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February 28, 2025

Senator Michael Tipping, Chair
Representative Amy Roeder, Chair
Joint Standing Committee on Labor
100 State House Station
Augusta, ME 04333-0100

Re: Resolves 2023, c. 139, February 2025 Update

I. Introduction

This February report is submitted by the Workers' Compensation Board ("Board") to the legislature pursuant to Resolves 2023, c. 139 (the "Resolve"). The Resolve directs the Board to analyze lost wage benefits paid for total disability (§ 212) and partial disability (§ 213) and for death (§ 215)[1]. When conducting this evaluation, the Board must use "data supplied by insurers, 3rd-party administrators, group self-insurers and individual self-insured employers [together with] other relevant data and available reports." At a minimum, the Board must consider the following claim information:

1. The claim identification number assigned by the board;
2. The claim identification number assigned by the insurer, 3rd-party administrator, group self-insurer or individual self-insured employer;
3. The date of injury;
4. The average weekly wage;
5. The compensation rate;
6. For a claimant pursuant to Title 39-A, section 212, the number of weeks of compensation and benefits paid;
7. For a claimant pursuant to Title 39-A, section 213, the number of weeks of compensation and benefits paid and the number of weeks for which the benefit was 100% partial;
8. For a claimant pursuant to Title 39-A, section 215, the number of weeks of compensation and benefits paid;
9. The date the last payment was made and whether payments are continuing;10. The total amount of indemnity benefits paid; and
11. Any other information the board determines necessary to complete the analysis.

[1] More information about who qualifies for benefits pursuant to 39-A MRSA § 212 and § 213 is in the August 31, 2024 update.

II. FILING REQUIREMENTS

39-A MRSA § 205(2) requires insurers, self-insured employers and group self-insurers (collectively "insurers") to maintain records "of all payments made under this Act and of the time and manner of making the payments" and to "furnish reports, based upon these records, to the board as it may reasonably require." Section § 152(2) authorizes the Board to "define terms [and] prescribe forms." Section 357 mandates that insurers "shall fill out any blanks and answer all questions submitted that may relate to . . . compensation paid." Section 152(10) requires the Board to "assume an active and forceful role in the administration of this Act" and to "continually monitor individual cases to ensure that benefits are provided in accordance with this Act."

As envisioned by the Act, the board has promulgated forms that insurers must fill out and file with the Board so that it can monitor the nature and extent of work related injuries, the benefits that are due, the amounts are paid, the dates of modifications, reductions, and discontinuances, the reasons for those changes, and other pertinent information that becomes relevant during the life of a claim. What follows are examples of events that trigger an insurer's duty to submit information on claim forms:

- If an employee misses a day of work because of an injury, a First Report of Injury ("FROI") must be filed within 7 days.
- If the employee returns to work within the 7-day waiting period,[2] the insurer must report the date the employee returned to work.
- If the incapacity extends beyond the waiting period, the insurer must file a Wage Statement and either:
    - Commence paying the claim and file a Memorandum of Payment ("MOP"); or,
    - Decline to pay and file a Notice of Controversy ("NOC").
- If payments for lost time change, the insurer must notify the Board by filing either a Modification Form ("MOD") or Discontinuance Form ("DISC").
    - Insurers must periodically send the Board Statements of Compensation forms that summarize lost time payments.

Insurers submit forms through either a modern computer-to-computer transmission system or on forms that are e-mailed, faxed or mailed to the Board. The latter method requires staff to manually enter information into the Board's database. Currently, only FROIs and NOCs 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. Not surprisingly, the modern fast-track approach afforded by electronic transmission is more efficient than the hard copy/fax method.

[2] Employees whose incapacity lasts for seven days or less are not entitled to incapacity benefits. Benefits begin on the eighth day of incapacity. If the incapacity lasts for more than 14 days the employee is entitled to payment from the date of injury. The waiting period does not apply to firefighters 39-A M.R.S.A. § 204.

With respect to the eleven data points that the Resolve requires the Board to apply in its benefit analysis, only the first three – jurisdiction claim number (assigned by the Board upon receipt of a FROI), the insurer's file number and the date of injury – are received via computer-to-computer communication. Insurers transmit the remaining data on forms. Board employees manually extract the data and enter it into the Board's database. The following chart shows the number of forms received and entered in calendar year 2024.

CALENDAR YEAR 2024			
FORM	**Computer-to-computer**	**Staff**	**Total**
FROI	**27,379**	**59**	**27,438**
NOCs	**8,665**	**16**	**8,681**
Petitions		**1,343**	**1,343**
Answers to Petitions		**395**	**395**
Wage Statements		**9,824**	**9,824**
Fringe Benefits Worksheet		**4,660**	**4,660**
MOPs (including revisions)		**6,400**	**6,400**
All other including DISCs		**15,604**	**15,604**
Statement of Compensation		**12,008**	**12,008**
	36,044	**50,309**	**86,353**

III. DATA COLLECTION FOR THIS STUDY

By way of background, in 2023, the Board asked insurers for information about the number of workers injured in 2020 who were receiving 100% of their benefit pursuant to § 212 along with how many workers injured in 2020 were receiving 100% partial benefits pursuant to § 213. [3] Some information was provided, but not enough to conduct an analysis in time for the Board to report to the Labor and Housing Committee.

In seeking information for this Resolve in April of 2024, the Board drew from lessons learned from its previous attempt and streamlined the process. The Board asked insurers to submit forms that appeared to be missing for injuries that occurred between 2018 and 2023. Specifically, the Board identified cases where it appeared that indemnity payments were ongoing but where Statements of Compensation Paid, Discontinuance forms, and/or Modification forms had not been entered into the Board's database. Once this process was complete, the Board, in May of 2024, requested information about the eleven components set forth in the Resolve, but only for injuries that occurred in 2018. The Board is still reconciling this information. In the meantime, some issues have been identified.

[3] See, Report to the Labor and Housing Committee Regarding the L.D. 1896 Stakeholder Group, December 11, 2023, pp. 3-4.

Insurers are not, as contemplated by the Act, identifying each weekly payment as being made pursuant to § 212 or § 213. This information is necessary because the COLA in § 212(4) is due only after 260 weeks of payments. Weeks paid pursuant to either § 213 and § 215 do not count toward the 260-week threshold. The Board is assuming this change was not made because it would have been a significant, and potentially costly, change from prior practice (this level of detail was not required for dates of injury prior to 2020) for what is likely to be fraction of overall claims.

Also, the Board has identified, and is working to eliminate, issues with respect to information filed on forms. Specifically, data is missing from some of the 2018 injury claims. In some cases, this makes it appear that a payment obligation may be ongoing, when in fact it has ended. There are a few reasons this can happen. It is possible the form was never filed. It is possible the form was filed but the information did not get entered. It is possible that the form was received but, because there were errors or inconsistencies, the form could not be entered into the Board's database. In those situations, a request for clarification was sent. If no response was received, information on the form could not be entered by Board staff database.

IV. CONCLUSION

The Board is finishing its analysis of the 2018 data and will be reporting on that soon. In the meantime, the Board is continuing to discuss the issue regarding categorization of weekly payments. The Board continues to attempt to improve its system. Changes are being made to allow forms with errors to be entered into the database with the errors noted. The Board can, for some forms, track whether or not insurers are responding to requests for additional information. If responses are not submitted, the Board will continue to attempt to follow up, but this puts a strain on resources.

There are far fewer opportunities for error if information is submitted in a computer-to-computer manner. Accordingly, the Board is working to develop ways to enhance a modern automated filing system. At the same time, the Board is undertaking a review, with stakeholders, of its forms in an effort to make sure the Board gets the information it needs in a manner that is as efficient as possible for all involved.

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