LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND FIFTEENTH LEGISLATURE

FIRST REGULAR SESSION
December 5, 1990 to July 10, 1991

FIRST SPECIAL SESSION
July 11, 1991 to July 18, 1991

THE GENERAL EFFECTIVE DATE FOR
FIRST REGULAR SESSION
NON-EMERGENCY LAWS IS
OCTOBER 9, 1991

PUBLISHED BY THE REVISOR OF STATUTES
IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

J.S. McCarthy Company
Augusta, Maine
1991

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officer's designee; the Director of Health Planning and Development or the director's designee; the Commissioner of Labor or the commissioner's designee; the Director of the State Planning Office or the director's designee; a member of the Maine Health Policy Advisory Council appointed by its chair; 2 representatives of the nursing profession appointed by the Governor; 2 representatives of other allied health professions appointed by the Governor; and one consumer appointed by the Governor.

Sec. 19. Report on postgraduate medical education. The Finance Authority of Maine shall report to the Joint Standing Committee on Education by January 15, 1992 on the existing programs for financial assistance for postgraduate medical education, including the Maine contract program and the osteopathic loan program. The report must include suggested changes to the programs designed to maximize the use of available funding to increase the supply of primary care physicians practicing in underserved areas of the State and to provide access to medical education for Maine students. In preparing its report, the Finance Authority of Maine shall consult with the Advisory Committee on Medical Education, the Special Select Commission on Access to Health Care, the Maine Medical Association, the Maine Osteopathic Association, the Maine Ambulatory Care Coalition, the Department of Human Services and other interested entities.

Effective October 17, 1991.

CHAPTER 613

H.P. 1230 - L.D. 1794

An Act to Amend the Minimum Requirements for Emergency Medical Technicians

Be it enacted by the People of the State of Maine as follows:

32 MRSA §85, sub-§3, as amended by PL 1989, c. 857, §69, is further amended to read:

3. Minimum requirements for licensing. In setting rules for the licensure of emergency medical services persons, the board shall ensure that a person is not licensed to care for patients unless that person's qualifications are at least those specified in this subsection. Any person who meets these conditions is considered to have the credentials and skill demonstrations necessary for the ambulance attendant level of licensure to provide basic emergency medical treatment.

A. The person must have completed successfully the United States Department of Transportation course for first responders, with supplemental training specified in rules adopted by the board pursuant to the Maine Administrative Procedure Act, or completed successfully the American Red Cross Advanced First Aid and Emergency Care Course, with supplemental training specified in rules adopted by the board pursuant to the Maine Administrative Procedure Act.

B. The person must have successfully completed the American Heart Association basic rescuer course in cardiopulmonary resuscitation or its American Red Cross equivalent.

C. The person must have successfully completed a state written and practical test for basic emergency medical treatment.

D. The person must be sponsored by a Maine licensed ambulance service or first responder service.

The board may set by rule intervals at which these qualifications must be renewed and appropriate courses and testing for that renewal.

For those individuals who are licensed or who relicense as basic emergency medical technicians after September 1, 1986, and who are not licensed at the advanced level, the basic emergency medical technician license is for a 3-year period. Licensure includes, but is not limited to, annual verification, as determined by the board through rules. ~~In addition, that licensure requires the successful passage of examinations not more than once every 3 years.~~ To maintain a valid license, a basic emergency medical technician ~~shall~~ must meet the criteria as set out in this subsection. If those criteria are not met, a person does not hold a valid license and must reapply for licensure.

Effective October 17, 1991.

CHAPTER 614

H.P. 1343 - L.D. 1934

An Act to Eliminate the Requirement of Reimbursement for Search and Rescue Activities

Be it enacted by the People of the State of Maine as follows:

12 MRSA §7035, sub-§4, ¶B, as amended by PL 1983, c. 819, Pt. A, §19, is repealed.

Effective October 17, 1991.

CHAPTER 615

H.P. 1397 - L.D. 1981

An Act to Make Changes in the Workers' Compensation System

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 20-A MRSA §12704, sub-§1, as enacted by PL 1985, c. 695, §11, is amended to read:

1. Long-term and short-term training. Providing, in close cooperation with the private sector, both the long-term education and training required for certain vocational and technical occupations, including occupational health and safety aspects of those occupations, and the short-term training necessary to meet specific private sector and economic development needs;

Sec. A-2. 24-A MRSA §1853, as amended by PL 1989, c. 168, §§26 and 27, is further amended by adding at the end a new paragraph to read:

The superintendent shall adopt rules to establish the standards for performance of the duties of the adjuster. In addition to the causes provided in section 1539, the superintendent may suspend, revoke or refuse a license of an adjuster for failure to perform the duties of the adjuster in accordance with the standards.

Sec. A-3. 24-A MRSA §2362-A is enacted to read:

§2362-A. Disclosure of premium information

All policies issued to employers for workers' compensation insurance must disclose clearly to the employer as separate figures the base rate, the employer's experience modification factor for each year included in the formula pursuant to section 2364, the medical, indemnity and administrative portions of the premium and the portion of the premium attributable to the workplace health and safety consultation services.

When a policy is issued to employers for workers' compensation insurance, it must be accompanied by a statement disclosing the percentages of premium expended during the previous year by the insurer for claims paid, loss control and other administrative costs, medical provider expenses, insurer and employee attorney's fees and private investigation costs.

Sec. A-4. 24-A MRSA §2362-B is enacted to read:

§2362-B. Workplace health and safety consultations

Workplace health and safety consultation services provided by workers' compensation insurance carriers to employers with an experience rating factor of one or more are subject to the following.

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

A. "Workplace health and safety consultations" means a service provided to an employer to advise and assist the employer in the identification, evaluation and control of existing and potential accident and occupational health problems.

2. Standards for workplace health and safety consultations. The superintendent shall adopt rules establishing the standards for approval of workplace health and safety consultations provided to employers by insurance carriers, including provision of adequate facilities, qualifications of persons providing the consultations, specialized techniques and professional services to be used and educational services to be offered to employers.

3. Required coverage and premium. All insurance carriers writing workers' compensation coverage in this State shall offer workplace health and safety consultations to each employer as part of the workers' compensation insurance policy. The premium for the workplace health and safety consultation must be identified as a separate amount that must be paid.

4. Optional purchase from another provider. An employer may elect to purchase workplace health and safety consultation services from a provider other than the insurer. Upon submission by the employer of a certificate of completion of workplace health and safety consultation services from another approved provider, the insurance carrier must refund to the employer the portion of the premium attributable to the workplace health and safety consultation.

5. Notification to employer; request for consultation services. An insurance carrier writing workers' compensation insurance coverage shall notify each employer of the type of workplace health and safety consultation services available and the address or location where these services may be requested. The insurer shall respond within 30 days of receipt of a request for workplace health and safety consultation services.

6. Reports to employers. In any workplace health and safety consultation that includes an on-site visit, the insurer shall submit a report to the employer describing the purpose of the visit, a summary of the findings of the on-site visit and evaluation and the recommendations developed as a result of the evaluation. The insurer shall maintain for a period of 3 years a record of all requests for workplace health and safety consultations and a copy of the insurer's report to the employer.

7. Safe workplace responsibility. Workplace health and safety consultations provided by an insurer do not diminish or replace an employer's responsibility to provide a

safe workplace. An insurance carrier or its agents or employees do not incur any liability for illness or injuries that result from any consultation or recommendation.

Sec. A-5. 24-A MRSA §2363, sub-§§1 and 2, as enacted by PL 1987, c. 559, Pt. A, §4, are amended to read:

1. Policies. Every insurance company or insurer issuing workers' compensation insurance policies covering the payment of compensation and benefits provided for in this subchapter ~~shall~~ must use only policy forms approved pursuant to section 2412.

2. Determination of rates. Every insurer issuing workers' compensation insurance policies shall file with the superintendent its classification of risks and maximum premium rates, which may not take effect until the superintendent has approved them. The superintendent shall apply the procedures and standards of this section in investigating, reviewing and determining just and reasonable rates. The superintendent may:

A. Require the filing of specific rates for workers' compensation insurance, including classification of risks, experience or any other rating information from insurance ~~companies~~ carriers authorized to transact insurance in this State;

B. Make or cause to be made investigations as ~~he deems~~ the superintendent considers necessary to ~~satisfy himself~~ determine that the rates to be promulgated are just and reasonable; and

C. At any time, after public hearing, withdraw ~~his~~ the superintendent's approval of a previously approved rate filing.

Sec. A-6. 24-A MRSA §2363, sub-§4, ¶A, as repealed and replaced by PL 1989, c. 423, §1, is amended to read:

A. Maine premium, loss and loss adjustment experience. Maine premium, loss and loss adjustment experience ~~shall~~ must show:

(1) Data from all ~~companies~~ carriers writing workers' compensation insurance in this State. If a company is excluded from the rate level, trend, loss development, expense determination, classification differentials or investment income calculations, that company and its market share ~~shall~~ must be identified and an explanation provided for its exclusion;

(2) Premiums calculated at current rate level. Whenever on-level factors are used, their derivation ~~shall~~ must be shown. The derivation of the percentages of total premium written and earned at various rate levels ~~shall~~ must also be shown;

(3) The amount of premium collected from the expense constant. This premium ~~shall~~ must be provided in dollars and as a percentage of the standard earned premium and as a percentage of net earned premium. If the percentage of premium collected in this manner is expected to change, the extent of the change ~~shall~~ must be estimated and the details of this estimation provided;

(4) The amount of premium collected by the minimum premium. This premium ~~shall~~ must be provided in dollars and as a percentage of standard earned premium and as a percentage of earned premium. If the percentage of premium collected in this manner is expected to change, the extent of the change ~~shall~~ must be estimated and the details of this estimation provided;

(5) Earned premiums, which ~~shall~~ must include premium collected from the specific disease loading. If disease loadings have been excluded, a justification ~~shall~~ must be provided;

(6) The latest earned premiums and market shares for the 10 largest workers' compensation insurers, by group, in this State;

(7) The following information on ~~companies~~ carriers deviating from bureau workers' compensation rates for each of the last 3 years:

(a) A list of all deviating ~~companies~~ carriers;

(b) The total standard premium written at deviated rates;

(c) The percentage of the entire statewide standard premium written at deviated rates;

(d) The total amount of deviations in dollars;

(e) The average percentage deviation for deviating companies; and

(f) The average percentage deviation for all ~~companies~~ carriers;

(8) The following information on ~~company~~ carriers' workers' compensation dividend practices for each of the last 3 years:

(a) A list of all ~~companies~~ carriers issuing dividends;

(b) The total amount of dividends in dollars;

(c) The average percentage dividend issued by ~~companies~~ carriers issuing dividends; and

(d) The average percentage dividend issued by all ~~companies~~ carriers;

(9) All policy year and accident year incurred loss data used in the filing, provided in the aggregate and also separated into paid losses, case-incurred and incurred but not reported losses; and

(10) The related incurred losses for all incurred loss adjustment expense data contained in the filing;

Sec. A-7. 24-A MRSA §2363, sub-§4, ¶N, as enacted by PL 1989, c. 423, §1, is amended to read:

N. The level of capital and surplus needed. The following information relating to the level of capital and surplus ~~shall~~ must be provided:

(1) Aggregate premium to surplus ratios and reserve to surplus ratios for the latest 5 calendar years for all ~~companies~~ carriers writing workers' compensation insurance in this State; and

(2) Estimates of comparable ratios for the years during which the rates will be in effect; and

Sec. A-8. 24-A MRSA §2363, sub-§7, ¶B, as enacted by PL 1987, c. 559, Pt. A, §4, is amended to read:

B. In establishing just and reasonable rates, the superintendent shall consider:

(1) ~~The~~ When applicable, the reasonableness of any return on capital and surplus allocable to the coverage of risks in this State;

(2) The reasonableness of the amounts of capital and surplus allocable to the coverage of risks in this State;

(3) The reported investment income earned or realized from funds generated from business in this State;

(4) The reported loss reserves, including the methods and the interest rates used in determining the present value for reported reserves and the use of those reserves in the determination of the proposed rates;

(5) The reported annual losses and loss adjustment expenses;

(6) The measures taken to contain costs, including loss control, loss adjustment and employee safety engineering programs;

(7) The relationship of the aggregate amount of operating expenses reported by all ~~companies~~ carriers to the annual operating expenses reported in the filing and the annual insurance expense exhibits filed by each ~~company~~ carrier with the superintendent;

(8) The impact of operating and management ~~efficeney~~ efficiency of the ~~companies~~ carriers on expense levels and the effect of variations in expense levels on rates; and

(9) Any premium surcharges or credits ordered by the superintendent pursuant to section 2367.

Sec. A-9. 24-A MRSA §2363, sub-§7-A, as enacted by PL 1989, c. 467, §2, is amended to read:

7-A. Fee for servicing residual market. In every rate filing in which a rating bureau requests a rate adjustment, the superintendent shall take evidence on the issue of whether the fee for servicing the residual market is reasonable. Concurrent with the decision on the rate adjustment, the superintendent shall issue a decision on whether the fee is reasonable, taking into account the rate adjustment approved. If the superintendent determines that the fee is not reasonable, the superintendent shall order an adjustment to the fee, as necessary, to ensure that the fee is reasonable. The superintendent shall adopt rules establishing standards for the performance of adjustment services and requiring that servicing fees for individual insurance carriers be separately reviewed.

Sec. A-10. 24-A MRSA §2364, sub-§4, ¶A, as enacted by PL 1987, c. 559, Pt. A, §4, is amended to read:

A. The uniform experience rating plan ~~shall~~ must be the exclusive means for providing prospective premium adjustments based upon the past claim experience of an individual insured. The experience rating plan must provide that the claims experience for the 3 most recent years for which data is available be considered on the following basis.

(1) The claims and exposure for the most recent year for which data is available must be given 40% weight.

(2) The claims and exposure for the 2nd most recent year for which data is available must be given 35% weight.

(3) The claims and exposure for the 3rd most recent year for which data is available must be given 25% weight.

If data is available for only 2 years of claims experience, the weighting must be 60% for the most recent year and 40% for the 2nd most recent year.

Sec. A-11. 24-A MRSA §2365-A is enacted to read:

§2365-A. Medical expense deductibles

Each insurer transacting or offering to transact workers' compensation insurance in this State shall offer deductibles for medical expenses as follows.

1. Optional deductible of $250. To employers who are not experience-rated, insurers shall offer a deductible of $250 per occurrence.

2. Optional deductible of $250 or $500. To employers whose premium is between 100% and 500% of the premium qualifying for experience rating and to all employers in the logging and lumbering industries, including employers of drivers, and sawmill industries, insurers shall offer a deductible of $250 or $500 per occurrence.

3. Mandatory deductible of $500. Except for employers that qualify under subsections 1 and 2, insurers shall provide a deductible of $500 per occurrence to employers of more than 10 employees whose premium is over 500% of the premium qualifying for experience rating.

Sec. A-12. 24-A MRSA §2366, sub-§1-A is enacted to read:

1-A. Rules. The superintendent shall adopt rules for the purpose of encouraging workers' compensation insurers to take workers' compensation policies out of the residual market by establishing credits applicable to any assessments that may be ordered under section 2367 or by any other means. The criteria for applying credits must include consideration for policies taken out of the residual market prior to as well as after the effective date of the rules.

Sec. A-13. 24-A MRSA §2366, sub-§2, ¶B, as enacted by PL 1987, c. 559, Pt. A, §4, is amended to read:

B. An employer is eligible for insurance from the Accident Prevention Account if:

(1) The employer has at least 2 lost-time claims over $10,000 and a loss ratio greater than 1.00 over the last 3 years for which data is available; and

(2) The employer has attempted to obtain insurance in the voluntary market and has been refused by at least 2 insurers ~~which~~ that write that insurance in this State. For the purpose of this section, an employer ~~shall be~~ is considered to have been refused if offered insurance only under a retrospective rating plan or plans.

Sec. A-14. 24-A MRSA §2366, sub-§3, ¶¶A and B, as enacted by PL 1987, c. 559, Pt. A, §4, are amended to read:

A. The Safety Pool is an insurance plan that provides for an alternative source of insurance for employers with good safety records ~~and is intended to operate within the framework of the voluntary insurance market~~.

B. An employer ~~shall be~~ is eligible for the Safety Pool if that employer:

(1) Has had no more than one lost-time claim in the last 3 years for which data is available, regardless of the resulting loss ratio;

(2) Has a loss ratio ~~which~~ that does not exceed 1.0 or has had no more than one lost-time claim over $10,000 over the last 3 years for which data is available; or

(3) Has been in business for less than 3 years, provided that the eligibility ~~shall terminate~~ terminates if ~~his~~ the employer's loss ratio exceeds 1.0 and the employer has at least 2 lost-time claims over $10,000 each at the end of any year.

Sec. A-15. 24-A MRSA §2366, sub-§4, ¶A-1 is enacted to read:

A-1. The plan must include a procedure to handle appeals filed pursuant to Title 39, section 106, subsection 2, paragraph B.

Sec. A-16. 24-A MRSA §2366, sub-§5, ¶C is enacted to read:

C. In a residual market rate proceeding, the superintendent may order payment of dividends to insureds in the Safety Pool to the extent that the pool's experience supports them. The superintendent may adopt rules establishing a dividend plan for the Safety Pool to provide an incentive for implementation of safety programs by insureds in the pool. The superintendent may employ outside consultants to assist in the development of these rules, the costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

Sec. A-17. 24-A MRSA §2366, sub-§7-A is enacted to read:

7-A. Credits for qualifying safety programs. The superintendent shall adopt rules to establish dividend plans and premium credits between 5% and 15% of net annual premiums for policyholders that establish or maintain qualifying safety programs. The rules must identify the classifications by which policyholders are eligible for the credits and establish criteria for qualifying safety programs and procedures to be followed by servicing carriers in approving and auditing compliance with the safety programs. The superintendent may employ outside consultants to assist in the development of rules under this subsection, the costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

Sec. A-18. 26 MRSA §42-A, sub-§2, ¶E-1, as enacted by PL 1987, c. 782, §3, is amended to read:

E-1. The development and administration of programs to educate employers and employees regarding the Whistleblowers' Protection Act, chapter 7, subchapter V-B; ~~and~~

Sec. A-19. 26 MRSA §42-A, sub-§2, ¶E-2 is enacted to read:

E-2. The support for the development of long-term strategies to improve occupational health and safety professional education and resources. The department may award contracts to public and private nonprofit organizations as seed money to develop programs that will serve this purpose and that will develop other funding sources in the future; and

Sec. A-20. 39 MRSA §2, sub-§2, ¶G is enacted to read:

G. "Average weekly wages, earnings or salary" does not include fringe benefits, including but not limited to employer payments for or contributions to a retirement, pension, health and welfare, life insurance, training, social security or other employee or dependent benefit plan for the employee's or dependent's benefit or any other employee's dependent entitlement.

Sec. A-21. 39 MRSA §5 is enacted to read:

§5. Predetermination of independent contractor status

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

A. The predetermination by the Department of Labor creates a rebuttable presumption that the determination is correct in any later claim for benefits under this Act.

B. Nothing in this section requires a worker, an employer or a workers' compensation insurance carrier to request predetermination.

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

3. Predetermination submission. A party may submit, on forms approved by the Department of Labor, a request for predetermination regarding the status of a person or job description as an employee or independent contractor. The status requested by a party is deemed to have been approved if the Department of Labor does not deny or take other appropriate action on the submission within 14 days.

4. Hearing. A hearing, if requested by a party within 10 days of the Department of Labor's decision on a petition, must be conducted under the Maine Administrative Procedure Act.

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

6. Rulemaking. The Commissioner of Labor is authorized to adopt reasonable rules pursuant to the Maine Administrative Procedure Act to implement the intent of this section, which is to afford speedy and equitable predetermination of employee and independent contractor status.

Sec. A-22. 39 MRSA §21-A, sub-§4 is enacted to read:

4. Workplace health and safety training programs. The following workplace health and safety plan requirements apply to all employers in the State required to secure payment of compensation in conformity with this Title.

A. The Commissioner of Labor or the commissioner's designee shall adopt rules regarding workplace health and safety programs.

B. The Superintendent of Insurance shall communicate to the Department of Labor the names of em-

ployers that receive in any policy year an experience rating of 2 or more. The Department of Labor shall notify each employer on that list that the employer is required to undertake a workplace health and safety program, shall provide a statistical evaluation of the employer's workplace health and safety experience and shall enclose a set of workplace health and safety options, including on-site consultation, education and training activities and technical assistance.

C. The employer shall submit a workplace health and safety plan to the Department of Labor for review and comment, complete the elements of the plan and notify the Department of Labor of its completion. The plan may include attendance at a Maine technical college or the Department of Labor workplace health and safety training programs.

D. The Department of Labor shall notify the Superintendent of Insurance of any employer that fails to complete the workplace health and safety program as required by this section and the rules. The superintendent shall assess a surcharge of 5% on that employer's workers' compensation insurance premium or the imputed premium for self-insurers, to be paid to the Treasurer of State who shall credit 1/2 of that amount to the Safety Education and Training Fund, as established by Title 26, section 61, and 1/2 to the Occupational Safety Loan Fund, as established by Title 26, section 62.

E. The Commissioner of Labor shall report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters and the joint standing committee of the Legislature having jurisdiction over labor matters by October 1, 1993 on the rules adopted, performance by employers and any surcharges imposed by the Superintendent of Insurance.

Sec. A-23. 39 MRSA §23, sub-§1-A is enacted to read:

1-A. Pilot projects. Workers' compensation health benefits pilot projects are authorized under the following provisions.

A. The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with workers' compensation medical payments benefits through comprehensive health insurance that covers workplace injury and illness. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this Title. The superintendent shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.

B. The comprehensive health insurance may provide for health care by a health maintenance organization or a preferred provider organization. The premium must be paid entirely by the employer. The program may use deductibles, coinsurance and copayment by the employees not to exceed $5 per visit or $50 maximum per occurrence.

C. The superintendent shall report annually to the joint standing committees of the Legislature having jurisdiction over banking and insurance and labor matters by November 1st on the status of any pilot projects approved by the superintendent.

D. Unless continued or modified by law, this section is repealed on October 31, 1996.

Sec. A-24. 39 MRSA §23, sub-§2, as amended by PL 1989, c. 435, §2, is further amended to read:

2. Proof of solvency and financial ability to pay; trust. By furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and deposit cash, satisfactory securities or a surety bond, with the Workers' Compensation Commission, in such sum as the superintendent may determine pursuant to subsection 6; such bond to run to the Treasurer of State and the Treasurer of State's successor in office, and to be conditional upon the faithful performance of this Act relating to the payment of compensation and benefits to any injured employee. In case of cash or securities being deposited, the cash or securities ~~shall~~ must be placed in an account at interest by the Treasurer of State, and the accumulation of interest on the cash or securities so deposited ~~shall~~ must be credited to the account and ~~shall~~ may not be paid to the employer to the extent that the interest is required to support any present value discounting in the determination of the amount of the deposit. Any security deposit ~~shall~~ must be held by the Treasurer of State in trust for the benefit of the self-insurer's employees for the purposes of making payments under the Act.

The superintendent shall prescribe the form of the surety bond ~~which~~ that may be used to satisfy, in whole or in part, the employer's responsibility under this section to post security. The bond ~~shall~~ must be continuous, ~~shall~~ be subject to nonrenewal only upon not less than 60 days' notice to the superintendent and ~~shall~~ cover payment of all present and future liabilities incurred under the Act while the bond is in force and cover payments ~~which~~ that become due while the bond is in force ~~which~~ that are attributable to injuries incurred in prior periods and ~~which are~~ otherwise unsecured by cash or acceptable securities. A bond ~~shall~~ must be held until all payments secured thereby have been made or until it has been replaced by a bond issued by a qualified successor surety ~~which~~ that covers all outstanding liabilities. Payments under the bond ~~shall be~~ are due within 30 days after notice has been given to the surety by ~~the chair of~~ the

commission that the principal has failed to make a payment required under the terms of an award, agreement or governing law. A surety bond ~~shall~~ may not be used to fund a trust established to satisfy the requirements of this section.

As an alternative to the method described in the first paragraph of this subsection, an eligible employer may establish an actuarially fully funded trust, funded at a level sufficient to discharge those obligations incurred by the employer pursuant to this Act as they become due and payable from time to time, provided that the superintendent requires that the value of trust assets ~~shall~~ be at least equal to the present value of ultimate expected incurred claims and claims settlement costs. The present value of ultimate expected incurred claims and claims settlement costs for a group self-insurer may not be more than the amount actuarially determined considering the value of trust assets and excess insurance to satisfy a 90% confidence level. A group self-insurer may elect to fund at a higher confidence level through the use of cash, marketable securities, surety bonds or excess insurance. If a member of a group self-insurer terminates its membership in the group for any reason, then that member shall fund its proportionate share of the liabilities and obligations of the trust to the 95% confidence level. If for any reason the departing member fails to fund its proportionate share of the trust's exposure to the 95% level of confidence, then the remaining members of the group shall make such additional contribution no later than the anniversary date of the program as required to fund the departing member's exposure in accordance with this provision. ~~The trust~~ Trust assets ~~shall~~ must consist of cash or marketable securities of a type and risk character as specified in subsection 7~~;~~ and ~~shall~~ have a situs in the United States. The trustee shall submit a report to the superintendent not less frequently than quarterly ~~which~~ that lists the assets comprising the corpus of the trust, including a statement of their market value and the investment activity during the period covered by the report. The trust ~~shall~~ must be established and maintained subject to the condition that trust assets ~~cannot~~ may not be transferred or revert in any manner to the employer except to the extent that the superintendent finds that the value of the trust assets exceeds the present value of incurred claims and claims settlement costs with an actuarially indicated margin for future loss development. In all other respects, the trust instrument, including terms for certification, funding, designation of trustee and pay out ~~shall~~, must be as approved by the superintendent; provided~~;~~ that the value of the trust account ~~shall~~ must be actuarially calculated at least annually by a casualty actuary who is a member of the American Academy of Actuaries and adjusted to the required level of funding. For purposes of this paragraph, an "eligible employer" is one who is found by the superintendent to be capable of paying compensation and benefits required by this Act and:

A. Has positive net earnings; or

B. Can demonstrate a level of working capital adequate in relation to its operating needs.

Notwithstanding any provision of this section or chapter, any bond or security deposit required of a public employer ~~which~~ that is a self-insurer ~~shall~~ may not exceed $50,000, provided that such public employer has a state-assessed valuation equal to or in excess of $300,000,000 and either a bond rating equal to or in excess of the 2nd highest standard as set by a national bond rating agency or a net worth equal to or in excess of $25,000,000. If a county, city or town relies upon a bond rating, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value ~~shall~~ must be incorporated in the annual audit of the county, city or town together with disclosure of funds appropriated to discharge incurred claims expenses. "Public employer" includes the State, the University of Maine System, counties, cities and towns.

In consideration of a self-insuring entity's application for authorization to operate a plan of self-insurance, the superintendent may require or permit an applicant to employ valid risk transfer by the utilization of primary excess insurance, subject to the provisions of subsection 6. Standards respecting the application of primary excess insurance ~~shall~~ must be contained in a regulation promulgated by the superintendent pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375. Primary excess insurance ~~shall~~ must be defined as insurance covering workers' compensation exposures in excess of risk retained by a self-insurer.

As a further alternative to the methods described in this subsection, an employer ~~shall be~~ is eligible for approved self-insurance status pursuant to this Act if the employer submits a written guarantee of the obligations incurred pursuant to this Act, the guarantee to be issued by a United States or Canadian corporation ~~which~~ that is a member of an affiliated group of which the employer is a member, and which corporation is solvent and demonstrates an ability to pay the compensation and benefits, and the guarantee is in a form acceptable to the superintendent. The guarantor shall provide quarterly financial statements, audited annual financial statements and such other information as the superintendent may require, and the employer shall provide a bond as otherwise required by this Act in an amount not less than $1,000,000. Any such guarantor ~~shall be~~ is deemed to have submitted to the jurisdiction of the Workers' Compensation Commission and the courts of this State for purposes of enforcing any such guarantee. The guarantor, in all respects, ~~shall be~~ is bound by and subject to the orders, findings, decisions or awards rendered against the employer for payment of compensation and any penalties or forfeitures provided under this Act. The superintendent, following hearing, may revoke the self-insured status of the employer if at any time the assets of the guarantor become impaired, encumbered or are otherwise found to be inadequate to support the guarantee.

Sec. A-25. 39 MRSA §51-B, sub-§7, as amended by PL 1989, c. 502, Pt. D, §22, is further amended to read:

7. Notice of controversy. If the employer, prior to making payments under subsection 3, controverts the claim to compensation, the employer shall file with the commission, within 14 days after an event ~~which~~ that gives rise to an obligation to make payments under subsection 3, a notice of controversy in a form prescribed by the commission. If the employer, prior to making payments under subsection 4, controverts the claim to compensation, the employer shall file with the commission, within 75 or 90 days, as applicable, after an event ~~which~~ that gives rise to an obligation to make payments under subsection 4, a notice of controversy in a form prescribed by the commission. The notice ~~shall~~ must indicate the name of the claimant, name of the employer, date of the alleged injury or death and the grounds upon which the claim to compensation is controverted. The employer shall promptly furnish the employee with a copy of the notice.

If, at the end of the 14-day period in subsection 3 or the 90-day or 75-day periods in subsection 4, the employer has not filed the notice required by this subsection, the employer shall begin payments as required under those subsections. In the case of compensation for incapacity under subsection 3, the employer may cease payments or continue payments as provided in subsection 8 and file with the commission a notice of controversy, only as provided in this subsection, no later than ~~44~~ 60 days after an event ~~which~~ that gives rise to an obligation to make payments under subsection 3. Failure to file the required notice of controversy prior to the expiration of the ~~44-day~~ 60-day period, in the case of compensation under subsection 3, constitutes acceptance by the employer of the compensability of the injury or death. Failure to file the required notice of controversy does not constitute such an acceptance by the employer when it is shown that the failure was due to employee fraud or excusable neglect by the employer, except when payment has been made and a notice of controversy is not filed within ~~44~~ 60 days of that payment. Failure to file the required notice of controversy prior to the expiration of the 90-day period under subsection 4 constitutes acceptance by the employer of the extent of impairment claimed. Failure to file the required notice of controversy prior to the expiration of the 75-day period under subsection 4 for compensation for medical expenses, aids or other services pursuant to section 52 constitutes acceptance by the employer of the reasonableness and propriety of the specific medical services for which compensation is claimed and requires payment for those services, but does not constitute acceptance of the compensability of the injury or death.

If, at the end of the ~~44-day~~ 60-day period the employer has not filed a notice of controversy, or if, pursuant to a proceeding before the commission, the employer is required to make payments, the payments may not be decreased or suspended, except as provided in section 100.

Sec. A-26. 39 MRSA §52-A, sub-§2, as enacted by PL 1981, c. 514, §2, is repealed and the following enacted in its place:

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

A. Within 5 business days from the completion of a medical examination or within 5 business days from the date notice of injury is given to the employer, whichever is later, the employee's health care provider shall forward to the employer and the employee a diagnostic medical report, on forms prescribed by the Medical Coordinator, for the injury for which compensation is being claimed. The report must include the employee's work capacity, likely duration of incapacity, return to work suitability and treatment required. The Medical Coordinator may assess penalties up to $500 per violation upon health care providers who fail to comply with the 5-day requirement of this subsection.

B. If ongoing medical treatment is being provided, every 30 days the employee's health care provider shall forward to the employer and the employee a diagnostic medical report on forms prescribed by the Medical Coordinator. An employer may request, at any time, medical information concerning an employee's condition pertaining to the condition for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request.

C. Any health care provider shall submit to the employer and the employee a final report of treatment within 5 working days of the termination of treatment, except that only an initial report must be submitted if the provider treated the employee on a single occasion.

D. In the event that an employee changes physicians or is referred to a different health care provider or facility, any health care provider or facility having medical records regarding the employee, including x rays, shall forward all medical records relating to an injury or disease for which compensation is claimed to the next physician upon request of the employee. When an employee is scheduled to be treated by a different physician or in a different facility, the employee shall request to have the records transferred.

E. The reporting requirements of paragraph A do not apply to claims for medical benefits only.

F. The provider may not charge the employer or carrier an amount in excess of the fees prescribed in section 52-B for the submission of reports prescribed by this section and for the submission of any additional records. An insurer or self-insurer may withhold payment of fees for the submission of reports of treatment required by this section to any provider who fails to submit the reports on the forms prescribed by the Medical Coordinator and within the time limits provided. The insurer or self-insurer is

not required to file a notice of controversy under these circumstances, but must notify the provider that payment is being withheld due to the failure to use prescribed forms or to submit the reports in a timely fashion. In the case of dispute, any interested party may petition the commission to resolve the dispute.

Sec. A-27. 39 MRSA §52-B, as enacted by PL 1987, c. 559, Pt. B, §22, is amended by adding at the end a new paragraph to read:

In order to qualify for reimbursement for health care services provided to employees under this Title, health care providers providing individual health care services and courses of treatment may not charge more for the services or courses of treatment for employees than is charged to private 3rd-party payers for similar services or courses of treatment. An employer is not responsible for charges that are determined to be excessive or treatment determined to be inappropriate by an independent medical examiner pursuant to section 92-A.

Sec. A-28. 39 MRSA §52-C is enacted to read:

§52-C. Restriction on reimbursement for health care providers

To qualify for reimbursement for health care services provided after October 31, 1995, to employees under this Title, health care providers providing individual health care services and courses of treatment must have successfully completed the occupational health training program established in section 83-A.

Sec. A-29. 39 MRSA §53-C is enacted to read:

§53-C. Effect of volunteer service

An employee may serve in a volunteer capacity, if that capacity is consistent with any medical restrictions, for a public entity or nonprofit organization organized under the provisions of Title 13-B, subsection 405 or the Internal Revenue Code, section 501(C)(3) and the fact of that volunteer service has no effect on any determination of capacity to work under this Title.

Sec. A-30. 39 MRSA §57, as amended by PL 1985, c. 372, Pt. A, §22, is repealed.

Sec. A-31. 39 MRSA §57-B, sub-§13, as enacted by PL 1985, c. 372, Pt. A, §23, is amended to read:

13. Applicability. Reimbursement under this section is available solely with respect to employees who are injured and rehabilitated after the effective date of this section. If reimbursement is available from the Employment Rehabilitation Fund under this section, reimbursement ~~shall~~ may not be available ~~from the Second Injury Fund~~ under section ~~57~~ 57-D.

Sec. A-32. 39 MRSA §57-C, sub-§3, as enacted by PL 1985, c. 372, Pt. A, §23, is amended to read:

3. Assessment waived. If, at the end of a calendar quarter, the amount of deposit in the Employment Rehabilitation Fund, in that portion attributable to this section, is equal to or exceeds the amount derived from the last assessment, the assessment for that quarter ~~shall~~ must be waived and not levied or imposed.

A. The Treasurer of State shall notify the State Tax Assessor on the day after the end of the calendar quarter, if the fund equals or exceeds that amount.

B. If so notified, the State Tax Assessor shall immediately notify each insurer that the assessment is waived for that quarter.

Sec. A-33. 39 MRSA §57-D is enacted to read:

§57-D. Permanent total incapacity due partly to prior injury

1. Payment for second injuries. If an employee who has a permanent impairment from any cause or origin that is, or is likely to be, a hindrance or obstacle to employment sustains a personal injury arising out of and in the course of employment that, in combination with the earlier preexisting impairment, results in total permanent incapacity, the employer or the employer's insurance carrier is liable for all compensation provided by this section. The employer or insurance carrier must be reimbursed from the Employment Rehabilitation Fund for compensation payments not attributable to the second injury.

2. Permanent impairment. As used in this section, "permanent impairment" means any permanent physical or mental condition, whether congenital or due to injury or disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee should become unemployed.

3. Employer knowledge. In order to qualify under this section for reimbursement from the Employment Rehabilitation Fund, the employer must establish that the employer had knowledge of the permanent impairment at the time that the employee was hired or at the time the employee was retained in employment after the employer acquired that knowledge.

4. Jurisdiction. The commission has jurisdiction over all claims brought by employers or insurance carriers against the Employment Rehabilitation Fund. The Employment Rehabilitation Fund may not be bound as to any question of law or fact by reason of any award or any adjudication to which it was not a party or in relation to which it was not notified, at least 3 weeks prior to the award or adjudication, that it might be subject to liability for the injury or death. An employer or its insurance carrier shall

notify the commission of any possible claim against the Employment Rehabilitation Fund as soon as practicable, but in no event later than 3 years after the injury or death.

5. Legal representation. The Attorney General shall provide legal representation for any claim made under this section. The reasonable expenses of prosecution or defense by the Attorney General of claims against the Employment Rehabilitation Fund, subject to the approval of the Workers' Compensation Commission, are payable out of the Employment Rehabilitation Fund. The Attorney General may not defend the Employment Rehabilitation Fund against any claim brought by the State. The commission is authorized to hire, using funds from the Employment Rehabilitation Fund, private counsel to defend any claim brought against the Employment Rehabilitation Fund by the State.

6. Contributions to Employment Rehabilitation Fund. Until the chair of the commission determines that the Second Injury Fund is no longer required under section 57-E, in every case of the death of any employee when there is no person entitled to compensation, the employer shall pay to the Treasurer of State a sum equal to 100 times the average weekly wage in the State as computed by the Employment Security Commission for benefit of the Second Injury Fund.

7. Transitional eligibility. Employers and insurance carriers that were eligible for or were receiving reimbursement under the Second Injury Fund are eligible for reimbursement under this section.

8. Applicability. This section does not apply to cases in which reimbursement is available from the Employment Rehabilitation Fund under section 57-B.

Sec. A-34. 39 MRSA §57-E is enacted to read:

§57-E. Contribution from employers; transfer from Second Injury Fund

After the chair determines that the Second Injury Fund is no longer required under this section, in every case of the death of an employee when there is no person entitled to compensation, the employer shall pay to the Treasurer of State a sum equal to 100 times the average weekly wage in the State as computed by the Employment Security Commission for benefit of the Employment Rehabilitation Fund.

When the chair of the commission determines that the Second Injury Fund established pursuant to former section 57 is no longer required for payments to employers or insurance carriers, the chair shall direct that the Treasurer of State transfer the balance in the account to the Employment Rehabilitation Fund and the Treasurer of State shall deposit the balance to the Employment Rehabilitation Fund.

Sec. A-35. 39 MRSA §65, 2nd ¶, as repealed and replaced by PL 1965, c. 408, §8, is amended to read:

The commission or any commissioner may at any time after the injury appoint a competent and impartial physician or surgeon to act as medical examiner, the reasonable fees of whom ~~shall be~~ are fixed by the commission. Upon order of the commission or any commissioner, the fee for the examination must be paid by the employer. Such medical examiner, after being furnished with such information in regard to the matter as may be deemed essential for the purpose, shall thereupon and as often as the commission or the said commissioner may direct, examine such injured employee in order to determine the nature, extent and probable duration of the injury, or the percentage of permanent impairment. ~~He~~ The medical examiner shall file in the office of the commission a report of every such examination, and a copy thereof ~~shall~~ must be sent to each of the interested parties, who upon request therefor ~~shall~~ must be given the opportunity at a hearing, before decree is rendered, to question said impartial examiner as to any matter included in such report.

Sec. A-36. 39 MRSA §65, 4th ¶, as repealed and replaced by PL 1965, c. 408, §8, is amended to read:

If any employee refuses or neglects to submit ~~himself~~ to any reasonable examination provided for in this Act, or in any way obstructs any such examination, or if ~~he~~ the employee declines a service ~~which~~ that the employer is required to provide under this Act, then, upon the filing of a petition ~~of said~~ or of a notice of automatic discontinuance by the employer ~~and hearing before the commission~~ pursuant to section 100, such employee's rights to compensation ~~shall be~~ are forfeited during the period of said infractions if the commission finds that there is adequate cause to do so.

Sec. A-37. 39 MRSA §66-A, sub-§3, as amended by PL 1989, c. 388, is further amended to read:

3. Time period; discrimination prohibited. The employer's obligation to reinstate the employee continues until one year, or ~~2~~ 3 years if the employer has over ~~250~~ 200 employees, after the ~~employee has reached the stage of maximum medical improvement in the judgment of the commission~~ date of the injury. An employer who reinstates an employee under this section may not subsequently discriminate against that employee in any employment decision, including decisions related to tenure, promotion, transfer or reemployment following a layoff, because of the employee's assertion of a claim or right under this Act. Nothing in this subsection may be construed to limit any protection offered to an employee by section 111.

Sec. A-38. 39 MRSA §66-A, sub-§4, as enacted by PL 1987, c. 559, Pt. B, §35, is repealed.

Sec. A-39. 39 MRSA §66-B is enacted to read:

§66-B. Light-duty work pools

Employers may form light-duty work pools for the purpose of encouraging the return to work of injured employees.

Sec. A-40. 39 MRSA §72, as amended by PL 1981, c. 291, §1, is further amended to read:

§72. Interest on awards

Upon each award of the Workers' Compensation Commission, interest ~~shall~~ must be assessed from the date on which the petition is filed at a rate of ~~6%~~ 8% per year, ~~provided~~ except that if the prevailing party at any time requests and obtains a continuance for a period in excess of 30 days interest will be suspended for the duration of the continuance. From and after the date of the decree, interest ~~shall be~~ is allowed at the rate of ~~10%~~ 15% per year. Payment of any interest allowed after the 10th day following the date of the decree is not an element of loss for the purpose of establishing rates for workers' compensation insurance. This section ~~shall~~ must be enforced by the Workers' Compensation Commission.

Sec. A-41. 39 MRSA §92, sub-§10 is enacted to read:

10. Information. The commission shall maintain a toll-free telephone number to enable employees and employers to obtain information from the commission.

Sec. A-42. 39 MRSA §94-A, sub-§1-A is enacted to read:

1-A. Notice to employer. The commission shall notify an employer when an informal conference or formal hearing is scheduled, when a notice of settlement is filed and when any other proceeding regarding a claim of an employee of that employer is scheduled.

Sec. A-43. 39 MRSA §94-B, sub-§3, as amended by PL 1983, c. 479, §19, is further amended by adding a new 2nd blocked paragraph to read:

The employer or representative of the employer or insurer who attends the informal conference must be familiar with the employee's claim and has full authority to make decisions regarding the claim. The commissioner may assess a penalty in the amount of $100 against any employer or representative of the employer or insurer who attends the conference without full authority to make decisions regarding the claim. If a representative of the employer attends the informal conference or any other proceeding of the commission, the representative shall notify the employer of all actions by the representative on behalf of the employer and any other actions at the proceeding.

Sec. A-44. 39 MRSA §95, as amended by PL 1989, c. 256, §4, is further amended to read:

§95. Time for filing petitions

Any employee's claim for compensation under this Act ~~shall be~~ is barred unless an agreement or a petition as provided in section 94 ~~shall be~~ is filed within 2 years after the date of the injury, or, if the employee is paid by the employer or the insurer, without the filing of any petition or agreement, within 2 years of any payment by such employer or insurer for benefits otherwise required by this Act. The 2-year period in which an employee may file a claim does not begin to run until the employee's employer, if the employer has actual knowledge of the injury, files a first report of injury as required by section 106 of the Act. Any time during which the employee is unable by reason of physical or mental incapacity to file the petition ~~shall~~ is not ~~be~~ included in the period provided in this section. If the employee fails to file the petition within that period because of mistake of fact as to the cause and nature of the injury, the employee may file the petition within a reasonable time. In case of the death of the employee, there ~~shall be~~ is allowed for filing said petition one year after that death. No petition of any kind may be filed more than ~~10~~ 6 years following the date of the latest payment made under this Act. For the purposes of this section, payments of benefits made by an employer or insurer pursuant to section 51-B or 52 ~~shall be~~ are considered payments under a decision pursuant to a petition, unless a timely notice of controversy has been filed.

Sec. A-45. 39 MRSA §103-B, sub-§2-A, as enacted by PL 1989, c. 412, §§2 and 5, is amended to read:

2-A. Basis. There ~~shall~~ may be no appeal upon questions of fact found by the commission or by any commissioner, except to correct manifest error or injustice. Unless continued by law, this subsection is repealed June 30, 1993.

Sec. A-46. 39 MRSA §103-B, sub-§2-B is enacted to read:

2-B. Basis; effective date. There may be no appeal upon questions of fact found by the commission or any commissioner. This section takes effect June 30, 1993.

Sec. A-47. 39 MRSA §104-A, sub-§2-A, as enacted by PL 1987, c. 559, Pt. B, §45, is amended to read:

2-A. Failure to pay within time limits. An employer or insurance carrier who fails to pay compensation, as provided in this section, ~~shall~~ must be penalized as provided in this subsection.

A. Except as otherwise provided by section 51-B, subsection 9, if an employer or insurance carrier fails to pay compensation as provided in this section, the ~~commission~~ Superintendent of Insurance shall assess against the employer or insurance carrier a forfeiture of up to ~~$100~~ $200 for each day of noncompliance. If the ~~commission~~ Superintendent of Insurance finds that the employer or insurance carrier was prevented from complying with this section because of circumstances beyond their control, no forfeiture may be assessed.

(1) ~~One-half of the forfeiture shall be paid to the employee to whom compensation is due and 1/2 shall be paid~~ The forfeiture for each day of noncompliance must be divided as follows: Of each day's forfeiture amount, the first $50 must be paid to the employee to whom compensation is due and the remainder must be paid to the commission and be credited to the General Fund.

(2) If a forfeiture is assessed against any employer or insurance carrier under this subsection on petition by an employee, the employer or insurance carrier shall pay reasonable costs and attorney fees, as determined by the ~~commission~~ Superintendent of Insurance, to the employee.

(3) Forfeitures assessed under this subsection may be enforced by the Superior Court in the same manner as provided in section 103-E.

B. Payment of any forfeiture assessed under this subsection ~~shall~~ is not ~~be~~ considered an element of loss for the purpose of establishing rates for workers' compensation insurance.

Sec. A-48. 39 MRSA §104-B, sub-§3, as enacted by PL 1981, c. 474, §4, is amended to read:

3. Subrogation. Any insurer determined to be liable for benefits under subsection 2 ~~shall~~ must be subrogated to the employee's rights under this Act for all benefits the insurer has paid and for which another insurer may be liable. Any such insurer may, in accordance with rules ~~prescribed~~ adopted by the ~~commission~~ Superintendent of Insurance, file a ~~petition for an~~ request for appointment of an arbitrator to determine apportionment of liability among the responsible insurers. ~~The commission has jurisdiction over all claims for apportionment under this section. In any proceeding for apportionment, no insurer is bound as to any finding of fact or conclusion of the law made in a prior proceeding in which it was not a party.~~ The arbitrator's decision is limited to a choice between the submissions of the parties and may not be calculated by averaging. Within 30 days of the request, the Superintendent of Insurance shall appoint a neutral arbitrator who shall decide, in accordance with the rules adopted by the Superintendent of Insurance, respective liability among or between insurers. Arbitration pursuant to this subsection will be the exclusive means for resolving apportionment disputes among insurers and the decision of the arbitrator is conclusive and binding among all parties involved. Apportionment decisions made under this subsection may not affect an employee's rights and benefits under this Act.

Sec. A-49. 39 MRSA §106, sub-§1, as repealed and replaced by PL 1987, c. 559, Pt. B, §46, is amended to read:

1. Injuries. Whenever any employee has reported to an employer under the Act any injury arising out of and in the course of ~~his~~ the employee's employment ~~which~~ that has caused the employee to lose a day's work ~~or has required the services of a physician~~, or whenever the employer has knowledge of any such injury, the employer shall report the injury to the commission within 7 days after ~~he~~ the employer receives notice or has knowledge of the injury. The employer shall also report the average weekly wages or earnings of the employee, together with any other information required by the commission. The employer shall report whenever the injured employee resumes ~~his~~ the employee's employment and the amount of ~~his~~ the employee's wages or earnings at that time. The employer shall complete a first report of injury form for any injury that has required the services of a health care provider within 7 days after the employer receives notice or has knowledge of the injury. The employer shall provide a copy of the form to the injured employee and retain a copy for the employer's records but is not obligated to submit the form to the commission unless the injury later causes the employee to lose a day's work.

Sec. A-50. 39 MRSA §106, sub-§2, as repealed and replaced by PL 1987, c. 559, Pt. B, §46, is repealed and the following enacted in its place:

2. Settlements. Settlements are subject to this subsection as follows.

A. Whenever any settlement is made with an injured employee by the employer or insurance carrier for compensation covering any specific period under an approved agreement or a decree or covering any period of total or partial incapacity that has ended, the employer or carrier shall file with the commission a duplicate copy of the settlement receipt or agreement signed by the employee showing the total amount of money paid to the employee for that period or periods, but the settlement receipt or agreement is not binding without the commission's approval.

B. At least 14 days prior to submitting any residual market settlement agreement that is in excess of $10,000 to the commission for approval, the insurance carrier shall give notice of the settlement to the

employer. If the employer objects to the settlement agreement, the employer shall give notice of the grounds for objection to the carrier within 7 days of receipt of the agreement. If an employer gives notice of objection under this paragraph, within 60 days of the commission approving a settlement the employer may appeal inclusion of all or part of the settlement payment in calculation of the experience modification factor to the Superintendent of Insurance. Within 30 days from the date notice of appeal was filed, both parties shall submit any relevant information to the superintendent and within 60 days from receipt of the appeal notice the superintendent shall issue a decision based upon the written submissions of the parties. Upon issuance of a decision by the superintendent, either party may request a hearing before the superintendent pursuant to Title 24-A, section 229. The procedures set forth in Title 24-A, section 2320 do not apply to appeals pursuant to this section.

C. A settlement approved under paragraph A while the injured employee is participating in a rehabilitation plan does not affect the injured employee's rights to complete the plan.

Sec. A-51. 39 MRSA §106, sub-§3, as repealed and replaced by PL 1987, c. 559, Pt. B, §46, is amended to read:

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

Sec. A-52. 39 MRSA §106, sub-§4 is enacted to read:

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

Sec. A-53. 39 MRSA §114 is enacted to read:

§114. Compilation of claims information

A person or entity may not compile for the purpose of distribution and sale listings of employee names and information regarding their claims with the commission. Any person or entity found by the commission to have violated this section is subject to the remedy provision of the Maine Human Rights Act, Title 5, sections 4613 and 4614.

Sec. A-54. 39 MRSA §192, first ¶, as amended by PL 1977, c. 696, §415, is further amended to read:

On request of a party or on its own motion the commission may in occupational disease cases appoint one or more competent and impartial physicians~~, their reasonable fees and expenses to be fixed and paid by the commission~~. Upon order of the commission, the fees and expenses of the health care provider or health care providers must be paid by the employer. These appointees shall examine the employee and inspect the industrial conditions under which ~~he~~ the employee has worked in order to determine the nature, extent and probable duration of ~~his~~ the occupational disease, the likelihood of its origin in the industry and the date of incapacity. Section 65 of the Workers' Compensation Act ~~shall apply~~ applies to the filing and subsequent proceedings on their report, and to examinations and treatments by the employer.

Sec. A-55. Report. The Director of the Maine Human Rights Commission and the Chair of the Workers' Compensation Commission shall consult and issue a joint report by October 1, 1992 to the Joint Standing Committee on Banking and Insurance and the Joint Standing Committee on Labor on unlawful discrimination against injured employees, the need for coordination between the Maine Human Rights Commission and the Workers' Compensation Commission and any legislation and agency rules needed to protect injured employees from unlawful discrimination.

Sec. A-56. Public advocate for insurance study. The Office of Policy and Legal Analysis shall study the establishment of a public advocate for insurance to represent the public interest in proceedings with regard to all lines of insurance. A report containing background information and options for legislative action must be presented to the Joint Standing Committee on Banking and Insurance for the Second Regular Session of the 115th Legislature no later than November 1, 1991.

Sec. A-57. Allocation. The following funds are allocated from the Safety Education and Training Fund to carry out the purposes of this Act.

	1991-92	1992-93
LABOR, DEPARTMENT OF		
Bureau of Labor Standards		
All Other	$120,000	$100,000
Provides funds of $20,000 for fiscal year 1991-92 for workplace health and safety training programs in the Maine Technical College System. Provides funds of $50,000 for fiscal year 1991-92 and $50,000 for fiscal year 1992-93 for the Center for Occupational Health and Safety at the Central Maine Technical College. Provides funds of $50,000 for fiscal year 1991-92 and $50,000 for fiscal year 1992-93 to fund contracts to support the development of long-term strategies to improve occupational health and safety professional education and resources pursuant to the Maine Revised Statutes, Title 26, section 42-A, subsection 2, paragraph E-2.		

PART B

Sec. B-1. Special Commission to Study the Workers' Compensation Commission. There is established the Special Commission to Study the Workers' Compensation Commission.

1. Membership. The commission consists of 13 members. Six members are appointed by the Governor, 3 members are appointed by the President of the Senate and 3 members are appointed by the Speaker of the House of Representatives. Appointments of the Governor, the President of the Senate and the Speaker of the House of Representatives must be made within 30 days of the effective date of this section. At the commission's first meeting, the members shall select the 13th member by majority vote and that member shall serve as the commission chair. The appointing authorities shall notify the Executive Director of the Legislative Council at the time appointments are made.

2. Scope of study. The Governor, the Joint Standing Committee on Labor, the Joint Standing Committee on Banking and Insurance and any other interested parties may each submit a list of proposed areas for investigation by the commission. All proposals submitted under this section must be submitted to the Executive Director of the Legislative Council no later than October 25, 1991. At its first meeting, the commission shall select, by majority vote, from proposals submitted those that it will review. The scope of the commission's study is limited to those selected proposals.

3. Chair; meetings. The Chair of the Legislative Council shall convene the first meeting of the commission no later than November 1, 1991. At the first meeting, the commission shall elect a chair as provided in section 1 and define its scope of study as provided in section 2. The commission shall meet as often as necessary to complete the study, but must meet at least once each month.

4. Report. The commission shall submit an interim report on the status of the study and any preliminary findings to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by December 1, 1991. A final report including findings, recommendations and any necessary implementing legislation must be submitted to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by March 1, 1992.

5. Staff. The commission may request staff assistance from the Legislative Council and from the Department of Professional and Financial Regulation.

6. Compensation. Legislative members are compensated as provided in the Maine Revised Statutes, Title 3, section 2. Nonlegislative members are compensated for any reasonable expenses.

Sec. B-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92
LEGISLATURE	
Special Commission to Study the Workers' Compensation Commission	
Personal Services	$2,860
All Other	6,700
Provides funds for the Special Commission to Study the Workers' Compensation Commission including per diem for legislative members, expenses for all members, printing costs and other miscellaneous expenses.	
LEGISLATURE TOTAL	$9,560

Sec. B-3. Special Commission to Study the Regulation of the Insurance Industry. There is

established the Special Commission to Study the Regulation of the Insurance Industry.

1. Membership. The commission consists of 13 members. Six members are appointed by the Governor, 3 members are appointed by the President of the Senate and 3 members are appointed by the Speaker of the House of Representatives. Appointments of the Governor, the President of the Senate and the Speaker of the House of Representatives must be made within 30 days of the effective date of this section. At the commission's first meeting, the members shall select the 13th member by majority vote and that member shall serve as the commission chair. The appointing authorities shall notify the Executive Director of the Legislative Council at the time appointments are made.

2. Scope of study. The Governor, the Joint Standing Committee on Labor, the Joint Standing Committee on Banking and Insurance and any other interested parties may each submit a list of proposed areas for investigation by the commission. All proposals submitted under this section must be submitted to the Executive Director of the Legislative Council no later than October 25, 1991. At its first meeting, the commission shall select, by majority vote, from proposals submitted those that it will review. The scope of the commission's study is limited to those selected proposals.

3. Chair; meetings. The Chair of the Legislative Council shall convene the first meeting of the commission no later than November 1, 1991. At the first meeting, the commission shall elect a chair as provided in section 1 and define its scope of study as provided in section 2. The commission shall meet as often as necessary to complete the study, but must meet at least once each month.

4. Report. The commission shall submit an interim report on the status of the study and any preliminary findings to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by December 1, 1991. A final report including findings, recommendations and any necessary implementing legislation must be submitted to the Governor, the Joint Standing Committee on Labor and the Joint Standing Committee on Banking and Insurance by March 1, 1992.

5. Staff. The commission may request staff assistance from the Legislative Council and from the Department of Professional and Financial Regulation.

6. Compensation. Legislative members are compensated as provided in the Maine Revised Statutes, Title 3, section 2. Nonlegislative members are compensated for any reasonable expenses.

Sec. B-4. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92
LEGISLATURE	
Special Commission to Study the Regulation of the Insurance Industry	
Personal Services	$2,860
All Other	6,700
Provides funds for the Special Commission to Study the Regulation of the Insurance Industry including per diem for legislative members, expenses for all members, printing costs and other miscellaneous expenses.	
LEGISLATURE TOTAL	$9,560

PART C

Sec. C-1. 24-A MRSA §2364, sub-§4, ¶C-1 is enacted to read:

C-1. An experience or merit rating plan may not permit in the calculation of experience modification factors consideration of those lost-time cases attributable to work-related injuries that are aggravations of or that combine with any prior lost-time work-related injury to produce an incapacity. The superintendent shall adopt rules to protect employers from the impact of these subsequent injury claims and to equitably compensate insurers that provide coverage to these employers.

Sec. C-2. 24-A MRSA §2366, sub-§11 is enacted to read:

11. Producer fees. The servicing carrier in the residual market shall pay a fee to the producer designated by the employer on renewed policies upon payment of premium due. The fee must be 4% of the first $5,000 of renewal premium and 2.5% of renewal premium in excess of $5,000. The fee must be based on the state standard premium.

Sec. C-3. 39 MRSA §51-B, sub-§8, as amended by PL 1983, c. 682, §6, is further amended to read:

8. Effect of payment. If, within the ~~44-day~~ 60-day period established in subsection 7 and after the payment of compensation for incapacity without an award, the employer elects to controvert the claim to compensation for incapacity, the payment of compensation ~~shall~~ may not be considered to be an acceptance of the claim or an admission of liability. Notwithstanding the provisions of section 99-C, the acceptance of compensation in any case, except by decision or agreement, by the injured employee or ~~his~~ the employee's dependents ~~shall~~ is not ~~be~~ consid-

ered an admission by the employee or ~~his~~ the employee's dependents as to the nature and scope of the employer's liability or a waiver of the right to question the amount of compensation or the duration of the same or the nature of the injury and its consequences.

The employer may continue the payment of compensation for incapacity under subsection 3 following the filing of a notice of controversy and up to the convening of the formal hearing if the notice of controversy was filed prior to the expiration of the 60-day period established in subsection 7. The continuation of payments under these circumstances is not an acceptance of the claim or an admission of liability on the part of the employer. When benefits paid under this paragraph are discontinued prior to a formal hearing but beyond the 60-day period established in subsection 7, the employer must give written notice to the employee at the time of discontinuing and the employee is entitled to an expedited hearing within 14 days after the employee requests a hearing.

Sec. C-4. 39 MRSA §52, first ¶, as amended by PL 1981, c. 93, is further amended to read:

An employee sustaining a personal injury arising out of and in the course of ~~his~~ that employee's employment or ~~is~~ disabled by occupational disease ~~shall be~~ is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer. An injured employee ~~shall have~~ has the right ~~to make his own selection of~~ select a physician or surgeon authorized to practice as such under the laws of the State. Initially the employee may select the employee's own health care provider. Once an employee selects a health care provider, the employee may not change health care providers more than once without seeking approval from an independent medical examiner or the employer. This provision does not limit an employee's right to be treated by a specialist when a referral is made by the employee's health care provider. Once an employee has begun treatment with the specialist, the employee may not seek treatment from a different specialist in the same specialty without prior approval from an independent medical examiner or the employer.

Sec. C-5. 39 MRSA §52, as amended by PL 1989, c. 434, §8, is further amended by adding at the end 2 new paragraphs to read:

The Medical Coordinator, in consultation with the appropriate professional organization representing the health care specialty involved, shall propose rules establishing specific protocols pertaining to the extent and duration of treatment for specific injuries and illnesses, and the chair may adopt these rules.

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

Sec. C-6. 39 MRSA §52-A, sub-§1, as amended by PL 1989, c. 668, is repealed and the following enacted in its place:

1. Certificate of authorization. Authorization from the employee for release of medical information by health care providers to the employer is not required under the following circumstances:

A. The information pertains only to treatment of an injury or disease after the occurrence of an event that gives rise to an obligation to make payments under this Act; and

B. The information pertains only to the initial treatment in paragraph A and all treatments within 5 days of the initial treatment.

Sec. C-7. 39 MRSA §65, first ¶, as amended by PL 1965, c. 513, §81, is further amended to read:

Every employee shall after an injury, at all reasonable times during the continuance of ~~his~~ disability if so requested by ~~his~~ the employer, submit ~~himself~~ to an examination by a physician or surgeon authorized to practice as such under the laws of this State, to be selected and paid by the employer. Once an employer selects a health care provider to examine an employee, the employer may not request that the employee be examined by more than one other health care provider without prior approval from the independent medical examiner or the employee. This provision does not limit an employer's right to request that the employee be examined by a specialist upon referral by the health care provider. Once the employee is examined by the specialist, the employer may not request that the employee be examined by a different specialist in the same specialty without prior approval from the independent medical examiner or the employee. The employee ~~shall have~~ has the right to have a physician or surgeon of ~~his~~ the employee's own selection present at such examination, whose costs ~~shall be~~ are paid by the employer. The employer shall give the employee notice of said right at the time ~~he~~ the employer requests such examination.

Sec. C-8. 39 MRSA §100-A, as amended by PL 1989, c. 580, §20, is repealed.

Sec. C-9. 39 MRSA §100-B is enacted to read:

§100-B. Trial work periods

An employee's return to any work, including work other than the employee's preinjury position or work with a different employer, is governed by this section. An employee's return to any work following the signing of an agreement to discontinue benefits is not governed by this section.

1. Trial work period. A trial work period is deemed to exist for the first 15 working days following an employee's return to any work, except that the employer and employee may agree to a longer trial work period. During this time and while the employee is receiving payment for the employment:

A. The employee's compensation may be reduced to reflect the wages, earnings or salary received from employment; and

B. All obligations under subchapter III-A are suspended.

The employee must provide to the employer a memorandum from the employee's treating health care provider stating that the employee is able to return to work.

2. Restoration of benefits. Any reduction in the employee's weekly compensation must cease and compensation must be restored immediately to the amount being paid before the commencement of the trial work period under the following circumstances:

A. The employee's employment was involuntarily terminated or suspended without good cause; or

B. The employee attempted a trial work period and was unable to adequately perform during the period due to the effects of the employee's prior compensable injury and has submitted to the employer, within 14 days of leaving employment, a memorandum from the same health care provider that furnished the memorandum under subsection 1. The health care provider shall include in the memorandum the provider's opinion that the employee was unable to adequately perform during the period due to the effects of the employee's prior compensable injury and the provider's opinion as to the employee's capacity for other work.

If the employee supplies a memorandum from the employee's health care provider after leaving the employment but in a timely fashion under paragraph B, the employer shall restore benefits retroactively to the date the employee left employment. If the employee does not supply a memorandum from the employee's health care provider in a timely fashion under paragraph B, the employer need not automatically restore benefits and the employee must file a petition for restoration of compensation under section 100.

PART D

Sec. D-1. 24-A MRSA c. 52 is enacted to read:

CHAPTER 52

MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY

§3701. Purpose

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

§3702. Definitions

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

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

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

§3703. Creation

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

1. Workers' compensation. The company shall provide workers' compensation insurance. The company may not write other lines of insurance.

2. Exclusion from guaranty funds. The company and its policyholders are exempt from participation and may not join or contribute financially to, nor be entitled to the protection of, any plan, pool, association or guaranty or insolvency fund authorized or required by this Title.

3. Initial board of directors. The Governor shall appoint the initial board of directors of the company upon notification by the superintendent that sufficient funds have been collected in accordance with section 3704. Upon appointment, the board shall establish its charter consistent with this chapter and pursue the company's authorization as a domestic mutual insurance company of this State.

The board shall establish appropriate underwriting criteria for the acceptance of risks to ensure the sound financial integrity of the company.

§3704. Prerequisites to operations

1. Prerequisites to operations. As of July 1, 1994, if the premium volume of the voluntary market is less than 20% of the total statewide premium volume, or if, by December 31, 1995, the premium volume of the voluntary market is less than 25% of the total statewide premium volume, the operations of the company may be initiated as provided in this section.

For the purpose of this section, the imputed premium of any policyholder that is granted initial authority to self-insure after the effective date of this section is considered to be voluntary market premium.

The determinations required under this section must be made within 8 months after the dates prescribed in the first paragraph.

If the superintendent determines that the voluntary market premiums fail to meet those thresholds, the superintendent shall notify the Governor and the Legislature.

2. Company becomes operational upon appropriation. The company becomes operational only upon the receipt of funds provided by appropriation of the Legislature of no more than $20,000,000. The appropriation must be repaid by the company, plus interest at market interest rate calculated from the time that the company accepts the appropriation. The appropriation repayments must be amortized by the Treasurer of State over a 10-year period and must be repaid by the company to the General Fund in equal installments at the end of each fiscal year. The repayment must begin once there exists sufficient earned surplus to comply with state law.

3. Application for certificate of authority. The Governor shall appoint the initial board of directors, as provided in section 3703, subsection 3, which shall as soon as practicable apply for a certificate of authority. If the application complies with the standards prescribed in this Title, the superintendent shall issue a certificate of authority.

§3705. Nonstate agency

The company is not considered a state agency or instrumentality of the State for any purpose.

§3706. Reports and information

1. Annual report. The board shall submit an annual report to the Governor and Legislature indicating the business done by the company during the previous year and containing a statement of the resources and liabilities of the fund and any other information considered appropriate by the board.

2. Statistical and actuarial data. The company must compile and maintain statistical and actuarial data related to the determination of proper premium rate levels, the incidence of work-related injuries, costs related to those injuries and any other data that the company considers desirable. The company must provide this data to the Superintendent of Insurance, the Chair of the Workers' Compensation Commission and the Department of Labor annually and upon request.

Sec. D-2. 39 MRSA §2, sub-§3-B is enacted to read:

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

Sec. D-3. 39 MRSA §51, sub-§4 is enacted to read:

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

Sec. D-4. 39 MRSA §52-B, as enacted by PL 1987, c. 559, Pt. B, §22, is amended to read:

§52-B. Medical fees; reimbursement levels

In order to ensure appropriate limitations on the cost of health care services, the ~~commission~~ Medical Coordinator shall propose to the chair and the chair may adopt or amend rules under Title 5, chapter 375, that establish:

1. Maximum charges. Standards, schedules or scales of maximum charges for individual services, procedures of courses of treatment. The maximum charges ~~shall~~ may not be less than the usual, customary and reasonable charge paid by private 3rd-party payors for similar services provided by Maine health care providers. In establishing these standards, schedules or scales, the commission shall consult with organizations representing health care providers and other appropriate groups. The standards ~~shall~~ must be adjusted annually to reflect any appropriate changes in levels of reimbursement. The standards shall ~~not~~ apply to hospital costs and health care providers and must be in effect no later than January 1, 1992; and

2. Depositions or hearings. Various fees for preparation of materials, including reports of treatment required in section 52-A, subsection 2, or attendance at depositions or hearings as may be required under this Act.

Sec. D-5. 39 MRSA §52-D is enacted to read:

§52-D. Medical utilization review and case management

1. Purpose. To ensure quality treatment for injured employees and to provide reasonable and proper health care services, the Medical Coordinator shall develop and implement a medical utilization review and case management program consistent with the requirements of this section. The Medical Coordinator shall utilize independent medical examiners from the lists maintained pursuant to section 92-A to perform the medical utilization review and case management.

2. Medical utilization review. A commissioner, employee, employer or insurer may request a medical utilization review of services rendered by a health care provider as follows.

A. The following issues relating to the treatment or proposed treatment of an employee may be presented to an independent medical examiner:

(1) Whether treatment or proposed treatment is excessive, unreasonable or improper;

(2) Whether the services rendered are inadequate with respect to either the level or quality of care;

(3) Whether fees charged by a provider are in excess of the medical fee schedule under section 52-B;

(4) Whether a provider charged more for services provided to an employee under this Act than charged for services to a private 3rd-party payor in violation of section 52-B; or

(5) Whether a proposed surgical procedure is reasonable and necessary to the proper treatment of an employee.

The issues that may be presented to the independent medical examiner may be expanded through rulemaking by the chair, as proposed to the chair by the Medical Coordinator.

B. An employee, employer or insurer may initiate the medical utilization review process by submitting to the Medical Coordinator, the other parties and the provider whose treatment will be reviewed, a request on forms prescribed by the Medical Coordinator.

Within 15 days after a request for medical utilization review has been submitted, the Medical Coordinator shall appoint an independent medical examiner to perform the review and notify the parties and the provider whose treatment will be reviewed of the appointment. The independent medical examiner must be from the same health care field as the provider whose services are being reviewed. The independent medical examiner may not have any prior knowledge of the case or have examined the employee at an earlier time in connection with the case.

C. All parties shall, when notified that an independent medical examiner has been appointed, supply immediately copies of any medical reports or statements relating to the treatment under review to the independent medical examiner. Upon request of the independent medical examiner, the provider shall submit any additional medical records or information within 3 working days of the examiner's request. The independent medical examiner shall review medical information and records regarding the services that are the subject of the review. The independent medical examiner may interview and examine the employee or order the performance of additional medical tests if necessary.

D. If determined necessary by the independent medical examiner, the employee shall submit to an examination at any reasonable time during the review process. The rights of an employee with respect to examinations and penalties as described in section 65 are applicable to this section.

E. The independent medical examiner shall submit the examiner's findings and recommendations to the parties, the provider and the commission within 30 days from the appointment of the examiner. The independent medical examiner may make recommendations appropriate to the issue that is the subject of the review, including but not limited to:

(1) That a provider be paid or not be paid for services that were inappropriate, unreasonable or excessive;

(2) That a provider be partially paid for services charged in excess of the medical fee schedule;

(3) That a provider be partially paid for services provided to an employee under this Act that exceeded the provider's charge for services to a private 3rd-party payor in violation of section 52-B;

(4) That a provider reimburse an employer or insurer for services that were paid for and are found to be inappropriate, unreasonable or excessive; or

(5) That a proposed surgical procedure is not reasonable and necessary to the proper treatment of an employee.

F. Any employee, employer, insurer or provider that seeks to implement the recommendations of the independent medical examiner or that seeks resolution of a dispute related to the treatment under review may file a petition with the commission. The commissioner shall adopt the medical findings of the independent medical examiner unless there is substantial evidence in the record that does not support the medical findings. "Substantial evidence" means at least a preponderance of evidence. "Substantial evidence" does not include medical evidence not considered by the independent medical examiner. The commissioner must state in writing the reasons for not accepting the medical findings of the independent medical examiner.

G. The party requesting the review shall pay the costs of the review. The Medical Coordinator shall establish a reasonable per diem to be paid to the independent medical examiner and set a maximum charge for other expenses the Medical Coordinator finds necessary for the review process.

3. Case management program. The Medical Coordinator shall create a case management program for cases involving unusually lengthy or expensive medical services, or cases involving chronic conditions that are unresponsive to standard medical treatment. The program must use independent medical examiners acting as case managers. The program must include at least the following elements:

A. The guidelines for the types of cases that may be reviewed by a case manager;

B. The process by which a party or a commissioner may request that an independent medical examiner may be appointed to act as a case manager;

C. The treatment issues that may be addressed by the case manager; and

D. The method by which the recommendations of the case manager may be enforced.

4. Penalties. If the Medical Coordinator finds from a review of the findings of independent medical examiners that a provider has demonstrated a pattern of overcharging for services or of rendering services that are inappropriate, unreasonable or excessive, or has submitted false testimony or a false report in connection with any claim, the Medical Coordinator shall provide the licensing board of the provider with full documentation of this determination. The Medical Coordinator may also order an appropriate remedy including, but not limited to, an order barring the provider from receiving any payment under this Act for services rendered for a period not to exceed one year in the first instance and 3 years in the 2nd instance. The Medical Coordinator may permanently bar a provider from eligibility for payment of services under the Act for subsequent instances. The provider may appeal any order of the Medical Coordinator to the chair.

5. Rules. The Medical Coordinator may propose to the chair rules to carry out the purposes of this section and the chair may adopt those rules. In proposing these rules, the Medical Coordinator shall consult with organizations knowledgeable about health care utilization and cost containment, including health care providers and insurers that have implemented utilization review and case management.

Sec. D-6. 39 MRSA §54-B, sub-§2, as enacted by PL 1987,c. 559, Pt. B, §27, is amended to read:

2. Limitation. Any employee who ~~has reached maximum medical improvement and~~ is able to perform full-time remunerative work in the ordinary competitive labor market in the State, regardless of the availability of such work in and around ~~his~~ that employee's community, is not eligible for compensation under this section, but may be eligible for compensation under section 55-B. Reasonable moving and relocation expenses for employees who are retrained or rehabilitated under this Act are available as provided in section 87, subsection 2.

Sec. D-7. 39 MRSA §55-B, as amended by PL 1989, c. 575, is repealed and the following enacted in its place:

§55-B. Compensation for partial incapacity

While the incapacity for work is partial, the employer shall pay the injured employee a weekly compensation equal to 2/3 the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefit under section 53-B. An employee is not eligible to receive compensation under this section after the employee has received 520 weeks of compensation under section 54-B, this section or both sections.

1. Evaluation standards. This subsection governs the determination of an injured employee's degree of incapacity under this section.

A. During the first 40 weeks from the date of the injury, the commission shall consider the availability of work that the employee is able to perform in and around the employee's community and the employee's ability to obtain such work considering the effects of the employee's work-related injury. If no such work is available in and around the employee's community or if the employee is unable to obtain such work in and around the employee's community due to the effects of a work-related injury, the employee's degree of incapacity under this section is 100%. The employee has the burden of production and proof on the availability of work.

B. After the first 40 weeks from the date of injury, the employer has the burden of production regarding the employee's capacity to perform work and the burden of producing a list of suitable and available job positions within the State. The employee has the burden of production regarding a good-faith exploration of the positions on the list. The employee bears the ultimate burden of proof to show that the employee was not hired for one of the positions. The employer shall pay all reasonable expenses incurred by the employee in conducting the exploration of the positions on the list provided by the employer.

2. Relocation expenses. If an employee is hired for a permanent position obtained from the list of positions provided by the employer under subsection 1, paragraph B, and that position requires the employee to move and the employee changes residence to take the position, the employer must pay the employee up to $1,000 for actual moving expenses.

Sec. D-8. 39 MRSA §56-B, sub-§1, as enacted by PL 1987, c. 559, Pt. B, §33, is amended to read:

1. Weekly benefit. In the case of permanent impairment, the employer shall pay the injured employee a weekly benefit equal to 2/3 of the state average weekly wage, as computed by the Bureau of Employment Security, for the number of weeks shown in the following schedule:

A. One week for each percent of permanent impairment to the body as a whole from 0 to 14%;

B. Three weeks for each percent of permanent impairment to the body as a whole from 15% to 50%;

C. Four and 1/2 weeks for each percent of permanent impairment to the body as a whole from 51% to 85%; and

D. Eight weeks for each percent of permanent impairment to the body as a whole greater than 85%.

Compensation under this section is ~~in addition to~~ reduced by any compensation under section 54-B or 55-B received by the employee.

Sec. D-9. 39 MRSA §82, sub-§3, ¶D, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

D. The administrator shall assist the ~~chairman~~ chair in developing rules under section 92, subsection 1, regarding rehabilitation, including, but not limited to, rules governing minimum standards for providers of rehabilitation services, the types of services each category of provider is qualified to provide and procedures for rehabilitation cases.

The minimum standards for approved providers of rehabilitation services must include a combination of medical and employment rehabilitation education and experience and are governed by the following requirements.

(1) The standards must separately consider the providers of the following 3 employment rehabilitation services:

(a) Evaluations of suitability for employment rehabilitation;

(b) Development of a plan for employment rehabilitation; and

(c) Implementation of the employment rehabilitation plan.

(2) The standards must include minimum levels of success in the completion by the employee of the rehabilitation plan in placement in suitable employment as similar as possible to the employee's regular employment at a wage as close as possible to the employee's wage at the time of injury.

(3) The standards must state that providers of evaluations of suitability may not perform employment rehabilitation development or implementation services or be employed by or have an ownership interest in any firm or organization that provides rehabilitation plan development or implementation services.

Sec. D-10. 39 MRSA §82, sub-§3, ¶F, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

F. The administrator shall develop fee schedules for providers of rehabilitation services, listing the maximum allowable fees for testing, evaluations of suitability, development of rehabilitation plans and other rehabilitation services.

(1) In setting a fee, the administrator shall take into account the usual fee charged to provide that service in the State and the reasonable and necessary costs of providing the service.

(2) The administrator may grant prior approval of a fee higher than the maximum in the rate schedule in exceptional circumstances.

(3) Fee schedules developed under this paragraph do not apply to services provided by in-house providers of rehabilitation services.

(4) The fee schedule for the provider of a rehabilitation plan must include a maximum

amount for administrative services and costs, not to exceed 30% of the total cost of a plan.

Sec. D-11. 39 MRSA §83, sub-§1, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

1. Reports. Within 120 days following an injury ~~which~~ that gives rise to a claim under this Act, or within 120 days following the first day of a subsequent period of incapacity due to that injury, ~~where~~ when an employee has not returned to ~~his~~ the employee's previous employment, the employer shall submit a report to the administrator to assist in the early identification of those employees who may need rehabilitation to achieve job placement.

A. The report ~~shall~~ must be in the form prescribed by rule of the commission and ~~shall~~ include information to the best of the employer's knowledge on whether the employee is likely to return to ~~his~~ the employee's previous employment and any other information required by the rule.

B. The report ~~shall~~ must be forwarded to the administrator and a copy provided to the employee.

C. If the employer is unable to determine whether the employee is likely to return to ~~his~~ the employee's previous employment, the employer shall include in the report a date by which ~~he~~ the employer expects this determination to be made and the basis for selecting that date.

D. If the employer reports that the employee is likely to return to ~~his~~ the employee's previous employment, the employer shall include in the report the date by which ~~he~~ the employer expects the employee to return to work and the basis for selecting that date.

E. ~~In either instance, the~~ The employer shall file a supplemental report under this subsection on or before ~~that~~ the date selected in paragraph C or D unless the administrator requires otherwise.

Sec. D-12. 39 MRSA §83, sub-§3, ¶D is enacted to read:

D. The plan must consider the relative costs of proposed services to the employer. In no case may a plan last longer than 2 years nor cost more than $5,000 without demonstration of special and unusual circumstances in that case.

Sec. D-13. 39 MRSA §83-A is enacted to read:

§83-A. Early evaluation screening

The administrator shall adopt rules establishing criteria for early evaluation screening to identify disabilities appropriate for early screening and early entry into employment rehabilitation. In developing the rules and in reviewing them periodically, the administrator shall convene a temporary panel of medical, vocational and rehabilitation experts.

The temporary panel of medical, vocational and rehabilitation experts shall also do the following:

1. Occupational health training program. Develop a short-term occupational health training program that concentrates on workplace evaluation and modification to be provided by physicians who are board certified in occupational medicine; and

2. Medical management services. Identify those occupational illnesses and injuries that would benefit from provision of medical management services by an approved rehabilitation provider prior to beginning employment rehabilitation under this Title.

Sec. D-14. 39 MRSA §84, sub-§1, as enacted by PL 1985, c. 372, Pt. A, §29, is amended to read:

1. Applicability. This section applies to all employers in the State ~~which~~ that maintain~~, on January 1, 1986,~~ a certified rehabilitation counselor on premises to provide rehabilitation services that meet the requirements of this subchapter. These services ~~must~~ may be provided only to their own employees.

Sec. D-15. 39 MRSA §85, sub-§1, as amended by PL 1989, c. 580, §11, is further amended to read:

1. Order of evaluation. When a compensable injury exists and the employee has requested employment rehabilitation upon referral by the treating health care provider or occupational health center, when the employee meets the screening criteria for early evaluation for employment rehabilitation or when the report required under section 83, subsection 1, indicates that the employee is not likely to return to the employee's previous employment, the administrator shall order an evaluation of the suitability of rehabilitation for the employee. If the parties agree to an evaluation, the order is deemed to have been made by the administrator unless notice to the contrary is received by the parties within 14 days after written notice of the agreement is sent to the administrator.

Sec. D-16. 39 MRSA §85, sub-§2-A, ¶F, as enacted by PL 1989, c. 580, §11, is repealed.

Sec. D-17. 39 MRSA §85, sub-§4-A, ¶B is enacted to read:

B. The settlement of a claim between an employee and an employer does not affect the employer's obligation to the fund under this section or under section 57-B, subsection 6, paragraph B, subparagraph (2).

Sec. D-18. 39 MRSA §90, sub-§4 is enacted to read:

4. Repeal. Upon receipt of the report required under subsection 3, the effectiveness of this subchapter must be reviewed by the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. Unless continued by law, this subchapter is repealed September 1, 1993.

Sec. D-19. 39 MRSA §92-A is enacted to read:

§92-A. Independent medical examiners

1. Examiner system. The Medical Coordinator shall develop and implement an independent medical examiner system consistent with the requirements of this section. As part of this system, the Medical Coordinator shall create and maintain a list of health care providers experienced and competent in the treatment of work-related injuries to serve as independent medical examiners from each of the health care fields that the Medical Coordinator finds most commonly used by injured employees. The Medical Coordinator shall propose to the chair rules establishing fees for services rendered by independent medical examiners and any rules considered necessary to effectuate the purposes of this section and the chair may adopt those rules.

2. Duties. The independent medical examiners shall render medical findings on the medical condition of the employee and related issues as specified under this section. The physician or other provider appointed as the independent medical examiner in a case may not be the employee's treating health care provider and may not have treated the employee with respect to the injury for which benefits are being paid. Nothing in this subsection precludes the selection of providers authorized to receive reimbursement under section 52 to serve in the capacity of an independent medical examiner. A physician who has examined an employee at the request of an insurance company or employer in accordance with section 65 during the previous 52 weeks is not eligible to serve as an independent medical examiner.

3. Appointment. The commissioner may select an independent medical examiner from the list of qualified examiners to render medical findings in any dispute relating to the medical condition of a claimant, including disputes that involve the following:

A. Incapacity for work under sections 54-B and 55-B;

B. Determination of maximum medical improvement and degree of impairment under section 56-B;

C. Determination of the proper cost of medical services or aids under section 52 or 52-B;

D. Evaluation of the employee's ability to return to work including physical limitations on ability to commute; and

E. Review of medical services under section 52, 52-B, 52-C or 52-D.

If the commissioner fails to act within 5 days of receipt of a request for an independent medical examination review or report, the Medical Coordinator may select an independent medical examiner.

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

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

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

7. Weight. The commissioner shall adopt the medical findings of the independent medical examiner unless there is substantial evidence in the record that does not support the medical findings. "Substantial evidence" means at least a preponderance of evidence. "Substantial evidence" does not include medical evidence not considered by the independent medical examiner. The commissioner must state in writing the reasons for not accepting the medical findings of the independent medical examiner.

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

9. Annual review. The Medical Coordinator shall create a review process to oversee on an annual basis the quality of performance and the timeliness of the submission of medical findings by the providers approved to serve as independent medical examiners.

Sec. D-20. 39 MRSA §98, as repealed and replaced by PL 1983, c. 479, §21, is amended by adding at the end a new paragraph to read:

The commission shall provide for an expedited process for the scheduling and hearing of petitions for review of automatic discontinuances or reductions under section 100, subsections 4-A and 4-B upon the request of either party. Insofar as practicable, expedited cases must be set for a single hearing and take precedence over all other pending cases for scheduling purposes.

Sec. D-21. 39 MRSA §100, as amended by PL 1987, c. 559, Pt. B, §§41 and 42, is further amended to read:

§100. Petitions for review; automatic discontinuance or reduction of benefits

1. Relief available. Upon the petition of either party, a single commissioner shall review any automatic discontinuance or reduction by an employer pursuant to subsection 4-A or any compensation payment scheme required by this Act for the purposes of ordering the following relief, as the justice of the case may require:

A. Increase, decrease, restoration or discontinuance of compensation.

2. Standard for review. The basis for granting relief under this section is as follows.

A. On the first petition for review brought by a party to an action, the commissioner shall determine the appropriate relief, if any, under this section by determining the employee's present degree of incapacity.

B. Once a party has sought and obtained a determination under this section, it is the burden of that party in all proceedings on ~~his~~ subsequent petitions under this section to prove that the employee's earning incapacity attributable to the work-related injury has changed since that determination.

C. When an order has been issued pursuant to subsection 4-A denying the employee's petition for reinstatement of benefits, the commissioner may not reinstate benefits after a hearing if any of the conditions in subsection 4-A are met.

3. Petition procedure. Sections 96-A to 99 apply to petitions brought under this section.

~~**3-A. Petitions during rehabilitation.** A petition may not be brought during the development or implementation of a rehabilitation plan under section 83, subsection 3 or 4, except in the event of substantial change in the employee's medical condition.~~

~~**4. Payments pending hearing and decision.** If the employee is receiving payments at the time of the petition, the payments may not be decreased or suspended pending the hearing and final decision upon the petition, except in the following circumstances:~~

~~A. The employer and the employee file an agreement with the commission;~~

~~B. The employer or his insurance carrier files a certificate with the commission stating that:~~

~~(1) The employee has left the State for reasons other than returning to his permanent residence at the time of injury;~~

~~(2) The employee's whereabouts are unknown; or~~

~~(3) The employee has resumed work;~~

~~C. The employer or his insurance carrier files a certificate with the commission stating that the employee refuses to submit to an examination; or~~

~~D. The employee refuses an offer of reinstatement to a position which is suitable to his physical condition or the employee is able to return to work and there is work available, in or near the community in which he resides, which is suitable to his physical condition.~~

~~(1) If the employee refuses an offer of reinstatement or fails to return to available suitable work, his benefits shall be reduced in an amount equal to the difference between the employee's weekly benefit and the benefits he would have been entitled to receive if he had accepted reinstatement or returned to available suitable work.~~

~~(2) Benefits shall not be suspended or reduced pending hearing under this paragraph unless the employer has provided the employee with written notice that benefits may be suspended or reduced together with any information relied on by the employer to support the proposed suspension or reduction. The employee has 20 days, after receiving that notice, to submit to the commission any additional information relating to his continued entitlement to benefits.~~

~~(3) Benefits shall not be suspended or reduced pending hearing under this paragraph if the employee shows that, despite a good faith work search, the employee is unable to obtain suitable work.~~

~~(4) Within 30 days after notice to the employee under subparagraph (2), the commission shall enter a provisional order providing for the suspension, reduction or continuation of benefits pending a hearing on the petition. The order shall be based upon the information submitted by both the employer and the employee under this section.~~

~~(5) If benefits are suspended or reduced under this paragraph and the commission, after hearing, reverses the provisional order, either in whole or in part, the commission shall order a lump sum payment of all benefits withheld together with interest at the rate of 6% a year. The employer shall pay this lump sum within 10 days of the order.~~

4-A. Automatic discontinuance or reduction. The employer may discontinue or reduce benefits by sending a certificate by certified mail to the employee and to the commission, together with any information on which the employer relied to support the discontinuance or reduction. The employer may discontinue or reduce benefits under paragraphs A and B no earlier than 21 days from the date that the certificate was mailed to the employee. The certificate must advise the employee of the date when the employee's benefits will be discontinued or reduced, as well as other information as prescribed by the commission, including the employee's appeal rights. The employer may discontinue or reduce benefits pursuant to this section under the following circumstances only:

A. If the employee refuses an offer of reinstatement to a position that is suitable to the employee's medical condition, age, education, skills and prior work experience and the employee's physician or an independent medical examiner has determined that the employee is medically able to perform the employment being offered;

B. If the employee's physician or the independent medical examiner determines that the employee is able to perform actually available employment and:

(1) There is employment suitable to the employee's medical condition, age, education, skills and prior work experience actually available within the community; or

(2) After 40 weeks from the date of the injury, within the State, if the employer demonstrates by affidavit that the position is actually available for the employee by required age, education, skills and prior work experience. If the employee demonstrates by affidavit that the employee applied for up to 3 of the identified positions within 10 days of being notified of availability and, through no fault of the employee, was not employed, the employee must be automatically reinstated;

C. If the employee returns to work other than during a trial work period under section 100-B, or if the employee continues to work following a trial work period;

D. If the employee refuses to submit to a medical examination pursuant to subsection 5;

E. If the employer and the employee file an agreement with the commission;

F. If the employee has left the State for reasons other than returning to the employee's permanent residence at the time of injury and the employer has given notice to the employee by certified mail as evidenced by a signed return receipt or has completed a diligent search;

G. If the employee's whereabouts are unknown and the employer has completed a diligent search for the employee; or

H. If the employee's treating physician or the independent medical examiner determines that the employee is able to return to work without any medical restrictions due to the injury.

The work search standards and burdens of proof described in section 55-B, subsections 1 and 2, are applicable to all hearings under paragraph B.

The report of the independent medical examiner under paragraph H may be dated no earlier than 30 days before the filing of the employer's certificate under this subsection.

If the employee refuses an offer of reinstatement or fails to return to available suitable work, benefits must be reduced in an amount equal to the difference between the employee's weekly benefit and the benefits the employee would have been entitled to receive if the employee had accepted reinstatement or returned to available suitable work.

4-B. Employee's right to hearing. The employee may file a petition for review, contesting the employer's discontinuance or reduction under subsection 4-A. Regardless of whether the employee files a petition prior to the date of the discontinuance or reduction, benefits may be discontinued or reduced as described in the employer's certificate.

A. The commissioner, within 21 days after the employee files a petition for review, may enter an order providing for the continuation or reinstatement of benefits pending a hearing on the petition. The order must be based upon the information submitted by both the employer and the employee under this section.

B. The commissioner shall adopt the medical findings of the independent medical examiner unless there

is substantial evidence in the record that the medical findings are in error. "Substantial evidence" means at least a preponderance of evidence. "Substantial evidence" does not include medical evidence not considered by the independent medical examiner. The commissioner shall state in writing the reasons for not accepting the medical findings of the independent medical examiner.

C. If either party disagrees with the order of the commissioner under paragraph A, that party may request an expedited hearing on the pending petition pursuant to section 98.

D. If an order is not issued under paragraph A and the commissioner, after hearing, reverses that decision, either in whole or in part, the commissioner shall order payment of all benefits withheld together with interest at the rate of 6% a year. The employer shall pay this amount within 10 days of the order.

E. Except as provided in subsection 4-A, paragraph B, the employer has the burden of proof in any hearing under this section.

5. Medical examination. Upon the request of the ~~petitioner, the commission shall order~~ employer or the independent medical examiner, the employee ~~to~~ shall submit to examination by ~~an impartial physician or surgeon designated by the commission from the geographical area where the employee resides~~ the independent medical examiner. The fee for the examination ~~shall~~ must be paid by the employer. ~~Payment of compensation may be decreased or suspended by the commissioner pending final decision on the petition if:~~

~~A. The physician or surgeon certifies to the commission after examination that in his opinion the employee is able to resume work; or~~

~~B. The employee refuses to submit to an examination.~~

6. Recovery of overpayments. ~~Compensation~~ Any compensation paid ~~by the employer after the employee has resumed work may be recovered~~ to an employee from the date the employee is not qualified for compensation to the date the employer automatically discontinued or reduced benefits pursuant to subsection 4-A is recoverable from the employee ~~in a legal action brought by the employer~~ if: the employer discontinued compensation pursuant to subsection 4-A, paragraphs C to G.

~~A. At the time of his filing a petition under this section, the employer also filed a certificate that the employee had resumed work; and~~

~~B. After the hearing the commissioner finds that the petition was properly filed and decrees that compensation cease.~~

7. Report. The chair of the commission shall provide a report to the joint standing committee of the Legislature having jurisdiction over labor matters by December 1, 1992, regarding automatic suspension and reduction of benefits under this section. The report must include:

A. The number of cases in which employers automatically suspended or reduced benefits under subsection 4-A, paragraphs A to H;

B. The number of cases in which employees requested a hearing pursuant to subsection 4-B;

C. The number of cases in which a commissioner entered an order under subsection 4-B, paragraph A and the number of cases in which the order was entered within 21 days;

D. The number of cases in which a commissioner upheld an employer's automatic suspension or reduction of benefits after hearing; and

E. Any other information that the chair considers useful.

Sec. D-22. 39 MRSA §110, sub-§3 is enacted to read:

3. Attorney's fees. Attorney's fees for lump-sum settlements are limited as follows. The employer may be assessed an attorney's fee based on a lump-sum settlement for services on behalf of the employee. The fee may not exceed:

A. Ten percent of the first $50,000 of the settlement;

B. Nine percent of the first $10,000 over $50,000 of the settlement;

C. Eight percent of the next $10,000 over $50,000 of the settlement;

D. Seven percent of the next $10,000 over $50,000 of the settlement;

E. Six percent of the next $10,000 over $50,000 of the settlement; and

F. Five percent of any amount over $100,000 of the settlement.

Sec. D-23. 39 MRSA c. 1, sub-c. V is enacted to read:

SUBCHAPTER V

MEDICAL COORDINATION

§121. Office of Medical Coordination established

The Office of Medical Coordination is established to coordinate medical and occupational health services to injured employees to ensure the delivery of appropriate medical and occupational health services and to implement the medical examiner system and administer and supervise independent medical examiners, medical utilization review and case management under this Title.

§122. Medical Coordinator

1. Appointment. The Medical Coordinator shall direct the Office of Medical Coordination. The Medical Coordinator is referred to in this subchapter as the "coordinator." At any time the position of Medical Coordinator is vacant, the chair of the commission, after consultation with the Commissioner of Human Services and the Commissioner of Professional and Financial Regulation shall submit the names of 3 candidates for the position of Medical Coordinator to the Governor. The Governor may appoint one of the candidates as Medical Coordinator, or may, at the Governor's discretion, reject all candidates and request another list of candidates from the chair. The Medical Coordinator serves for a term of 5 years or until a successor is appointed and qualified.

2. Qualifications. The coordinator must be qualified by training, professional experience or education in employment rehabilitation, medical treatment and occupational health and safety and must be familiar with the workers' compensation system.

3. Powers and duties. In addition to any other provisions in this subchapter, the coordinator has the following powers and duties.

A. The coordinator is responsible for the receipt of reports and other information required under this Title and may require supplementary information needed to fulfill the purposes of this subchapter.

B. The coordinator shall propose rules to the chair and the chair may adopt those rules pursuant to Title 5, chapter 375 to carry out the purposes of this subchapter including, but not limited to the following:

(1) Rules required to create and maintain a list of health care providers experienced and competent in the treatment of work-related injuries to serve as independent medical examiners from each of the health care fields that the coordinator finds most commonly used by injured employees;

(2) Rules required to develop and implement an independent medical examiner system for resolution of disputes by independent medical examiners, including procedures before the independent medical examiner and the parties' ability to propound questions relating to the medical condition of the employee to be submitted to the independent medical examiner;

(3) Rules required to develop and implement a medical utilization and case management program consistent with the requirements of section 52-D. In establishing these rules, the coordinator shall consult with organizations knowledgeable about health care utilization and cost containment, including health care providers and insurers that have implemented utilization review and case management; and

(4) Rules establishing specific protocols pertaining to the extent and duration of treatment for specific injuries and illnesses, and the chair may adopt these rules.

In adopting rules, the chair shall distinguish among and respect the different types of health care providers and health care services.

C. The coordinator shall:

(1) Monitor medical and occupational health services provided to injured workers under this Title;

(2) Encourage agreement and attempt to conciliate differences on medical and occupational health services issues;

(3) Provide leadership in the development of occupational health centers;

(4) Review and make recommendations on the fee schedule established in section 52-B;

(5) Oversee medical utilization review pursuant to section 52-D; and

(6) Together with the chair establish and maintain the fee schedule pursuant to section 52-B.

D. The coordinator may not provide direct medical services. Medical services under this subchapter must be provided by private and public medical professionals and occupational health centers.

E. The coordinator shall make efforts to educate and disseminate information to all persons interested in medical and occupational health services as those services relate to injured workers.

4. Access to records. Except for purposes directly connected with the administration of the Office of Medical Coordination, a person may not solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of any list of, or names of, or any information concerning individuals applying for or receiving

medical coordination services, directly or indirectly derived from the records, papers, files or communications of the Office of Medical Coordination or acquired in the course of the performance of official duties. This subsection does not prevent any employee or that person's employer from obtaining or viewing information relating to the medical coordination services provided to the employee under this subchapter.

Sec. D-24. Implementation of rate reductions. The Superintendent of Insurance shall, in the workers' compensation proceeding authorized pursuant to Private and Special Law 1991, chapter 16 and subsequent rate proceedings, order appropriate reductions in workers' compensation rates to reflect the impact of this Act. The superintendent shall report to the Legislature whether the percentage reductions attested to by the Bureau of Insurance actuary as a result of this Act is adequately reflected in the reductions in these proceedings.

Sec. D-25. Application; retroactivity; average weekly wages, earnings or salary. That section of this Act that enacts the Maine Revised Statutes, Title 39, section 2, subsection 2, paragraph G applies to employees injured on or after the effective date of this Act and retroactively to employees injured before the effective date of this Act except those employees awarded compensation consistent with the holding in Ashby vs. Rust Engineering, 559 A.2d 774 (Me. 1989).

Sec. D-26. Applications. Except as otherwise provided, this Act applies only to injuries occurring on or after the effective date of this Act.

Sec. D-27. Effective date. The following sections take effect January 1, 1992:

1. Those sections in Part A enacting the Maine Revised Statutes:

Title 24-A, section 2362-A;
Title 24-A, section 2362-B;
Title 24-A, section 2365-A;
Title 24-A, section 2366, subsection 5, paragraph C; and
Title 24-A, section 2366, subsection 7-A;

2. Those sections in Part A amending:

Title 24-A, section 2364, subsection 4, paragraph A;
Title 24-A, section 2366, subsection 2, paragraph B;
Title 24-A, section 2366, subsection 3, paragraphs A and B; and
Title 39, section 72; and

3. Those sections in Part C enacting:

Title 24-A, section 2364, subsection 4, paragraph C-1; and
Title 24-A, section 2366, subsection 11.

PART E

Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92	1992-93
WORKERS' COMPENSATION COMMISSION		
Workers' Compensation Commission		
All Other	$35,000	$39,450
Provides funds to establish and operate an "800" telephone number and to provide written notification to employees of workers' compensation actions.		
Office of Medical Coordination		
Positions	(2.0)	(2.0)
Personal Services	$51,677	$77,483
All Other	12,948	17,198
Capital Expenditures	3,500	
TOTAL	$68,125	$94,681
Provides funds to establish the Office of Medical Coordination to include one Medical Coordinator position and one Secretary position with related operating expenses and capital expenditure funds for computer equipment.		
WORKERS' COMPENSATION COMMISSION TOTAL	$103,125	$134,131
PART E TOTAL APPROPRIATIONS	$103,125	$134,131

Effective October 17, 1991, unless otherwise indicated.

CHAPTER 616

S.P. 786 - L.D. 1982

An Act Relating to Average Final Compensation for Purposes of the Maine State Retirement System

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, state employees not deemed essential to the functioning of State Government were unable to work for 8 days during the month of July 1991 and are not being compensated for those days; and