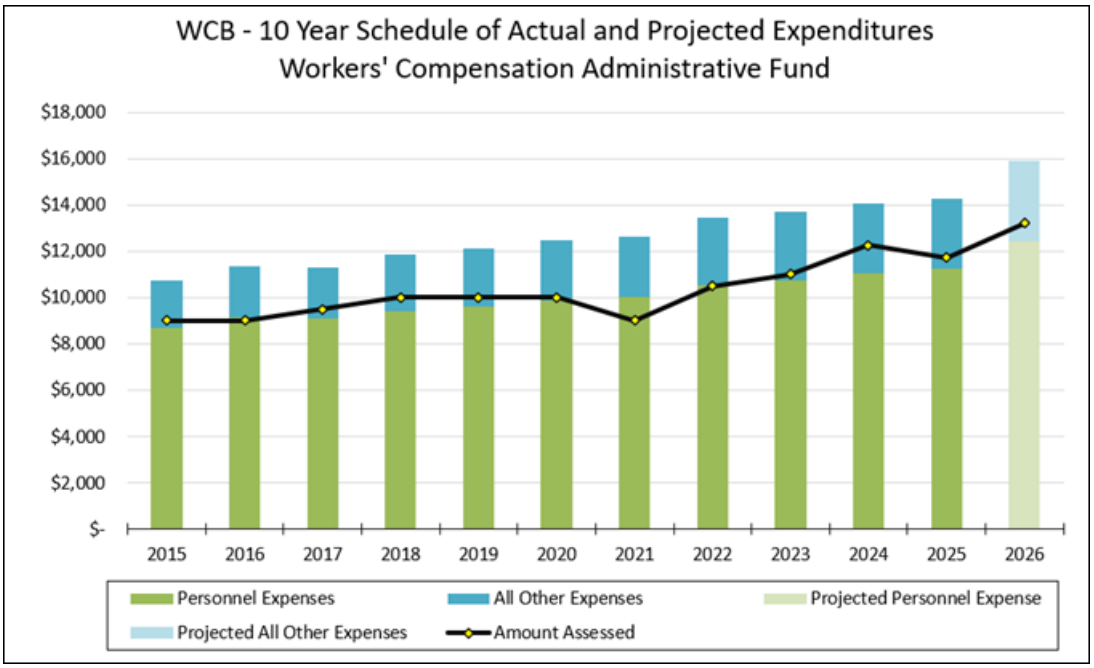
The Board's assessment, for many years, was capped by a specific dollar amount. Due to inflation and other rising costs, the cap had to be amended periodically. From 1993 through 2024, the Board had 15 different assessment caps. As a result, the effect of the cap was to occasionally, and in recent years, frequently, complicate the process of submitting a balanced

budget. Even in years where the Board agreed on its spending plan, if it could not agree on what to do with the cap, it would find itself in a position of requesting a budget it could not fund.

To remedy this situation, the Act was amended in 2025 to ensure the Board will be able to fund expenditures allocated by the Legislature and maintain its reserves. As amended, § 154(6) still contains a maximum assessment. Instead of a fixed number, the maximum assessment will be set by the Legislature when it approves the Board's budget. The assessment will be no more than needed to produce sufficient revenue to fund the Board's allocated expenditures and maintain its reserve.

The Board may vote to use funds from the reserve account to assist in funding "Personal Services," "All Other" expenditures, and other reasonable costs incurred to administer the Act. The chairs of the committee with jurisdiction over labor matters are notified if the Bureau of the Budget and Governor approve use of reserve funds and the use of the reserve increases the Board's allotment above its legislatively approved allocation.

The following chart shows actual expenditures through FY25 and projected expenditures for FY 2026. The chart also shows assessed amounts through FY25.



Since 2000, the Board has reduced staff from 122.5 to 107 in FY 2025. Despite the decrease during this period, the Board has accommodated staffing for the Monitoring, Audit & Enforcement (MAE) program, and the Advocate Division. The Board has expanded programs and increased responsibility while managing the staffing reductions. The Board is fortunate to have many uniquely talented employees who have fostered a positive work environment. These employees have been instrumental in incorporating new automation programs, such as Microsoft Office 365, to streamline business services. One example is the availability of all Business Services forms on the Board's website. These include forms that auto calculate, reduce error rates and increase efficiency.

Coordination with Other Agencies

The Workers' Compensation Board is an independent agency charged with performing discrete functions within state government. Despite this, the Board coordinates and collaborates with other agencies. The Department of Labor (DOL) and Bureau of Insurance (BOI) are major collaborators; the Bureau of Human Resources (BHR), the Office of Information Technology (OIT), and the Attorney General's Office are agencies the Board works with regularly.

Department of Labor

The Board and the Department of Labor (DOL) used to share an employer database for the Board to identify employers operating without required workers' compensation coverage. Although the two agencies no longer share that database, the Abuse Investigation Unit has access to pertinent information at DOL which permits it to investigate employers that do not procure necessary workers' compensation insurance and employers that misclassify workers as independent contractors. The Board and DOL work together to ensure the Board has access to data it needs to perform its oversight function through the Coverage Department.

To help workers to return to suitable employment as quickly as possible, the Board refers injured workers to Board approved vocational rehabilitation specialists. In addition, injured workers may seek assistance from employment rehabilitation providers at DOL. These providers evaluate injured workers and develop rehabilitation plans.

The Bureau of Labor Standards (BLS), a division within DOL, uses claim information gathered by the Board to produce statistical reports on workplace safety. These reports are used by the Board, policy makers, and others to understand and improve workplace safety.

Bureau of Insurance

While the Board has primary responsibility for implementing Maine's Workers' Compensation Act, the Bureau of Insurance (BOI) is responsible for overseeing certain aspects of Maine's system that require the two agencies to work cooperatively. A primary area of collaboration revolves around the Board's annual assessment. In order to ensure proper and adequate funding, the Board works with BOI to obtain information on premiums written, predictions on market trends, and paid losses information for self-insured employers. This information is utilized by the Board when calculating the annual assessment figures.

The Board's Monitoring, Auditing, and Enforcement (MAE) Unit works directly with BOI on compliance and enforcement cases pursuant to 39-A M.R.S.A. §359(2). When insurers, self-insurers and/or third-party administrators are found, after audit, to have failed to comply with the requirements of the Act, the Board certifies this information and forwards it to BOI. BOI then takes appropriate action to ensure questionable claims handling is addressed.

Additionally, the Board assists BOI in its investigation of potential violations of Bureau Rule 530. Rule 530 requires health and disability insurers to make provisional claims payments when a Notice of Controversy is filed contesting the work-relatedness of an illness or injury. Pursuant to a Memorandum of Understanding, the Board helps confirm whether workers' compensation claims exist for Maine consumers on the BOI's lists, whether workers' compensation carriers made any payments toward those claims, and whether NOCs were filed.

OTHER AGENCIES

The Board has entered into agreements with other agencies to provide services that were previously provided in-house by Board employees. For instance, the Board's human resources needs are now managed principally by the Bureau of Human Resources.

The Board also works with the Office of Information Technology (OIT), another DAFS Bureau, with respect to computer hardware and software.

The Board works with the Department of Health and Human Services (DHHS) to assist in recovering past due child support payments and to ensure MaineCare does not pay for medical services that should be covered by workers' compensation insurance.

The Board also works with the Maine Health Data Organization to gather information regarding payments for medical services made by private third-party payors. The Board uses this data to evaluate whether its medical fee schedule sets appropriate limits on payments for health care services while maintaining broad access to care for injured workers.

The Board works with the Occupational Safety and Health Administration (OSHA) of the United States Department of Labor in cases involving employee misclassification. The Board has provided assistance to OSHA with guidance about Maine workers' compensation laws and Board employees testified at an OSHA hearing involving a Maine employer. Per an MOU, the Board's Abuse Investigation Unit shares resources with OSHA when the agencies are investigating the same employer.

Finally, the Board works with the Attorney General's office on various matters including retaining outside counsel, contracting, employee misclassification, criminal prosecution of uninsured employers, and collection of penalties that are assessed and not paid consistent with board decrees.

Constituency Served by the Board

The constituencies served by the Board are identified in its Mission Statement:

> The board's mission is to serve the **employees** and **employers** of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.

39-A M.R.S.A. § 151-A

Alternative Delivery Systems

MoveIT

The Maine Workers' Compensation Board utilizes several alternative delivery systems for secure and efficient transfer of data and shared file access. For Electronic Data Interchange (EDI) transactions the Board employs MoveIT, which functions as an FTP (File Transfer Protocol) site. This system ensures the secure and reliable exchange of mandated electronic data.

Programming

The development and maintenance of the Board's main application, which is built on the Progress platform, is supported by a small team consisting of both a contract worker and an employee of MaineIT.

Advocate Services

When the demand of legal advocacy exceeds our internal capacity due to staff shortages, the Advocate Division will engage external resources such as experienced private attorneys or legal interns on a temporary basis.

Contract Administrative Law Judges

To maintain impartiality and avoid any appearance of conflict of interest, the Board occasionally utilizes contract Administrative Law Judges (ALJs) when a case involves a staff member or presents a similar internal conflict with our full-time ALJs.

Emerging Issues for the Board

Continued Labor - Management Cooperation

Enactment of Resolves 2023, c. 139 (the "Resolve") presented the Workers' Compensation Board (the "Board") with the specific task of examining the effect of inflation on weekly incapacity benefits as well as the potential cost impact of modifying the existing cost-of-living adjustment ("COLA") in 39-A M.R.S.A. §212. More broadly, the Board was tasked with considering whether the Workers' Compensation Act (the "Act") provides substantial protection to injured workers at an affordable cost to employers.

To accomplish these tasks, the Board developed a framework within which the directors could evaluate the Resolve's questions. In so doing, the Board made great strides in achieving its mission to "facilitate labor-management cooperation." 39-A M.R.S.A. §151-A.

Evaluating whether Maine's workers' compensation system provides substantial protection to injured workers at an affordable cost to employers is not a discrete project. It will require ongoing work by the Board and a continued focus on fostering labor-management in order to be successful.

Timely and Accurate Data

The Board receives data from insurers, 3rd-party administrators, group self-insurers and individual self-insured employers ("claim administrators") in a couple of different ways. The majority of information is, or should be, received on an ongoing basis pursuant to filing requirements in the Act and accompanying rules.

Claim administrators submit forms through either a computer-to-computer transmission system or, alternatively, by e-mailing, faxing or mailing them which requires Board staff to manually enter information into the Board's database. Currently, only First Reports Of Injury and Notices Of Controversy and Proof of Coverage are transmitted by way of the computer-to-computer system.

This is preferable because errors are quickly identified, insurers are immediately notified, and the forms are corrected. Accordingly, the Board is working to develop ways to expand its modern automated filing system.

Employment Rehabilitation

The goals of providing substantial protection to injured workers at an affordable cost to employers are best served by safely allowing injured employees to stay at work or, if that is not possible, returning injured employees to work as soon as possible after an injury. This can be

facilitated, in some cases, by providing temporary accommodations. Sometimes, returning an injured employee to work requires more extensive services including employment rehabilitation.

Because returning injured workers back to work as soon as possible after a period of incapacity is an important objective of the workers' compensation system, the Board needs data to understand how well Maine's workers' compensation system is performing in this regard. With respect to services provided by claim administrators, the Board does not have data about the amount or types of services provided and how successful those services are in terms of returning injured workers to employment.

The Board will examine its data collection practices to ensure it is receiving the information it needs – how many employees return to work for the same employer, how many return to work for different employers, how long does it take for employees to return to work, how long do they stay in jobs they return to, how often do rehabilitation services cause an injured employee to successfully return to work, and, how do post-injury wages compare to pre-injury earnings.

Other Information Specifically Requested by the Committee of Jurisdiction

No other information was specifically requested by the Joint Standing Committee on Labor.

Comparison of Related Federal Laws and Regulations to the State Laws Governing the Agency and the Rules Implemented by the Agency or Program

The Longshore and Harbor Workers' Compensation Act (LHWCA) is the closest federal equivalent to Maine's Workers' Compensation Act.

> "The [Longshore Act] is a federal workers' compensation statute designed in part to provide compensation for injuries sustained by persons engaged in maritime employment." *Bouford v. Bath Iron Works,* 514 A.2d 470, 472 (Me. 1986). The applicability of the Longshore Act does not, however, prevent a state from applying its workers' compensation scheme to land-based injuries that are also covered by the Federal Act. *Sun Ship, Inc. v. Pennsylvania,* 447 U.S. 715, 717-19, 721-22, 100 S. Ct. 2432, 65 L. Ed. 2d 458 (1980); *Bouford,* 514 A.2d at 471. In other words, the Longshore Act and a state Workers' Compensation Act may apply concurrently. *Sun Ship,* 447 U.S. at 719, 721-22; *see also Bath Iron Works Corp. v. Dir., Office of Workers' Comp. Programs, U.S. Dep't of Labor,* 125 F.3d 18, 20 (1st Cir. 1997) ("It is not uncommon for employees connected to maritime affairs to be covered by both federal and state compensation statutes . . . ."); *McElheney v. Kvaerner Phila. Shipyard,* 596 Pa. 48, 940 A.2d 351, 359 (Pa. 2008) (holding that maritime employee injured during land-based activity is entitled to concurrent compensation under both the Longshore Act and the Pennsylvania Workers' Compensation Act).
>
> When jurisdiction is concurrent, the injured worker is free to apply for benefits under either system. *Sun Ship,* 447 U.S. at 724. Most critical to our analysis, the employee is not required to elect one remedy to the exclusion of the other. *Parker v. Bath Iron Works Corp.,* 644 A.2d 1037, 1039-40 (Me. 1994). "Election of remedies involves a choice between *inconsistent* remedies. State and Longshore benefits are not inconsistent but complementary, just as different state benefits are complementary to each other . . . ." 9 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* § 145.07[5] (2006) (footnote omitted). Thus, there is no jurisdictional bar to an employee first seeking benefits pursuant to a state workers' compensation act, then pursuing more generous benefits available pursuant to the Federal Act, or the reverse, so long as there is no double recovery or contradictory claim. *See id.; see also Bath Iron Works,* 125 F.3d at 23 (stating that "successive claims under federal and state law are entirely permissible" subject to limitations on duplicative recovery and conventional limitations such as collateral estoppel).

St. Mary's Reg'l Med. Ctr. v. Bath Iron Works, 2009 ME 92, ¶¶ 8-9.

Pursuant to 39-A M.R.S.A. § 209-A, the Board has adopted a medical fee schedule that reflects the methodology established by the Centers for Medicare and Medicaid Services.

Agency Policies for Collecting, Managing and Using Personal Information

Access to Workers' Compensation Board records, which are stored on a secure server, concerning individual employees is strictly limited by both statute and regulation. Pursuant to 39-A M.R.S. § 152(2):

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

The Board complied with this directive by adopting 90-351 MAR Ch. 16.

Accordingly, the Board only releases records to those who meet these standards. To help ensure that records are not inadvertently released, the Board has assigned a single employee the overall responsibility for processing requests for records. If there are any questions as to whether information can be released and, if so, whether information identifying individual injured employees should be redacted, then the matter is referred to the Workers' Compensation Board's General Counsel who determines what, if any, information to release.

List of Reports, Applications and Paperwork Required of Public

The list must include:
(1) The statutory authority for each filing requirement;
(2) The date each filing requirement was adopted or last amended by the agency;
(3) The frequency that filing is required;
(4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and
(5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication.

A. First Reports of Injury

(1) Required pursuant to 39-A M.R.S.A. § 303.

(2) Last substantive regulatory amendment: December 27, 2010

(3) Per statute, First Reports of Injury must be filed within 7 days of notice or knowledge of an injury that causes an employee to lose a day's work.

(4) (a) Filings of Lost Time First Reports of Injury previous two years:

(i) 2023: 13,032

(ii) 2024: 12,469

(b) Anticipated filings next two years: Approximately 13,000 per year

(5) First Reports of Injury are filed electronically with the Board.

B. Notices of Controversy

(1) Notices of Controversy are required pursuant to 39-A M.R.S.A. § 205.

(2) Last amendment to the filing requirement: September 4, 2023.

(3) Pursuant to 39-A M.R.S.A. § 205(2) and Board Rule Ch. 1, section 1, Notices of Controversy must be filed within 14 days after notice or knowledge of a claim for incapacity and/or within 30 days of receipt of a medical bill.

(4) (a) Filings previous two years:

(i) 2023: 8,664

(ii) 2024: 8,665

(b) Anticipated filings next two years: Approximately 8,600 per year

(5) Notices of Controversy are filed electronically with the Board.

C. Memorandum of Payment

(1) Memoranda of Payment are required by 39-A M.R.S.A. § 205(7).

(2) The Board adopted a rule pertaining to Memoranda of payment in March of 1995.

(3) Pursuant to 39-A M.R.S.A. § 205(7), Memoranda of Payment must be filed immediately upon the first payment of benefits.

(4) (a) Filings previous two years:

(i) 2023: 3,420

(ii) 2024: 3,690

(b) Anticipated filings next two years: Approximately 3,700 per year

(5) The Board is considering ways to allow for the electronic filing of payment related information.

D. Forms Reporting Changes to Benefit Payments

(1) Pursuant to 39-A M.R.S.A. § 205(9), benefits may be reduced or discontinued either by the filing of a discontinuance or the filing of a Certificate of Discontinuance. Pursuant to Board rule Ch. 8, § 18, parties may use a consent form in lieu of these filings.

(2) Last substantive regulatory amendment: September 1, 2018

(3) The aforementioned forms must be filed whenever an employee's benefit payments are changed; either increased, decreased or terminated.

(a) Discontinuance filings previous two years:

(i) 2023: 16,704

(ii) 2024: 12,888

(4) Anticipated filings next two years: Approximately 14,000 per year

(5) The Board is considering ways to allow for the electronic filing of some of these documents.

E. Proof of Coverage

(1) Required pursuant to 39-A M.R.S.A. § 403(1).

(2) The most recent amendment was adopted on August 22, 2009.

(3) By rule, proof of coverage must be filed within 14 days after the issuance, renewal or endorsement of a policy.

(4) (a) Filings previous two years:

(i) 2023: 59,832

(ii) 2024: 61,200

(b) Anticipated filings next two years: Approximately 60,000 per year

(5) Proof of coverage is filed electronically with the Board.

F. Statement of Compensation Paid

(1) Required pursuant to 39-A M.R.S.A. §§ 152(2), 152(7), 152(10), 153(1), 153(4) and 357(1).

(2) The last amendment was adopted on March 4, 2001.

(3) The First Statement of Compensation paid form must be filed within 195 days of an injury if incapacity payments are made, and then within 15 days of each anniversary date of the injury.

(4) (a) Filings previous two calendar years:

(i) 2023: 11,208

(ii) 2024: 12,012

(b) Anticipated filings next two years: Approximately 12,000 per year

(5) The Board is considering ways to allow for the electronic filing of Statements of Compensation Paid forms.

G. Wage Statements

(1) Required pursuant to 39-A M.R.S.A. § 303.

(2) The last amendment was adopted on March 4, 2001.

(3) Wage Statements must be filed within 30 days of notice or knowledge of a claim for incapacity.

(4) a) Filings previous two calendar years:

(i) 2023: 9,672

(ii) 2024: 9,828

(b) Anticipated filings next two years: Approximately 9,700 per year

(5) The language enacted by the Legislature in section 303 was proposed by the Board several years ago in an effort to strike a balance between minimizing filing requirements while ensuring that sufficient information is available to adjust and monitor claims for incapacity. The Board is currently working to find a way to allow Wage Statements to be completed and entered into the Board's database electronically.

H. Fringe Benefit Worksheets

(1) Required pursuant to 39-A M.R.S.A. § 303.

(2) The last amendment was adopted on March 4, 2001.

(3) Fringe benefit worksheets must be filed within 30 days of notice or knowledge of a claim for incapacity.

(4) a) Filings previous two calendar years:

(i) 2023: 5,712

(ii) 2024: 4,656

(b) Anticipated filings next two years: Approximately 5,100 per year

(5) The language enacted by the Legislature in section 303 was proposed by the Board several years ago in an effort to strike a balance between minimizing filing requirements while ensuring that sufficient information is available to adjust and monitor claims for incapacity. The Board is currently working to find a way to allow Fringe Benefit Worksheets to be completed and entered into the Board's database electronically.

List of Reports Required by Legislature

(1) Pursuant to 39-A M.R.S.A. § 153(9), the Board must submit an annual compliance report detailing compliance with the Workers' Compensation Act by insurers, third-party administrators and self-insured employers.

(2) Pursuant to 39-A M.R.S.A. § 358-A(1), the board, in consultation with the Superintendent of Insurance and the Director of the Bureau of Labor Standards within the Department of Labor, shall submit an annual report to the Governor and the joint standing committees of the Legislature having jurisdiction over labor and banking and insurance matters by February 15th of each year regarding the status of the workers' compensation system. At a minimum, the report must include an assessment of the board's implementation of the following provisions:

A. The number of individual cases monitored to ensure the provision of benefits in accordance with law, pursuant to section 152, subsection 10;
B. The number of cases monitored to ensure the payments are initiated within the time limits of sections 205 and 324 and the adequacy of compensation provided pursuant to section 153, subsection 1;
C. The number of investigations performed pursuant to section 153, subsection 7;
D. The number of lump-sum settlements cases monitored and a summary of post-settlement employment experience pursuant to section 352, subsection 6;
E. The number of audits performed and an assessment of compliance with this Act based on audit results pursuant to section 359, subsection 1;
F. The number of penalties assessed and the reasons for the assessments pursuant to section 205, subsection 3; section 313, subsection 4; section 324, subsections 2 and 3; section 359, subsection 2; and section 360;
G. The results of the monitoring program giving side-by-side information compilations for the past 5 years pursuant to section 359, subsection 3; and
H. The timeliness of examinations conducted pursuant to section 312 and any other data regarding independent medical examiners and examinations.

The report must contain specific data regarding compliance, including benchmarks measuring individual insurers, self-insurers, or 3rd-party administrator's compliance with the provisions of this Act and any penalties assessed. Benchmarks must be developed by the board with input from insurers, self-insurers and 3rd-party administrators and other parties the board considers appropriate. The board shall also report on the utilization of troubleshooters, advocates and retained legal counsel, with correlating outcomes.

Required Legislative Review of Statutes to Align with Federal Law, Other State Law or Decisions of the Courts

The Board is unaware of any provisions that need review in order to align the Workers' Compensation Act with federal law, other state law or decisions of the United States Supreme Court or the Supreme Judicial Court.