LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND FIFTEENTH LEGISLATURE

THIRD SPECIAL SESSION
October 1, 1992 to October 6, 1992

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J.S. McCarthy Company
Augusta, Maine
1993

PUBLIC LAWS

OF THE

STATE OF MAINE

AS PASSED AT THE

THIRD SPECIAL SESSION

of the

ONE HUNDRED AND FIFTEENTH LEGISLATURE

1991

CHAPTER 885

H.P. 1783 - L.D. 2464

An Act to Reform the Workers' Compensation Act and Workers' Compensation Insurance Laws

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

Whereas, the need for reform of the state workers' compensation system is widely recognized; and

Whereas, the Blue Ribbon Commission to Examine Alternatives to the Workers' Compensation System has been established to recommend workers' compensation system reforms; and

Whereas, that commission has completed its study and proposed draft legislation, which it recommends for immediate enactment; and

Whereas, immediate enactment of workers' compensation reform legislation is necessary to protect the interests of injured workers, businesses and insurers; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

PART A

Sec. A-1. 2 MRSA §6, sub-§7, ¶A, as enacted by PL 1985, c. 372, Pt. A, §1, is repealed.

Sec. A-2. 2 MRSA §7, sub-§2, as amended by PL 1989, c. 502, Pt. A, §5, is repealed.

Sec. A-3. 3 MRSA §927, sub-§11, ¶B, as amended by PL 1991, c. 801, §1 and affected by §9, is further amended to read:

B. Independent agencies:

(1) State Civil Service Appeals Board;

(2) Maine Labor Relations Board;

(3) Workers' Compensation ~~Commission~~ Board;

(4) Board of Accountancy;

(5) State Board of Social Worker Licensure;

(6) Electricians' Examining Board;

(7) Maine Occupational Information Coordinating Committee;

(8) State Employee Health Commission;

(9) Board of Counseling Professionals Licensure; and

(10) Board of Real Estate Appraisers.

Sec. A-4. 5 MRSA §953, as repealed and replaced by PL 1985, c. 601, §1, is repealed.

Sec. A-5. 5 MRSA §12004-G, sub-§35 is enacted to read:

35. Workers' Compensation	Workers' Compensation Board	Lost wages up to $100; expenses	39-A MRSA §151

Sec. A-6. 5 MRSA §12004-I, sub-§§89 and 90, as enacted by PL 1987, c. 786, §5, are repealed.

Sec. A-7. 39 MRSA, as amended, is repealed.

Sec. A-8. 39-A MRSA is enacted to read:

TITLE 39-A

WORKERS' COMPENSATION

PART 1

MAINE WORKERS' COMPENSATION ACT OF 1992

CHAPTER 1

GENERAL PROVISIONS

§101. Short title

This Part may be known and cited and referred to in proceedings and agreements under this Part as the "Maine Workers' Compensation Act of 1992."

§102. Definitions

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

1. After-tax average weekly wage. "After-tax average weekly wage" means average weekly wage, as defined in subsection 4, reduced by the prorated weekly amount that would have been paid under the Federal Insurance Contributions Act, 26 United States Code, Sec-

tions 3101 to 3126, state income tax and federal income tax calculated on an annual basis, using as the number of exemptions the disabled employee's dependents plus the employee, and without excess itemized deductions. Effective January 1, 1993 and each January 1st thereafter, the applicable federal and state laws in effect on the preceding July 1st are used in determining the after-tax weekly wage. Each December 1st the board shall publish tables of the average weekly wage and 80% of after-tax average weekly wage that will take effect on the following January 1st. These tables are conclusive for the purpose of converting an average weekly wage into 80% of after-tax average weekly wage.

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

A. The planting, cultivating, producing, growing and harvesting of agricultural or horticultural commodities on those premises;

B. The raising of livestock and poultry on those premises; or

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

(1) Are incident to or in conjunction with growing and harvesting farm operations of the same employer; and

(2) Are not provided as a service for other farm operations or employers.

3. Aquaculture. "Aquaculture" means the commercial culture or husbandry of oysters, clams, scallops, mussels, salmon or trout.

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

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

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

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

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

(2) Notwithstanding subparagraph (1), the term "seasonal worker" includes, but is not limited to, any employee who is employed directly in agriculture or in the harvesting or initial hauling of forest products.

D. When the methods set out in paragraph A, B or C of arriving at the average weekly wages, earnings or salary of the injured employee can not reasonably and fairly be applied, "average weekly wages" means the sum, having regard to the previous wages, earnings or salary of the injured employee and of other employees of the same or most similar class working in the same or most similar employment in the same or a neighboring locality, that reasonably represents the weekly earning capacity of the injured employee in the employment in which the employee at the time of the injury was working.

E. When the employee is employed regularly in any week concurrently by 2 or more employers, for one of whom the employee works at one time

and for another of whom the employee works at another time, the employee's average weekly wages are computed as if the wages, earnings or salary received by the employee from all such employers were wages, earnings or salary earned in the employment of the employer for whom the employee was working at the time of the injury.

F. When the employer has paid the employee a sum to cover any special expense incurred by the employee by the nature of the employee's employment, the sum paid is not reckoned as part of the employee's wages, earnings or salary.

G. The fact that an employee has suffered a previous injury or received compensation for a previous injury does not preclude compensation for a later injury or for death; but, in determining the compensation for a later injury or death, the employee's average weekly wages are the sum that will reasonably represent the employee's weekly earning capacity at the time of the later injury in the employment in which the employee was working at that time, and are computed according to and subject to the limitations of this subsection.

H. "Average weekly wages, earnings or salary" does not include any fringe or other benefits paid by the employer that continue during the disability. Any fringe or other benefit paid by the employer that does not continue during the disability must be included for purposes of determining an employee's average weekly wage to the extent that the inclusion of the fringe or other benefit will not result in a weekly benefit amount that is greater than 2/3 of the state average weekly wage at the time of injury.

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

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

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

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

A. A wife upon a husband with whom she lives, or from whom she is living apart for a justifiable cause or because he has deserted her, or upon whom she is actually dependent in any way at the time of the injury. A wife living apart from her husband shall produce a court order or other competent evidence as to separation and actual dependency;

B. A husband upon a wife with whom he lives, or upon whom he is actually dependent in any way at the time of the injury; and

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

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

(1) A school, college or university operated or directly supported by the United States or by any state or local government or political subdivision thereof;

(2) A school, college or university that has been accredited by a state or by a state-recognized or nationally recognized accrediting agency or body;

(3) A school, college or university not accredited pursuant to subparagraph (2) but whose credits are accepted, on transfer, for credit on the same basis as if transferred from an accredited institution by not fewer than 3 institutions accredited pursuant to subparagraph (2); or

(4) An additional type of educational or training institution as defined by the board, but not after the dependent reaches the age of 23 or has completed 4 years of education beyond the high school level, except that,

when the dependent's 23rd birthday occurs during a semester or other enrollment period, the dependent continues to be considered a student until the end of the semester or other enrollment period. A child is not deemed to have ceased to be a student during any interim between school years if the interim does not exceed 5 months and if the dependent shows to the satisfaction of the board that the dependent has a bona fide intention of continuing to pursue a full-time course of education or training during the semester or other enrollment period immediately following the interim or during periods of reasonable duration during which, in the judgment of the board, the dependent is prevented by factors beyond the dependent's control from pursuing the dependent's education. A child is not deemed to be a student under this Act during a period of service in the Armed Forces of the United States.

In all other cases, questions of total or partial dependency must be determined in accordance with the fact as the fact was at the time of the injury. If there is more than one person wholly dependent, the compensation must be divided equally among them and persons partly dependent, if any, are not entitled to a part of the compensation during the period in which compensation is paid to persons wholly dependent. If there is no one wholly dependent and more than one person who is partly dependent, the compensation must be divided among them according to the relative extent of their dependency. If a dependent is an alien residing outside the United States or outside the Dominion of Canada, the compensation paid to any such dependent is 1/2 that provided in the case of the death of an employee.

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

10. Design professional. "Design professional" means:

A. An architect, professional engineer, landscape architect, land surveyor, geologist or soil scientist licensed to practice that profession in the State in accordance with Title 32; or

B. Any corporation or partnership, professional or general, that employs one or more of any of the professionals described in paragraph A and whose sole purpose is the rendering of professional services practiced by any professional described in paragraph A.

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

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

(1) Persons engaged in maritime employment or in interstate or foreign commerce who are within the exclusive jurisdiction of admiralty law or the laws of the United States;

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

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

spect to any corporation that secures compensation by making a contract of workers' compensation insurance, specific inclusion of the executive officer in the contract causes the officer to be an employee of the corporation under this Act;

(4) Any person who, in a written statement to the board, waives all the benefits and privileges provided by the workers' compensation laws, provided that the board has found that person to be a bona fide owner of at least 20% of the outstanding voting stock of the corporation by which that person is employed or a shareholder of the professional corporation by which that person is employed and that this waiver was not a prerequisite condition to employment. For the purposes of this subparagraph, the term "professional corporation" has the same meaning as found in Title 13, section 703, subsection 1.

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

(5) The parent, spouse or child of a sole proprietor who is employed by that sole proprietor or the parent, spouse or child of a partner who is employed by the partnership of that partner may state, in writing, that the parent, spouse or child waives all the benefits and privileges provided by the workers' compensation laws if the board finds that the waiver is not a prerequisite condition to employment;

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

(7) An independent contractor; or

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

B. "Employee" includes, if the person elects to be personally covered by this Title, any person who regularly operates a business or practices a trade, profession or occupation, whether individually or in partnership or association with other persons, whether or not the person hires employees. Such a person shall elect personal coverage by insuring and keeping insured the payment of compensation and other benefits under a workers' compensation insurance policy. The insurance policy must clearly indicate the intention of the parties to provide coverage for the person electing to be personally covered. The insurance company shall file with the board notice, in such form as the board approves, of the issuance of any workers' compensation policy to a person electing personal coverage. That insurance may not be cancelled within the time limited in that policy for its expiration until at least 30 days after mailing a notice of the cancellation of that insurance to the board and the person electing personal coverage. In the event that the person electing personal coverage has obtained a workers' compensation insurance policy from another insurance company, and that insurance becomes effective prior to the expiration of the 30 days, cancellation is effective as of the effective date of the other insurance. The Superintendent of Insurance is authorized to review for approval, at the superintendent's discretion, an appropriate classification for this class of persons and a reasonable rate.

C. "Employee" does not include any person who is otherwise an employee, if the person is injured as a result of the person's voluntary participation in an employer-sponsored athletic event or an employer-sponsored athletic team.

D. "Employee" does not include a real estate broker or salesperson whose services are performed for remuneration solely by way of commission if the broker or salesperson has signed a contract with the agency indicating the existence of an independent contractor relationship.

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

prisoner during incarceration and while the prisoner is:

(1) A prisoner in a county jail under final sentence of 72 hours or less and is assigned to work outside of the county jail;

(2) Employed by a private employer;

(3) Participating in a work release program;

(4) Sentenced to imprisonment with intensive supervision under Title 17-A, section 1261; or

(5) Employed in a program established under a certification issued by the United States Department of Justice under 18 United States Code, Section 1761.

12. Employer. The term "employer" includes:

A. Private employers;

B. The State;

C. Counties;

D. Cities;

E. Towns;

F. Water districts and all other quasi-public corporations of a similar nature;

G. Municipal school committees;

H. Union school committees; and

I. Design professionals.

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

13. Independent contractor. "Independent contractor" means a person who performs services for another under contract, but who is not under the essential control or superintendence of the other person while performing those services. In determining whether such a relationship exists, the board shall consider the following factors:

A. Whether or not a contract exists for the person to perform a certain piece or kind of work at a fixed price;

B. Whether or not the person employs assistants with the right to supervise their activities;

C. Whether or not the person has an obligation to furnish any necessary tools, supplies and materials;

D. Whether or not the person has the right to control the progress of the work, except as to final results;

E. Whether or not the work is part of the regular business of the employer;

F. Whether or not the person's business or occupation is typically of an independent nature;

G. The amount of time for which the person is employed; and

H. The method of payment, whether by time or by job.

In applying these factors, the board may not give any particular factor a greater weight than any other factor, nor may the existence or absence of any one factor be decisive. The board shall consider the totality of the relationship in determining whether an employer exercises essential control or superintendence of the person.

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

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

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

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

17. Private employer. "Private employer" includes corporations, including professional corporations, partnerships and natural persons. Any agricultural employer otherwise included under this Act is not included when harvesting 150 cords of wood or less each year from farm wood lots, provided that, in order to qualify for this exemption, the employer must be covered by an employer's liability insurance policy with total limits of not less than $25,000 and medical payment coverage of not less than $1,000.

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

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

§103. Common-law defenses lost

In an action to recover damages for personal injuries sustained by an employee arising out of and in the course of the employee's employment, or for death resulting from such injuries, it is not a defense to an employer, except as hereinafter specified:

1. Employee negligent. That the employee was negligent;

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

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

§104. Applicability to certain actions and employers; exemptions

An employer who has secured the payment of compensation in conformity with sections 401 to 407 is exempt from civil actions, either at common law or under sections 901 to 908, Title 14, sections 8101 to 8118, and Title 18-A, section 2-804, involving personal injuries sustained by an employee arising out of and in the course of employment, or for death resulting from those injuries. These exemptions from liability apply to all employees, supervisors, officers and directors of the employer for any personal injuries arising out of and in the course of employment, or for death resulting from those injuries. These exemptions also apply to occupational diseases sustained by an employee or for death resulting from those diseases. These exemptions do not apply to an illegally employed minor as described in section 408, subsection 2.

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

§105. 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 board or judicial scrutiny when raised in a subsequent workers' compensation claim, then, depending on the final outcome of that subsequent proceeding, either the workers' compensation insurance carrier shall return excess premium collected or the employer shall remit premium subsequently due in order to put the parties in the same position as if the final outcome under the contested claim were predetermined correctly.

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.

§106. Invalidity of waiver of rights; claims not assignable

No agreement by an employee, unless approved by the board or by the Commissioner of Labor, to waive the employee's rights to compensation under this Act is valid. No claims for compensation under this Act are assignable or subject to attachment or liable in any way for debt, except for the enforcement of a current support obligation or support arrears pursuant to Title 19, chapter 7, subchapter V or Title 19, chapter 14-A, or for reimbursement of general assistance pursuant to Title 22, section 4318.

§107. Liability of 3rd persons; election of employee; subrogation

When an injury or death for which compensation or medical benefits are payable under this Act is sustained under circumstances creating in some person other than the employer a legal liability to pay damages, the injured employee may, at the employee's option, either claim the compensation and benefits or obtain damages from or proceed at law against that other person to recover damages.

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

If the employee or the employee's beneficiary recovers damages from a 3rd person, the employee shall repay to the employer, out of the recovery against the 3rd person, the benefits paid by the employer under this Act, less the employer's proportionate share of cost of collection, including reasonable attorney's fees.

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

§108. Preference of claims

A claim for compensation under this Act and any compensation payment scheme are entitled to a preference over the unsecured debts of the employer to the same amount as the wages of labor are preferred by the laws of this State. Nothing in this section may be construed as impairing any lien that the employee may have acquired.

§109. Compilation of claims information

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

§110. Collective bargaining

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

A. Alternative dispute resolution systems that may include, but are not limited to, mediation or binding arbitration or the use of mediation and binding arbitration;

B. Preferred provider systems for the delivery of health care services or treatment;

C. The use of a designated or limited list of independent medical examiners;

D. Light-duty, modified job or return-to-work programs;

E. Vocational rehabilitation or retraining programs; or

F. A 24-hour coverage program.

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

§111. Alternative programs

After consultation with the Superintendent of Insurance, the board may approve an agreement entered into between an employer and some or all of the employer's employees to secure the payment of compensation and benefits through an alternative program that is different from but not less than the compensation and benefits provided by this Act. The alternative program may not be approved by the board unless it provides for compensation and benefits in addition to those required by this Act and unless it is for a fixed period of time.

CHAPTER 3

WORKERS' COMPENSATION BOARD

§151. Workers' Compensation Board

1. Board established. Pursuant to Title 5, section 12004-G, subsection 35, the Workers' Compensation Board is established as an independent board composed of 8 members. The members of the board must be appointed by the Governor within 30 days after a new board member is authorized or a vacancy occurs, subject to review by the joint standing committee of the Legislature having jurisdiction over state and local government matters and confirmation by the Legislature. Notwithstanding the provisions of Title 3, section 151, the designated committee shall complete its review of the appointments of the Governor within 15 days of the Governor's written notice of appointment and the vote of the Legislature must be taken no later than 7 days after the vote of the designated committee.

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

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

A member of the board may not be a lobbyist required to be registered with the Secretary of State, a service provider to the workers' compensation system or a representative of a service provider to the workers' compensation system.

Members of the board hold office for staggered terms of 4 years, except for the initial members of the board. The terms of one member representing management and one member representing labor expire February 1st of each year. A member may not serve for more than 2 full terms.

The Governor shall initially designate one member representing management and one member representing labor for terms expiring February 1, 1994; one member representing management and one member representing labor for terms expiring February 1, 1995; one member representing management and one member representing labor for terms expiring February 1, 1996; and one member representing management and one member representing labor for terms expiring February 1, 1997.

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

3. Vacancies. If a vacancy occurs during a term of a member, the Governor shall appoint a replacement to fill the unexpired part of the term. The replacement must be from the group represented by the member being replaced. In case the office of chair becomes vacant, the board member who has served for the longest period of time shall act as chair until the Governor makes an appointment to fill the vacancy.

4. Chair. The board shall annually elect one of its members to serve as chair for a one-year term expiring February 1st each year. The term as chair of the first member elected to that position expires February 1, 1994. The chair must alternate between management and labor members. The chair may vote on all matters before the board.

5. Voting requirements. The board may take action only by majority vote of its membership. Decisions regarding the employment of an executive director and the appointment and retention of hearing officers require the affirmative votes of at least 2 board members representing management and at least 2 board members representing labor.

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

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

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

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

§152. Authority of board; administration

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

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

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

3. Employment of executive director. The board shall employ an executive director who shall conduct the day-to-day operations of the board in accordance with policies established by the board and otherwise implement board policy. Except as otherwise provided, the executive director shall, at the direction of the board, hire personnel as necessary to administer this Act, subject to the Civil Service Law. The executive director is an unclassified employee serving at the pleasure of the board.

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

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

A. The board may contract for the services of hearing officers and mediators, in which case they must be paid reasonable per diem fees for their services plus reimbursement of their actual, necessary and reasonable expenses incurred in the performance of their duties, consistent with policies established by the board; or

B. The board may employ hearing officers and mediators to serve at the pleasure of the board and who are not subject to the Civil Service Law. They are entitled to receive reimbursement of their actual, necessary and reasonable expenses incurred in the performance of their duties, consistent with policies established by the board.

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

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

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

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

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

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

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

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

§153. Board actions

In addition to other actions required of or permitted the board under this Act, the board shall perform the actions required by this section to ensure just and efficient administration of claims.

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

A. Payments are initiated within the time limits established in section 205; and

B. Payments to the employee provide the full amount of compensation to which the employee is entitled and are properly indicated on the memorandum of payment.

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

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

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

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

A. The board shall, subject to the Civil Service Law, appoint at least 2 abuse investigators who must be qualified by experience and training to perform their duties.

B. The unit shall, at the direction of the board, investigate all complaints or allegations of fraud, illegal or improper conduct or violation of this Act or rules of the board relating to workers' compensation insurance, benefits or programs, including those acts by employers, employees or insurers. All records, correspondence and reports of investigation in connection with actual or alleged fraud, illegal or improper conduct or violation of this Act or rules of the board and all records, correspondence and reports of criminal prosecution or civil action are confidential. The confidential nature of any such record, correspondence or report does not limit or affect the use of those materials in any prosecution or action.

C. Each employer or employee and each state, county, municipal or quasi-governmental agency shall cooperate fully with the unit and provide any information requested by it.

D. The unit shall report all its findings to the board.

E. Whenever the board determines that a fraud, attempted fraud or violation of this Act or rules of the board may have occurred, the board shall report in writing allinformation concerning it to the Attorney General or the Attorney General's delegate for appropriate action, including a civil action for recovery of funds and criminal prosecution by the Attorney General.

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

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

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

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

B. The board shall collect and analyze data from Maine cases, studies from other states and generally accepted medical guidelines for occupational impairment to examine the feasibility and desirability of establishing an objectively ascertainable functional capacity standard to be used for determining eligibility for benefits under this Act consistent with section 213, subsection 2.

§154. Dedicated fund; assessment on workers' compensation insurers and self-insured employers

The Workers' Compensation Board Administrative Fund is established to accomplish the purposes of this Act. All income generated pursuant to this section must be recorded on the books of the State in a separate account and deposited with the Treasurer of State and be credited to the Workers' Compensation Board Administrative Fund.

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

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

3. Assessment on workers' compensation insurers. Every insurance company or association authorized to write workers' compensation insurance in this State shall, for the purpose of providing partial support and maintenance of the board, pay an assessment on all gross direct premiums written, whether in cash or in notes absolutely payable on contracts written on risks located or resident in the State for workers' compensation insurance, less return premiums and less all dividends paid to policy holders.

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

5. Amounts of premiums and losses. The Bureau of Insurance shall provide to the board the amounts of gross direct workers' compensation premiums written by each insurance carrier and the amounts of aggregate benefits paid by each self-insurer and group self-insurer on or before August 1st of each year.

6. Assessment levied. The assessments levied under this section may not produce more than $6,000,000 in revenues annually beginning in the 1993-94 fiscal year. The board shall determine the assessments prior to March 1st and shall assess each insurance company or association and self-insured employer its pro rata share for expenditures during the fiscal year beginning July 1st. Each insurance company or association and self-insured employer shall pay the assessment on or before June 1st.

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

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

9. Deposit of funds; investment. All revenues derived from assessments levied against insurance companies, associations and self-insured employers described in this section must be reported and paid to the Trea-

surer of State and credited to the Workers' Compensation Board Administrative Fund. The Treasurer of State may invest the funds in accordance with state law. All interest must be paid to the fund.

CHAPTER 5

COMPENSATION AND SERVICES

§201. Entitlement to compensation and services generally

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

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

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

A. The work stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee; and

B. The work stress, and not some other source of stress, was the predominant cause of the mental injury.

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

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

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

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

§202. Injury or death due to willful intention or intoxication

Compensation or other benefits are not allowed for the injury or death of an employee when it is proved that the injury or death was occasioned by the employee's willful intention to bring about the injury or death of the employee or of another, or that the injury or death resulted from the employee's intoxication while on duty. This provision as to intoxication does not apply if the employer knew at the time of the injury that the employee was intoxicated or that the employee was in the habit at that time of becoming intoxicated while on duty.

§203. Incarceration of employee

1. Compensation while incarcerated. Compensation for incapacity under section 212 or 213 may not be paid to any person during any period in which that person is a sentenced prisoner in actual execution of a term of incarceration imposed in this State or any other jurisdiction for a criminal offense, except in relation to compensable injuries suffered during incarceration and while the prisoner is:

A. Employed by a private employer;

B. Participating in a work release program;

C. Sentenced to imprisonment with intensive supervision under Title 17-A, section 1261; or

D. Employed in a program established under a certification issued by the United States Department of Justice under 18 United States Code, Section 1761.

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

§204. Waiting period; when compensation payable

Compensation for incapacity to work is not payable for the first 7 days of incapacity, except that firefighters must receive compensation from the date of incapacity. In case incapacity continues for more than 14 days, compensation is allowed from the date of incapacity.

§205. Benefit payment

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

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

3. Penalty for delay. When there is not an ongoing dispute, if weekly compensation benefits or accrued weekly benefits are not paid within 30 days after becoming due and payable, $50 per day must be added and paid to the worker for each day over 30 days in which the benefits are not paid. Not more than $1,500 in total may be added pursuant to this subsection. For purposes of ratemaking, daily charges paid under this subsection do not constitute elements of loss.

4. Payment of medical bills. When there is no ongoing dispute, if medical bills are not paid within 30 days after the carrier has received notice of nonpayment by certified mail, $50 or the amount of the bill due, whichever is less, must be added and paid to the Workers' Compensation Board Administrative Fund for each day over 30 days in which the medical bills are not paid. Not more than $1,500 in total may be added pursuant to this subsection.

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

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

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

A. The names of the employee, employer and insurance carrier;

B. The date of the injury;

C. The names of the employee's other employers, if any, or a statement that there is no multiple employment, if that is the case; and

D. The initial weekly compensation rate.

8. Information. If the employer is making compensation payments under this section, the employer shall file with the board a statement of the employee's average weekly wages, as defined in section 2, subsection 4 within 30 days after the initial payment, together with a wage statement or wage statements in the case of multiple employment. A copy of this information must be mailed to the person receiving payments. When the only compensation claimed or payable is for medical services, wage statements need not be submitted.

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

A. If the employee has returned to work with or has received an increase in pay from an employer that is paying compensation under this Act, that employer or that employer's insurer or group self-insurer may discontinue or reduce payments to the employee.

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

(1) If no order or award of compensation or compensation scheme has been entered, the employer, insurer or group self-insurer may discontinue or reduce benefits by sending a certificate by certified mail to the employee and to the board, together with any information on which the employer, insurer or group self-insurer relied to support the discontinuance or reduction. The employer may discontinue or reduce benefits no earlier than 21 days from the date the certificate was mailed to the employee. The certificate must advise the employee of the date when the employee's benefits will be discontinued or reduced, as well as other information as prescribed by the board, including the employee's appeal rights.

(2) If an order or award of compensation or compensation scheme has been entered, the employer, insurer or group self-insurer shall petition the board for an order to reduce or discontinue benefits and may not reduce or discontinue benefits until the matter has been finally resolved through the dispute resolution procedures of this Act, any appeal proceedings have been completed and an order of reduction or discontinuance has been entered by the board.

C. The employee may file a petition for review, contesting the employer's discontinuance or reduction of compensation under this subsection. Regardless of whether the employee files a petition prior to the date of the discontinuance or reduction, benefits may be discontinued or reduced as described in paragraph A or B.

D. The board, within 21 days after the employee filed a petition for review, may enter an order providing for the continuation or reinstatement of benefits pending a hearing on the petition. The order must be based upon the information submitted by both the employer, insurer or group self-insurer and the employee under this subsection.

E. In all cases under this subsection, the board shall provide for an expedited procedure that must be available upon request of any party.

F. If benefits have been discontinued or reduced pursuant to paragraph A or B and the board, after hearing, determines that benefits have been wrongfully withheld, the board shall order payment of all benefits withheld together with interest at the rate of 6% a year. The employer shall pay this amount within 10 days of the order.

§206. Duties and rights of parties as to medical and other services; cost

An employee sustaining a personal injury arising out of and in the course of employment or disabled by occupational disease is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer.

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

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

A. If the employer can not show cause why the employee should not commence or continue treatment with the health care provider of the employee's choice, the hearing officer shall order that the employer is responsible for payment for treatment received from the health care provider; or

B. If the employer can show cause why the employee should not commence or continue treatment with the health care provider of the employee's choice, the hearing officer shall order that the employer is not responsible and that the employee is responsible for payment for treatment received from the health care provider from the date the order is mailed.

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

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

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

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

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

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

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

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

11. Generic drugs. Providers shall prescribe generic drugs whenever medically acceptable for the treatment of an injury or disease for which compensation is claimed. An employee shall purchase generic drugs for the treatment of an injury or disease for which compensation is claimed if the prescribing physician indicates that generic drugs may be used and if generic drugs are available at the time and place of purchase. 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.

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

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

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

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

§207. Medical examinations of employees; acceptance of treatment or employment rehabilitation

An employee being treated by a health care provider of the employee's own choice shall, after an injury and at all reasonable times during the continuance of disability if so requested by the employer, submit to an examination by a physician 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, other than an independent medical examiner appointed pursuant to section 312, without prior approval from the employee or a hearing officer. This provision does not limit an employer's right to request that the employee be examined by a specialist upon referral by the health care pro-

vider. Once the employee is examined by the specialist, the employer may not request that the employee be examined by a different specialist in the same specialty, other than an independent medical examiner appointed pursuant to section 312, without prior approval from the employee or the board. The employee has the right to have a physician or surgeon of the employee's own selection present at such an examination, whose costs are paid by the employer. The employer shall give the employee notice of this right at the time the employer requests an examination.

Nothing in this Act may be construed to require an employee who in good faith relies on treatment by prayer or spiritual means, in accordance with the tenets and practice of a recognized church or religious denomination, by a duly accredited practitioner of those healing methods, to undergo any medical or surgical treatment. Such an employee or the employee's dependents may not be deprived of any compensation payments to which the employee would be entitled if medical or surgical treatments were employed.

If any employee refuses or neglects to submit to any reasonable examination provided for in this Act, or in any way obstructs any such examination, or if the employee declines a service that the employer is required to provide under this Act, then such employee's rights to compensation are forfeited during the period of the infractions if the board finds that there is adequate cause to do so.

§208. Medical information

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

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

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

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

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

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

E. A health care provider may not charge the insurer or self-insurer an amount in excess of the fees prescribed in section 209 for the submission of reports prescribed by this section and for the submission of any additional records.

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

§209. Medical fees; reimbursement levels

1. Standards, schedules or scales. In order to ensure appropriate limitations on the cost of health care services, the board shall adopt rules that establish:

A. Standards, schedules or scales of maximum charges for individual services, procedures or courses of treatment. In establishing these standards, schedules or scales, the board shall consider maximum charges paid by private 3rd-party payors for similar services provided by health care providers in the State and shall consult with organizations representing health care providers and other appropriate groups. The standards must be ad-

justed annually to reflect any appropriate changes in levels of reimbursement. The standards apply to hospital costs and health care providers and must be in effect no later than January 1, 1993; and

B. Fees for the preparation of materials, including reports of treatment required in section 208, subsection 2, or attendance at depositions or hearings as may be required under this Act.

2. Payment for services. A health facility or health care provider must be paid either its usual and customary charge for any health care services or the maximum charge established under the rules adopted pursuant to subsection 1, whichever is less.

3. Limitation on reimbursement. 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 payors 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 appointed pursuant to section 312 or by the insurance carrier, self-insurer or group self-insurer pursuant to section 210, subsection 7 or the board pursuant to section 210, subsection 8.

§210. Medical utilization review

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

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

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

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

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

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

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

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

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

§211. Maximum benefit levels

Effective January 1, 1993 the maximum weekly benefit payable under section 212, 213 or 215 is $441 or 90% of state average weekly wage, whichever is higher. Beginning on July 1, 1994 the maximum benefit level is the higher of $441 or 90% of the state average weekly wage as adjusted annually utilizing the state average weekly wage as determined by the Bureau of Employment Security.

§212. Compensation for total incapacity

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

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

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

A. Total and permanent loss of sight of both eyes;

B. Actual loss of both legs or both feet at or above the ankle;

C. Actual loss of both arms or both hands at or above the wrist;

D. Actual loss of any 2 of the members or faculties in paragraph A, B or C;

E. Permanent and complete paralysis of both legs or both arms or one leg and one arm;

F. Incurable insanity or imbecility; and

G. Permanent and total loss of industrial use of both legs or both hands or both arms or one leg and one arm.

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

3. Specific loss benefits. In cases included in the following schedule, the incapacity is considered to continue for the period specified, and the compensation due is 80% of the after-tax average weekly wage subject to the maximum benefit set in section 211. Compensation under this subsection is available only for the actual loss of the following:

A. Thumb, 65 weeks;

B. First finger, 38 weeks;

C. Second finger, 33 weeks;

D. Third finger, 22 weeks;

E. Fourth finger, 16 weeks;

F. The loss of the first phalange of the thumb, or of any finger, is considered to be equal to the loss of 1/2 of that thumb or finger, and compensation is 1/2 of the amounts specified in paragraphs A to E. The loss of more than one phalange is considered as the loss of the entire finger or thumb. The amount received for more than one finger may not exceed the amount provided in this schedule for the loss of a hand;

G. Great toe, 33 weeks;

H. A toe other than the great toe, 11 weeks. The loss of the first phalange of any toe is considered to be equal to the loss of 1/2 of that toe, and compensation is 1/2 of the amounts specified in paragraphs F and G. The loss of more than one phalange is considered the loss of the entire toe;

I. Hand, 215 weeks. An amputation between the elbow and wrist that is 6 or more inches below the elbow is considered a hand;

J. Arm, 269 weeks. An amputation above the point specified in paragraph I is considered an arm;

K. Foot, 162 weeks. An amputation between the knee and the foot 7 or more inches below the tibial table, or plateau, is considered a foot;

L. Leg, 215 weeks. An amputation above the point specified in paragraph K is considered a leg; and

M. Eye, 162 weeks. Eighty percent loss of vision of one eye constitutes the total loss of that eye.

In case of the loss of one member while compensation is being paid for the loss of another member, compensation must be paid for the loss of the 2nd member for the period provided in this section. Payments for the loss of the 2nd member begin at the conclusion of the payments for the first member.

§213. Compensation for partial incapacity

1. Benefit and duration. While the incapacity for work is partial, the employer shall pay the injured employee a weekly compensation equal to 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the after-tax average weekly wage that the injured employee

is able to earn after the injury, but not more than the maximum benefit under section 211. Compensation must be paid for the duration of the disability if the employee's permanent impairment, determined according to the impairment guidelines adopted by the board pursuant to section 153, subsection 8 resulting from the personal injury is in excess of 15% to the body. In all other cases an employee is not eligible to receive compensation under this section after the employee has received 260 weeks of compensation under section 212, subsection 1, this section or both. The board may in the exercise of its discretion extend the duration of benefit entitlement beyond 260 weeks in cases involving extreme financial hardship due to inability to return to gainful employment. This authority may not be delegated to a hearing officer and such decisions must be made expeditiously.

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

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

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

§214. Determination of partial incapacity

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

A. If an employee receives a bona fide offer of reasonable employment from the previous employer or another employer or through the Bureau of Employment Security and the employee refuses that employment without good and reasonable cause, the employee is considered to have voluntarily withdrawn from the work force and is no longer entitled to any wage loss benefits under this Act during the period of the refusal.

B. If an employee is employed at any job and the average weekly wage of the employee is less than that which the employee received before the date of injury, the employee is entitled to receive weekly benefits under this Act equal to 80% of the difference between the injured employee's after-tax weekly wage before the date of injury and the after-tax weekly wage that the injured employee is able to earn after the date of injury, but not more than the maximum weekly rate of compensation, as determined under section 211.

C. If an employee is employed at any job and the average weekly wage of the employee is equal to or more than the average weekly wage the employee received before the date of injury, the employee is not entitled to any wage loss benefits under this Act for the duration of the employment.

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

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

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

(3) If the employee becomes reemployed at any employment, the employee is then entitled to receive partial disability benefits as provided in paragraph B.

E. If the employee, after having been employed at any job following the injury for less than 100 weeks, loses the job through no fault of the employee, the employee is entitled to receive compensation based upon the employee's wage at the original date of injury.

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

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

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

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

§215. Death benefits

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

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

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

A. If the injury received by the employee was the proximate cause of the employee's death and the deceased employee leaves dependents wholly or partially dependent on the employee for support, the death benefit must be a sum sufficient, when added to the indemnity benefits that at the time of death have been paid or become payable under section 212 or 213 to the deceased employee, to make the total compensation for the injury and

death equal to the full amount that the dependents would have been entitled to receive under subsection 1 if the injury had resulted in immediate death. Benefits under this paragraph are payable in the same manner as if the injury resulted in immediate death.

B. If an application for benefits has been filed but has not been decided by the board or is on appeal and the employee dies from a cause unrelated to the employee's injury, the proceedings may be continued in the name of the employee's personal representative. In such a case, any benefits awarded are payable up to time of death and must be paid to the same beneficiaries and in the same amounts as would have been payable if the employee had suffered a compensable injury resulting in death.

§216. Burial expenses; incidental compensation

If the employee dies as a result of the injury, the employer shall pay, in addition to any compensation and medical benefits provided for in this Act, the reasonable expenses of burial, not to exceed $4,000 and an additional payment of $3,000 as incidental compensation. Burial expense reimbursement must be paid to the person who has paid or who is responsible for paying the employee's burial expenses. The incidental compensation must be paid to the employee's estate.

§217. Employment rehabilitation

When as a result of injury the employee is unable to perform work for which the employee has previous training or experience, the employee is entitled to such employment rehabilitation services, including retraining and job placement, as reasonably necessary to restore the employee to suitable employment.

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

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

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

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

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

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

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

§218. Worker reinstatement rights

Upon petition of an injured employee, the board may require, after hearing, that the employee be reinstated as required by this section.

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

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

A. The size of the employer's business;

B. The number of employees employed by the employer;

C. The nature of the employer's operations; and

D. Any other relevant factors.

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

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

A. Supervisory or confidential positions within the meaning of the 29 United States Code, Section 152; or

B. Any position for which the employee is not qualified.

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

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

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

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

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

§219. Light-duty work pools

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

§220. Reduction of benefits due to unemployment compensation

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

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

A. Inform the board as to whether the claimant has received since the date of injury or is currently receiving unemployment benefits;

B. Notify the board in the event that the claimant subsequently applies for and receives unemployment benefits; and

C. Notify the board whenever the claimant ceases to receive unemployment benefits.

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

§221. Coordination of benefits

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

A. Old-age insurance benefit payments under the United States Social Security Act, 42 United States Code, Sections 301 to 1397f;

B. Payments under a self-insurance plan, a wage continuation plan or a disability insurance policy provided by the employer; or

C. Pension or retirement payments pursuant to a plan or program established or maintained by the employer.

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

2. Definitions. As used in this section, "after-tax amount" means the gross amount of any benefit under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5) reduced by the prorated weekly amount which would have been paid, if any, under the Federal Insurance Contributions Act, 26 United States Code, Sections 3101 to 3126, state income tax and federal income tax, calculated on an annual basis using as the number of exemptions the disabled employee's dependents plus the employee, and without excess itemized deductions. In determining the "after-tax amount" the tables provided for in section 102, subsection 1 must be used. The gross amount of any benefit under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5) is presumed to be the same as the average weekly wage for purposes of the table. The applicable 80% of after-tax amount as provided in the table, multiplied by 1.25, is conclusive for determining the "after-tax amount" of benefits under subsection 3, paragraph A, subparagraph (2), (3), (4) or (5).

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

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

(1) Fifty percent of the amount of the old-age insurance benefits received or being received under the United States Social Security Act;

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

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

(4) The after-tax amount of the pension or retirement payments received or being received pursuant to a plan or program established or maintained by the same employer from whom benefits under section 212 or 213 are received, if the employee did not contribute directly to the pension or retirement plan or program;

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

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

B. A credit or reduction under this section may not occur because of an increase granted by the Social Security Administration as a cost-of-living adjustment granted after the benefits are coordinated.

C. A credit or reduction under this section may not occur because of an increase in a pension or

retirement plan or program granted after the benefits are coordinated.

D. Except as provided in subsections 6 and 7, a credit or reduction of benefits otherwise payable for any week may not be taken under this section until there has been a determination of the benefit amount otherwise payable to the employee under section 212 or 213 and the employee has begun receiving the benefit payments.

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

F. No savings or insurance of the injured employee independent of this Act may be taken into consideration in determining the compensation to be paid, nor may benefits derived from any source other than the employer be considered in fixing the compensation due.

G. The employer shall pay or cause to be paid to the employee the balance due in either weekly or lump sum payments to satisfy any obligations remaining under section 212 or 213 after the application of this section.

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

A. Make application for social security benefits;

B. Provide the employer or carrier with proof of that application; and

C. Provide the employer or carrier with an authority for release of information which may be used by the employer to obtain necessary benefit entitlement and amount information from the social security administration.

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

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

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

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

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

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

10. Exceptions for certain disability payments. This section does not apply to any payments received or to be received under a disability insurance plan provided by the same employer if that plan is in existence on Decem-

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

§222. Provisional payment of certain disability benefits

1. No delay of benefits. If an employee is due benefits from an employer under an insured disability plan or insured medical payments plan because of a personal injury or disease, the employer may not delay or refuse payment of those benefits because the employee filed a workers' compensation claim based on the same personal injury or disease.

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

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

A. These rules must impose any requirements on employers or health, disability or workers' compensation insurance carriers that the superintendent finds necessary or desirable to ease the financial burden on injured employees whose workers' compensation claims are controverted and who are awaiting board determinations on their claims.

B. The superintendent shall consult with the chair of the board in formulating and adopting these rules.

§223. Presumption of earnings loss for retirees

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

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

CHAPTER 7

PROCEDURES

SUBCHAPTER I

BOARD PROCEEDINGS

§301. Notice of injury within 90 days

Proceedings for compensation under this Act, except as provided, may not be maintained unless a notice of the injury is given within 90 days after the date of injury. The notice must include the time, place, cause and nature of the injury, together with the name and address of the injured employee. The notice must be given by the injured employee or by a person in the employee's behalf, or, in the event of the employee's death, by the employee's legal representatives, or by a dependent or by a person in behalf of either.

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

§302. Sufficiency of notice; knowledge of employer; extension of time for notice

A notice given under section 301 may not be held invalid or insufficient by reason of any inaccuracy in stat-

ing any of the facts required for proper notice, unless it is shown that it was the intention to mislead and that the employer was in fact misled by the notice. Want of notice is not a bar to proceedings under this Act if it is shown that the employer or the employer's agent had knowledge of the injury. Any time during which the employee is unable by reason of physical or mental incapacity to give the notice, or fails to do so on account of mistake of fact, may not be included in the 90-day period specified. In case of the death of the employee within that period, there is allowed for giving the notice 3 months after the death.

§303. Reports to board

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

§304. Board notice

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

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

3. Notice by board. Within 15 days of receipt of an employer's report of injury, as required by section 303, unless it has received a petition for award of compensation relating to the injured employee, the board shall take reasonable steps to notify the employee that, unless the employer disputes the claim, the employer is required to pay compensation within the time limits established in section 205; that a petition for award may be filed; and that rights under this Act may not be protected unless a petition of award or memorandum of payment is on file with the board within 2 years of the injury.

§305. Petition for award; protective decree

In the event of a controversy as to the responsibility of an employer for the payment of compensation, any party in interest may file in the office of the board a petition for award of compensation setting forth the names and residences of the parties, the facts relating to the employment at the time of the injury, the knowledge of the employer or notice of the occurrence of the injury, the character and extent of the injury and the claims of the petitioner with reference to the injury, together with such other facts as may be necessary and proper for the determination of the rights of the petitioner.

If, following an injury that causes no incapacity for work, the employer and employee reach an agreement that the employee has received a personal injury arising out of and in the course of employment, a memorandum of such an agreement signed by the parties may be filed in the office of the board. The memorandum must set forth the names and residences of the parties, the facts relating to the employment at the time of the injury, the time, place and cause of the injury, and the nature and extent of the injury. Any member of the board is empowered, without the necessity of the filing of a petition for award, to render a protective decree based on that memorandum.

§306. Time for filing petitions

An employee's claim for compensation under this Act is barred unless an agreement or petition 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 303 of this Act. Any time during which the employee is unable by reason of physical or mental incapacity to file the petition is not included in the period provided in this section. If the employee fails to file the petition within that period because of mistake of fact as to the cause and nature of the injury, the employee may file the petition within a reasonable time. In case of the death of the employee, there is allowed for filing the petition one year after that death. No petition of any kind may be filed more than 6 years following the date of the latest payment made under this Act. For the purposes of this section, payments of benefits made by an employer or insurer pursuant to section 205 or 206 are considered payments under a decision pursuant to a petition.

§307. Procedure for filing petitions; no response required; mediation

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

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

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

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

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

§308. Employment

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

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

§309. Subpoenas; evidence; discovery

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

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

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

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

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

4. Contempts before board. A person may not, in proceedings before the board disobey or resist any law-

ful order, process or writ; misbehave during a hearing or so near the place of hearing as to obstruct the hearing; neglect to produce, after having been ordered to do so, any pertinent document; or refuse to appear after having been subpoenaed or, upon appearing, refuse to be examined according to law.

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

§310. Protection

Except for statements made in proceedings before the board, a statement to any investigator or employer's representative, of any kind, oral or written, recorded or unrecorded, made by the injured employee is not admissible in evidence or considered in any way in any proceeding under this Act, except in accordance with this section.

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

A. It is in writing;

B. A true copy of the statement is delivered to the employee by certified mail; and

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

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

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

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

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

(5) That the employer may not discriminate against the employee in any manner for refusing to make such a statement or exercising in any way the employee's rights under this Act.

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

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

§311. Inadmissible statements

No statement of any kind made by the injured employee to any investigator, employer or employer's representative, whether oral or written, recorded or unrecorded, may be admitted into evidence or considered in any way in any proceeding under this Act if it was obtained by means of duress on the part of the investigator, employer or employer's representative.

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

A. Implied or expressed threats relating to the employment of the employee or the employment of a relative of the employee;

B. Implied or expressed threats of extensive litigation and appeals of the employee's claim;

C. Misleading, false or incomplete statements of law or any misleading, false or incomplete legal opinion given to the employee relating to the employee's eligibility for benefits under this Act;

D. Misleading, false or incomplete statements of fact knowingly made to the employee;

E. The taking of unfair advantage of an employee's physical, mental or economic problems or shortcomings; and

F. Interrogations or investigations conducted under such circumstances as to be severely intimidating to the employee.

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

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

§312. Independent medical examiners

1. Examiner system. The board shall develop and implement an independent medical examiner system consistent with the requirements of this section. As part of this system, the board shall, in the exercise of its discretion, create, maintain and periodically validate a list of not more than 50 health care providers that it finds to be the most qualified and to be highly experienced and competent in their specific fields of expertise and in the treatment of work-related injuries to serve as independent medical examiners from each of the health care specialties that the board finds most commonly used by injured employees. The board shall establish a fee schedule for services rendered by independent medical examiners and adopt any rules considered necessary to effectuate the purposes of this section.

2. Duties. An independent medical examiner shall render medical findings on the medical condition of an employee and related issues as specified under this section. The independent medical examiner in a case may not be the employee's treating health care provider and may not have treated the employee with respect to the injury for which the claim is being made or the benefits are being paid. Nothing in this subsection precludes the selection of a provider authorized to receive reimbursement under section 206 to serve in the capacity of an independent medical examiner. A physician who has examined an employee at the request of an insurance company, employer or employee in accordance with section 207 during the previous 52 weeks is not eligible to serve as an independent medical examiner.

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

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

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

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

7. Weight. If the parties agree to a medical examiner, the examiner's findings are binding. If the board assigns an independent medical examiner, the board shall adopt the medical findings of the independent medical examiner unless there is clear and convincing evidence to the contrary in the record that does not support the medical findings. Contrary evidence does not include medical evidence not considered by the independent medical examiner. The board shall state in writing the reasons for not accepting the medical findings of the independent medical examiner.

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

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

§313. Procedure upon notice of controversy or other indication of controversy; mediation

1. Procedure. Upon filing of notice of controversy or other indication of controversy, the matter must be referred by the board to mediation.

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

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

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

A. Assessment of costs and attorney's fees;

B. Reductions of attorney's fees; or

C. If the party is the moving party, suspension of proceedings until the party has cooperated or produced the requested material.

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

§314. Arbitration

Any case for which an application for a hearing has been filed may be heard by an arbitrator mutually agreed upon in writing by the parties.

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

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

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

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

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

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

7. Fee. The board shall by rule provide for the amount of the fee to be paid to the arbitrator by the board.

§315. Time and place of formal hearing

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

The board shall provide for an expedited process for the scheduling and hearing of matters involving medical care or the right to benefits for total incapacity.

§316. Guardians and other representatives for minors and incompetents

If an injured employee is a minor or is mentally incompetent or, when death results from the injury, if any of the employee's dependents entitled to compensation are minors or mentally incompetent at the time when

any right, privilege or election accrues under this Act, the parent, guardian or next friend of the minor or incompetent, or some disinterested person designated by the board, may claim and exercise that right, privilege or election, or file any petition or answer, on behalf of the minor or incompetent. No limitation of time provided in this Act may run as long as the minor or incompetent has no parent living or guardian.

If the board has reasonable grounds for believing that compensation paid under this Act, either in weekly installments or in a lump sum, will be squandered or wasted by the injured employee or the employee's dependents, the board may designate in writing some disinterested person to act as trustee for the injured employee or the dependents. The trustee shall file an account at least once a year with the board showing the amounts of receipts and expenditures in behalf of the injured employee or the dependents.

§317. Appearance by officer or employee of corporation or partnership

The appearance before the board of an authorized officer, employee or representative of a party in any hearing, action or proceeding in which the party is participating or desires to participate is not an unauthorized practice of law and is not subject to any criminal sanction. If the appearance of such an officer, employee or representative prevents the efficient processing of any proceeding, the board, in its discretion, may remove that person from representation of the party.

§318. Hearing and decision

The hearing officer shall hear those witnesses as may be presented or, by agreement, the claims of both parties as to the facts may be presented by affidavits. If the facts are not in dispute, the parties may file with the hearing officer an agreed statement of facts for a ruling on the applicable law. From the evidence or statements furnished, the hearing officer shall in a summary manner decide the merits of the controversy. The hearing officer's decision must be filed in the office of the board and a copy, attested by the clerk of the board, mailed promptly to all parties interested or to the attorney of record of each party. The hearing officer's decision, in the absence of fraud, on all questions of fact is final; but if the hearing officer expressly finds that any party has or has not sustained the party's burden of proof, that finding is considered a conclusion of law and is reviewable in accordance with section 322.

The hearing officer, upon the motion of a party made within 20 days after notice of the decision or upon its own motion, may find the facts specially and state separately the conclusions of law and file the appropriate decision if it differs from the decision filed before the request was made. Those findings and conclusions and the revised decision must be filed in the office of the board and a copy, attested by the clerk of the board, must be mailed promptly to all parties interested. The running of the time for appeal is terminated by a timely motion made pursuant to this section and the full time for appeal commences to run from the filing of those findings and conclusions and the revised decision.

Clerical mistakes in decrees, orders or other parts of the record and errors arising from oversight or omission may be corrected by the board at any time of its own initiative, at the request of the hearing officer or on the motion of any party and after notice to the parties. During the pendency of an appeal, these mistakes may be corrected before the appeal is docketed in the Law Court and thereafter, while the appeal is pending, may be corrected with leave of the Law Court.

§319. Petition for reopening

Upon the petition of either party, the board may reopen and review any compensation payment scheme, award or decree on the grounds of newly discovered evidence that by due diligence could not have been discovered prior to the time the payment scheme was initiated or prior to the hearing on which the award or decree was based. The petition must be filed within 30 days of the payment scheme, award or decree.

§320. Review by full board

Within 5 days of issuing a decision, a hearing officer may request that the full board review a decision of the hearing officer if the decision involves an issue that is of significance to the operation of the workers' compensation system. There may be no such review of findings of fact made by a hearing officer.

If a hearing officer asks for review, the time for appeal to the Law Court pursuant to section 322 is stayed and no further action may be taken until a decision of the board has been made. If the board reviews a decision of a hearing officer, any appeal must be from the decision of the board.

Upon the approval of a majority of the members of the board, the request for review may be granted. The board may delegate responsibility for reviewing the decision of the hearing officer under this section to panels of board members consisting of equal numbers of representatives of labor and management. Review must be on the record and on written briefs only. Upon a majority vote, the board shall issue a written decision affirming, reversing or modifying the hearing officer's decision. The written decision of the board must be filed with the board and mailed to the parties or their counsel. The decision of the hearing officer stands if the result of the voting is less than a majority vote.

§321. Reopening for mistake of fact or fraud

1. Agreements. Upon the petition of either party at any time, the board may annul any agreement that has been approved by the board if it finds that the agreement has been entered into through mistake of fact by the petitioner or through fraud. Except in the case of fraud on the part of the employee, an employee is not barred by any time limit from filing a petition to have the matters covered by the agreement determined in accordance with this Act as though the agreement had not been approved.

2. Compensation payment scheme. A party may petition the board, within one year of initiation of a payment scheme, award or decree, to reopen any case in which fraud on the part of the opposing party is alleged. If the board finds that the petitioning party exercised due diligence in investigating the initial claim and further finds that fraud occurred, the board may reopen the case as to any issue that may have been affected by the fraudulent act and the board may terminate or modify an employer's obligation to make payment upon a finding that fraud on the part of a party affected the employer's obligation to make payment.

Except in the case of fraud on the part of the employee, an employee is not barred by any time limit from filing a petition to have any issues determined in accordance with this Act as though the payment scheme had not been initiated.

§322. Appeal from decision of hearing officer or board

1. Appeals. Any party in interest may present a copy of the decision of a hearing officer or a decision of the board, if the board has reviewed a decision pursuant to section 320, to the clerk of the Law Court within 20 days after receipt of notice of the filing of the decision by the hearing officer or the board. Within 20 days after the copy is filed with the Law Court, the party seeking review by the Law Court shall file a petition seeking appellate review with the Law Court that sets forth a brief statement of the facts, the error or errors of law that are alleged to exist and the legal authority supporting the position of the appellant.

2. Procedures. The Law Court shall establish and publish procedures for the review of petitions for appellate review of decisions of the board.

3. Discretionary appeal; action. Upon the approval of 3 or more members of a panel consisting of no fewer than 5 Justices of the Law Court, the petition for appellate review may be granted. If the petition for appellate review is denied, the decision of the board is final. The petition must be considered on written briefs only.

If the petition for appellate review is granted, the clerk of the Law Court shall notify the parties of the briefing schedule consistent with the Maine Rules of Civil Procedure and in all respects the appeal before the Law Court must be treated as an appeal in an action in which equitable relief has been sought, except that there may be no appeal upon findings of fact. The Law Court may, after due consideration, reverse, modify or affirm any decision of the board.

§323. Enforcement of board decision

Any decision of the board is enforceable by the Superior Court by any suitable process, including execution against goods, chattel and real estate and proceedings for contempt for willful failure or neglect to obey the orders or decrees of the court or in any other manner that decrees for equitable relief are enforced. Any party in interest may present copies, certified by the clerk of the board, of any order or decision of the board or of any memorandum of agreement approved by the board to the clerk of courts for the county in which the injury occurred or, if the injury occurred outside the State, to the clerk of courts for Kennebec County. Any Justice of the Superior Court shall then render a pro forma decision in accordance with the order, decision or memorandum and cause all interested parties to be notified. The decision has the same effect and all proceedings in relation to the decision are the same as though rendered in an action in which equitable relief is sought, duly heard and determined by the court. The decision must be for enforcement of a board decision, order or agreement. Appeals from a board decision, order or agreement must be in accordance with section 322.

§324. Compensation payments; penalty

1. Order or decision. The employer or insurance carrier shall make compensation payments within 10 days after the receipt of notice of an approved agreement for payment of compensation or within 10 days after any order or decision of the board awarding compensation. If the board enters a decision awarding compensation and an appeal is filed with the Law Court pursuant to section 322, payments may not be suspended while the appeal is pending. The employer or insurer may recover from an employee payments made pending appeal to the Law Court if and to the extent that the Law Court has decided that the employee was not entitled to the compensation paid. The board has full jurisdiction to determine the amount of overpayment, if any, and the amount and schedule of repayment, if any. The board, in determining whether or not repayment should be made and the extent and schedule of repayment, shall consider the financial situation of the employee and the employee's family and may not order repayment that would work hardship or injustice.

2. Failure to pay within time limits. An employer or insurance carrier who fails to pay compensation, as provided in this section, is penalized as follows.

A. Except as otherwise provided by section 205, if an employer or insurance carrier fails to pay compensation as provided in this section, the board shall assess against the employer or insurance carrier a forfeiture of up to $200 for each day of noncompliance. If the board finds that the employer or insurance carrier was prevented from complying with this section because of circumstances beyond its control, no forfeiture may be assessed.

(1) The forfeiture for each day of noncompliance must be divided as follows: Of each day's forfeiture amount, the first $50 is paid to the employee to whom compensation is due and the remainder must be paid to the board and be credited to the Workers' Compensation Board Administrative Fund.

(2) If a 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's fees related to the forfeiture, as determined by the board, to the employee.

(3) Forfeitures assessed under this subsection may be enforced by the Superior Court in the same manner as provided in section 323.

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

3. Failure to secure payment. If any employer who is required to secure the payment to that employer's employees of the compensation provided for by this Act fails to do so, the employer is subject to the penalties set out in paragraphs A, B and C. The failure of any employer to procure insurance coverage for the payment of compensation and other benefits to the employer's employees in compliance with sections 401 and 403 constitutes a failure to secure payment of compensation within the meaning of this subsection.

A. The employer is guilty of a Class D crime.

B. The employer is liable to pay a civil penalty of up to $10,000, payable to the Employment Rehabilitation Fund.

C. The employer, if organized as a corporation, is subject to revocation or suspension of its authority to do business in this State as provided in Title 13-A, section 1302. The employer, if licensed, certified, registered or regulated by any board authorized by Title 5, section 12004-A or whose license may be revoked or suspended by proceedings in the Administrative Court or by the Secretary of State, is subject to revocation or suspension of the license, certification or registration.

Prosecution under paragraph A does not preclude action under paragraph B or C.

If the employer is a corporation, any agent of the corporation having primary responsibility for obtaining insurance coverage is liable for punishment under this section. Criminal liability must be determined in conformity with Title 17-A, sections 60 and 61.

4. Certificate. Notwithstanding any other provision of law or rule of evidence, the certificate of the executive director, under seal of the board, must be received in any court in this State as prima facie evidence of facts pertaining to insurance coverage records contained in the certificate or within the documents attached to the certificate.

§325. Costs; attorney's fees allowable

1. Costs and attorney's fees. Except as otherwise provided by law, by the Maine Rules of Civil Procedure or by rule of court, each party is responsible for the payment of the party's own costs and attorney's fees. In the event of a disagreement as to those costs or fees, an interested party may apply to the board for a hearing.

2. Restriction on attorney's fees. An attorney representing an employee in a proceeding under this Act may receive a fee from that client for an activity pursuant to the Act only as provided in this section. The fees and payment of fees to all attorneys for services provided to employees under this Act are subject to the approval of the board. The board may approve the payment of attorney's fees by the employee for services provided to the employee pursuant to this Act. Any attorney who violates this section must forfeit any fee in the case and is liable in a court suit to pay damages to the client equal to 2 times the fee charged to that client.

3. Rules. The board shall adopt rules to prescribe maximum attorney's fees and the manner in which the amount is determined and paid by the employee. The maximum attorney's fees prescribed by the board in a case tried to completion may not exceed 30% of the benefits accrued, after deducting reasonable expenses incurred on behalf of the employee, or be based on a weekly benefit amount after coordination that is higher than 2/3 of the state average weekly wage at the time of injury. The board may by rule allow attorney's fees to be increased above or decreased below the amount specified in the rule when in the discretion of the board that action is determined to be appropriate.

4. Attorney's fees for lump-sum settlements. Attorney's fees for lump-sum settlements pursuant to section 352 must be determined as follows:

A. Before computing the fee, reasonable expenses incurred on the employee's behalf must be deducted from the total settlement, including:

(1) Medical examination fee and witness fee;

(2) Any other medical witness fee, including cost of subpoena;

(3) Cost of court reporter service; and

(4) Appeal costs; and

B. The computation of the fee, based on the amount resulting after deductions according to paragraph A, may not exceed:

(1) Ten percent of the first $50,000 of the settlement;

(2) Nine percent of the first $10,000 over $50,000 of the settlement;

(3) Eight percent of the next $10,000 over $50,000 of the settlement;

(4) Seven percent of the next $10,000 over $50,000 of the settlement;

(5) Six percent of the next $10,000 over $50,000 of the settlement; and

(6) Five percent of any amount over $90,000 of the settlement.

5. Attorney's fees in cases in which the injury occurred prior to January 1, 1993. In cases in which the injury to the employee occurred prior to January 1, 1993, the amount of the attorney's fees is determined by the law in effect at the date of the injury and is payable by the employer. If the employee attended a mediation pursuant to section 313 after January 1, 1993 and was represented by an attorney, the attorney's fees may include compensation from the date of the mediation session.

§326. Death of petitioner

No proceedings under this Act abate because of the death of the petitioner, but may be prosecuted by the employee's legal representatives or by any person entitled to compensation by reason of the death under this Act.

§327. When employee killed or unable to testify

In any claim for compensation, when the employee has been killed or is physically or mentally unable to testify, there is a rebuttable presumption that the employee received a personal injury arising out of and in the course of employment, that sufficient notice of the injury has been given and that the injury or death was not occasioned by the willful intention of the employee to injure or kill the employee or another.

§328. Cardiovascular injury or disease and pulmonary disease suffered by a firefighter or resulting in a firefighter's death

Cardiovascular injury or disease and pulmonary disease suffered by a firefighter or resulting in a firefighter's death are governed by this section.

1. Firefighter defined. For the purposes of this section, "firefighter" means an active member of a municipal fire department or of a volunteer firefighters association if that person is a member of a municipal fire department or volunteer firefighters association and if that person aids in the extinguishment of fires, regardless of whether or not that person has administrative duties or other duties as a member of the municipal fire department or volunteer firefighters association.

2. Presumption. There is a rebuttable presumption that a firefighter received the injury or contracted the disease arising out of and in the course of employment, that sufficient notice of the injury or disease has been given and that the injury or disease was not occasioned by the willful intention of the firefighter to cause self-injury or injury to another if the firefighter has been an active member of a municipal fire department or a volunteer firefighters association, as defined in Title 30-A, section 3151, for at least 2 years prior to a cardiovascular injury or the onset of a cardiovascular disease or pulmonary disease and if:

A. The disease has developed or the injury has occurred within 6 months of having participated in fire fighting, or training or drill that actually involves fire fighting; or

B. The firefighter had developed the disease or had suffered the injury that resulted in death within 6 months of having participated in fire fighting, or training or drill that actually involved fire fighting.

SUBCHAPTER II

MISCELLANEOUS

§351. Nonresidents

If an employee receiving weekly payments under this Act ceases to reside in the State or if the employee's residence at the time of the injury is in another state, the board upon application of either party may, in its discretion, having regard to the welfare of the employee and the convenience of the employer, authorize payments to be made monthly or quarterly instead of weekly.

§352. Lump-sum settlements

1. Agreement. An insurer, self-insurer or self-insured group and an employer and employee may by agreement discharge any liability for compensation, in whole or in part, by the employer's payment of an amount to the employee if:

A. The insurer, the employer, the employee or the employee's dependents petition the board for an order commuting all payments for future benefits to a lump sum;

B. Six months' time has elapsed from the date of an injury; and

C. The provisions of this section have been met and the agreement has been approved by the board.

2. Policy. The board shall by rule adopt policies establishing the circumstances under which lump-sum payments may be approved under this section. The circumstances must be at least as restrictive as those set forth in this section.

3. Review. Before approving any lump-sum settlement, the board shall review the following factors with the employee:

A. The employee's rights under this Act and the effect a lump-sum settlement would have on those rights, including, if applicable, the effect of the release of an employer's liability for future medical expenses;

B. The purpose for which the settlement is requested;

C. The employee's post-injury earnings and prospects, considering all means of support, including the projected income and financial security resulting from proposed employment, self-employment or any business venture or investment and the prudence of consulting with a financial or other expert to review the likelihood of success of these projects; and

D. Any other information, including the age of the employee and of the employee's dependents, that would bear upon whether the settlement is in the best interest of the claimant.

4. Procedure. The board shall initiate the review within 14 days of receipt of a request for a settlement review. An employer is considered a party for the purposes of this section.

5. Approval. The board may not approve any lump-sum settlement unless there is an agreement pursuant to subsection 1 or, in the event the employer refuses to agree to the settlement, the board has reviewed the proposed agreement and finds it to be in the best interests of the parties, and unless:

A. The employee has fully participated in the review process, except in circumstances amounting to good cause;

B. The board finds the settlement to be in the employee's best interest in light of the factors reviewed with the employee under subsection 3; and

C. In the case of a lump-sum settlement that requires the release of an employer's liability for future medical expenses of the employee, the board finds that the parties would be unlikely to reach agreement on the amount of the lump-sum payment without the release of liability for future medical expenses.

6. Monitoring of lump-sum settlement recipients. The board shall establish and maintain a program to monitor the postsettlement employment experience of employees who settle their claims pursuant to this section to help develop future policy. The Bureau of Employment Security shall cooperate with the board in the establishment and operation of this monitoring program.

§353. Discrimination

An employee may not be discriminated against by any employer in any way for testifying or asserting any claim under this Act. Any employee who is so discriminated against may file a petition alleging a violation of this section. The matter must be referred to a hearing officer for a formal hearing under section 315, but any hearing officer who has previously rendered any decision concerning the claim must be excluded. If the employee prevails at this hearing, the hearing officer may award the employee reinstatement to the employee's previous job, payment of back wages, reestablishment of employee benefits and reasonable attorney's fees.

This section applies only to an employer against whom the employee has testified or asserted a claim under this Act. Discrimination by an employer who is not the same employer against whom the employee has testified or asserted a claim under this Act is governed by Title 5, section 4572, subsection 1, paragraph A.

§354. Multiple injuries; apportionment of liability

1. Applicability. When 2 or more occupational injuries occur, during either a single employment or successive employments, that combine to produce a single incapacitating condition and more than one insurer is responsible for that condition, liability is governed by this section.

2. Liability to employee. If an employee has sustained more than one injury while employed by different employers, or if an employee has sustained more than one injury while employed by the same employer and that employer was insured by one insurer when the first injury occurred and insured by another insurer when the subsequent injury or injuries occurred, the insurer providing coverage at the time of the last injury shall initially be responsible to the employee for all benefits payable under this Act.

3. Subrogation. Any insurer determined to be liable for benefits under subsection 2 must be subrogated to the employee's rights under this Act for all benefits the insurer has paid and for which another insurer may be liable. Any such insurer may, in accordance with rules adopted by the Superintendent of Insurance, file a request for appointment of an arbitrator to determine apportionment of liability among the responsible insurers. 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 is 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.

4. Consolidation. The board may consolidate some or all proceedings arising out of multiple injuries.

§355. Employment Rehabilitation Fund

If an employee who has completed a rehabilitation program under section 217, whether implementation is approved or ordered by the board, subsequently sustains a personal injury arising out of and in the course of employment and that injury, in combination with the prior injury, results in a reduction in earning capacity that is substantially greater in duration or degree, or both, than that which would have resulted from the subsequent injury alone, taking into account the age, education, employment opportunities and other factors related to the employee, the employer at the time of the subsequent injury is entitled to reimbursement from the Employment Rehabilitation Fund, referred to in this section as the "fund," as provided in this section.

1. Fund administration and contributions. There is established a special fund, known as the Employment Rehabilitation Fund, for the sole purpose of making payments in accordance with this Act. The fund is administered by the board. The Treasurer of State is the custodian of the fund. All money and securities in the fund must be held in trust by the Treasurer of State for the purpose of making payments under this Act and are not money or property for the general use of the State. The fund does not lapse.

The Treasurer of State may disburse money from the fund only upon written order of the board. The Treasurer of State shall invest the money of the fund in accordance with law. Interest, income and dividends from the investments must be credited to the fund.

2. Limitations. An employer is not entitled to reimbursement from the fund in the event of subsequent injury if an injured employee returns to the employee's preinjury job with the same employer without the provision of significant rehabilitation services or significant modification of the workplace.

3. Reimbursement. The employer must be reimbursed at least quarterly from the fund for any weekly wage replacement benefits for which the employer is liable under section 212, 213 or 215 and that are paid by that employer.

A. An employer entitled to reimbursement under this section remains liable to the employee for all payments otherwise required from the employer by this Act and remains responsible for carrying out the rehabilitation efforts required by this Act as a result of the subsequent injury.

B. The board shall order a reduction, suspension or termination of reimbursement of an employer under this section if the board finds that the employer has not made a bona fide effort to return the employee to continuing suitable employment.

4. Apportionment. Reimbursement under this section must be reduced by the amount of any contribution paid to the employer by any other employer for wage replacement benefits on the basis of apportioned liability under section 354.

A. If insurers disagree on the apportionment of liability in a case under this section, the matter must be considered by the board before an insurer may file a petition under section 354. The board shall encourage agreement between the insurers and, if agreement can not be achieved, shall make a recommendation on the apportionment of liability.

5. Employer knowledge. An employer otherwise entitled to reimbursement under this section is entitled to that reimbursement regardless of whether the employer

has knowledge at any time that the employee had completed an approved rehabilitation plan.

6. Hiring incentive; wage credit. If an employer hires an employee after the employee has completed a rehabilitation program under section 217, that subsequent employer may apply for a wage credit under this subsection. For the purposes of this subsection, the term "employer" does not include the insurer of a subsequent employer or the same employer for whom an employee worked when the employee sustained the injury for which the employee received rehabilitation.

A. The subsequent employer must file an application for a wage credit by providing the board, within 2 weeks after the close of the first 90 days of employment of the employee, with a statement of the total direct wages, earnings or salary the employer paid to the employee for the first 90 days of employment along with such verification as may be required by rule of the board. Within 2 weeks after the close of the first 180 days of employment, the subsequent employer must provide to the board a supplemental report of the direct wages, earnings and salary for the 2nd 90-day period, along with the required verification.

B. The board shall compute the wage credit, which consists of a sum equal to 50% of the average weekly direct wages, earnings or salary for the 90-day period listed in the subsequent employer's application or statement, but may not exceed the amount of workers' compensation benefits that the employee did not receive because of the employment but would have been entitled to for the wage credit period, based on the average weekly workers' compensation benefits during the most recent 60-day period in which the employee did receive benefits preceding the employee's hiring by the employer.

(1) On adequate verification of the application or statement, the board shall pay the amount for each 90-day period in a lump sum to the subsequent employer within 30 days of receiving the application or statement.

(2) The board shall bill these sums to the insurer or self-insurer that was responsible for payment of the compensation received by the employee immediately before the employee's hiring by the subsequent employer. When the sum is received from the insurer or self-insurer, the board shall deposit it in the fund.

C. If the employment with the subsequent employer is terminated by the employer without good cause before the completion of 12 consecutive months of employment, the subsequent employer shall return to the board all wage credits received by the employer for that employee and all sums paid into the fund by the insurer or self-insurer must be returned to that insurer or self-insurer.

D. When the wage credit is paid from the fund to an employer, the insurer or self-insurer who paid the sum into the fund has no further obligation to pay any sums into the fund for any future reemployment of that employee, except as provided in paragraph E.

(1) Total wage credit payments under a plan may not exceed a period of 180 days, not including periods subject to refunds under paragraph C.

(2) The board shall inform subsequent employers of the number of days of wage credits available, if it is less than 180 days.

E. Wage credit payments are not dependent on the receipt by the fund of payments from an insurer or self-insurer.

7. Plan implementation costs; payment; reimbursement. The actual and direct costs of implementing plans ordered by the board under section 217, subsection 2 must be paid from the fund. Payments must be made directly to the rehabilitation providers or other persons who provide services under the plan. Upon an order of recovery of plan implementation costs under section 217, subsection 3, the board shall assess the employer who refused to agree to implement the plan under section 217 an amount equal to 180% of the costs paid from the fund under this subsection. An employer may appeal the imposition or amount of this assessment to the board. The employee may not be a party to this appeal.

8. Jurisdiction. The board has jurisdiction over all claims brought against the fund.

A. The fund is not bound as to any question of law or fact by reason of any award or any adjudication to which the fund was not a party or in relation to which the fund was not notified, at least 21 days prior to the award or adjudication, that the fund might be subject to liability for the injury or death of an employee.

B. An employer shall notify the board of any possible claim for subsequent injury reimbursement against the fund as soon as practicable, but in no event later than one year after the injury or death of an employee. Failure to provide timely notice bars the claim.

9. Legal representation. The Attorney General shall provide legal representation for any claim made

under this section, including the enforcement of an assessment made under subsection 7 or the defense of an employer's appeal of that assessment.

A. The reasonable expense of prosecution or defense by the Attorney General of assessments to or claims against the fund, subject to the approval of the board, are payable out of the fund.

B. The Attorney General may not prosecute an assessment against the State or defend the fund against any claim brought by the State. The board may hire, using money from the fund, private counsel for this purpose.

10. Effect on obligations of prior employers. The availability of reimbursement under this section does not limit or reduce the obligation of any previous employer to provide benefits under this Act to the employee.

11. Freedom from liability. The State is not liable for any claim against the fund that is in excess of the fund's current ability to pay. If any claim against the fund is denied due to an inadequate fund balance, that claim is entitled to priority over later claims when an adequate balance is restored.

12. Applicability. Reimbursement under this section is available solely with respect to employees who are injured and rehabilitated after November 20, 1987.

13. Reimbursement. The fund must be used to reimburse employers, insurers and group self-insurers for their payments of compensation to employees under section 213, subsections 3 and 4.

§356. Funding of Employment Rehabilitation Fund

1. Assessment. The board may levy an assessment on each insurer based on its actual paid losses during the previous calendar year when the amount of money in the Employment Rehabilitation Fund is less than $500,000.

2. Death of an employee. 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 to be credited to the Employment Rehabilitation Fund.

3. Records and reports. Every insurer shall keep as permanent records a record of the amount and date of each loss paid. The records must be open for inspection at all times. Every insurer shall, on or before the 60th day following the end of a calendar quarter, render a report to the State Tax Assessor stating the amount of losses paid by the insurer during the preceding calendar quarter. That report must contain any further information the board prescribes by rule.

4. Appropriation of money received. The State Tax Assessor shall pay daily all receipts from any assessment and any receipts received under subsection 2 to the Treasurer of State daily. The Treasurer of State shall deposit all receipts as received in the Employment Rehabilitation Fund.

5. Inspections. The State Tax Assessor or the State Tax Assessor's duly authorized agent or the board, for the purpose of determining the truth or falsity of any statement or return made by the insurer, may:

A. Enter any place of business of an insurer to inspect any books or records of the insurer;

B. Notwithstanding any other provision of law, inspect any records or reports filed by an insurer with the Superintendent of Insurance; and

C. Delegate these powers to the Superintendent of Insurance, the superintendent's deputies, agents or employees.

6. Civil action. Whenever any insurer fails to pay any assessment due under this section within the time limit, the Attorney General shall enforce payment by civil action against that insurer for the amount of the assessment in the Superior Court in and for the county or the District Court in the division in which that insurer has the insurer's place of business, or in the Superior Court of Kennebec County.

7. Insurer defined. For the purposes of this section, "insurer" means an insurance company or association that does business or collects premiums for workers' compensation insurance in this State or an individual or group self-insurer under this Act, including the State and other public or governmental authority.

§357. Information from insurance companies

1. Completion of forms. Every insurance company insuring employers under this Act shall fill out any blanks and answer all questions submitted that may relate to policies, premiums, amount of compensation paid and such other information as the board or the Superintendent of Insurance may determine important, either for the proper administration of this Act or for statistical purposes.

2. Explanation of reserving policy. Every insurance company subject to Title 24-A, chapter 25, subchapter II-B shall, not later than 30 days after filing its annual statement, file with the Superintendent of Insurance a detailed explanation of its reserve policy in regard to claims under this Act, including specific reserve guidelines.

§358. Reports and data collection

1. Occupational injuries and illnesses. The Director of the Bureau of Labor Standards shall provide an annual report concerning the number and character of occupational injuries and illnesses and their effects, as required under Title 26, section 42.

The board's executive director shall assist the Director of the Bureau of Labor Standards to ensure that necessary information regarding the administrative processes, costs and other factors related to this Act and the occupational disease laws and are included in the report. The Commissioner of Human Services and the Director of the Bureau of Health shall provide the Director of the Bureau of Labor Standards with any information in their possession related to occupational injuries and illnesses. The Superintendent of Insurance shall provide the following information to the Director of the Bureau of Labor Standards on an annual basis:

A. A tabulation of premium and loss data, on an accrual accounting basis, regarding those insurance companies authorized by the Bureau of Insurance to write workers' compensation in the State; and

B. Similar data for self-insurance workers' compensation plans regulated by the Bureau of Insurance.

2. Workers' compensation system. The Director of the Bureau of Labor Standards, the Superintendent of Insurance and the board's executive director shall meet at least 3 times a year with appropriate staff and other state agencies to review the areas of data collection pertaining to the workers' compensation system, as well as interpret and coordinate appropriate data collection programs. The Director of the Bureau of Labor Standards shall chair this group. The group shall submit an annual report to the Governor and the Legislature as to the results of its data collection as well as a profile of the workers' compensation system, including costs, administration, adequacy and timeliness of benefits and an evaluation of the entire workers' compensation system.

The Director of the Bureau of Labor Standards, the Superintendent of Insurance and the boards's executive director shall provide any further occasional reports through their joint or individual efforts that they consider necessary to the improved function and administration of the this Act and the occupational disease laws.

§359. Audits; penalty; monitoring

1. Audits. The board shall audit claims, including insurer, self-insurer and 3rd-party administrator claim files, on an ongoing basis to determine whether insurers, self-insured employers and 3rd-party administrators have met their obligations under this Act and to identify the disputes that arose, the reasons for the disputes, the method and manner of their resolution, the costs incurred, the reasons for attorney involvement and the services rendered by the attorneys.

If as a result of an examination and after providing the opportunity for a hearing the board determines that any compensation, interest, penalty or other obligation is due and unpaid to an employee, dependent or service provider, the board shall issue a notice of assessment detailing the amounts due and unpaid in each case and shall order the amounts paid to the unpaid party or parties.

2. Penalty. In addition to any other penalty assessment permitted under this Act, the board may assess civil penalties not to exceed $10,000 upon finding, after hearing, that an employer, insurer or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims. The board shall certify its findings to the Superintendent of Insurance, who shall take appropriate action so as to bring any such practices to a halt. This certification by the board is exempt from the provisions of the Maine Administrative Procedure Act.

3. Monitoring. No later than July 1, 1993 the board shall implement a monitoring program to evaluate and compare the cost, utilization and performance of the workers' compensation system for each calendar year beginning with 1988. The information compiled must include the number of injuries occurring and claims filed as compared to employment levels, the type and cost of the benefits provided, attorney involvement and litigation levels, and the long-term, postinjury economic status of injured workers, as well as any other data that is actuarially valid and can be utilized to accomplish the purposes of this Act, including rulemaking and recommending legislation.

§360. Penalties

1. Reporting violations. The board may assess a civil penalty not to exceed $100 for each violation on any person:

A. Who fails to file or complete any report or form required by this Act or rules adopted under this Act; or

B. Who fails to file or complete such a report or form within the time limits specified in this Act or rules adopted under this Act.

2. General authority. The board may assess, after hearing, a civil penalty in an amount not to exceed $1,000 for an individual and $10,000 for a corporation, partnership or other legal entity for any willful violation of this Act, fraud or intentional misrepresentation. The board may also require that person to repay any compensation

received through a violation of this Act, fraud or intentional misrepresentation or to pay any compensation withheld through a violation of this Act, fraud or misrepresentation, with interest at the rate of 10% per year.

3. Appeal. Imposition of a penalty under this section is deemed to be final agency action subject to appeal to the Superior Court, as provided in Title 5, chapter 375, subchapter VII. Notwithstanding Title 5, section 11004, execution of a penalty assessed under this section is stayed during the pendency of any appeal under this subsection. The Attorney General shall represent the board in any appeal under this subsection or the board may retain private counsel for that purpose.

4. Enforcement and collection. Penalties assessed under this section are in addition to any other remedies available under this Act and are enforceable by the Superior Court under section 323.

A. The Attorney General shall prosecute any action necessary to recover penalties assessed under this section or the board may retain private counsel for that purpose.

B. If any person fails to pay any penalty assessed under this section and enforcement by the Superior Court is necessary:

(1) That person shall pay the costs of prosecuting the action in Superior Court, including reasonable attorney's fees; and

(2) If the failure to pay was without due cause, any penalty assessed on that person under this section must be doubled.

C. All penalties assessed under this section are payable to the General Fund.

5. Not an element of loss. An insurance carrier's payment of any penalty assessed under this section may not be considered an element of loss for the purpose of establishing rates for workers' compensation insurance.

CHAPTER 9

INSURANCE AND SELF-INSURANCE

§401. Liability of employer

1. Private employers. Every private employer is subject to this Act and shall secure the payment of compensation in conformity with this section and sections 402 to 407 with respect to all employees, subject to the provisions of this section.

A private employer who has not secured the payment of compensation under this section and sections 402 to 407 is not entitled, in a civil action brought by an employee or the employee's representative for personal injuries or death arising out of and in the course of employment, to the defense set forth in section 103. The employee of any such employer may, instead of bringing a civil action, claim compensation from the employer under this Act.

The following employers are not liable under this section for securing the payment of compensation in conformity with this section and sections 402 to 407 with respect to the employees listed, nor deprived of the defenses listed in section 103:

A. Employers of employees engaged in domestic service;

B. Employers of employees engaged in agriculture or aquaculture as seasonal or casual laborers, if the employer maintains coverage by an employer's liability insurance policy with total limits of not less than $25,000 and medical payment coverage of not less than $1,000.

(1) As used in this subsection, "casual" means occasional or incidental. "Seasonal" refers to laborers engaged in agricultural or aquacultural employment beginning at or after the commencement of the planting or seeding season and ending at or before the completion of the harvest season; and

C. Employers of 6 or fewer agricultural or aquacultural laborers, if the employer maintains an employer's liability insurance policy with total limits of not less than $100,000 multiplied by the number of agricultural or aquacultural laborers employed by that employer and medical payment coverage of not less than $1,000.

(1) In computing the number of agricultural or aquacultural laborers under this paragraph, immediate family members of unincorporated employers, immediate family members of bona fide owners of at least 20% of the outstanding voting stock of an incorporated agricultural employer and seasonal and casual workers are not included. For the purposes of this subparagraph, "immediate family members" means parents, spouse, brothers, sisters and children.

(2) This exemption does not apply if the employer has employed more than 6 agricultural or aquacultural laborers in regular and concurrent manner, as computed under subparagraph 1, at any time during the 52 weeks immediately preceding the injury.

The burden of proof to establish an exempt status under this subsection is on the employer claiming the exemption.

2. Governmental bodies. The State and every county, city and town is subject to this Act and shall secure the payment of compensation in conformity with sections 402 to 407.

3. Failure to conform. The failure of any private employer not exempt under subsection 1 or of any governmental body, as defined in subsection 2, to procure insurance coverage for the payment of compensation pursuant to sections 402 to 407 constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3, and subjects the employer to the penalties prescribed by that section. For purposes of this subsection, the term "insurance coverage" includes authorization by the Superintendent of Insurance to self-insure.

4. Liability of landowner. A landowner subject to this Act who contracts to have wood harvested from the landowner's property by a contractor who is subject to this Act and who has not complied with the provisions of this section and who does not comply with the provisions of this section prior to the date of an injury or death for which a claim is made is liable to pay to any person employed in the execution of the work any compensation under this Act that the landowner would have been liable to pay if that person had been immediately employed by the landowner.

A landowner is not liable for compensation if at the time the landowner enters into the contract with the contractor, the landowner requests and receives a certificate of insurance, issued by the contractor's insurance carrier, certifying that the contractor has obtained the required coverage and indicating the effective dates of the policy, and if the landowner requests and receives at least annually similar certificates indicating continuing coverage during the performance of the work.

A landowner required to pay compensation under this section is entitled to be indemnified by the contractor and may recover the amount paid in an action against that contractor. A landowner may demand that the contractor enter into a written agreement to reimburse the landowner for any loss incurred under this section due to a claim filed for compensation and other benefits. The employee is not entitled to recover at common law against the landowner for any damages arising from such injury if the employee takes compensation from that landowner.

Landowners willfully acting to circumvent the provisions of this section by using coercion, intimidation, deceit or other means to encourage persons who would otherwise be considered employees within the meaning of this Act to pose as contractors for the purpose of evading this section are liable subject to the provisions of section 324, subsection 3. Nothing in this section may be construed to prohibit an employee from becoming a contractor subject to the provisions of section 102, subsection 13.

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

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

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

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 technical college in the State 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 adopted pursuant to paragraph A. The Superintendent of Insurance shall assess a surcharge of 10% on that employer's workers' compensation insurance premium or the imputed premium for self-insurers, which must be paid to the Treasurer of State who shall credit 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. Employers who fail to complete a required workplace health and safety program and who are assessed a surcharge prior to January 1, 1994, must be assessed a surcharge of 5%. Employers who fail to complete a required workplace health and safety program and who are assessed a surcharge after January 1, 1994, must be assessed a surcharge of 10%.

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.

§402. Prepayment of premium

An insurance company that issues workers' compensation insurance policies may not require prepayment of premium more than 1/4 year in advance.

§403. Insurance by assenting employer; requirements as to self-insurers

An employer subject to this Act shall secure compensation and other benefits to the employer's employees in one or more of the ways described in this section. The failure of any employer subject to this Act to procure insurance coverage for the payment of compensation and other benefits to the employer's employees in one of the ways described in this section constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3 and subjects the employer to the penalties prescribed by that section.

1. Insuring under workers' compensation insurance policy. The employer may comply with this section by insuring and keeping insured the payment of such compensation and other benefits under a workers' compensation insurance policy. The insurance company shall file with the board notice, in the form required by the board, of the issuance of any workers' compensation policy to an employer. The insurance may not be cancelled within the time limited in such policy for its expiration until at least 30 days after the insurance company mails to the board and to the employer a notice of the cancellation of the insurance. In the event that the employer has obtained a workers' compensation policy from another insurance company, or has otherwise secured compensation as provided in this section, and such insurance or other security becomes effective prior to the expiration of the 30-day notice period, cancellation takes effect on the effective date of the other insurance or on receipt of security.

2. 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 health care benefits covering workplace injury and illness and nonworkplace injury and illness and other health care benefits in comprehensive pilot projects. The health care benefits may be provided by: organizations authorized to do business under Title 24; insurers or health maintenance organizations authorized to do business under Title 24-A; employee benefit plans; and benefit plans of employers who self-insure under this section. 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. Notwithstanding the provisions of section 206, the comprehensive health care benefits pilot project may allow for case management and cost control mechanisms, including the use of preferred provider organizations. The premium for coverage of the employee must be paid entirely by the employer. The deductible for the health care of the employee may not exceed a maximum of $50 per injury or illness and the coinsurance may not exceed $5 per treatment of the employee by the health care provider.

C. The Superintendent of Insurance 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 subsection is repealed on October 31, 1996.

3. Proof of solvency and financial ability to pay; trust. The employer may comply with this section by furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and depositing cash, satisfactory securities, irrevocable standby letters of credit issued by a qualified financial institution or a surety bond with the board, in such sum as the superintendent may determine pursuant to subsection 8, such bond to run to the Treasurer of State 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 must be placed in an account at interest by the Treasurer of State, and the accumulation of interest on the cash or securities so deposited must be credited to the account and may not be paid to the employer to the extent that the interest is required to support any present value discounting in the determination of the amount of the deposit. Any security deposit must be held by the Treasurer of State in trust for the benefit of the self-insurer's employees for the purposes of making payments under this Act.

An individual self-insurer may, with the approval of the superintendent, use a surety bond, an irrevocable standby

letter of credit or financial assets, including cash deposits and acceptable securities, singly or in combination to satisfy the self-insurer's responsibility to post security required by the superintendent. An individual self-insurer that proposes to use an irrevocable standby letter of credit shall maintain at all times a net worth of not less than $50,000,000, have a ratio of current assets to current liabilities of at least 1.1 to 1 and have a ratio of long-term debt to tangible net worth not in excess of 1.3 to 1. For purposes of this section, "tangible net worth" means equity less assets that have no physical existence and depend on expected future benefits for their ascribed value.

An employer who seeks to use an irrevocable standby letter of credit as proof to the superintendent of provision of required security shall file with the superintendent a copy of the proposed letter of credit, copies of any agreements or other documents establishing the terms and conditions of the employer's reimbursement obligations to the financial institution issuing the letter of credit, together with copies of any required security agreements, mortgages or other agreements or documents granting security for the employer's reimbursement obligations and any other agreements that contain conditions, restrictions or limitations of any kind upon the employer, the superintendent or the Treasurer of State. The superintendent, upon receipt of the original irrevocable standby letter of credit, shall promptly forward it to the Treasurer of State.

The superintendent shall adopt rules to establish the qualifications for financial institutions issuing irrevocable standby letters of credit, which must include maintenance of a long-term unsecured debt rating of at least A by either Moody's Investors Service, Inc. or Standard and Poor's Corporation, and to prescribe the form of the irrevocable standby letter of credit that may be used to satisfy, in whole or in part, the employer's responsibility under this subsection to post security. The irrevocable standby letter of credit must be the individual obligation of the issuing financial institution, may not be subject to any agreement, condition or qualification between the financial institution and the employer and may not in any way be contingent on reimbursement by the employer. If the rating of an issuing financial institution that has issued an irrevocable standby letter of credit pursuant to this section falls below the required standard, the employer must obtain a new irrevocable standby letter of credit from a qualified financial institution or must provide substitute proof of solvency and financial ability to pay consistent with this section. The irrevocable standby letter of credit is automatically extended for one year from the date of expiration unless, 90 days prior to any expiration date, the issuing financial institution notifies the superintendent that the financial institution elects not to renew the irrevocable standby letter of credit.

An irrevocable standby letter of credit that has been issued by a qualified financial institution and accepted by the superintendent binds the issuing financial institution to pay one or more drafts drawn by the Treasurer of State as long as the draft does not exceed the total amount of the irrevocable standby letter of credit. Any draft presented by the Treasurer of State must be promptly honored if accompanied by the certification of the superintendent that any obligation under this chapter has not been paid when due or that a proceeding in bankruptcy has been initiated by or with respect to the employer in a court of competent jurisdiction.

If the superintendent certifies that the superintendent has been notified by the issuing financial institution that the irrevocable standby letter of credit will expire by its terms in 30 days or less, that the irrevocable standby letter of credit was not replaced within 15 days after that notice to the superintendent by a substitute irrevocable standby letter of credit and that other eligible security of equal value has not been posted, then the full amount of the irrevocable letter of credit must be paid over to the Treasurer of State without further certification.

Any proceeds from a draw on such an irrevocable standby letter of credit by the Treasurer of State must be held by the Treasurer of State on behalf of workers' compensation claimants to secure payment of claims until either the Superintendent of Insurance authorizes the Treasurer of State to release those proceeds to the employer upon provision by the employer of replacement security adequate to meet the requirements for security set by the superintendent or the superintendent directs distribution of the proceeds in accordance with this Title.

The Superintendent of Insurance shall consider the following form of letter acceptable.

IRREVOCABLE STANDBY LETTER OF CREDIT

Irrevocable standby letter of credit no. .....

We hereby issue our irrevocable standby letter of credit (hereinafter referred to as "letter of credit") in favor of the Treasurer of State, State of Maine for drawings up to U.S. $..... effective immediately and expiring immediately at our .....(bank address)..... with our close of business on ..... .

We hereby undertake to honor promptly your sight draft(s) drawn on us, indicating our letter of credit no. ....., for all or part of this letter of credit if presented at .....(bank address)..... on or before the expiration date or any automatically extended date.

Except as stated in this letter of credit, this undertaking is not subject to any condition or qualification. The obligation of the bank under this letter of credit is the individual obligation of the bank, in

no way contingent upon reimbursement with respect thereto.

It is a condition of this letter of credit that it is automatically extended without amendment for one year from the expiration of this letter of credit, or any future expiration date, unless 90 days prior to any expiration date we notify the Chair of the Workers' Compensation Board and the Superintendent of Insurance by registered mail that we elect not to consider this letter of credit renewed for any additional period.

It is a further condition of this letter of credit that any interruptions of the bank's conduct of business caused by an Act of God, riot, civil commotion, insurrection, war or other cause beyond the bank's control will automatically extend the expiration date of the letter of credit, as well as any future expiration date, by the period of the interruption.

To the extent not inconsistent with Maine law, this letter of credit is subject to and governed by the Uniform Customs and Practice for Documentary Credits, 1983, International Chamber of Commerce Publication No. 400. If any legal proceedings are initiated with respect to payment of this letter of credit, it is agreed that such proceedings are subject to Maine courts and law.

The superintendent shall prescribe the form of the surety bond that may be used to satisfy, in whole or in part, the employer's responsibility under this section to post security. The bond must be continuous, be subject to nonrenewal only upon not less than 60 days' notice to the superintendent and cover payment of all present and future liabilities incurred under this Act while the bond is in force and cover payments that become due while the bond is in force that are attributable to injuries incurred in prior periods and otherwise unsecured by cash, irrevocable standby letters of credit or acceptable securities. A bond must be held until all payments secured thereby have been made or until it has been replaced by a bond issued by a qualified successor surety that covers all outstanding liabilities. Payments under the bond are due within 30 days after notice has been given to the surety by the board that the principal has failed to make a payment required under the terms of an award, agreement or governing law. A trust established to satisfy the requirements of this section may not be funded by a surety bond. An irrevocable standby letter of credit may be utilized by a group self-insurer that maintains a trust account actuarially funded to the 90% confidence level as long as the value of the letter of credit does not exceed 5% of the value of the 90% confidence level.

As an alternative to the methods described in 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 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 reinsurance 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 or excess insurance. If a member of a group self-insurer terminates membership in the group for any reason, then that member shall fund the member's proportionate share of the liabilities and obligations of the trust to the 95% confidence level. If for any reason the departing member fails to fund the member's proportionate share of the trust's exposure to the 95% level of confidence, 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. Trust assets must consist of cash or marketable securities of a type and risk character as specified in subsection 9 and have a situs in the United States. The trustee shall submit a report to the superintendent not less frequently than quarterly that lists the assets comprising the corpus of the trust, including a statement of their market value and the investment activity during the period covered by the report. The trust must be established and maintained subject to the condition that trust assets may not be transferred or revert in any manner to the employer except to the extent that the superintendent finds that the value of the trust assets exceeds the present value of incurred claims and claims settlement costs with an actuarially indicated margin for future loss development. In all other respects, the trust instrument, including terms for certification, funding, designation of trustee and payout, must be as approved by the superintendent, provided that the value of the trust account must be actuarially calculated at least annually by a casualty actuary who is a member of the American Academy of Actuaries and adjusted to the required level of funding. 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 the employer's operating needs.

Notwithstanding any provision of this chapter, any bond or security deposit required of a public employer that is a self-insurer 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 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 reinsurance, subject to the provisions of subsection 8. Standards respecting the application of reinsurance must be contained in a rule adopted by the superintendent pursuant to the Maine Administrative Procedure Act. Reinsurance must be defined as insurance covering workers' compensation exposures in excess of risk retained by a self-insurer.

As a further alternative to the methods described in this subsection, an employer 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 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 is deemed to have submitted to the jurisdiction of the board and the courts of this State for purposes of enforcing any such guarantee. The guarantor, in all respects, is bound by and subject to the orders, findings, decisions or awards rendered against the employer for payment of compensation and any penalties or forfeitures provided under this Act. The superintendent, following hearing, may revoke the self-insured status of the employer if at any time the assets of the guarantor become impaired, encumbered or are otherwise found to be inadequate to support the guarantee.

Each individual self-insurer shall submit with its application and not less frequently than annually thereafter a financial statement of current origin that has been audited by a certified public accountant. In the case of a self-insurer that qualifies on the basis of a financial guarantee, the superintendent may accept an audited financial statement of the guarantor in satisfaction of this requirement if combining statements are provided in an array that is reconciled to the consolidated report unless the self-insured entity comprises such a minimal proportion of total consolidated operations that audit reliance can not be taken therefrom.

4. Group self-insurers; application. Except for the provision relating to individual public employer self-insurers, subsection 3 is equally applicable in all respects to group self-insurers. Any employer or group of employers desiring to become a self-insurer shall submit to the Superintendent of Insurance with an application for self-insurance, in a form prescribed by the superintendent, the following:

A. A payroll report for each participating employer of the group for the 3 preceding annual fiscal periods;

B. A report of compensation losses incurred, payments plus reserves, by each participating employer of the group for the periods described in paragraph A;

C. A sworn itemized statement of the group's assets and liabilities; satisfactory proof of financial ability to pay compensation for the employers participating in the group plan; and the group's reserves, their source and assurance of continuance;

D. A description of the safety organization maintained by the employer or group for the prevention of injuries;

E. A statement showing the kind of operations performed or to be performed;

F. An indemnity agreement in a form prescribed by the superintendent that jointly and severally binds the group and each member to comply with the provisions of this Act; and

G. Any other agreements, contracts or other pertinent documents relating to the organization of the employers in the group.

If, upon examination of the sworn financial statement and other data submitted, the superintendent is satisfied as to the ability of the employer or group to make current compensation payments and that the employer's or group's tangible assets make reasonably certain the payment of all obligations that may arise under this Act, the application must be granted subject to the terms and conditions setting out the exposure of cash deposits or securities or an acceptable surety bond, as required by the superintendent. Security against shock or catastrophe loss must be provided either by depositing securities with the board in such amount as the superintendent may determine or by filing with the superintendent and the board an insurance carrier's certificate of a standard self-insurer's reinsurance contract issued to the self-insurer or group in a form approved by the superintendent, providing coverage against losses arising out of one injury in such amounts as the superintendent may

determine, or a combination of the foregoing, satisfactory to the superintendent. Notwithstanding any provision of this chapter, no specific or aggregate reinsurance may be required of any individual public employer who is self-insured and has a state-assessed valuation equal to or in excess of $300,000,000 and either a net worth equal to or in excess of $25,000,000 or a bond rating equal to or in excess of the 2nd highest standard as set by a national bond rating organization, provided that, if the self-insurer relying on a bond rating is a county, city or town, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value must be incorporated in the annual audit of the county, city or town together with disclosure of funds appropriated to discharge incurred claims expenses.

Yearly reports in a form prescribed by the superintendent must be filed by each self-insurer or group. The superintendent may, in addition, require the filing of quarterly financial status reports whenever the superintendent has reason to believe that there has been a deterioration in the financial condition of either an individual or group self-insurer that adversely affects the individual's or group's ability to pay expected losses. The reports must be filed within 30 days after the superintendent's request or at such time as the superintendent shall otherwise set.

After approving any application for self-insurance, the superintendent shall promptly notify the board and forward to it copies of the application and all supporting materials.

5. Group self-insurance; participation. Participation in a group self-insurance plan is governed by the following provisions.

A. Any group of employers may adopt a plan for self-insurance, as a group, for the payment of compensation under this Act to their employees. No group may be approved to operate a self-insurance plan in the form of a corporation. Under a group self-insurance plan the group shall assume the liability of all the employers within the group and pay all compensation for which the employers are liable under this chapter. When the plan is adopted, the group shall furnish satisfactory proof to the Superintendent of Insurance of its financial ability to pay such compensation for the employers in the group and its revenues, their source and assurance of continuance. The superintendent shall require the deposit with the board of such securities as the superintendent determines necessary of the kind prescribed in subsection 9 or the filing of a bond issued by a surety company authorized to transact business in this State, in an amount to be determined to secure its liability to pay the compensation of each employer as above provided in accordance with subsection 9. Such surety bond must be approved as to form by the superintendent. The superintendent may also require that any agreements, contracts and other pertinent documents relating to the organization of the employers in the group be filed with the superintendent at the time the application for group self-insurance is made. The application must be on a form prescribed by the superintendent. The superintendent has the authority to deny the application of the group to pay such compensation for failure to satisfy any applicable requirement of this section. The superintendent shall approve or disapprove an application within 90 days. The group qualifying under this paragraph is referred to as a self-insurer.

B. An employer participating in group self-insurance is not relieved from the liability for compensation prescribed by this chapter, except by the payment of the compensation by the group self-insurer or by the employer. As between the employee and the group self-insurer, notice to or knowledge of the occurrence of the injury on the part of the employer is deemed notice or knowledge, as the case may be, on the part of the group self-insurer; jurisdiction of the employer is, for the purpose of this chapter, jurisdiction of the group self-insurer and the group self-insurer is in all things bound by and subject to the orders, findings, decisions or awards rendered against the participating employer for the payment of compensation under this chapter. The insolvency or bankruptcy of a participating employer does not relieve the group self-insurer from the payment of compensation for injuries or death sustained by an employee during the time the employer was a participant in group self-insurance. The group self-insurer shall promptly notify the Superintendent of Insurance and the board, on a prescribed form, of the addition of any participating employer or employers. The approval of the superintendent is not necessary in order to add participating employers to the group self-insurer. Notice of termination of a participating employer is not effective until at least 10 days after notice of that termination, on a prescribed form, has been filed in the offices of the superintendent and the board or sent to both offices by registered mail. The group self-insurer shall give notice of the termination of any participating member to all other participating members at least quarterly each year. Written notice must be given to any new participating member at the time of admission that the specific membership of the group and its members as prescribed in this section is not affected by the group's failure to provide its members with prior or immediate notice of changes in the membership of the group if notice is given at least quarterly, as long as the termination or admission of members was effected in compliance with all group agreements and bylaws and this section and the rules adopted pursuant to it.

C. Each group self-insurer, in its application for self-insurance, shall set forth the names and addresses of its officers, directors, trustees and general manager. Notice of any change in the officers, directors, trustees or general manager must be given to the Superintendent of Insurance and the board within 10 days of the change. An officer, director, trustee or employee of the group self-insurer may not represent or participate directly or indirectly on behalf of an injured worker or the worker's dependents in any workers' compensation proceeding. All employees of employers participating in group self-insurance are deemed to be included under the group self-insurance plan.

D. If for any reason the status of a group self-insurer under this paragraph is terminated, the securities, the surety bond, the letter of credit or the deposit required by this section continues to be held by the Treasurer of State and remains subject to the control of the board until all claims secured by the securities, surety bond, letter of credit or deposit have been discharged. When all such claims have been discharged or after such period as the Superintendent of Insurance determines proper, the superintendent may accept in lieu thereof, and for the additional purpose of securing such further and future contingent liability as may arise from prior injuries to workers and be incurred by reason of any change in the condition of such workers warranting the board making subsequent awards for payment of additional compensation, a policy of insurance furnished by the group self-insurer, its successor or assigns or other entity carrying on or liquidating such self-insurance group. The policy must be in a form approved by the superintendent and issued by any insurance company licensed to issue this class of insurance in the State. It may only be issued for a single complete premium payment in advance by the group self-insurer. It must be given in an amount determined by the superintendent and when issued is noncancellable for any cause during the continuance of the liability secured and so covered.

E. The Superintendent of Insurance may provide for the administration of this section relating to self-insurance in the manner prescribed in Title 24-A, section 212.

F. If an employer is a partnership or a sole proprietorship and is a member of a self-insurance group associated pursuant to this section, the employer may elect to include as an employee any member of the partnership or owner of the sole proprietorship for purposes of obtaining workers' compensation coverage under this Act. In the event of such an election, the electing employer shall serve upon the group self-insurance association written notice naming the partner or sole proprietor to be covered, and an election is deemed not to have been made within this Act until such notice has been given. By making such an election, the partnership member or sole proprietor is deemed to have stipulated that for premium payment purposes the annual salary or wage of the electing partnership member or sole proprietor is the average weekly wage in the State as computed by the Bureau of Employment Security multiplied by 52 and rounded to the nearest $100. The assumed average annual wage must be adjusted as of July 1st using the average weekly wage from the prior calendar year.

G. Fee schedules applicable to group self-insurers are those set forth in Title 24-A, section 601.

H. Each group self-insurer shall record its loss expense and experience in accordance with Title 24-A, section 2323.

I. Annual examinations of each group self-insurer, as required by the Superintendent of Insurance, must be performed by public accountants acceptable to the superintendent and reports must be rendered to the superintendent within a reasonable period, as determined by the superintendent, subsequent to the group self-insurers elected fiscal year. The examinations must be conducted pursuant to generally accepted accounting principles, as they are consistent with precepts prescribed by the superintendent, that place sound values on assets and liabilities of group self-insurers. Other examinations of the affairs, transactions, accounts, records and assets of each group self-insurer and of any person as to any matter relevant to the financial affairs of the group self-insurer must be conducted as often as the superintendent determines advisable. The expense of examination of a group self-insurer must be borne by the group that is examined.

J. In any fiscal year, a group self-insurer may not be required to obtain aggregate reinsurance with a policy limit that exceeds a multiple of 1.5 of its annual standard workers' compensation premium for that fiscal year. The Superintendent of Insurance may set lower policy limits for aggregate reinsurance when, in the superintendent's judgment, lower limits may be prudent.

K. Upon approval by the Superintendent of Insurance, a group self-insurer may dedicate a portion of its unimpaired surplus to increase its self-insured retention level under the aggregate reinsurance policy by an amount equal to the amount of surplus so dedicated. The superintendent before granting approval shall consider among other factors:

(1) The level of alternate revenues available to the group self-insurer to cover the further assumed costs; and

(2) The adequacy of the fund's surplus to meet obligations of the group self-insurer.

At the expiration of a period of 10 calendar days after the superintendent has received a plan for the dedication of a portion of the unimpaired surplus of a group self-insurer to increase its self-insured retention level and any additional information the superintendent has determined necessary, the plan is deemed approved unless prior to the expiration of that time period it has been affirmatively approved or disapproved by the superintendent.

L. Upon the filing of a plan that meets the approval of the Superintendent of Insurance, a group self-insurer may be authorized to issue subordinated loan certificates, the proceeds of which must be made part of the group self-insurer's surplus account and be available as other surplus funds for dedication to increase the self-insured retention level. To the extent that the proceeds of these loan certificates are utilized by a group self-insurer to increase its self-insured retention in any fiscal year, the aggregate proceeds of the loan certificates so utilized may not exceed 25% of the annual standard premium for that fiscal year. The obligation to redeem these loan certificates after the proceeds of the loan certificates have been dedicated to increase the aggregate excess self-insured retention level of the group self-insurer is subordinate to covered claims and may not be redeemed after the dedication without the approval of the superintendent.

6. Annual renewal; actuarial evaluation. Renewal and actuarial evaluation are governed by this subsection.

A. Any approval granted by the Superintendent of Insurance to an individual self-insurer or group self-insurer must be for a term of not more than one year. Application for renewal of approval to self-insure must be submitted to the superintendent not less than 21 days prior to the self-insurer's renewal date, except that evidence of reinsurance coverage may be submitted up to 3 working days prior to renewal. A renewal application must contain: all reports, statements and other data required to be filed annually under rules adopted by the superintendent; copies of any proposed reinsurance contracts, binders or cover notes; evidence of security posted; notice of any changes in servicing arrangements; and notice of any change in control of the self-insurer and its effect, if any, on guarantees provided pursuant to subsection 3. The superintendent may refuse to grant or renew self-insurance approval based upon any of the following grounds:

(1) Failure to submit any information that is required by law or rule or is reasonably requested by the superintendent;

(2) Failure of a self-insurer to establish that it has met all applicable requirements of law or rule;

(3) Fraud or misrepresentation in the application; or

(4) Any ground upon which approval may be suspended or revoked as provided in subsection 13.

B. Each individual self-insured employer, except those utilizing an actuarially fully funded trust pursuant to subsection 3, is required to obtain an actuarial evaluation of undischarged claims and claims settlement liabilities at least once every 3 years. This review and evaluation must be performed by a casualty actuary who is a member of the American Academy of Actuaries. Upon approval to self-insure, the Superintendent of Insurance shall indicate the deadline for that self-insurer to complete an actuarial review. In addition to this triennial review, the superintendent may require the reserves and liabilities of a self-insurer to be reviewed and evaluated as often as the superintendent determines necessary.

Any self-insurer that develops an imputed annual standard premium not exceeding $50,000 and demonstrates that it has provided security for its workers' compensation exposures in an amount that is at least 135% of its case-based claims reserves, as evaluated annually, is excused from providing an actuarial evaluation in any year in which these conditions are satisfied. For the purposes of this subsection, "case-based claims reserves" means undischarged claims that have arisen during the period of self-insurance and of which the employer has had formal notice. This exception may not be construed to limit the superintendent's authority to require an actuarial evaluation when the superintendent determines one is necessary.

C. Each individual self-insurer except a public employer shall demonstrate in its initial or renewal application that it has working capital adequate to its operating needs.

D. When a self-insurer's reinsurance contract expires on a date other than the renewal date for its self-insurance approval, the self-insurer shall file evidence of any required reinsurance coverage no later than 3 working days before the date of expiration of its coverage.

7. Self-insurance. "Self-insurance," as used in this section, means the system of securing compensation as provided in subsections 2 to 16.

8. Security deposit and reinsurance requirements for individual self-insurers. The following security deposit and reinsurance requirements apply to individual self-insurers.

A. The bond or security deposit required of an individual self-insurer must be at least an amount determined by the following formula or $50,000, whichever is larger. The bond or security deposit must be in an amount equal to the loss and loss adjustment expense portion of the annual standard premium for the prospective fiscal coverage period or the outstanding loss reserves minus recoveries from all excess carriers and subrogation reduced to net collections plus 25% of annual standard premiums for the prospective fiscal coverage period, whichever is larger. The percentage factor used to determine the portion of annual standard premium allocated for loss and loss adjustment expenses must be acceptable to the Superintendent of Insurance. For the purposes of this paragraph, "annual standard premium" means the annual premium produced by applying the manual rates, rating rules, excluding any premium discount, and the experience rating procedure approved by the superintendent for the Safety Pool of the residual market mechanism, as described in Title 24-A, section 2386, to the exposure and experience of the individual self-insurer.

For individual self-insurers who have a net worth equal to or in excess of $10,000,000; who have had positive net earnings demonstrated by certified statements of financial condition audited by a certified public accountant for at least 3 of the 5 latest fiscal years, including one of the 2 most recent years; and whose mean annual earnings for the 5 latest fiscal years are at least equal to the normal annual premium for the prospective fiscal coverage period, the minimum security deposit or bond must be an amount determined by the formula in this paragraph or as adjusted for applicable levels of working capital funds.

An employer meeting the standards of this paragraph may deduct from the penal value of its surety bond or from the market value of securities deposited an amount not exceeding demonstrated working capital in such current statement of financial condition; the bond or deposit must be at least $100,000.

Self-insurers that are unable to meet the preceding standards shall deposit acceptable funds or a surety bond in that amount produced by the formula described in paragraph A written by a corporate surety that meets the qualifications prescribed by rules adopted by the superintendent.

Within 30 days after notice by the superintendent, the self-insurer shall post the deposit indicated. This deadline may be extended by the superintendent for good cause, but in no event may exceed one year from the deadline for compliance as stated in the notice given to the self-insurer.

A bond or security deposit in excess of the amount prescribed by this subsection may be required if the superintendent determines that the self-insurer has experienced a deterioration in financial condition that adversely affects the self-insurer's ability to pay expected losses.

No judgment creditor other than claimants for benefits under this Act has a right to levy upon the self-insurer's assets held in deposit pursuant to this paragraph.

B. All individual self-insurers shall maintain specific reinsurance unless the Superintendent of Insurance, in the superintendent's discretion, waives such a requirement. Specific reinsurance must generally have a limit of at least $2,000,000. Higher limits may be required for those businesses with a high risk of multiple injury from a single occurrence. The retention underlying specific reinsurance policies must be the lowest retention generally available for businesses of similar size and exposure, but may, at the superintendent's discretion, be established at higher levels consistent with the employer's claims experience and financial condition.

All individual self-insurers shall maintain aggregate reinsurance unless the superintendent, in the superintendent's discretion, waives this requirement.

C. The Superintendent of Insurance may adopt rules establishing specific requirements applicable to security deposits and reinsurance, including, but not limited to, provisions governing standards for waiver of reinsurance, use of trusts in lieu of security deposits and release or application of deposit funds.

9. Acceptable deposit funds or surety bonds; letters of credit. In addition to cash, the deposit funds acceptable to the Superintendent of Insurance as a security deposit include United States Government bonds, notes or bills, issued or guaranteed by the United States of America; bonds secured by the full faith, credit and taxing power of political subdivisions of the United States rated in the 3 highest grades by a national rating agency such as Moody's Investors Service, Inc., Standard and Poor's Corporation or Fitch Investors Service, Inc. as of

the foregoing year-end; money market funds invested only in United States Government or government agency obligations with a maturity not exceeding one year; high grade commercial paper rated as either A-1 or P-1 by a nationally recognized bond rating service such as Moody's Investors Service, Inc., Standard and Poor's Corporation or Fitch Investors Service, Inc., or money market funds invested in such paper; certificates of deposit issued by a duly chartered commercial bank or thrift institution in the State protected by the Federal Deposit Insurance Corporation if such a bank or institution possesses assets of at least $100,000,000 and maintains a ratio of capital to assets equal to or greater than 6 1/2%; savings certificates issued by any savings and loan association in the State protected by the Federal Savings and Loan Insurance Corporation if such an association possesses assets of at least $100,000,000 and maintains a ratio of capital to assets equal to or greater than 6 1/2%; surety bonds in a form prescribed by the superintendent issued by any corporate surety that meets the qualifications prescribed by rule of the superintendent; irrevocable standby letters of credit issued to the Treasurer of State by financial institutions with long-term unsecured debt ratings of at least A by either Moody's Investors Service, Inc. or Standard and Poor's Corporation or with commercial paper within the 3 highest short-term rating categories established by Moody's Investors Service, Inc. or Standard and Poor's Corporation; and such other investments approved by the superintendent.

10. Form of reinsurance contracts. All reinsurance contracts issued or renewed after the effective date of this subsection must be issued by companies that meet the requirements of subsection 11 and must name the self-insurer and the Maine Self-Insurance Guarantee Association as coinsureds to the extent of their respective interests. These reinsurance contracts must recognize the Maine Self-Insurance Guarantee Association's rights of recovery, within the terms of coverage provided by the contract, for payments made by the association to or on behalf of claimants regarding covered claims and for claims in the course of settlement, the value of which when reduced to payments will create an obligation on the part of the reinsurance carrier to reimburse the association to the extent of funds disbursed by the association to discharge covered claims. The requirements of this subsection apply to any reinsurance contract issued to any individual or group self-insurer as part of a self-insurance program approved for use within this State and are in addition to any other requirement applicable to reinsurance contracts imposed by law or rule.

Reinsurance contracts must further specify that the reinsurance carrier and the Maine Self-Insurance Guarantee Association may enter into agreements on the terms of settlement and distribution of benefits accruing to claimants within the limits of the authority of the parties to make settlements with respect to any coverage year.

To the extent that the Maine Self-Insurance Guarantee Association succeeds to a recovery of benefits from any reinsurance carrier on behalf of claimants, those benefits must be timely disbursed by the association to or on behalf of claimants as they become due and payable pursuant to this Act. Funds recovered under reinsurance contracts on behalf of claimants must be applied consistent with the terms of coverage under the contract to loss, loss adjustment expense and attorneys' fees that are payable under this Act.

11. Qualifications for reinsurance carriers. A workers' compensation contract or policy issued after the effective date of this section may not be recognized by the Superintendent of Insurance in considering the ability of an individual or group self-insurer to fulfill its financial obligations under this Act, unless the contract or policy is issued by an admitted insurance company or a reinsurance company that meets on a continuous basis the requirements of Title 24-A, chapter 9, subchapter III and the reinsurance company has been approved by the superintendent to issue in this State contracts of primary workers' compensation reinsurance, or by Lloyd's of London, a syndicate of unincorporated alien insurers that has established and maintains United States trust funds consistent with the requirements of Title 24-A, chapter 9, subchapter III. Each contract of primary workers' compensation reinsurance that is proposed for use in this State must be filed for approval in the manner set out in Title 24-A, section 2412. Insofar as is practicable, a contract so approved may be modified with less than 30 days advance filing notice if the superintendent determines the modifications suggested are not contrary to provisions of Title 24-A, section 2412, this Title or Bureau of Insurance Rule Chapter 250 and are necessary to effect required reinsurance coverage to authorize the self-insurer to operate a plan of workers' compensation self-insurance.

12. Qualifications for claims personnel. Persons who investigate, settle or negotiate the settlement of claims on behalf of self-insurers or employees of self-insurers are required to be licensed as insurance adjusters pursuant to Title 24-A, chapter 17, subchapters I and IV.

13. Revocation or termination of self-insurance privilege. The following may constitute grounds for denial of the right of any individual or group to continue the option of self-insurance:

A. Failure to comply with rules adopted by the Superintendent of Insurance or any provisions of this Act within 14 days of notice of such failure or such other time as may be established by order of the superintendent;

B. Failure to comply with any lawful order of the Superintendent of Insurance;

C. Repeated failure to comply with rules of the Superintendent of Insurance or any provisions of this Act;

D. Committing an unfair or deceptive act or practice as defined in Title 24-A, sections 2151 to 2167;

E. Deterioration of financial condition adversely affecting the self-insurer's ability to pay expected losses; or

F. Failure to pay any lawful assessment of the Maine Self-Insurance Guarantee Association.

Notwithstanding Title 5, section 10051, the superintendent is expressly granted the authority to revoke or suspend the right of an individual or group to continue the option to self-insure after a hearing held on not less than 7 days' notice in accordance with Title 5, chapter 375, subchapter IV and Title 24-A, chapter 3.

14. Termination of self-insurance. If a self-insured employer elects to terminate its self-insurance program or a portion of a self-insurance program, it shall submit a termination plan to the Superintendent of Insurance at least 45 days before terminating its program. The requirements of this subsection apply to that part of the self-insurance program that is being terminated. The termination plan must specify, but is not limited to, procedures for claims handling, reservation of assets to be maintained in the State to discharge claims liabilities and other obligations under this Act, and a description of how ultimate reserves were determined that require reservation of funds. The termination plan must contain a written agreement that the self-insurer will continue to be subject to informational filings respecting financial condition and actuarial evaluations of claims and claims expense reserves and loss transfers when determined necessary by the superintendent to ensure that claims are adequately secured. The plan must also comply with any terms and conditions prescribed by rule by the superintendent. In order to protect the interests of claimants, the superintendent may require a further deposit to be held in trust by the Treasurer of State or may require full funding of workers' compensation liabilities.

If a self-insurer's approval is revoked, suspended or otherwise terminated in a manner other than by its election, the Superintendent of Insurance shall issue an order that prescribes terms and conditions related to the termination that must, to the extent practicable, conform to the requirements governing termination plans as prescribed by this subsection and rules adopted under this subsection. In the event that a self-insurer attempts to terminate its approval in this State without filing a plan acceptable to the superintendent, the superintendent shall issue an order prescribing the terms and conditions of the termination. Any order issued pursuant to this subsection, including an order directing a self-insurer to produce relevant information, may be enforced as provided by Title 24-A, section 214.

This subsection applies to any termination of a self-insurer's approval, whether in whole or in part, including those resulting from a business sale, split-up, spin-off, leveraged buyout, reorganization, termination of a guarantee provided under subsection 3, or cessation of business in the State.

15. Confidentiality of information. All written, printed or graphic matter or any mechanical or electronic data compilation from which information can be obtained, directly or after translation into a form susceptible of visual or aural comprehension, all information contained in the minutes of trustee meetings and all information relating to individual compensation cases, that a self-insurer is required to file with or make available to the superintendent under this section, section 304 or rules adopted pursuant to it are confidential and are not public records.

The confidential nature of any such information does not limit or affect its use by the superintendent in administering this Act, including, but not limited to, communications with the service agent, the Workers' Compensation Board or the Maine Self-Insurance Guarantee Association.

16. Registration of self-insurers. Registration of self-insurers is governed as follows.

A. All employers claiming the status of self-insurer as defined by this Title shall apply for registration with the Bureau of Insurance on forms prescribed by the Superintendent of Insurance. The application must contain a statement identifying the employer as a self-insurer, which includes the legal organization and name of each self-insuring employer. The superintendent may require the submission of any further information the superintendent deems necessary in order to determine whether a self-insurer has been approved pursuant to this section. If an employer is unable to establish that it has been approved to act as a self-insurer, the superintendent shall deny the application for registration. Upon denial of registration, an employer may make application for approval to act as a self-insurer in accordance with all requirements of this Act and the rules adopted pursuant to this Act.

B. On January 1st of each year, the Superintendent of Insurance shall promulgate an official list of self-insurers that are approved and registered as of that date and the list of self-insurers must be forwarded to the Maine Self-Insurance Guarantee Association. The superintendent shall add to the list at any time during the year the name or names of any self-insurer or self-insurers the superintendent has approved and registered subsequent to the promulgation of the list and shall similarly delete the name or names of any self-insurer or self-insurers whose authority to self-insure has been terminated. Additions to or deletions from the official list of self-insurers must be forwarded to

the Maine Self-Insurance Guarantee Association when made. Failure to become registered pursuant to this subsection terminates an employer's authority to self-insure under this Act.

§404. Maine Self-Insurance Guarantee Association

1. Created; purpose. There is created the Maine Self-Insurance Guarantee Association, a nonprofit unincorporated legal entity referred to in this section as the "association," to provide mechanisms for the payment of covered claims under self-insurance coverage, to avoid excessive delay in payment, to avoid financial loss to claimants because of the insolvency of a self-insurer and to assist, when called upon to do so by the Superintendent of Insurance, in the detection of self-insurer insolvencies. It is declared that the Maine Self-Insurance Guarantee Association is an instrumentality of the State, but the debts and liabilities of the association do not constitute debts and liabilities of the State.

2. Membership required. All self-insurers, as defined in this Title, must be members of the association as a condition of authority to self-insure in this State, except that all public employers that are individual self-insurers, with a state-assessed valuation equal to or in excess of $300,000,000 and have either a net worth equal to or in excess of $25,000,000 or a bond rating equal to or in excess of the 2nd highest standard as set by a national bond rating organization, are not subject to this subsection. Public employers that are group self-insurers with a state-assessed valuation equal to or in excess of $5,000,000,000 are not subject to this subsection. However, if a self-insurer relying on a bond rating is a county, city or town, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value must be incorporated in the annual audit of the county, city or town together with disclosure of funds appropriated to discharge incurred claims expenses. The association shall perform its functions under a plan of operation established or amended, or both, and approved by the superintendent and shall exercise its powers through the board of directors established in this section.

A. A self-insurer is deemed to be a member of the association for purposes of another self-insurer's insolvency, as defined in subsection 6, when:

(1) The self-insurer is a member of the association when an insolvency occurs; or

(2) The self-insurer has been a member of the association at some point in time during the 36-month period immediately preceding the insolvency in question.

B. A self-insurer is deemed to be a member of the association for purposes of its own insolvency when:

(1) The self-insurer is a member of the association when the insolvency occurs, but claims relating to a compensable event that occurred prior to the date the self-insurer joined the association are not included under this paragraph; or

(2) The self-insurer becomes insolvent after leaving the association, but claims relating to a compensable event that occurred prior to the date the self-insurer joined the association are not included under this paragraph, and claims relating to a compensable event that occurred after the self-insurer ceased to be an approved self-insurer are not afforded coverage under this paragraph.

C. In determining the membership of the association pursuant to paragraphs A and B, no employer claiming self-insurer status may be deemed to be a member of the association, unless that employer is at that time registered as a self-insurer by the Superintendent of Insurance pursuant to section 403, subsection 16.

3. Board of directors. The board of directors of the association consists of at least 7 persons serving terms as established in the plan of operation pursuant to subsection 5. The members of the board must be selected by the member self-insurers, subject to the approval of the Superintendent of Insurance. Vacancies on the board must be filled for the remaining period of the term in the same manner as initial appointments, except that vacancies may be filled by majority vote of the remaining directors, subject to the approval of the superintendent, until the next annual meeting of the members.

In approving selections to the board, the superintendent shall consider among other things whether all member self-insurers are fairly represented.

Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

4. Powers and duties of association. The powers and duties of the association are as follows.

A. The association:

(1) Shall obtain from each member and file with the Superintendent of Insurance individual reports specifying the aggregate benefits each member paid during the previous calendar year and the annual standard premium that would have been paid by each self-insurer during the previous calendar year. These reports are due on or before July 15th following the close of that calendar year,

except that this deadline may be extended by the superintendent for up to 3 additional months for good cause shown;

(2) Shall assess each member of the association as follows:

(a) Each individual self-insurer must be annually assessed an amount equal to 1% of the annual standard premium that would have been paid by that individual self-insurer during the prior calendar year; payment to the association must be made by September 15th following the close of that calendar year. When any such assessment is paid based in whole or in part upon estimates of annual standard premium for the prior calendar year, the next year's assessment must include an adjustment of the assessment of such prior year based on actual audited annual standard premium. Regardless of the size of the fund referred to in subparagraph (3), during its first 30 months of membership, no individual self-insurer may discount or reduce this 1% assessment;

(b) Each group self-insurer must be annually assessed an amount equal to .1% of the total annual standard premium that would have been paid by all the members of that group self-insurer during the prior calendar year; payment to the association must be made by September 15th following the close of that calendar year. When any such assessment is paid based in whole or in part upon estimates of annual standard premium for the prior calendar year, the next year's assessment must include an adjustment of the assessment of such prior year based on actual audited annual standard premium. Regardless of the size of the fund referred to in subparagraph (3), during its first 30 months of membership, no group self-insurer may discount or reduce this .1% assessment;

(c) Each member self-insurer must be notified of the assessment at least 30 days before it is due;

(d) If a self-insurer is a member of the association for less than a full calendar year, the annual standard premium must be adjusted by that portion of the year the self-insurer is not a member of the association; and

(e) If application of the contribution rates referred to in divisions (a) and (b) would produce an amount in excess of the limits of the fund established in subparagraph (3), an equitable proration must be made;

(3) Shall administer a fund, to be known as the Maine Self-Insurance Guarantee Fund, which must receive the assessments required in subparagraph (2). Prior to December 1, 1992, this fund may not exceed $1,000,000, except that once the fund reaches $1,000,000, the fund may not exceed $1,000,000 plus all subsequent initial assessments of new member self-insurers that are required to be made in subparagraph (2), divisions (a) and (b). After November 30, 1992, this fund may not exceed $2,000,000, except that once the fund reaches $2,000,000, the fund may not exceed $2,000,000 plus all subsequent initial assessments of new member self-insurers that are required to be made in subparagraph (2), divisions (a) and (b). The costs of administration by the association must be borne by the fund and the association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the fund to effectuate the purpose of the association, subject to the approval of the Superintendent of Insurance.

(a) The association may purchase primary excess insurance from an insurer licensed in this State for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one or more of its members. Any excess insurance so purchased must be limited to coverage of postassessment liability of the association's members and the association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered funds available that have not been raised by imposition of any preassessment or postassessment. The association may obtain from each member any information it may reasonably require in order to facilitate the securing of this primary excess insurance. The association shall establish reasonable safeguards designed to ensure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Is obligated to the extent of covered claims occurring prior to the determination of the self-insurer's insolvency or occurring after such determination but prior to the obtaining of workers' compensation insurance by the self-insurer as otherwise required under this Title. Nothing in this section obligates the association to pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this section.

(a) For the purposes of this subsection, "covered claim" means an unpaid claim against an insolvent self-insurer that relates to an injury that occurs while the self-insurer is a member of the association and that is compensable under this Act;

(5) After paying any claim resulting from a self-insurer's insolvency, is subrogated to the rights of the injured employee and dependents and is entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Shall assess the fund in an amount necessary to pay:

(a) The obligations for the association under this section subsequent to an insolvency;

(b) The expenses of handling covered claims subsequent to an insolvency;

(c) The costs of examinations under subsection 8; and

(d) Other expenses authorized by this chapter;

(7) Shall investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association may review settlements to which an insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Shall notify the persons that the Superintendent of Insurance directs under subsection 7;

(9) Shall handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Superintendent of Insurance, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association;

(11) Shall pay the other expenses of the association authorized by this section; and

(12) Shall establish in the plan of operation a mechanism to calculate the assessments required by subparagraphs (1), (2) and (3) by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

B. The association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

C. The following pertains to postinsolvency assessment.

(1) In the event the assets of the fund are not sufficient to pay the obligations of the association, the association shall make an additional assessment as follows.

(a) Each individual self-insurer must be assessed an amount not in excess of 2% each year of the annual standard premium that would have been paid by the individual self-insurer during the prior calendar year. The as-

sessments of each member individual self-insurer must be in the proportion that the annual standard premium of the individual self-insurer for the premium calendar year bears to the annual standard premium of all member self-insurers for the preceding calendar year.

(b) Each group self-insurer must be assessed an amount not in excess of .2% each year of the total annual standard premium that would have been paid by all the members of that group self-insurer during the prior calendar year. The assessments of each member group self-insurer must be in the proportion that the annual standard premium of the group self-insurer for the premium calendar year bears to the annual standard premium of all member self-insurers for the preceding calendar year.

(2) Each member self-insurer must be notified of the assessment no later than 30 days before it is due.

(3) The association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subparagraph (3), must bear interest at the rate to be established by the board, but not exceed the discount rate of the Federal Reserve Bank, Boston, Massachusetts, on the due date of the assessment, plus 4% annually, computed from the due date of the assessment.

(5) The association shall establish in the plan of operations a mechanism to calculate the assessments required by subparagraph (1) by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

D. No individual self-insurer may be assessed in any calendar year an amount greater than 2.5% of the annual standard premium that would have been paid by that self-insurer during the prior calendar year. No group self-insurer may be assessed in any calendar year an amount greater than .25% of the total annual standard premium that would have been by all the members of that group self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available must be prorated and the unpaid portion must be paid as soon thereafter as funds become available.

There must be established in the plan of operations a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

E. For the purposes of this subsection, "annual standard premium for an individual self-insurer" means the annual premium produced by applying the manual rates, rating rules, excluding any premium discount, and experience rating procedure approved by the Superintendent of Insurance for the Safety Pool of the residual market mechanism described in Title 24-A, section 2386, to the exposure and experience of the individual self-insurer.

F. For the purposes of this subsection, "annual standard premium for a group self-insurer" means the total annual premium that would have been paid by all members of that group using the manual rates, rating rules, excluding any premium discount, and experience rating procedure approved by the Superintendent of Insurance for that self-insurer.

5. Plan of operation. The plan of operation is as follows.

A. The association shall submit to the Superintendent of Insurance a plan of operation and any amendments to it that are necessary to ensure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments to it become effective upon approval in writing by the superintendent. If the association fails to submit a suitable plan of operation or if the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, adopt rules that are necessary to administer this section. These rules continue in force until modified by the superintendent or the rules are superseded by a plan submitted by the association and approved by the superintendent.

B. All member self-insurers shall comply with the plan of operation.

C. The plan of operation must:

(1) Establish the procedures by which all the powers and duties of the association under subsection 4 will be performed;

(2) Establish procedures for handling assets of the association;

(3) Adopt a reasonable mechanism and procedure to achieve equity in assessing the funds required in subsection 4, paragraph A, subparagraphs (1), (2) and (3); subsection 4, paragraph C, subparagraph (1); and subsection 4, paragraph D.

Consideration must be given to adjustments for audited payroll, differential effects caused by rate changes and other relevant factors;

(4) Establish the amount and method of reimbursing members of the board of directors under subsection 3;

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. A list of such claims must be periodically submitted to the association;

(6) Establish regular places and times for meetings of the board of directors;

(7) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(8) Provide that any member self-insurer aggrieved by any final action or decision of the association may appeal to the Superintendent of Insurance within 30 days after the action or decision;

(9) Establish the procedures by which selections for the board of directors are submitted to the Superintendent of Insurance; and

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

6. Insolvency. A self-insurer is insolvent for the purposes of this section under the following circumstances:

A. Determination of insolvency by a court of competent jurisdiction; or

B. Institution of bankruptcy proceedings by or regarding the member self-insurer.

7. Powers and duties of superintendent. The powers and duties of the Superintendent of Insurance are as follows.

A. The Superintendent of Insurance shall notify the association of the existence of an insolvent member self-insurer within 30 days of the date the superintendent receives notice of an insolvency pursuant to the standards set forth in subsection 6.

B. The Superintendent of Insurance may:

(1) Require that the association notify the insureds of the insolvent self-insurer and any other interested parties of the insolvency and of their rights under this section. Such notifications must be made by mail at their last known addresses, when available, but if required information for notification is not available, notice by publication in a newspaper of general circulation in this State is sufficient; and

(2) Revoke the designation of any servicing facility if the superintendent finds that claims are being handled unsatisfactorily.

8. Examination of association. The association is subject to examination and regulation by the Superintendent of Insurance. The board of directors shall submit, by March 30th of each year, a financial report for the preceding calendar year in a form approved by the superintendent.

9. Tax exemption. The association is exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real or personal property.

10. Immunity. There is no liability on the part of, and a cause of action of any nature does not arise against, any member self-insurer, the association or its agents or employees, the board of directors or its individual members, or the Superintendent of Insurance or the superintendent's representatives for any acts or omissions taken by them in the performance of their powers and duties under this chapter. The immunity established by this subsection does not extend to willful neglect or malfeasance that would otherwise be actionable.

11. Nonduplication of recovery. Any person having a covered claim that may be recovered under more than one insurance or self-insurance guarantee association or its equivalent shall seek recovery first from the association of the place of residence of the claimant. Any recovery under this section must be reduced by the amount of recovery from any other insurance guarantee association or its equivalent.

12. Stay of proceedings. All proceedings under this Act to which the insolvent insurer is a party either before the board or a court in this State and the running of all time periods against either the insolvent self-insurer or the association under this Act are stayed for 60 days from the date of notice to the association of the insolvency in order to permit the association to investigate, prosecute or defend properly any petition, claim or appeal under this Act. The payment of weekly compensation for incapacity under former Title 39, section 54, 54-A, 54-B, 55, 55-A, 55-B, 56, 56-A, or 56-B or under section 212 or 213 must be made during the time periods in

which proceedings affecting the payment of weekly compensation are stayed.

13. Disposition of assets upon dissolution. In the event of dissolution of the association, all assets remaining after provision for satisfaction of all outstanding claims must be distributed to the Treasurer of State for establishment of a reserve to satisfy potential claims against the association and, when all claims are satisfied, for inclusion in the general assets of the State.

14. Statistical advisory organization. The association is authorized to act as the statistical advisory organization designated by the Superintendent of Insurance to collect and report data for self-insurers in accordance with Title 24-A, section 2384-B. All individual and group self-insurers are subject to this subsection as a condition of authority to self-insure in this State. The association is authorized to amend its plan of operation adopted pursuant to subsection 5 or to adopt a separate plan of operation to further the purposes of this subsection. The amendment or plan must provide for an equitable method of distributing the reasonable and necessary costs of performing the data collection and reporting functions required by law and rules adopted by the superintendent and that method may include one or a combination of the following: the assessment of all individual and group self-insurers, the assessment of nonmember self-insurers or the use of other funds available to the association. Any assessment must be made equitably and may be computed on the basis of claims paid, the annual standard premium as set forth in subsection 4 or any other basis approved by the association. For purposes of this subsection, nonmember self-insurers must comply with the association's plan of operation.

§405. Voluntary election

Any private employer, any of whose employees are exempt from this Act, may become subject to this Act with respect to the employer's employees and the act of the employer in securing the payment of compensation to such employee or class of employees in conformity with sections 401 to 407 constitutes the employer's election to become subject to this Act without any further act on the employer's part, but only for that employee or that class of employees for whom the employer has secured compensation as provided in sections 401 to 407, except that, for any employer who secures compensation by making a contract of workers' compensation insurance, the election is deemed to have been made on the effective date of the insurance policy.

§406. Notices of assent to be posted

A notice in a form as the board approves, stating that the employer has conformed to this Act, together with other information as the board determines, must be posted by the employer and kept posted by the employer in each of the employer's mills, factories or places of business. The notice must be conspicuous and posted in a place accessible to the employer's employees.

§407. Preservation of existing employer status

An employer with a currently approved workers' compensation policy or a currently accepted self-insurance policy under sections 401 to 407 is deemed to be in compliance with this Act until the expiration or cancellation date of the current assent based on the policy or plan.

§408. Waiver of right of action; minors

Except as provided in subsection 2, an employee of an employer who has secured the payment of compensation as provided in sections 401 to 407 is deemed to have waived the employee's right of action at common law and under section 104 to recover damages for the injuries sustained by the employee.

1. Legally employed minors. A minor is deemed sui juris for the purpose of this Act if the minor's employer was not in violation of Title 26, section 771, 772 or 773 at the time of the minor's injury. No other person has any cause of action or right to compensation for an injury to that minor employee except as provided in this section.

2. Illegally employed minors. A minor is not deemed to have waived the minor's right of action at common law and under section 104 if the minor's employer was in violation of Title 26, section 771, 772 or 773 at the time of the minor's injury.

A. The minor employee, the minor's parent or guardian or any other person, as permitted by common law or statute, may file a civil action permitted under this subsection.

B. The minor employee is entitled to compensation under this Act in addition to any right of action permitted under this subsection.

C. If the employer is self-insured for liability under this Act, any award received by the minor in an action permitted under this subsection must be reduced by the amount of compensation received under this Act.

D. If the employer is insured for liability under this Act, the employer is considered a 3rd party under section 107, and the employer's insurer is entitled to all rights ofsubrogation, contribution or other rights granted to an employer under section 107.

§409. Assessment for the expenses of administering the Self-insurer's Workers' Compensation Program

The Superintendent of Insurance shall annually assess on self-insuring employers approved pursuant to section 403, respecting the operations of each self-insurer conducted in the State to defray the cost of administration of the Bureau of Insurance. The annual assessment upon approved self-insuring employers must be calculated using the imputed annual standard premium relating to business operations in the State that each self-insurer would have paid during the previous calendar year pursuant to manual rates established by the principal rating organization in the State and using the experience rating procedure approved by the Superintendent of Insurance for that self-insurer. The assessment must be applied to the budget of the bureau for the fiscal year commencing July 1st. The assessment must be in an amount not exceeding 1/10 of 1% of the imputed annual standard premium. When the superintendent calculates the amount of the annual assessment, the superintendent shall consider, among other things, the staffing level required to administer workers' compensation self-insurance oversight responsibilities of the bureau.

1. Annual standard premium. The superintendent shall utilize the annual standard premium for each approved self-insurer as reported to the Bureau of Insurance by the Maine Self-Insurance Guarantee Association pursuant to section 404, subsection 4 in determining the amount of the assessment.

2. Expense of examination. The expense of examination of group self-insurers subject to section 403, subsection 5, paragraph I is payable by the person examined.

3. Minimum assessment. In any year in which a self-insurer has no annual standard premium in the State or in which the annual standard premium is not sufficient to produce at the rate prescribed by law an amount equal to or in excess of $100, the minimum assessment payable by any self-insurer is $100.

4. Notification of assessment. On or before July 1st, next following receipt of the report from the Maine Self-Insurance Guarantee Association, the Superintendent of Insurance shall notify each self-insurer of the assessment due.

5. Time of payment. Payment must be made on or before August 10th.

6. Revocation or termination. If the assessment is not paid on or before the prescribed date, the right of any individual or group to continue the option of self-insurance may be revoked or terminated by the Superintendent of Insurance.

7. Recalculation of assessment. Immediately following the close of the fiscal year ending June 30, 1987, and at the close of each 2nd succeeding fiscal year, the Superintendent of Insurance shall recalculate the assessment on each self-insurer subject to this section. If, in any instance, any assessment paid under this section is based in whole or in part on the annual standard premium estimated in the calendar year utilized for assessment purposes, the recalculation must recognize the actual audited annual standard premium, as available, for each affected self-insurer. Actual expenditures of the Bureau of Insurance during the preceding fiscal year must also be recognized. On or before October 1st, the Superintendent of Insurance shall render to each self-insurer a statement showing the difference between the self-insurer's respective recalculated assessment and the amount paid during the preceding biennium. Any overpayment of annual assessment resulting from complying with the requirements of this section must be refunded or, at the option of the assessed party, applied as a credit against the assessment for the succeeding fiscal year. Any overpayment of $100 or less must be applied as a credit against the assessment for the succeeding fiscal year.

8. Deposit with Treasurer of State. The Superintendent of Insurance shall deposit all payments made pursuant to this section with the Treasurer of State. The money must be used for the sole purpose of paying the expenses of the Bureau of Insurance for administration of the Self-insurer's Workers' Compensation Program.

9. Exclusions. This section does not apply to the State or the University of Maine System.

10. Applicability. This section applies with respect to fiscal years commencing on or after July 1, 1986.

PART 2

OCCUPATIONAL DISEASE LAW

CHAPTER 15

OCCUPATIONAL DISEASE LAW

§601. Short title

This chapter may be known and cited as the "Occupational Disease Law."

§602. Application

Except as otherwise specifically provided, incapacity to work or death of an employee arising out of and in the course of employment and resulting from an occupational disease must be treated as the happening of a personal injury arising out of and in the course of the employment, within the meaning of the Workers' Compensation Act, and all the provisions of that Act apply to such occupational diseases. This chapter applies only to cases in which the last exposure to an occupational disease in an occupation subject to the hazards of such disease occurred in the State and after January 1, 1946.

§603. Occupational disease defined

As used in this chapter, the term "occupational disease" means only a disease that is due to causes and conditions characteristic of a particular trade, occupation, process or employment and that arises out of and in the course of employment.

§604. False reports

Compensation is not payable for an occupational disease if the employee who was employed on January 1, 1946 or who, at the time of entering into the employment of the employer by whom the compensation would otherwise be payable, falsely represents in writing that the employee has not previously been disabled, laid off or compensated in damages or otherwise because of such disease.

§605. Aggravation of occupational disease

When an occupational disease is aggravated by any other disease or infirmity not itself compensable, or death or incapacity from any other cause not itself compensable is aggravated, prolonged, accelerated or in any way contributed to by an occupational disease, the compensation payable must be reduced and limited to the proportion only of the compensation that would be payable if the occupational disease were the sole cause of the incapacity or death as the occupational disease, as a causative factor, bears to all the causes of that incapacity or death, the reduction in compensation to be effected by reducing the number of weekly or monthly payments or the amounts of the payments as, under the circumstances of the particular case, may be for the best interest of the claimant or claimants.

§606. Date from which compensation is computed; employer liable

The date when an employee becomes incapacitated by an occupational disease from performing the employee's work in the last occupation in which the employee was injuriously exposed to the hazards of the occupational disease is the date of the injury equivalent to the date of injury under the Workers' Compensation Act. Where compensation is payable for an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of the occupational disease and the insurance carrier, if any, on the risk when the employee was last exposed under that employer, are liable. The amount of the compensation must be based on the average wages of the employee when last exposed under that employer and notice of injury and claim for compensation must be given to that employer. The only employer and insurance carrier liable are the last employer in whose employment the employee was last injuriously exposed to the hazards of the disease during a period of 60 days or more and the insurance carrier, if any, on the risk when the employee was last so exposed, under that employer.

§607. Notice of incapacity; filing of claim

Sections 301 to 307 with reference to giving notice, making claims and filing petitions apply to cases under this chapter, except that, in cases under this chapter, the date of incapacity defined in section 606 is equal to the date of injury in sections 301 to 307, and the notice under section 301 must include the employee's name and address, the nature of the occupational disease, the date of incapacity, the name of the employer in whose employment the employee was last injuriously exposed for a period of 60 days to the hazards of the disease and the date when employment with that employer ceased. After compensation payments for an occupational disease have been legally discontinued, claim for further compensation for that occupational disease not due to further exposure to an occupational hazard tending to cause that disease are barred if not made within one year after the last previous payment.

§608. Partial incapacity

Compensation is payable for partial incapacity due to occupational diseases as provided in section 213.

§609. Compensation limits

Compensation for partial or total incapacity or death from occupational disease is payable as provided in sections 212, 213 and 215. Compensation is not payable for incapacity by reason of occupational diseases unless the incapacity results within 3 years after the last injurious exposure to the occupational disease in the employment.

The 3-year limitation under this section does not apply to a full-time firefighter who files a claim for an occupationally related cancer under this chapter and whose last injurious exposure to a carcinogen in the employer's employment occurred after January 1, 1985. For the purposes of this subsection, "full-time firefighter" means a regular full-time member, active or retired, of a municipal fire department if that person has aided in the extinguishment of fires, whether or not that person had administrative duties or other duties as a member of the municipal fire department.

§610. Examination of employees

An employer may request any of the employer's employees or prospective employees to be examined for the purpose of ascertaining if any of them are in any degree affected by an occupational disease or peculiarly susceptible to an occupational disease. Refusal to submit to such an examination bars that employee or prospective employee from compensation or other benefits provided by this chapter resulting from exposure to the hazards of occupational disease subsequent to the employee's refusal and while in the employ of the employer.

§611. Impartial medical advice

On request of a party or on its own motion the board may in occupational disease cases appoint one or more competent and impartial physicians. Upon order of the board, the fees and expenses of the health care provider or health care providers must be paid by the employer. These appointees shall examine the employee and inspect the industrial conditions under which the employee has worked in order to determine the nature, extent and probable duration of the occupational disease, the likelihood of its origin in the industry and the date of incapacity. Section 207 applies to the filing and subsequent proceedings on the report of the appointees and to examinations and treatments by the employer.

If a claim is made for death from an occupational disease, an autopsy may be ordered by the board under the supervision of impartial appointees. All proceedings for or payments of compensation to any claimant refusing to permit such an autopsy when ordered are suspended on and during the continuance of such a refusal.

§612. Occupational loss of hearing

In case of loss of hearing resulting from occupational disease, the following rules are applicable in determining eligibility for compensation and the period during which compensation is payable.

1. Definition. As used in this chapter, "occupational hearing loss" means a sensorineural loss of hearing in one or both ears due to prolonged exposure to injurious noise in employment. Injurious noise means sound capable of producing occupational hearing loss.

2. Limitations on sound frequencies. Losses of hearing due to industrial noise for compensation purposes is limited to the frequencies of 500, 1,000 and 2,000 cycles per second. Loss of hearing ability for frequency tones above 2,000 cycles per second does not constitute disability for hearing.

3. Determination of hearing loss. The percent of hearing loss, for purposes of the determination of compensation claims for occupational deafness, must be calculated as the average, in decibels, of the thresholds of hearing for the frequencies of 500, 1,000 and 2,000 cycles per second. Hearing levels must be measured by means of pure-tone air-conduction audiometric instruments calibrated in accordance with American National Standards Institute Standards S3.6-1969-R 1973 and S3.13-1972, referred to in this section as the "ANSI standard," or American Standards Association Standard Z24.5, 1951, referred to in this section as the "ASA standard," and in an area with ambient noise level within the limits specified in American National Standards Institute Criteria for Background Noise in Audiometric Room Standard S3.1, 1960-R 1977. If the losses of hearing average 25 decibels or less under the ANSI standard or 15 decibels or less under the ASA standard in the 3 frequencies, the losses of hearing do not constitute a compensable hearing disability. If the losses of hearing average 92 decibels or more under the ANSI standard or 82 decibels or more under the ASA standard in the 3 frequencies, then the losses are deemed a 100% compensable hearing loss.

4. Compensation payable. Permanent partial disability is payable as follows:

A. For total occupational deafness of one ear, 50 weeks of compensation;

B. For total occupational deafness of both ears, 200 weeks of compensation; and

C. For partial occupational deafness in one or both ears, compensation is payable for those periods as are proportionate to the relation that the hearing loss bears to the amount provided in this subsection for total loss of hearing in one or both ears, as the case may be.

The amount of hearing loss must be reduced by the average amount of hearing loss from nonoccupational causes found in the population at any given age.

5. Measurement of hearing impairment. In measuring hearing impairment, the lowest measured losses in each of the 3 frequencies must be added together and divided by 3 to determine the average decibel loss. For every decibel of loss exceeding 15 decibels under the ASA standard or 25 decibels under the ANSI standard, an allowance of 1 1/2% must be made up to the maximum of 100%, which is reached at 82 decibels under the ASA standard or 92 decibels under the ANSI standard.

6. Hearing impairment in both ears. In determining the percentage of loss in both ears, the percentage of impairment in the better ear is multiplied by 5. The resulting figure is added to the percentage of impairment in the poorer ear, and the sum of the 2 divided by 6. The final percentage represents the hearing impairment for both ears.

7. Deductions by age. Before determining the percentage of hearing impairment, in order to allow for the average amount of hearing loss from nonoccupational causes found in the population at any given age, 1/2 decibel for each year of the employee's age over 40 at the time of last exposure to industrial noise must be deducted from the total average decibel loss.

8. Filing of claims. A claim for compensation for occupational deafness may not be filed until after the employee has been separated from the occupational noise for a period of at least 30 days. The last day of this period is the date of disability. "Separation from the occupational noise" means the use of hearing protective devices or equipment, including noise attenuators and ear plugs.

9. Employers limit of liability. An employer is liable for the entire occupational deafness to which the employment has contributed, except that, if previous deafness is established by a hearing test or by other competent evidence, whether or not the employee was exposed to noise within 30 days preceding the test, the employer is not liable for previous loss so established. In addition, the employer is not liable for any loss for which compensation has previously been paid or awarded.

An employer is not liable for the payment of compensation for occupational deafness unless the employee claiming benefits has worked for the employer in employment exposing the employee to harmful noise for a total period of at least 90 days.

Consideration may not be given to the question of whether or not the ability of an employee to understand speech is improved by the use of a hearing aid.

10. Restriction on liability. Compensation is not be payable for temporary disability for loss of hearing due to exposure to injurious noise in employment.

§613. Silicosis

In the absence of evidence in favor of the claim, disability or death from silicosis is presumed not to be due to the nature of any occupation, unless during the 15 years immediately preceding the date of disability the employee was exposed to the inhalation of silica dust over a period of at least 2 years. If the employee has been employed by the same employer during the whole of the 2-year period, the employee's right to compensation against such employer is affected by the fact that the employee had been employed during any part of the 2-year period outside of the State.

§614. Special provisions for asbestos-related diseases

1. Definition. As used in this section, the term "asbestos-related disease" means a disease caused by exposure to asbestos.

2. Scope. This section applies only to asbestos-related diseases caused or contributed to by a last injurious exposure to asbestos that occurred on or after November 30, 1967.

Except as otherwise provided in this section, all provisions of this chapter apply to asbestos-related diseases.

3. Aggravation of condition. Section 605 does not apply to asbestos-related diseases.

4. Last employer liable; notice. Notwithstanding section 606, the only employer and insurance carrier liable is the last employer in whose employment the employee was last injuriously exposed to asbestos, and the insurance carrier, if any, on the risk when the employee was last so exposed under that employer. Notice of incapacity under section 607 must include the name of that employer and the date when employment with that employer ceased.

5. Compensation limit. The 3-year limit provided in section 609 does not apply to asbestos-related diseases.

Nothing in this section may be construed to require retroactive payments of compensation for periods of incapacity that occurred prior to October 1, 1983 or retroactive payments of death benefits for periods of time prior to October 1, 1983. Compensation for claims permitted under this section is payable only for periods of incapacity occurring after October 1, 1983.

6. Further compensation. Notwithstanding section 607, after compensation payments for incapacity or death caused by an asbestos-related disease have been legally discontinued, a claim for further compensation for that disease not due to further exposure to asbestos in that employment is barred if not made within 40 years after the last previous payment.

7. Compensation benefits. Compensation under this section is paid as follows.

A. If an employee is determined to be entitled to compensation for periods of total incapacity occurring on or after October 1, 1983, or if a dependent of an employee is determined to be entitled to full death benefits for periods occurring on or after October 1, 1983, and the employee became incapacitated or died on or after November 30, 1967 and before January 1, 1972, then the weekly compensation paid is equal to 2/3 of the average weekly wage in the State, as computed by the Bureau of Employment Security, that exists on the date the worker files a claim for compensation. If an employee is determined to be entitled to compensation for periods of partial incapacity occurring on or after October 1, 1983, and the employee became incapacitated on or after November 30, 1967 and before January 1, 1972, then the weekly compensation paid is equal to 2/3 of the difference, due to the injury, between the average weekly wage in the State, as computed by the Bureau of Employment Security, that exists on the date the worker files a claim for compensation and the weekly wages, earnings or salary that the employee is able to earn after the claim is filed. If a dependent of an employee is determined to be entitled to partial death benefits for periods occurring on or after October 1, 1983 and the employee died on or after November 30, 1967 and before January 1, 1972, then the weekly compensation paid is equal to the same proportion of the weekly payment provided in this paragraph for full death benefits, as the total amount contributed by the employee to

such partial dependents for their support during the year prior to incapacity bears to the employee's earnings during that period.

B. If an employee is determined to be entitled to compensation for periods of total or partial incapacity occurring on or after October 1, 1983 or if a dependent of an employee is determined to be entitled to full or partial death benefits for periods occurring on or after October 1, 1983 and the employee became incapacitated or died on or after January 1, 1972 and before October 1, 1983, then the initial weekly compensation paid is equal to the compensation that would have been paid had compensation payments begun at the time the employee became incapacitated or died and that compensation had been adjusted annually as provided in former Title 39, section 54, 55 or 58, whichever section was applicable. This subsection may not be interpreted as providing for any adjustment for inflation in excess of the adjustment provided in former Title 39, section 54, 55 or 58.

C. If an employee becomes incapacitated or dies on or after October 1, 1983, but before June 30, 1985, then compensation is payable in the same manner and amounts as provided in former Title 39, sections 54, 55 and 58. If an employee becomes incapacitated or dies on or after June 30, 1985 but before November 20, 1987, then compensation is payable in the same manner and amount as provided in former Title 39, sections 54-A, 55-A and 58-A. If an employee becomes incapacitated or dies on or after November 20, 1987 but before January 1, 1993, compensation is payable in the same manner and amount as provided in former Title 39, sections 54-B, 55-B and 58-A. If an employee becomes incapacitated or dies on or after January 1, 1993, compensation is payable in the same manner and amount as provided in sections 212, 213 and 215.

8. Section not applicable. This section does not apply to an asbestos-related disease of any worker who, at the time of the last injurious exposure to asbestos, was covered by the federal Longshore and Harbor Workers' Compensation Act of March 4, 1927, Chapter 509, 33 United States Code, Section 901, or the Federal Employees Compensation Act, 5 United States Code, Section 8101. A worker is deemed to be covered by one of those acts if, at the time of the worker's last injurious exposure to asbestos, the worker was an employee, as defined by those federal acts, and was employed in employment that is subject to any of those federal acts.

§615. Disability due to radioactive properties

Notwithstanding section 606 or any other provision of this chapter, the employee need not be exposed to radioactive substances for a period of 60 days or more, and the time for filing claims does not begin to run in cases of incapacity due to exposure to radioactive substances until the later of the time after incapacity or the time the person claiming benefits knew, or by exercise of reasonable diligence should have known of the causal relationship between the employment and the employee's incapacity.

PART 3

EMPLOYER'S LIABILITY

CHAPTER 19

EMPLOYER'S LIABILITY

§901. Definition of employer's liability; rights of employee

An employer is liable under this Part if personal injury is caused to an employee, who, at the time of the injury, is in the exercise of due care, by reason of:

1. Defects in ways, works or machinery. A defect in the condition of the ways, works or machinery connected with or used in the business of the employer, which arose from, or had not been discovered or remedied in consequence of, the negligence of the employer or of a person in the employer's service who had been entrusted by the employer with the duty of seeing that the ways, works or machinery were in proper condition;

2. Negligence of employee in superintending capacity. The negligence of a person in the service of the employer who was entrusted with and was exercising superintendence and whose sole or principal duty was that of superintendence or, in the absence of a superintendent, of a person acting as superintendent with the authority or consent of the employer; or

3. Negligence of employee in charge of railroad equipment. The negligence of a person in the service of the employer who was in charge or control of a signal, switch, locomotive engine or train on a railroad.

The employee or the employer's legal representatives, subject to sections 902 to 909, have the same rights to compensation and of action against the employer as if the employee had not been an employee, nor in the service, nor engaged in the work of the employer.

A car that is in use by, or that is in possession of, a railroad corporation is deemed a part of the ways, works or machinery of the corporation that uses it or has it in possession, within the meaning of subsection 1, whether it is owned by the railroad corporation or by some other company or person. One or more cars in motion, whether attached to an engine or not, constitute a train within the meaning of subsection 3, and whoever, as a part of the person's duty for the time being, physically controls or

directs the movements of a signal, switch, locomotive engine or train is deemed to be a person in charge or control of a signal, switch, locomotive engine or train within the meaning of said subsection.

§902. Actions for damages for death in addition to those for injury

If the injury described in section 901 results in the death of the employee, and the death is not instantaneous or is preceded by conscious suffering, and if there is any person who would have been entitled to bring an action under section 903, the legal representatives of the employee may, in the action brought under section 901, recover damages for the death in addition to those for the injury.

§903. Surviving spouse or next of kin; actions by

If, as the result of the negligence of an employer, or of a person for whose negligence an employer is liable under section 901, an employee is instantly killed or dies without conscious suffering, the surviving spouse or, if the employee leaves no surviving spouse, the next of kin, who, at the time of the employee's death, were dependent upon the wages of the employee for support, have a right of action for damages against the employer.

§904. Measure of damages in event of death

If, under either section 902 or 903, damages are awarded for the death, they must be assessed with reference to the degree of culpability of the employer or of the person for whose negligence the employer is liable.

The amount of damages that may be awarded in an action under section 901 for a personal injury to an employee, in which no damages for the death of the employee are awarded under section 902, may not exceed $4,000.

The amount of damages that may be awarded in an action under section 901, if damages for the death of the employee are awarded under section 902, may not exceed $5,000 for both the injury and the death, and must be apportioned by the jury between the legal representatives of the employee and the persons who would have been entitled, under section 903, to bring an action for the death of the employee if it had been instantaneous or without conscious suffering.

The amount of damages that may be awarded in an action brought under section 903 may not be less than $500 or more than $5,000.

§905. Notice of injury; requisites; sufficiency; limitation of actions

An action for the recovery of damages for injury or death under sections 901 to 904 may not be maintained unless notice of the time, place and cause of the injury is given to the employer within 60 days and the action is commenced within one year after the accident that causes the injury or death. The notice must be in writing, signed by the person injured or by a person in behalf of the person. If it is impossible from physical or mental incapacity for the person injured to give the notice within the time provided in this section, the person may give it within 10 days after the incapacity has been removed, and if the person dies without having given the notice and without having been for 10 days at any time after the injury of sufficient capacity to give it, the person's executor or administrator may give such notice within 60 days after appointment. A notice given under this section is not invalid or insufficient solely by reason of an inaccuracy in stating the time, place or cause of the injury, if it is shown that there was no intention to mislead and that the employer was not in fact misled by the inaccuracy.

If a notice given under this section is claimed by the employer to be insufficient for any reason, the employer shall notify in writing the person giving it within 10 days, stating the insufficiency claimed to exist, and the person whose duty it is to give the notice may, within 30 days, give a new notice with the same effect as if originally given.

§906. Liability not barred by contracts with independent contractors

If an employer enters into a contract, written or verbal, with an independent contractor to do part of the employer's work, or if an independent contractor enters into a contract with a subcontractor to do all or any part of the work comprised in the contractor's contract with the employer, the contract or subcontract does not bar the liability of the employer for injuries to the employees of the contractor or subcontractor, caused by any defect in the condition of the ways, works, machinery or plant, if they are the property of the employer or are furnished by the employer and if the defect arose, or had not been discovered or remedied, through the negligence of the employer or of some person entrusted by the employer with the duty of seeing that they were in proper condition.

§907. Employee's knowledge of defect or negligence

An employee or the employee's legal representatives are not entitled under sections 901 to 904 to any right of action for damages against the employer if the employee knew of the defect or negligence that caused the injury and failed within a reasonable time to give, or cause to be given, information about the defect to the employer or to some person superior to the employee in the service of the employer who was entrusted with general superintendence.

§908. Scope of sections 901 to 907; effect of judgment or settlement

Sections 901 to 907 do not apply to injuries caused to domestic servants or farm laborers by fellow employees or to those engaged in cutting, hauling or driving logs. Nothing in sections 901 to 907 may be construed to abridge any common-law rights or remedies which the employee may have against the employer, but a judgment recovered under sections 901 to 907 or a settlement of any action commenced or claim made for death or injury under the provisions of those sections is a bar to any claim made or action begun to recover for the same injury or the same death, under the common law or under any other statute.

§909. Contracts for exemption

A person may not, by a special contract with the employer's employees, exempt the employer or another person from liability under which the employer may be to them for injuries suffered by them in the employment of the employer and resulting from the negligence of the employer or the other person, or of a person in the employ of the employer.

Sec. A-9. Transition provisions. The following provisions apply to the transition of powers and duties of the Workers' Compensation Commission to the Workers' Compensation Board.

1. The Workers' Compensation Board is the successor in every way to the powers, duties and functions of the former Workers' Compensation Commission.

2. All existing contracts, agreements and compacts involving the Workers' Compensation Commission currently in effect remain in effect.

3. All records, property and equipment belonging to or allocated for the use of the former Workers' Compensation Commission on the effective date of this Part become part of the property of the Workers' Compensation Board.

4. The Workers' Compensation Board shall use all existing forms, letterheads and similar items bearing the name of or referring to the "Workers' Compensation Commission" until existing supplies of those items are exhausted.

5. Except as provided in this section, all positions authorized or allocated to the former Workers' Compensation Commission are authorized or allocated to the Workers' Compensation Board. Employees in classified positions on the effective date of this Act shall continue in those positions under the Workers' Compensation Board on the same terms and conditions of employment subject to the Civil Service Law and collective bargaining law. Each Workers' Compensation Commissioner holding office on December 31, 1992 on January 1, 1993 becomes a temporary hearing officer in the employ of the Workers' Compensation Board for the purpose of resolving claims assigned to that commissioner prior to January 1, 1993 and for the purpose of serving as a member of appellate division panels as necessary.

A. Temporary hearing officers work under the supervision of the Workers' Compensation Board and may be removed from office for the reasons and following the procedures established for removal of commissioners in former Title 39, section 91.

B. Former commissioners may serve as temporary hearing officers until January 1, 1994 at the latest and are entitled to the same compensation and benefits they received while serving as commissioners.

C. If, before January 1, 1994, a temporary hearing officer resolves all assigned claims pending before that hearing officer, the Workers' Compensation Board may reassign other unresolved pre-January 1, 1993 claims to that hearing officer.

D. If it becomes clear that a claim assigned to a former commissioner acting as a temporary hearing officer can not be resolved by January 1, 1994, the Workers' Compensation Board may reassign that claim to a hearing officer under this Part.

E. After January 1, 1994, the Workers' Compensation Board, at its discretion, may contract with former commissioners to serve as hearing officers under this Part.

6. Except for an amount set aside as necessary to pay for unemployment compensation, accrued vacation time and other outstanding obligations of the Workers' Compensation Commission, the balance of the Workers' Compensation Commission budget for fiscal year 1992-93 is transferred to the Workers' Compensation Board on January 1, 1993. The Workers' Compensation Board is authorized to make expenditures from the funds transferred from the Workers' Compensation Commission as if the Legislature had appropriated the funds to the Workers' Compensation Board.

7. The Workers' Compensation Board is authorized to employ on a temporary basis such staff as necessary to perform the functions of the board from January 1, 1993 to June 30, 1993. During the First Regular Session of the 116th Legislature, the Workers' Compensation Board shall obtain from the Legislature authorization for all staff positions and all expenditures required for fiscal year 1993-94.

Sec. A-10. Application. The application of the provisions of this Part is governed by the following provisions.

1. This Part applies to all matters in which an injury occurs on or after January 1, 1993. So as not to alter benefits for injuries incurred before January 1, 1993, for matters in which the injury occurred prior to that date, all the provisions of this Act apply, except that the Maine Revised Statutes, Title 39-A, sections 211, 212, 213, 214, 215, 221, 306, and 325 do not apply. With regard to matters in which the injury occurred prior to January 1, 1993, the applicable provisions of former Title 39 apply in place of Title 39-A, sections 211, 212, 213, 214, 215, 221, 306 and 325. The Workers' Compensation Board is authorized to and shall adopt rules governing the disposition of claims pending on January 1, 1993, in a manner that applies the applicable provisions of this Act to those claims to the maximum extent feasible.

2. Any appeal from a decision of the former Workers' Compensation Commission filed prior to January 1, 1993 must be considered by former commissioners acting as temporary hearing officers and serving as members of an appellate division panel. Appeals that have not been resolved prior to January 1, 1994 must be treated as if a hearing officer had requested review by the Workers' Compensation Board pursuant to the Maine Revised Statutes, Title 39-A, section 320.

Sec. A-11. Effective date. This Part takes effect January 1, 1993, except that the Governor shall appoint the members of the Workers' Compensation Board effective November 1, 1992. After November 1, 1992, the board shall take action necessary to ensure the readiness of the board to comply with this Act on January 1, 1993.

PART B

Sec. B-1. 24-A §2302, sub-§3, as amended by PL 1987, c. 559, Pt. A, §1, is further amended to read:

3. Workers' compensation ~~shall first be~~ is primarily subject to chapter 25, subchapter ~~II-A~~ II-B, but any other parts of this subchapter not inconsistent with ~~those sections shall~~ that subchapter also apply.

Sec. B-2. 24-A MRSA §2303, sub-§1, ¶C, as amended by PL 1989, c. 351, §5, is further amended to read:

C. Due consideration ~~shall~~ must be given:

(1) To past and prospective loss experience within and outside this State;

(2) To the conflagration and catastrophe hazards;

(3) To a reasonable margin for underwriting profit and contingencies;

(4) To dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

(5) To past and prospective expenses both countrywide and those specially applicable to this State;

(6) To all other relevant factors within and outside this State;

~~(6-A) In the case of workers' compensation rates, consideration shall be given to the information required to be filed under section 2363;~~

(7) In the case of fire insurance rates, ~~consideration shall be given~~ to the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available; and

(8) In the case of title insurance rates, ~~consideration shall be given~~ to the reasonableness of commission levels and other acquisition costs both countrywide and those specifically applicable to this State.

Sec. B-3. 24-A MRSA §2309, as amended by PL 1989, c. 797, §12 and affected by §§37 and 38, is repealed.

Sec. B-4. 24-A MRSA §2310, as amended by PL 1989, c. 797, §13 and affected by §§37 and 38, is repealed.

Sec. B-5. 24-A MRSA §2311, as amended by PL 1989, c. 797, §14 and affected by §§37 and 38, is repealed.

Sec. B-6. 24-A MRSA §2312, as amended by PL 1989, c. 797, §15 and affected by §§37 and 38, is repealed.

Sec. B-7. 24-A MRSA §§2313 and 2314, as amended by PL 1989, c. 797, §16 and affected by §§37 and 38, are repealed.

Sec. B-8. 24-A MRSA §2319, sub-§§1 and 2 as amended by PL 1989, c. 797, §20 and affected by §§37 and 38, are repealed and the following enacted in their place:

1. Application to the superintendent. Any insured aggrieved with respect to any filing, rate, expense or premium level that is in effect may make a written application to the superintendent for a hearing. The application must specify the grounds to be relied upon by the applicant in asserting that the filing, rate, expense or premium level is unjust or unreasonable.

2. Responsive filing and hearing. If the superintendent finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds were established and that such grounds otherwise justify holding a hearing, the superintendent shall, by written order, require that the insurer, advisory organization or rating organization prepare within 30 days a responsive filing containing information necessary, in the judgment of the superintendent, to review the application. A public hearing may be conducted and, if conducted, must be at least 30 days from the date the responsive filing is determined complete by the superintendent.

Sec. B-9. 24-A MRSA §2320-A, as amended by PL 1989, c. 878, Pt. A, §67, is repealed.

Sec. B-10. 24-A MRSA §2328, first ¶, as amended by PL 1973, c. 585, §12, is further amended to read:

The superintendent shall examine the affairs, transactions, accounts and records of each rating organization licensed in this State as provided in section 2310, of each advisory organization licensed in this State as ~~defined~~ provided in section ~~2321~~ 2321-A, and of joint underwriters and joint reinsurers as defined in section ~~2322~~ 2322-A, as often as ~~he~~ the superintendent deems advisable, but not less frequently than once every 5 years. The examination ~~shall~~ must be conducted in the same manner and is subject to the same applicable provisions as apply to examination of insurers in chapter 3. The reasonable costs of any such examination ~~shall~~ must be paid by the organization or association so examined. In lieu of any such examination, the superintendent may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state.

Sec. B-11. 24-A MRSA c. 25, sub-c. II-A, as amended, is repealed.

Sec. B-12. 24-A MRSA c. 25, sub-c. II-B is enacted to read:

SUBCHAPTER II-B

WORKERS' COMPENSATION RATING ACT

§2381. Title

This subchapter may be known and cited as the "Workers' Compensation Rating Act."

§2381-A. Purposes

The purposes of this Act are:

1. Prohibition of certain behavior. To prohibit price-fixing agreements and other anticompetitive behavior by insurers;

2. Protection for policyholders and the public. To protect policyholders and the public from the adverse effects of excessive, inadequate or unfairly discriminatory rates;

3. Promotion of price competition. To promote price competition among insurers so as to provide rates that are responsive to competitive market conditions;

4. Provision of regulatory procedures. To provide regulatory procedures for the maintenance of appropriate data reporting systems;

5. Improvement of insurance. To improve availability, fairness and reliability of insurance;

6. Authorization of action. To authorize essential cooperative action among insurers in the rate-making process and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly; and

7. Encouragement of practices. To encourage the most efficient and economical marketing practices.

§2381-B. Scope of application

This Act applies to workers' compensation insurance and employers' liability insurance written in connection with workers' compensation insurance.

§2381-C. Definitions

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

1. Advisory organization. "Advisory organization" means any entity that either has 2 or more member insurers or is controlled either directly or indirectly by 2 or more insurers and that assists insurers in activities related to workers' compensation rate making. Two or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for the purpose of this definition. "Advisory organization" does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management or their employees or manager.

2. Classification system or classification. "Classification system" or "classification" means the plan, system or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.

3. Expenses. "Expenses" means that portion of any rate attributable to acquisition and field supervision; collection expenses and general expenses; and taxes, licenses and fees.

4. Experience rating. "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

5. Loss trending. "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

6. Market. "Market" means the interaction between buyers and sellers of workers' compensation and employers liability insurance within this State pursuant to this Act.

7. Pure premium rate. "Pure premium rate" means that portion of the rate that represents the loss cost per unit of exposure including loss adjustment expense.

8. Rate. "Rate" means the cost of insurance per exposure base unit, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

9. Residual market. "Residual market" means the instrument to provide coverage to employers not able to obtain coverage in the voluntary market.

10. Statistical plan. "Statistical plan" means the plan, system or arrangement used in collecting data.

11. Superintendent. "Superintendent" means the Superintendent of Insurance.

12. Supplementary rate information. "Supplementary rate information" means any manual or plan of rates, classification system, rating schedule, minimum premium, policy fee, rating rule, rating plan and any other similar information needed to determine the applicable premium for an insured.

13. Supporting information. "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required by the superintendent to be filed.

14. Voluntary market. "Voluntary market" means the workers' compensation insurance market in which insurance companies voluntarily offer coverage to applicants who meet the insurers' underwriting standards or guidelines.

§2382. Rate standards

The following standards apply to the making and the use of rates under this Act.

1. Rates. Rates may not be excessive, inadequate, or unfairly discriminatory.

2. Excessive rates. Voluntary and residual market rates are subject to the following.

A. Rates in the voluntary market are not excessive.

B. Rates in the residual market are excessive if they are likely to produce a long-term profit that is unreasonably high for the insurance provided and for surplus requirements or if expenses are unreasonably high in relation to services rendered.

3. Inadequate rates. A rate is not inadequate unless insufficient to sustain projected losses and expenses and the use of the rate has had a tendency to create a monopoly or, if continued, will tend to create a monopoly in the market or will cause serious financial harm to the insurer.

4. Unfair discrimination. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

5. Determination of compliance. Determination of compliance with standards for rate factors, expenses and profits is as follows.

A. In determining whether rates comply with standards under this section, due consideration may be given to:

(1) Past and prospective loss and expense experience within and outside of the State;

(2) Catastrophe hazards and contingencies;

(3) Loadings for leveling premium rates over time;

(4) Dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers; and

(5) Past and prospective expenses, both countrywide and those specifically applicable to the State.

B. The expense provisions included in the rates to be used by an insurer must reflect the operating methods of the insurer, and, so far as credible, its own actual and anticipated expense experience.

C. Rates may contain provision for contingencies and allowance permitting a reasonable profit. In determining the reasonableness of profit, consideration must be given to all investment income attributable to premiums, the reserves associated with those premiums and the amount of capital and surplus allocable to the coverage of risks in the State.

§2382-A. Payment of dividends

Nothing in this Act prohibits or regulates the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, but in the payment of such dividends there may be no unfair discrimination between policyholders.

A plan for the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers is not a rating plan or system.

§2382-B. Uniform administration of classifications; reporting of rating and other information; membership in advisory organization

1. Uniform classification system; uniform experience rating plan. Every workers' compensation insurer, including self-insurers, shall adhere to a uniform classification system and uniform experience rating plan filed with the superintendent by an advisory organization designated by the superintendent and subject to the superintendent's disapproval. An insurer may develop subclassifications of the uniform classification system upon which a rate may be made; provided, however, that such subclassifications must be filed with the superintendent 30 days prior to their use. The superintendent shall disapprove a subclassification if:

A. The insurer fails to demonstrate that the data produced can be reported consistently with the uniform statistical plan and classification system; or

B. The proposed subclassification:

(1) Is not reasonably related to the exposure to claim;

(2) Is not adequately defined;

(3) Has not been shown to distinguish among insureds based on the potential for or hazard of loss; or

(4) Is or will be unfairly discriminatory.

2. Designation of advisory organization. The superintendent shall designate an advisory organization to assist the superintendent in gathering, compiling and reporting relevant statistical information. Every workers' compensation insurer shall record and report its workers' compensation experience to the designated advisory organization as set forth in the uniform statistical plan approved by the superintendent.

3. Filing of manual rules. The designated advisory organization shall develop and file manual rules, subject to the approval of the superintendent, reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and the uniform classification system. Every workers' compensation insurer shall adhere to the approved manual rules and experience rating plan in writing and reporting its business. An insurer may not agree with any other insurer or with an advisory organization to adhere to manual rules that are not reasonably related to the recording and reporting of data pursuant to the uniform classification system or the uniform statistical plan.

4. Advisory organization membership. Each workers' compensation insurer shall be a member or subscriber of the workers' compensation advisory organization designated by the superintendent.

§2382-C. Filing of rates and other rating information; filing of forms

1. Prefiling required. Every insurer shall file with the superintendent all rates and supplementary rate information to be used in the State, except as filed by an advisory organization as provided in section 2384-A. Such rates and supplementary rate information must be filed at least 30 days prior to the stated effective date. An insurer may adopt by reference, with or without deviation, the rates and supplementary rate information filed by another insurer. Upon application by the filer, the superintendent may authorize an earlier effective date.

2. Form and manner of filing. Rates filed pursuant to this section must be filed in a form and manner prescribed by the superintendent. If a filing is not accompanied by the information the superintendent has required under this section, the superintendent shall notify the insurer as soon as possible and the filing is deemed as not made until the information is provided.

3. Public records. All rates, supplementary rate information and any supporting information for risks filed under this Act are, as soon as filed, public records within the meaning of Title 1, chapter 13.

4. Additional period. The period during which the filing may not become effective may be extended by the superintendent for an additional period not to exceed 60 days if the superintendent gives written notice to the insurer or advisory organization that made the filing that the superintendent needs additional time for consideration of the filing.

5. Advisory organization. Subject to the provisions of this Act, the designated workers' compensation and advisory organization shall file with the superintendent:

A. Workers' compensation pure premium rates and rating plans;

B. Workers' compensation policy forms and endorsements to be used by its members;

C. The uniform experience rating plans and rules;

D. The uniform classification plan and rules;

E. A uniform statistical plan and rules; and

F. Any other information that the superintendent requests.

6. Approved forms. Every insurance company issuing workers' compensation insurance policies covering the payment of compensation and benefits shall use only policy forms filed and approved pursuant to section 2412. Filings required by that section may be made on behalf of members and subscribers by an approved advisory organization.

§2382-D. Uniform experience rating plan; merit rating plan

1. Required contents. The experience rating plan required under section 2382-C must contain:

A. Reasonable eligibility standards;

B. Incentives for loss prevention;

C. Sufficient premium differentials to encourage safety; and

D. Provisions for reasonable and equitable limitations on the ability of policyholders to avoid the impact of past adverse claims experience through change of ownership, control, management or operation.

2. Experience rating. The uniform experience rating plan must be the exclusive means for providing premium adjustments based on the past claim experience of an insured employer. 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 bases.

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

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

C. 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 experience, the weighting must be 60% for the most recent year and 40% for the 2nd most recent year.

3. Merit rating. If an insured is not eligible for the experience rating plan, a merit rating plan must be applied using the following guidelines.

A. A plan must provide for the following credits or debits to be applied to the otherwise applicable manual premium, based on the number of lost-time claims of the insured during the most recent 3-year period for which statistics are available:

(1) No claims or a loss ratio of less than 1.0, an 8% credit;

(2) One claim resulting in a loss ratio greater than 1.0, no credit or debit; and

(3) Two or more claims resulting in a loss ratio greater than 1.0, an 8% debit.

B. The insurer shall notify the insured of the premium adjustment and the reason for the adjustment.

4. Prior lost-time work-related injury. The experience rating or merit rating plan may not permit, in the calculation of experience modification factors, consideration of those lost-time claims attributable to work-related injuries that are aggravations of, or combine with, any prior lost-time work-related injury to produce 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.

5. Retrospective rating. Nothing in this section prevents an insurer or an advisory organization from filing rating plans that provide for retrospective premium adjustments based on the insured's experience during the policy period. Except as provided in section 2386, subsection 8, in the voluntary market and the residual market retrospective rating plans must be voluntary and may not be used without the prior consent of the insured.

6. Dividend plan. Nothing in this section prohibits an insurer from developing and operating a dividend plan based on the loss experience of the insured.

§2382-E. Disapproval of rates

1. Timing of disapproval. A rate that is found not to be in compliance with applicable sections of this Act may be disapproved at any time.

2. Basis of disapproval. The superintendent may disapprove a rate if the insurer fails to comply with the filing requirements under section 2382-C.

The superintendent shall disapprove a rate for the voluntary market if there is a finding that the rate is inadequate or unfairly discriminatory using the standards in section 2382.

The superintendent shall disapprove a rate for use in the residual market if there is a finding that the rate is excessive, inadequate or unfairly discriminatory, using the standards in section 2382.

The superintendent may disapprove, pursuant to this subsection, without hearing, rates that have not become effective. An insurer whose rates have been disapproved must be notified of the reason for disapproval and must be given a hearing upon a written request made within 30 days after the disapproval order.

3. Discontinuance of a rate; interim rates. Discontinuance of a rate and interim rates are subject to the following.

A. If the superintendent finds that a rate is not in compliance with the standards of section 2382 or is in violation of section 2382-C, the superintendent shall order that its use be discontinued for any policy issued or renewed after the date of the order, and the order may prospectively provide for premium adjustment of any policy then in force.

B. Whenever an insurer has no legally effective rates as a result of the superintendent's disapproval of rates or other act, the superintendent shall, on request of the insurer, specify interim rates for the insurer that are adequate to protect the interests of all parties and may order that a specified portion of the premiums be placed in a special reserve established by the insurer and approved by the superintendent. When new rates become legally effective, the superintendent shall order the specially reserved funds or any overcharge in the interim rates to be distributed appropriately, except that adjustments that are minimal may not be required.

§2383. Interchange of data

1. Exchange of information. To further uniform administration of rate regulatory laws, the superintendent, insurers and the designated advisory organization may exchange information and experience data with insurance regulatory officials, insurers and advisory organizations in other states and may consult with them with respect to the rating plans permitted by this Act.

2. Cooperation. Cooperation among advisory organizations or among advisory organizations and insurers in rating plans and other matters within the scope of this Act is authorized, but any filings resulting from such cooperation are subject to all provisions of this Act. The superintendent may review any such cooperative activities and practices and if, after hearing, any such activity or practice is found to violate the provisions of this Act, the superintendent may issue an order requiring the discontinuance of the activity or practice and may take any other action as permitted by law.

§2383-A. Monitoring competition

1. Monitoring. The superintendent shall monitor the degree of competition in the workers' compensation insurance market. The superintendent shall utilize existing relevant information and analytical techniques and may cause or participate in the development of new relevant information, analytical techniques and other sources.

2. Consideration of factors. The superintendent shall consider, in addition to any other relevant factors, the following:

A. The number of insurers actively engaged in providing coverage;

B. Market shares and changes in market shares;

C. Ease of entry and exit by insurers in and out of the workers' compensation insurance market; and

D. Tests relating to market structure, market performance and market conduct.

3. Degree of competition. The superintendent shall consider approved self-insured employers when evaluating the degree of competition in the insurance market. The superintendent shall report by November 1, 1994 and annually thereafter on the status of the market to the Governor and to the joint standing committee of the Legislature having jurisdiction over workers' compensation insurance rate regulation matters.

§2384. Workers' compensation advisory organizations

Sections 2321-A to 2321-D apply to workers' compensation insurers and advisory organizations to the extent not inconsistent with this Act.

§2384-A. Advisory organization filing requirements

1. Filing. Every advisory organization shall file with the superintendent every pure premium, manual of rating rules, rating schedule and change, amendment or modification of the foregoing proposed for use in the State at least 30 days prior to the proposed effective date.

2. Effective date. The superintendent may extend the proposed effective date for an additional period not to exceed 60 days if the superintendent gives written notice to the advisory organization that made the filing that the superintendent needs additional time for consideration of the filing. The superintendent may require any additional information necessary to evaluate the filing.

3. Disapproval. The superintendent may disapprove, without hearing, an advisory organization filing that has not become effective if the pure premiums are excessive, inadequate or unfairly discriminatory or if the rating rules or rating procedure would produce premiums that are excessive, inadequate or unfairly discriminatory. If the pure premium rates, rating rules or rating schedule has been disapproved, the advisory organization must be notified of the reason for disapproval and must be given a hearing upon a written request made within 30 days after the disapproval order.

§2384-B. Statistical recording and reporting

1. Collection and reporting system. The statistical advisory organization designated pursuant to section 2382-B, subsection 2 shall develop and file with the superintendent a plan that includes a comprehensive data collection and reporting system for insurers. The superintendent shall designate an organization to collect and report, to the extent applicable, the data for self-insurers required by this section. The purpose of the system is to permit the superintendent, in a timely manner, to analyze insurance rates and claims practices of insurers and self-insurers.

2. Data collected. The data collection and reporting system must contain, at a minimum, the following:

A. Basic information on each claim, including:

(1) Name, address and identification information of the employee, employer and insurer or self-insurer;

(2) File identification number or numbers, insurance policy number and occupation and classification codes;

(3) Date of hire, age of employee at injury and employee's prior workers' compensation claim history; and

(4) Attorney, if any, and date of involvement;

B. Claims history information on each claim, including:

(1) Date of injury or exposure to disease, date of first report, type of injury or exposure disclosure and affected body part;

(2) Preinjury wage history, date of initial payment and date of notice of controversy, if any, together with the reason for denial;

(3) Date of maximum medical improvement;

(4) Identification of cumulative or opened claims; and

(5) Duration of wage loss period or periods;

C. Information concerning former Workers' Compensation Commission and Workers' Compensation Board proceedings, including:

(1) For each informal conference, mediation and arbitration, the date, commissioner, hearing officer, mediator or arbitrator for the proceeding, involvement of attorney or other designated representative and the resolution; and

(2) For each hearing, the date, commissioner, hearing officer, involvement of attorney or other designated representative and the decision of the commissioner or the hearing officer. If a disputed claim results in multiple hearing dates, the decision must be reported for the last hearing date; and

D. Cost of payment information on each claim, identified as open or closed, including:

(1) Aggregate payments to date to any physician, hospital or other medical provider. The superintendent may require information on payments to date to any physician, hospital, medical rehabilitation provider or other medical provider, together with a description of the services, the name of the provider, the amount of payment and the date of service;

(2) Payments made to date for weekly compensation, impairment benefits, death benefits, funeral expenses, employee legal expenses, employer legal expenses, lump sums, witness fees, penalties, employment rehabilitation services with a description of the services and name of the rehabilitation provider, and any other type of payments under former Title 39 or Title 39-A;

(3) With respect to open claims, an estimate of total outstanding liability and separately stated outstanding liability for medical care, indemnity, employment rehabilitation and any other type of payments; and

(4) Identification, both on payments and outstanding liabilities, of benefit offsets for Social Security, unemployment insurance, employer-provided pensions and any other source.

For medical only claims, the superintendent may establish a claim threshold under which the detailed claim reporting requirements of this subsection do not apply.

3. Special data calls. The superintendent may, with prior notice, require the insurer and self-insurer statistical advisory organizations to conduct special data calls to collect information usable to evaluate the costs or operations of the workers' compensation system. Any special data call imposed by the superintendent under this provision must give due consideration to the information collected and maintained by insurers and self-insurers. Requests for information not being collected on the effective date of this subsection must be prospective.

4. Other data collection systems. The statistical advisory organization may rely on data collected and reported by other data gathering organizations or agencies, such as the Workers' Compensation Board or the Department of Labor. If the statistical advisory organization is to incorporate data from other sources, it must satisfy itself that the data is sufficiently complete and accurate for the purposes for which it is to be used. The Workers' Compensation Board and the Department of Labor shall assist the statistical advisory organization in the development and maintenance of a comprehensive data base by recording and making available information within the custody and control of each, respectively, pursuant to the request of the statistical advisory organization.

5. Noncompliance penalties. The statistical advisory organization must include as part of its plan a means of monitoring member or subscriber compliance with the reporting requirements and must include a schedule of monetary penalties for failure to comply with reporting requirements.

6. Reports. The superintendent shall prescribe the frequency of and schedule for reports by the statistical advisory organization. Reports must be required on at least an annual basis.

7. Rules. The superintendent shall have the authority to adopt reasonable rules with respect to the recording and reporting of claim information, including the recording and reporting of expense or experience items that are not specifically applicable to the State but require an allocation of experience or expenses to the State.

8. Confidentiality. Any report of information relating to a particular claim is confidential and may not be revealed by the superintendent, except that the superintendent may make compilations including this experience. Any information provided to the superintendent regarding self-insurance is confidential to the extent protected by Title 39-A, section 403.

9. Accuracy. The statistical advisory organization shall take all reasonable steps to ensure the accuracy of the information provided to it and reported by it.

10. Claims covered. This section applies to all claims occurring on or after January 1, 1989; to all death, permanent total and major permanent partial claims occurring between January 1, 1987 and December 31, 1988; and to a reasonable sample, as approved by the superintendent, of all other indemnity claims occurring between January 1, 1987 and December 31, 1988. The superintendent may suspend the reporting requirements of specific items for periods when information that is to be obtained from the Workers' Compensation Commission or Workers' Compensation Board is temporarily unavailable from those entities.

§2385. Optional deductibles

1. Optional deductible. Each insurer transacting or offering to transact workers' compensation insurance in the State shall offer optional deductibles to employers that may be used upon election by the insured.

2. Indemnity. Deductibles must be available for indemnity benefits in amounts of $1,000 and $5,000 per claim and in other reasonable amounts as may be approved by the superintendent.

3. Reimbursement. The deductible form must provide that the claim must be paid by the applicable insurer, which must then be reimbursed by the employer for any deductible amounts paid by the carrier. The employer is liable for reimbursement up to the limit of the deductible.

4. Deductible not required. An insurer is not required to offer a deductible to an employer if, as a result of a credit investigation, the insurer determines

that the employee is not sufficiently financially stable to be responsible for the payment of deductible amounts.

§2385-A. Medical expense deductibles

Each insurer transacting or offering to transact workers' compensation insurance in the 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.

§2385-B. 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 2382-D, 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.

§2385-C. 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 the 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.

§2385-D. Safety groups

A safety group is an insured plan that provides for an alternative source of insurance for members of an organization or association. An insurer may issue a workers' compensation and employers' liability policy or policies insuring a safety group if the following requirements are met.

1. Filings. The organization or association shall file with the superintendent:

A. A copy of its articles of incorporation and bylaws or its agreement of association and rules governing the conduct of its business, all certified by the custodian of the originals;

B. An agreement that only a member of the organization or association is eligible for insurance as a member of the group and that it will notify its insurers within 10 days if any member fails to remain a member in good standing in accordance with the standards and rules of the organization or association;

C. A description of the operation and makeup of a safety committee which, by means of education and otherwise, will seek to reduce the incidence and severity of accidents or claims; and

D. An agreement, if the policy is a group policy, duly executed, guaranteeing that, if the insurer notifies the safety group of the nonpayment of a premium by an insured member within 60 days after the premium was due, the safety group will pay to the insurer the amount of any past due premium that does not exceed the amount of the dividends that are due the safety group or its members from the insurer. The safety group shall promptly notify the insurer of the known insolvency of any member of the group and shall request, upon learning of the insolvency, the removal of the member from the group. A copy of the resolution of the governing superintendent of the group authorizing the execution of the guarantee agreement must be filed with the superintendent and with the insurer issuing the group policy.

2. Advance premium discounts. Any advance premium discount for any new or existing safety group must be filed with the superintendent not later than 5 days after the effective date.

3. Management. The safety group shall designate a person to act as the manager or authorized representative of the group. The manager or representative may be remunerated by the members for expenses, including all ordinary operating expenses of the group, but the amount charged to members may not exceed 10% of earned premiums.

4. Dividends. Dividends or returned premiums paid or credited to a safety group must be paid or credited to the individual members of the group, except that the indebtedness for any unpaid premium must be first deducted from any dividend or premium returned.

5. Other requirements. Any safety group formed or operating under this section is subject to the requirements of sections 2931 to 2940, except that the safety group or the insurer may establish reasonable underwriting standards regarding eligibility for acceptance and continued membership of the safety group. These underwriting standards must be filed with the superintendent and may be disapproved by the superintendent if they unreasonably limit membership in the safety group.

§2385-E. Workers' compensation insurance; registration of employee leasing companies

A corporation, partnership, sole proprietorship or other business entity that provides staff, personnel or employees to be employed in the State to other businesses pursuant to a lease arrangement or agreement must, before becoming eligible to be issued a policy of workers' compensation insurance, register with the superintendent pursuant to Title 32, chapter 125. Employee leasing companies are subject to rules applicable to workers' compensation insurance as adopted by the superintendent and to penalties as defined in Title 32, section 14058.

§2386. Workers' compensation insurance residual market mechanism

1. Participation. All insurers authorized to write workers' compensation and employers' liability insurance in this State shall participate in the workers' compensation insurance residual market mechanism, which is composed of an Accident Prevention Account and a Safety Pool. The residual market mechanism is not a state fund and the State has no proprietary interest in it or in any contributions made to it. This mechanism is exempt from any budgetary control or supervision by state agencies, except to the extent an insurance company is supervised or controlled by state agencies.

2. 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 2386-A 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.

3. Accident Prevention Account; eligibility. Eligibility for insurance from the Accident Prevention Account is as follows.

A. The Accident Prevention Account is an insurance plan that provides for the equitable apportionment among insurers of insurance that may be afforded applicants who are entitled to, but unable to, procure that insurance through ordinary methods because of their demonstrated accident frequency problem, measurably adverse loss ratio over a period of years or demonstrated attitude of noncompliance with safety requirements.

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 1.0 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 that write that insurance in the State. For the purpose of this section, an employer is considered to have been refused if offered insurance only under a retrospective rating plan or plans.

4. Safety Pool; eligibility. Eligibility under the Safety Pool is as follows.

A. The Safety Pool is an insurance plan that provides for an alternative source of insurance for employers with good safety records.

B. An employer 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 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 terminates if 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.

C. A member of the Safety Pool who fails to meet eligibility requirements under paragraph B must be ordered to leave the Safety Pool after notice under former Title 39, section 23, subsection 1.

5. Plan of operation. The superintendent shall adopt rules pursuant to Title 5, chapter 375, subchapter II, establishing a plan of operation for the residual market mechanism. The plan of operation must contain those terms that the superintendent in the superintendent's discretion determines necessary.

A. The plan must include an experience rating system and merit rating plan providing that the premium of each employer in the account is modified either prospectively or retrospectively. An experience modification may only be applied to the manual rate of the plan. The sensitivity of a rating system may vary by size of the risk involved.

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

C. The plan must provide for premium surcharges for employers in the Accident Prevention Account based on their specific loss experience within a specified period or other factors that are reasonably related to their risk of loss.

(1) No premium surcharge may be applied to a risk whose threshold loss ratio is less than 1.0. The threshold loss ratio is based on the ratio of "L" to "P" where:

(a) "L" is the actual incurred losses of a risk during the previous 3-year experience period as reported, except that the largest single loss during the 3-year period is limited to the amount of premium charged for the year in which the loss occurred; and

(b) "P" is the premium charged to a risk during that 3-year period.

(2) Premium surcharges apply to a premium that is experience or merit rating modified.

(3) Premium surcharges are based on an insured's adverse deviation from expected incurred losses in the State. The surcharge is based on the ratio of "A" to "B" where:

(a) "A" is the actual incurred losses of a risk during the previous 3-year experience period as reported; and

(b) "B" is the expected incurred losses of a risk during that period as calculated under the uniform experience or merit rating plan multiplied by the risk's current experience or merit rating modification factor.

(4) The premium surcharge is as follows:

Ratio of "A" to "B"	Surcharge
Less than 1.20	None
1.20 or greater, but less than 1.30	5%
1.30 or greater, but less than 1.40	10%
1.40 or greater, but less than 1.50	15%
1.50 or greater	20%

D. Commissions under a plan must be established at a level that is neither an incentive nor a disincentive to place an employer in the residual market.

E. In addition to factors in paragraphs A to C, any servicing contract must be approved on the basis of acceptable price and performance.

F. If after notice and hearing the superintendent determines that insurers are unwilling to provide services that are reasonably necessary for the operation of the plan, the superintendent may award service contracts within various areas of the State on the basis of acceptable price and performance. If the superintendent chooses to award such contracts, the specifications must give special consideration to loss control, safety engineering and any other factor that affects safety.

6. Rates. Rate filings for rates in the Accident Prevention Account and the Safety Pool must be made together and are subject to former section 2363.

A. A rate filing for the residual market must include experience and merit rating plans. The experience rating plan is the uniform experience rating plan. The merit plan must provide the maximum credits possible to Safety Pool members on the basis of individual loss experience, including frequency and severity, consistent with this chapter and sound actuarial principles.

B. The superintendent shall review the rates, rating plans and rules, including rates for individual classifications and subclassifications, in the Accident Prevention Account and the Safety Pool at least once every 2 years and may review rates more frequently if necessary.

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.

7. Mandatory deductible. A deductible applies to all workers' compensation insurance policies issued to employers in the Accident Prevention Account that meet the following qualifications:

A. A net annual premium of $20,000 or more subject to adjustment pursuant to this section in the State;

B. A premium not subject to retrospective rating; and

C. The employer's threshold loss ratio, as determined under subsection 4, paragraph B, subparagraph (1), is 1.0 or greater.

The deductible is $1,000 per claim but applies only to wage loss benefits paid on injuries occurring during the policy year. In no event may the sum of all deductibles in one policy year exceed the lesser of 15% of net annual premium or $25,000. Each loss to which a deductible applies must be paid in full by the insurer. After the policy year has expired, the employer shall reimburse the insurer the amount of the deductibles. This reimbursement must be considered as premium for purposes of cancellation or nonrenewal.

For purposes of calculations required under this section, losses must be evaluated 60 days from the close of the policy year.

Annually, on July 1st, the superintendent shall, by rule, adjust the $20,000 premium level established in this subsection to reflect any change in rates for the Accident Prevention Account and any change in wage levels in the preceding calendar year. Changes in wage levels are determined by reference to changes in the state average weekly wage, as computed by the Department of Labor, Bureau of Employment Security. Any adjustment is rounded off to the nearest $1,000 increment.

This subsection takes effect on the effective date of the first approved rate filing after the effective date of this Act.

8. Mandatory retrospective rating. The superintendent may impose retrospective rating plans under the following circumstances:

A. The superintendent shall by rule establish standards governing the application of retrospective rating plans under which the superintendent may order, after hearing, a retrospective rating plan for an employer in the Accident Prevention Account who has sufficient size in terms of premium and number of employees to warrant such rating and:

(1) For the 3 most recent years for which data is available, an experience modification

factor and a loss ratio that may indicate a serious problem of workplace safety; or

(2) A demonstrated record of repeated serious violations of workplace health and safety regulations adopted under the Maine Revised Statutes, Title 26, chapter 6, or 29 United States Code, Chapter 15, whichever is applicable.

B. The maximum premium, including any applicable surcharge under this section, may not exceed 150% of standard premium.

9. 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.

10. Contracts; consultants. The superintendent may, in the superintendent's discretion, enter into contracts for the provision of any services necessary or appropriate to the operation of the residual market mechanism and may retain consultants to provide such other technical and professional services as the superintendent may require for the discharge of the superintendent's duties. Qualification to serve as a contractor for servicing carrier purposes is not limited to licensed insurance carriers.

11. Report. Beginning in 1993, the superintendent shall annually issue a report on or before April 1st to the Governor, the President of the Senate and the Speaker of the House of Representatives. The report must include at least the following information relating to the Safety Pool:

A. The percentage of total insured premium in the State written in the Safety Pool;

B. The percentage of all insured employers in the State written in the Safety Pool;

C. The number of employers in the Safety Pool and the number who have entered or left;

D. The total earned premium, paid losses, reserves and incurred losses; and

E. The investment income of the Safety Pool and its method of allocation or determination.

12. Rules. The superintendent shall adopt rules to provide for an equitable distribution among insurers of any deficit or surplus in the residual market not subject to section 2386-A. The rules must give due consideration to efforts by individual insurers to underwrite risks in the voluntary market.

13. 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.

14. Termination of residual market mechanism. Workers' compensation and employers liability insurance coverage may not be issued through the workers' compensation insurance residual market mechanism on or after January 1, 1993.

15. Loan. The workers' compensation residual market pool is authorized to and shall, upon written request pursuant to section 3704, loan to the Maine Employers' Mutual Insurance Company, initial funding of up to $5,000,000.

§2386-A. Workers' compensation rates; annual surcharges and credits

Beginning in 1992, the superintendent shall annually determine whether premiums collected from risks in the residual market and investment income allocable to those premiums are greater or less than the incurred losses and expenses associated with that market. The superintendent shall hold a hearing before making the determination and issue the determination by the earlier of June 1st or the date of decision concerning any request for a rate change pending before the superintendent on January 1st of that year. In establishing surcharges under this section, the superintendent may approve application of surcharges to policies issued on or after January 1st, but prior to the date of the superintendent's order, provided that the policies contain language approved by the superintendent that is sufficient to notify policyholders that they may be subject to surcharges approved after the effective date of their policies. For purposes of this section, the residual market is the Accident Prevention Account and the Safety Pool. For purposes of this section, "deficit" means the amount by which incurred losses and expenses associated with the residual market exceed premiums collected from risks in that market and investment income allocable to those premiums. The superintendent shall also determine whether insurers have in good faith made their best efforts to maximize the number of risks in the voluntary market for workers' compensation insurance in the State. The superintendent may make timely and appropriate requests for any data determined necessary by the superintendent to make these determinations.

In making the determinations required by this section, the superintendent shall apply statutory insurance accounting standards and utilize sound actuarial principles. In making these determinations, losses for policies issued prior to January 1, 1988, may not considered. Each review must be on a policy-year basis and apply to the policy year prior to the year in which the review is being made and all other prior policy years beginning on or after January 1, 1988. The calculations and determinations required of the superintendent must be made on a cumulative basis for each policy year under consideration such that each year's determination must be based on all available data relating to a given policy year. For each year under review, the superintendent shall determine the following.

1. Premium surplus. If the superintendent determines that premiums collected from the insureds in the residual market and investment income allocable to those premiums are greater than the incurred losses and expenses attributable to the risks in that market, the superintendent shall order an appropriate credit applied to the premiums paid by policyholders in the residual market and employers who were policyholders during the policy year for which the surplus was determined but who have since become self-insured.

2. Premium deficit. Payment of any premium deficit is determined in the following manner.

A. If the superintendent determines that premiums and investment income attributable to those premiums are less than incurred losses and expenses in the residual market, the superintendent shall then determine the rate of return for the insurance industry in the entire workers' compensation market in the State. If the rate of return is found, considering all relevant factors, to be less than reasonable, the superintendent shall order a surcharge on premiums paid by insureds in both the voluntary and involuntary markets and employers who were in either market during the policy year for which the deficit was determined but who have since become self-insured.

B. Any deficit determined by the superintendent pursuant to paragraph A is not the responsibility of the insurers on an individual or collective basis but is the financial obligation of all insured employers in the State, including employers who were insured during the policy year for which the deficit has been determined but who have since become self-insured. The surcharge must be in an amount at least sufficient to offset the adverse cash flows resultant from the deficiency, provided that the application of the surcharge does not produce a rate of return in excess of a just and reasonable profit in the entire workers' compensation market in the State. In any event, the amount of the surcharge in any year must be at least equal to the investment income that would be earned in the 12 months following the surcharge on any portion of the deficit that is not recovered by surcharge in that year, except that the superintendent is not required to order this minimum amount in the first policy year in which a deficit is determined with respect to a policy year.

C. Beginning in 1992, the superintendent, after hearing and only if the rates in the entire workers' compensation market are inadequate to produce a reasonable rate of return, shall determine as of March 15th of each year whether insurers have in good faith made their best efforts to maximize the number of risks in the voluntary market. If the superintendent's determination is affirmative, the surcharge in paragraph A applies.

If the determination is negative, then the superintendent shall determine the percentage of workers' compensation insurance, by premium volume, that has been written voluntarily statewide. If the premium volume in the voluntary market is greater than or equal to the amount specified in the table below, then the surcharge in paragraph A applies.

Policy Year	Premium Volume
1989	50%
1990	60%
1991 and later	70%

If the superintendent determines that the percentage of premium in the voluntary market is less than the percentage in the table above, the deficit collectible from insured employers is reduced as follows: for each reduction of 5%, or part thereof, below the required percentage, the total deficit amount is reduced by 10% subject to a maximum reduction of 50% of the deficit.

3. Application of credit or surcharge. Credits or surcharges ordered by the superintendent apply to policies issued or renewed during the calendar year after the order of the superintendent is issued or for such other period as the superintendent may order. In the case of an employer who was insured during the policy year for which the surplus or deficit has been determined but who is self-insured in the year in which the surcharge or credit is ordered, individually or as part of a group, the surcharge must be applied to the lowest of the:

A. Discounted standard premium applicable to the employer for the period during which the employer was insured in the policy year the deficit was created;

B. Manual premium applicable to the employer for the year prior to the year to which the surcharge is applied, multiplied by a fraction, the numerator of which is the number of days the em-

ployer was insured in the policy year the deficit was created and the denominator of which is 365; or

C. Discounted standard premium applicable to the employer for the year prior to the year to which the surcharge is applied, multiplied by a fraction, the numerator of which is the number of days the employer was insured in the policy year the deficit was created and the denominator of which is 365.

The superintendent shall adopt rules to determine the method of collecting any surcharge or paying any credit ordered with respect to self-insured employers subject to surcharge or credit.

4. Rules regarding distribution of deficit. The superintendent shall adopt rules that provide for the equitable distribution among insurers of the portion of any deficit not surcharged to insured employers. The rules must give due consideration to efforts by individual insurers to underwrite risks in the voluntary market.

5. Review of market. The superintendent shall review, on an annual basis, the operation of the entire market to determine the effectiveness of this section. The superintendent may make such recommendations, on a prospective basis, to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters as the superintendent deems appropriate.

6. Public Advocate participation. The Public Advocate may participate as follows.

A. The Public Advocate, as appointed under Title 35-A, section 1701, may participate as a party in the hearing in which the superintendent makes the determinations required by this section. The Public Advocate may make timely and appropriate requests for data necessary to participate in those determinations.

B. At the time the superintendent begins the proceeding required by this subsection, the insurance carriers participating in the proceeding shall pay to the superintendent a fee of $20,000, which the superintendent shall immediately credit to the Public Advocate. The fee is to be segregated and expended for the purpose of employing outside consultants and paying other expenses, including staff salaries, to fulfill the requirements of this subsection. Any portion of the fee not so expended is to be returned to the insurance carriers.

7. Exemption from 1990 surcharge. Notwithstanding this section, employers who were policyholders during the policy year for which the deficit was determined but who are self-insured in 1990 are not subject to any surcharge ordered in 1990. This subsection does not exempt those employers from surcharges ordered after 1990 with respect to the deficit determined for the policy year beginning January 1, 1988.

8. Limit on deficits or surcharges. Notwithstanding any provision in this section, the procedures and obligations created by this section apply to policy years ending December 31, 1992. No deficits or surpluses arising from policies issued to employers on or after January 1, 1993 are subject to this section.

9. Final determination of deficit or surplus; timetable for surcharge or credit. In making the annual determination required by this section, the superintendent shall make a final determination of the deficit or surplus for any policy year with respect to which the superintendent has received 7 complete annual evaluations of residual market policy year experience. Regardless of receipt of 7 complete evaluations, the superintendent shall make a final determination regarding a policy year no later than the 8th calendar year following the close of the policy year under review. If the superintendent determines that there is a surplus for that policy year, the superintendent shall order a credit under subsection 1. If the superintendent determines that there is a deficit for that policy year, the superintendent shall establish a schedule of surcharges to recover the remainder of the deficit for that policy year over a period not to exceed 10 years, except that in each year application of the surcharge is subject to subsection 2.

10. Insurer responsibility. Insurers authorized in 1993 or becoming authorized in 1993 or in subsequent years are not liable for deficits for any prior years except for any liability resulting from prior authorization to write workers' compensation insurance in this State.

§2387. Penalty for violations

1. Civil penalties. A person or organization in violation of this chapter must be assessed by the superintendent a civil penalty not more than $1,000 for each violation, except that where a violation is willful, a civil penalty of not more than $10,000 must be assessed for each violation. These penalties may be in addition to any other penalty provided by law.

2. Separate violation. For purposes of this section, an insurer using a rate for which that insurer has failed to file the rate, supplementary rate information or supporting information as required by this subchapter, has committed a separate violation for each day that failure continues.

3. License. The license of an advisory organization, rating organization or insurer that fails to comply with an order of the superintendent may be suspended or revoked by the Administrative Court.

§2387-A. Public Advocate

1. Participation and duties. The Public Advocate shall represent the interests of insureds and policyholders in matters under this subchapter within the jurisdiction of the superintendent, including, but not limited to:

A. Rate filings under this chapter;

B. Rulemaking;

C. Petitions by insurers to terminate license authority, or withdrawal plans submitted pursuant to section 415-A;

D. Proceedings by the superintendent concerning the reasonableness and adequacy of the service provided by any insurer;

E. Proceedings by the superintendent concerning the reasonableness and adequacy of the rates charged by any insurer; and

F. Proceedings instituted by the superintendent concerning an insurer's license authority.

The Public Advocate has the same right to request data as any other party before the superintendent and may petition the superintendent, for good cause shown, to be allowed such other information as may be necessary to carry out the purposes of this section.

2. Petition. The Public Advocate has the right to request that the superintendent investigate the reasonableness of the service provided by, or the rates charged by, insurers.

3. Expert witnesses. The Public Advocate may employ witnesses and pay appropriate compensation and expenses to employ such witnesses. The funds for expert witnesses are available as indicated in section 2386.

4. Appeal from superintendent's orders. The Public Advocate has the same rights of appeal from the superintendent's orders or decisions to which the Public Advocate has been a party as other parties.

5. Application. This section applies to any proceeding under former section 2367 or section 2386-A for policy years 1988 through 1992 and for any other proceeding initiated prior to January 1, 1993 or any continuation or appeal of a proceeding initiated prior to January 1, 1993.

§2387-B. Savings provision

Any experience rating, classification, statistical or other rating plan on file and approved or legally in effect and not required to be revised by this Act or by a decision of the superintendent remains approved for use in the State. These plans need not be refiled on the effective date of this Act.

Any rates or forms approved for an insurer on file and approved or legally in effect and not required to be revised by this Act or by a decision of the superintendent remain approved for use in the State. These rates and forms need not be refiled on the effective date of this Act.

Sec. B-13. Effective date. This Part takes effect January 1, 1993.

PART C

Sec. C-1. 24-A MRSA §3701, as enacted by PL 1991, c. 615, Pt. D, §1, is amended to read:

§3701. Purpose

The Maine Employers' Mutual Insurance Company ~~may be~~ is established for the ~~purpose~~ purposes of providing workers' compensation insurance and employers' liability insurance incidental to and written in connection with workers' compensation coverage to employers of this State at the highest level of service and savings consistent with reasonable applicable actuarial standards and the sound financial integrity of the company. It is also the purpose of the company to encourage employer involvement and to be responsive to each division's experience, practice and operating effectiveness.

Sec. C-2. 24-A MRSA §3702, sub-§§3 to 6 are enacted to read:

3. Division. "Division" means an industry or geographic grouping as established under section 3712.

4. Superintendent. "Superintendent" means the Superintendent of Insurance.

5. Voluntary market. "Voluntary market" means the workers' compensation insurance market in which insurance companies voluntarily offer coverage to applicants who meet the insurers' underwriting standards or guidelines.

6. Workers' compensation residual market mechanism. "Workers' compensation residual market mechanism" means the instrument to provide coverage to employers not able to obtain coverage in the voluntary market that immediately preceded the Maine Workers' Compensation Mutual Insurance Company.

Sec. C-3. 24-A MRSA §3703, as enacted by PL 1991, c. 615, Pt. D, §1, is amended to read:

§3703. Establishment

The Maine Employers' Mutual Insurance Company ~~may be~~ is established as ~~a~~ an assessable domestic mutual insurance company subject to all the requirements and standards of this Title ~~except those from which it is~~ that are applicable to cash plan insurers unless specifically ~~excepted~~ exempted from or which are clearly inconsistent with the provisions contained in this chapter. 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 and employers' liability insurance incidental to and written in connection with workers' compensation coverage to employees in this State. The company may not write other lines of insurance. The company may not write reinsurance or excess 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.~~

4. Incorporation. The company must be incorporated pursuant to provisions of sections 3306 to 3309. Nine incorporators representing the 8 industry divisions established pursuant to section 3712, subsection 1, paragraphs A to H, plus one at-large member must be appointed by the Governor subject to review and approval by the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. The Governor shall make the appointments within 10 days after the effective date of this subsection. The joint standing committee shall complete its review and vote on the approval of the appointments of the Governor within 10 days of the Governor's written notice of the appointments. If the designated committee fails to act within the required 10 days, then the appointees put forward by the Governor become the required incorporators.

An incorporator may not be a lobbyist required to be registered with the Secretary of State, a service provider to the workers' compensation system or a representative of a service provider to the workers' compensation system.

Upon appointment, the incorporators shall execute a certificate of organization as required by this Title and immediately pursue a certificate of authority for a mutual assessment casualty insurance company.

The incorporators shall appoint the initial 9 policyholder members of the board of directors. One member of the board of directors shall serve at large. Eight members of the board of directors shall represent the 8 industry or geographic divisions.

5. Composition of the board. The board consists of up to 13 members. Nine members must be policyholders who purchase workers' compensation coverage from the Maine Employers' Mutual Insurance Company, except that the initial appointment may include employers who have purchased coverage through the workers' compensation residual market mechanism. Three members must be persons who represent the public interest of the company and must be appointed by the Governor within 30 days after a new board member is authorized or a vacancy occurs, subject to review and approval by the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. The designated committee shall complete its review and vote on approval of the appointments of the Governor within 15 days of the Governor's written notice of appointment. If the designated committee fails to act within the required 15 days, then the appointees put forward by the Governor become the required board members. Except for the initial selection of board members under subsection 4, each division as established pursuant to section 3712 must have one member on the board. One member must be an at-large policyholder member elected by the board. The remaining board member is the president and chief executive officer who shall serve on the board of directors while employed as president and chief executive officer.

A member of the board who is not elected by one of the divisions as specified in section 3712 may not be a lobbyist required to be registered with the Secretary of State, a service provider to the workers' compensation system or a representative of a service provider to the workers' compensation system.

6. Terms. The initial terms of the board of directors are staggered at 3 years, 2 years and one year. Of the initial division policyholders, 3 serve 3-year terms, 3 serve 2-year terms and 3 serve one-year terms. The initial public interest members serve one 3-year term, one 2-year term and one one-year term. A full term is 3 years. An individual may not serve more than 2 full terms as a director. All members shall serve for the terms provided and until their successors are appointed or elected and qualified.

7. Corporate governance. The initial board of directors shall, at the organizational meeting of the company to complete organization, adopt bylaws consistent with section 3359. The bylaws must provide a schedule of meetings and rules specifically relating to the conduct of meetings and voting procedures.

8. Annual report. In addition to any other reports required by this title, the company shall submit an annual report to the Governor and to the joint standing committee of the Legislature having jurisdiction over insurance matters that discloses the business transacted by the company during the previous year and states the resources and liabilities of the company together with other pertinent information considered appropriate by the board. The report must contain, at a minimum, a summary of the latest annual statement filing required to be filed under this Title with the Superintendent of Insurance prepared on a basis of statutory accounting precepts. Any variations between the annual statement and the annual report must be reconciled to clearly show variances and the basis for any different values.

9. Nominating committee. The board shall create a nominating committee. The nominating committee shall present to the board nominees for the at-large policyholder board member position.

Sec. C-4. 24-A MRSA §3704, as enacted by PL 1991, c. 615, Pt. D, §1, is repealed.

Sec. C-5. 24-A MRSA §3704-A is enacted to read:

§3704-A. Initial funding and operation

Upon appointment of the initial board, the board shall elect a chair and shall employ a president who shall serve as chief executive officer. The company may borrow from the policy year 1992 funds of the workers' compensation residual market mechanism initial start-up funds of up to $5,000,000. Any funds borrowed must be secured by future premiums collected and half of the funds borrowed plus interest must be repaid not later than March 31, 1994 and the remaining funds plus interest must be repaid not later than March 31, 1995. Any funds borrowed must be repaid with interest at the rate actually earned on workers' compensation residual market assets during the term of the loan.

Sec. C-6. 24-A MRSA §3705, as enacted by PL 1991, c. 615, Pt. D, §1, is amended to read:

§3705. Nonstate agency

The company is not considered a state agency or instrumentality of the State for any purpose. The company is not and may never be supported in any way by the State's General Fund or any guaranty by the State, any state agency or a division of the State. The State may not borrow or otherwise appropriate funds from the company.

Sec. C-7. 24-A MRSA §3706, sub-§1, as enacted by PL 1991, c. 615, Pt. D, §1, is amended to read:

1. Annual report. ~~The~~ In addition to any other reports required by this Title, the board shall submit an annual report to the Governor and the joint standing committee of the Legislature having jurisdiction over insurance matters 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. The report must contain, at a minimum, a summary of the latest annual statement required to be filed with the superintendent prepared in accordance with statutory accounting principles.

Sec. C-8. 24-A MRSA §§3707 to 3714 are enacted to read:

§3707. Powers of the board

The board has full power, authority and jurisdiction over the company.

1. General authority. The board may perform all acts necessary or convenient in the exercise of any power, authority or jurisdiction over the company, either in the administration of the company or in connection with the business of the company to fulfill the purposes of this chapter, except as otherwise provided to the divisions under section 3712.

2. Standard of performance. The board shall discharge its duties with the care, skill, prudence, and diligence as that of prudent directors acting in a similar enterprise and purpose.

3. Personal liability. The members of the board and officers or employees of the company are not liable personally, either jointly severally, for any debt or obligation created or incurred by the company.

4. President. The board shall appoint a president who shall serve as chief executive officer and may appoint other executive officers as it determines necessary.

5. Investment managers. The board shall appoint investment managers to oversee and manage the investment of assets of the corporation in a manner that safeguards the value of those assets and maximizes investment return commensurate with risk and liquidity restrictions contained in chapter 13.

A. An investment manager appointed by the board is subject to standards applicable to fiduciaries responsible for safeguarding assets of such a corporation. The investment manager must be appointed

pursuant to a contract in writing that clearly establishes the fiduciary nature of the relationship of the fiduciary to the company.

B. The board shall set investment policy for the investment managers of the company through an investment committee composed of not less than 3 members nor more than 5 members of the board. Transactions in the sale or purchase of securities by an investment manager may be in a nominee name as designated by the board. Authority to acquire or sell securities for the company must be conveyed to the investment manager in writing by the investment committee.

C. In any agreement empowering the investment managers to act for or on behalf of the company, there must be provisions for periodic reporting by the managers respecting investments held in the name of the company, the yield received on such investments and any principal cash balances held by depositories or the investment managers.

D. Securities and property of the corporation must be held in a manner consistent with the requirements for mutual insurance companies set forth in this Title.

§3708. General powers

1. Powers. For the specific purpose of exercising the responsibilities granted in this chapter and effectuating the purposes of this chapter, the company has the powers otherwise granted to a casualty insurer and may:

A. Hire employees or enter into contracts relating to the administration of a workers' compensation insurer;

B. Declare a dividend when there is an excess of assets over liabilities and surplus requirements established in this Title; and

C. Enter into agreements to reinsure all or part of the company's exposure to loss and to otherwise limit the risk to the company and manage its financial condition.

2. Assessments; plan of operation. The board shall:

A. Assess policyholders to cover its expenses, claims, obligations and other funding needs consistent with this chapter and Title; and

B. Develop and file with the superintendent for review and approval a plan of operation and any amendments to a plan of operation necessary or suitable to ensure the fair, reasonable and equitable administration of the company.

§3709. President and chief executive officer

1. Appointment. The board shall appoint a president who shall serve as chief executive officer and who is responsible for the operation of the company. The president must be qualified by education and experience to manage an organization with financial and operational obligations to its policyholders and claimants.

2. Term. The president serves at the will of the board.

3. Compensation. The president is entitled to compensation as established by the board and is subject to any reasonable requirements, including bonding, established by the board.

4. Board member. The president is a member of the board, but may not be the chair of the board.

5. Duties. The board, as part of its plan of operation, shall designate the powers and duties of the president. The president may, with direction from the board, assist in the development of the plan of operation and other start-up functions.

§3710. Funding; surplus

1. Initial funding. The company shall borrow funds, including those authorized in section 3704-A, for initial operating expenses. After consultation with the president and board, the superintendent shall set the rates for the divisions for the first year of operation of the company.

2. Ongoing funding. The company:

A. Shall collect from each applicant an advance premium of 25% of the estimated annual premium and shall bill subsequent premiums with advance notice to insureds to ensure that if periodic premiums are not paid by insureds in a timely manner, that adequate time is available to give proper notice of cancellation prior to previously collected premium being fully earned; and

B. May assess its policyholders for additional funds to meet operating needs or as required by law.

3. Transition surplus, premium levels. Notwithstanding other provisions of this Title, the company is permitted to operate for a period of up to 10 years with a level of surplus less than that otherwise required for a mutual insurer authorized to write casualty insurance if the following conditions are met.

A. The superintendent shall set the confidence level, which is the probability that the provision of actual costs will be less than the actual costs by a certain percentage, for the company. The com-

pany shall establish its rates at a level to cover its anticipated overhead expenses and to cover, on a discounted basis, the actuarially determined incurred claims and claim-settlement costs at not less than the confidence level set by the superintendent.

B. The company shall annually file with the superintendent an actuarial analysis of its reserves and its proposed rate level. The company shall establish its reserves, including provisions for incurred but not reported reserves, at not less than the confidence level set by the superintendent.

C. Any surpluses from any fund year must be retained by the company and credited toward its surplus account. No surplus may be returned to policyholders or credited to other fund years until the superintendent has certified that the company has achieved the surplus level required of an assessable domestic mutual insurance company authorized to write casualty insurance.

D. Not later than 10 years from January 1, 1993, the company, through premiums, retained dividends, sale of bonds, assessments or any other legally authorized means, shall accumulate surplus and obtain certification from the superintendent that the company has obtained the surplus otherwise required under this Title. If the superintendent finds, after hearing, that inadequate surplus exists and the 10-year transition period has expired, the superintendent shall declare the company impaired and take appropriate action to rehabilitate or liquidate the company. If the superintendent finds that surplus is not being accumulated at an adequate rate consistent with its premium volume during the 10-year period, the superintendent shall so inform the board.

E. If the superintendent finds at the expiration of 10 years of company operations, or earlier, that the company has accumulated or otherwise obtained surplus as required pursuant to this Title for casualty insurance companies operating on the cash plan, the requirements contained in paragraphs A to C terminate. The company shall at that point be subject to the standards of section 410 and other sections of this Title applicable to a mutual casualty insurer writing workers' compensation insurance.

§3711. Operation of the company

1. Coverage availability. On or after January 1, 1993, the company shall provide workers' compensation and incidental employers' liability coverage to employers otherwise entitled to coverage, but not able to or not electing to purchase coverage in the voluntary insurance market, and not authorized, either individually or as part of a group, to self-insure. An authorized self-insured is eligible for coverage upon termination of self-insurance.

2. Federal coverage. The board shall authorize the availability of federal workers' compensation coverage under the Longshore and Harbor Workers' Compensation Act, 33 United States Code, Section 901, et seq., the Defense Base Act, 42 United States Code, Section 1651, et seq., the Federal Employers Liability Act, 45 United States Code, Section 51, et seq., and any federal maritime or admiralty coverage. The board is authorized to make available Outer Continental Shelf Lands Act, 43 United States Code, Section 1331, et seq., coverage, Nonappropriated Fund Instrumentalities Employees' Retirement Credit Act of 1986, 5 United States Code, Section 8171, et seq., coverage, and any other coverages by special endorsements that may be required of an insured by contract or other needs.

3. Coverage denial. The company shall deny coverage to any employer who owes undisputed premiums to a previous workers' compensation carrier or to the workers' compensation residual market mechanism, or fails to comply with reasonable safety requirements the company is legally authorized to establish.

§3712. Divisions

The Maine Employer's Mutual Insurance Company consists of industry or geographic divisions and a high-risk division.

1. Initial divisions. The initial divisions are the following industry divisions:

A. Manufacturing, agriculture, fisheries and forestry;

B. Services;

C. Retail;

D. Construction;

E. Wholesale;

F. Transportation and public utilities;

G. Finance, insurance and real estate;

H. State and local government; and

I. High-risk.

Assignments to each division are made by the board. Not more than 30 days after the assignment, a policyholder may in writing appeal to the Bureau of Insurance on that assignment.

2. Changes in divisions. After 2 years of operation the board, with the approval of the superintendent, may change the separation of policyholders into revised divisions pursuant to subsection 1. Any proposed revisions must produce divisions that are large enough to produce predictable loss experience, cover expenses of operation and result in levels of employer involvement and access to safety and claims management services consistent with the purposes of this chapter.

3. High-risk division. The high-risk division is subject to the following provisions.

A. For the period January 1, 1993, to December 31, 1993, an employer may not be eligible for the industry divisions, and must be placed in the high-risk division if the employer has at least 2 lost-time claims, each greater than $10,000 and a loss ratio greater than 1.0, over the latest 3 years for which data is available.

B. On or after January 1, 1994 the board, with the approval of the superintendent, may modify the eligibility standards for the high-risk division, if those standards limit those in the division to employers who have measurably adverse loss experience, have a relatively high claim frequency record or have demonstrated an attitude or practice of noncompliance with reasonable safety requirements or claims management standards.

C. Eligibility requirements must be applied annually at the policy renewal date or, if the necessary claim history is not available at that time, 30 days after notice to the insured.

D. In addition to any rating differential approved for the high-risk division, during the period January 1, 1993 to December 31, 1993 the high-risk division shall provide for the following surcharges.

(1) A payment for coverage surcharge may be applied to a risk with a threshold loss ratio of 1.0 or higher. The threshold loss ratio is based on the ratio of "L" to "P" when:

(a) "L" is the actual incurred losses of a risk during the previous 3-year experience period as reported, except that the largest single loss during the 3-year period is limited to the amount of premium charged for the year in which the loss occurred; and

(b) "P" is the premium charged to a risk during that 3-year period.

(2) Premium surcharges apply to a premium that is experience rated or merit rated.

(3) Premium surcharges are based on a policyholder's adverse deviation from expected incurred losses in this State. The surcharge is based on the ratio of "A" to "B" when:

(a) "A" is the actual incurred losses of a risk during the previous 3-year experience period as reported; and

(b) "B" is the expected incurred losses of a risk during that period as calculated under the uniform experience rating or merit rating plan multiplied by the risk's current experience rating or merit rating modification factor.

(4) The premium surcharge is as follows:

Ratio of "A" to "B"	Surcharge
Less than 1.20	None
1.20 or greater but less than 1.30	5%
1.30 or greater but less than 1.40	10%
1.40 or greater but less than 1.50	15%
1.50 or greater	20%

On or after January 1, 1994, the board, with the approval of the superintendent, shall modify or eliminate a plan for surcharges for policyholders in the high-risk division based on their specific loss experience beyond the uniform experience rating plan approved by the superintendent. Any plan of surcharges must consider the actual claims experience of the employer and must provide for rate adjustments reasonably related to the employers' risk of loss.

E. Deductibles in the high-risk division are subject to this paragraph.

(1) A deductible applies to all coverage for policyholders in the high-risk division that meet the following qualifications:

(a) A net annual premium of $20,000 or more subject to adjustment, pursuant to this section, in the State;

(b) A premium not subject to retrospective rating; and

(c) The policyholder's threshold loss ratio, as determined under paragraph D, subparagraph (1), is 1.0 or greater.

The deductible is $1,000 a claim but applies only to wage loss benefits paid on injuries occurring during the year of coverage. The

sum of all deductibles in one year of coverage may not exceed the lesser of 15% of net annual payment for coverage or $25,000. Each loss to which a deductible applies must be paid in full by the company. After the year of coverage has expired, the policyholder shall reimburse the company the amount of the deductibles. This reimbursement is considered as payment for coverage for purposes of cancellation or nonrenewal.

Unless otherwise acted upon as provided for in subsection 2, beginning October 1, 1996, the board shall adjust, annually, the $20,000 payment of coverage level established in this subsection to reflect any change in rates for the high-risk division and any change in wage levels in the preceding calendar year. Changes in wage levels are determined by reference to changes in the state average weekly wage, as computed by the Department of Labor, Bureau of Employment Security. Any adjustment is rounded off to the nearest $1,000 increment.

(2) For policies effective on or after January 1, 1994, the board may modify, with the approval of the superintendent, the mandatory deductible elements. Any modification or elimination of this rating feature must consider the incentive impact on an employer, the reasonableness of the retained cost relative to the claim history, safety record or claims management practices of impacted employers and the ability of employers of all sizes to absorb these costs.

F. The board may file, with the superintendent, retrospective rating plans that, after hearing, may be imposed on an employer with a demonstrated record of repeated serious violations of workplace health and safety rules and regulations such as those adopted under Title 26, chapter 6 or 29 United States Code, Chapter 15, whichever is applicable.

G. The board shall develop and file with the superintendent, and, if not disapproved by the superintendent, make available to policyholders on a voluntary basis, retrospective rating plans. Such optional retrospective rating plans must be filed with the superintendent not later than January 1, 1994.

4. Division governing boards. Each division, except for the high-risk division, has its own governing board.

A. The governing board must be composed of representatives of policyholders and employees of the policyholders of the division.

B. There must be 9 governing board members for each division, 6 employers selected by the policyholders within the division and 3 employees selected from employees of the policyholders within the division. For the initial selection, members may be chosen from the workers' compensation residual market mechanism policyholders and their employees. The president, with the approval of the Maine Employers' Mutual Insurance Company board of directors, shall establish procedures for the initial and subsequent selection of governing board members, and procedures for the filing of vacancies and replacements. Terms are for 3 years on a staggered basis.

C. Each division governing board shall elect a chair, who shall serve as the representative of the division on the board of the company in accordance with the provisions of section 3703. If the chair is unwilling or unable to serve as the representative of the division on the board of the company, the division governing board shall elect a member to represent the division on the board of the company.

D. The division governing board has responsibility and authority in the following areas:

(1) Selection of workplace safety training staff or consultants;

(2) Selection of claims administration and adjusting staff or consultants;

(3) Monitoring and enforcement of policyholder compliance with governing board performance standards;

(4) Development of debit and credit plans reflecting member safety programs and experience;

(5) Handling policyholder grievances;

(6) Conducting premium audits;

(7) Holding division meetings; and

(8) Performing any other function delegated to the division governing board.

5. Functions not specifically granted. All functions not specifically granted to the division's governing boards are functions of the board of the company. The following functions must be conducted by the company board of directors, which shall contract or hire personnel to administer these functions for the benefit of the divisions:

(1) Investments;

(2) Accounting and auditing;

(3) Legal services;

(4) Actuarial services;

(5) Overall rate level decisions; and

(6) Authorization for assessments to employers and access to surplus funds.

6. High-risk division advisory committee. The high-risk division does not have a governing board but has a 7-member advisory committee. The board has responsibility and authority for operation of the high-risk division.

§3713. Servicing of the company and divisions

The president may enter into contracts, as directed by the board as provided for in this chapter. The divisions may enter into contracts within the scope of their authority for servicing as provided in this chapter and in accordance with the standards adopted by the board. The board shall, by rule or by the plan of operation, specify the requirements for and standards by which contracts are issued. Awarding of contracts must be based on price, qualification of the contractor or subcontractors and the quality and extent of services to be provided and is not limited to licensed insurance carriers. Servicing contracts for safety engineering, loss prevention, claim management, premium audit and other functions when there are multiple qualified contractors may be divided upon a geographical or other basis if, in the judgment of the governing committee of the division, those distributions are in the best interest of policyholders. The company may contract with licensed general lines insurance agents to submit applications and otherwise assist applicants and insureds.

§3714. Accounting; assessments

The following provisions apply to the financial operation of the company and the divisions.

1. Separate accounting. In addition to the financial reporting requirements applicable to the company, there must be a separate accounting of each division by fiscal year. These financial statements must be based on the premiums collected and earned, claims paid and incurred, expenses accrued or allocated, investment income allocated to and any other financial items that are associated with or allowable to each division.

2. Rates. Rates developed and filed by the company, and the supporting actuarial analysis, must consider, to the extent credible, the experience of each division based on sound actuarial principles.

3. Deficit. If there is a deficit for any fiscal year for any division, the board may authorize assessments on policyholders of that division to eliminate or amortize the deficit. If the company has not been certified as complying with the statutory surplus requirements as provided for in section 3710, the board shall eliminate or amortize any deficit by means of assessments.

4. Surplus. The surplus of the company is indivisible and is available for the benefit of all policyholders once certified by the superintendent.

5. Assessment. Any assessment levied against policyholders in a division is for the exclusive benefit of the policyholders subject to the assessment. Any policyholder not paying an undisputed assessment is not eligible for coverage from the company or in the voluntary market.

6. Deficits in the high-risk division. The following special provisions apply to deficits in the high-risk division.

A. Deficits up to 100% of the earned premium for the fiscal year of the deficit is levied on all policyholders that purchased coverage through the company in the high-risk division in the year of the deficit.

B. Any deficit beyond the amount collectible in paragraph A may be levied on all current policyholders from all divisions, including the high-risk division.

PART D

Sec. D-1. Report on workplace health and safety; transfer of workplace health and safety functions on July 1, 1994. On or before January 1, 1994 the Workers' Compensation Board shall report to the joint standing committee of the Legislature having jurisdiction over labor matters on the transfer of the workplace health and safety functions of the Department of Labor to the Workers' Compensation Board.

The report must include all legislation necessary to accomplish the transfer of functions on July 1, 1994. The report must include data on costs and funding sources and provisions for the redirection of funding sources to the Workers' Compensation Board. The report must identify the staff presently assigned to the workplace health and safety functions of the Department of Labor. The report must contain provisions that enable the Workers' Compensation Board to offer positions to members of the staff of the Department of Labor who are identified in the report as performing workplace health and safety functions to the extent consistent with the efficient performance of the workplace health and safety functions within the Workers' Compensation Board.

Sec. D-2. Maine Revised Statutes amended; revision clause. Wherever in the Maine Revised Stat-

utes the words "Workers' Compensation Commission" appear or reference is made to those words, they are amended to read and mean "Workers' Compensation Board," and the Revisor of Statutes shall implement this revision when updating, publishing or republishing the statutes.

PART E

Sec. E-1. 1 MRSA §1012, sub-§9, as enacted by PL 1989, c. 561, §4, is amended to read:

9. Self-employed. "Self-employed" means that the person qualifies as an independent contractor under ~~Title 39, section 2, subsection 13~~ Title 39-A, section 102, subsection 13.

Sec. E-2. 4 MRSA §9-B, as amended by PL 1979, c. 490, §1, is further amended to read:

§9-B. Committee on judicial responsibility and disability

The Supreme Judicial Court ~~shall have~~ has the power and authority to prescribe, repeal, add to, amend or modify rules relating to a committee to receive complaints, make investigations and make recommendations to the Supreme Judicial Court in regard to discipline, disability, retirement or removal of justices of the Supreme Judicial Court and the Superior Court and judges of the District Court, the probate courts and the Administrative Court. ~~The committee established pursuant to this section shall also have authority to hear claims of workers' compensation commissioners as to just cause for failing to meet the requirements of Title 39, section 99-B.~~

Sec. E-3. 4 MRSA §17, sub-§15, as amended by PL 1991, c. 622, Pt. L, §5, is further amended to read:

15. Provide for court security. Plan and implement arrangements for safe and secure court premises to ensure the orderly conduct of judicial proceedings. This includes the authority to contract for the services of qualified deputy sheriffs and other qualified individuals as needed on a per diem basis to perform court security-related functions and services. "Qualified deputy sheriffs and other qualified individuals" means those individuals who hold valid certification as law enforcement officers, as defined by the Maine Criminal Justice Academy, pursuant to Title 25, chapter 341, to include successful completion of such additional training in court security as provided by the academy or equivalent training. When under such contract and then only for the assignment specifically contracted for, the qualified deputy sheriffs or other qualified individuals have the same duties and powers throughout the counties of the State as sheriffs have in their respective counties. Qualified deputy sheriffs performing these contractual services continue to be employees of the counties in which they are deputized. Other qualified individuals performing such contractual services may not be considered employees of the State for any purpose, provided that the other qualified individuals are treated as employees of the State for purposes of the Maine Tort Claims Act and the Maine Workers' Compensation Act of 1992. They must be paid a reasonable per diem fee plus reimbursement of their actual, necessary and reasonable expenses incurred in the performance of their duties, consistent with policies established by the State Court Administrator. Notwithstanding any other provision of law, such plans, arrangements and files involving court security matters are confidential. Nothing in this section precludes dissemination of such information to another criminal justice agency.

In addition to the foregoing authority, the State Court Administrator may employ other qualified individuals to perform court security-related functions and services. These employees must have a valid certification as law enforcement officers, as defined by Title 25, chapter 341, including successful completion of additional training in court security as provided by the Maine Criminal Justice Academy or equivalent training and, when on assignment for court security functions, have the same powers and duties throughout the counties of the State as sheriffs have in their respective counties. These individuals are state employees for all purposes; and

Sec. E-4. 4 MRSA §807, sub-§3, ¶G, as repealed and replaced by PL 1989, c. 755, is amended to read:

> G. A person who is not an attorney, but is representing a party in any hearing, action or proceeding before the Workers' Compensation ~~Commission~~ Board as provided in Title ~~39~~ 39-A, section ~~110-A~~ 317; or

Sec. E-5. 4 MRSA §1353, sub-§6, as enacted by PL 1983, c. 853, Pt. C, §§15 and 18, is amended to read:

6. Reduction. The disability retirement allowance ~~shall~~ must be reduced if a disability beneficiary is receiving or has received payments for the same disability under the workers' compensation law, or similar law, except for amounts ~~which~~ that may be paid or payable under former Title 39, section 56 or 56-A or Title 39-A, section 212, subsection 2 or 3.

The total of the allowance, not including adjustments under section 1358 and the payment described in the preceding paragraph, ~~shall~~ may not exceed 80% of the beneficiary's average final compensation. The disability retirement allowance ~~shall~~ may in no event be reduced below the actuarial equivalent of the beneficiary's accumulated contributions at the time of retirement.

If the disability beneficiary has received a lump-sum settlement of workers' compensation benefits, any por-

tion of that settlement not attributable to vocational rehabilitation, attorneys' fees or medical expenses ~~shall~~ must reduce the disability retirement allowance in the same manner and amount as monthly workers' compensation benefits. The reduction ~~shall~~ must be prorated on a monthly basis in an equitable manner prescribed by the board.

If amounts paid or payable under workers' compensation or the amount of the lump-sum settlement or its attribution are in dispute, those disputes ~~shall~~ must be settled by a single member of the Workers' Compensation ~~Commission~~ Board as provided under Title ~~39~~ 39-A. Determinations of the commissioner may be appealed in the manner provided by Title ~~39~~ 39-A, section ~~103-B~~ 322.

Sec. E-6. 5 MRSA §19, sub-§1, ¶J, as enacted by PL 1989, c. 561, §14, is amended to read:

J. "Self-employed" means that the person qualifies as an independent contractor under Title ~~39~~ 39-A, section ~~2~~ 102, subsection 13.

Sec. E-7. 5 MRSA §4572, as amended by PL 1991, c. 99, §7, is further amended to read:

§4572. Unlawful employment discrimination

1. Unlawful employment. It is unlawful employment discrimination, in violation of this Act, except when based on a bona fide occupational qualification:

A. For any employer to fail or refuse to hire or otherwise discriminate against any applicant for employment because of race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of the applicant's previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions taken by the applicant that are protected under Title 26, chapter 7, subchapter V-B; or, because of those reasons, to discharge an employee or discriminate with respect to hire, tenure, promotion, transfer, compensation, terms, conditions or privileges of employment or any other matter directly or indirectly related to employment; or, in recruiting of individuals for employment or in hiring them, to utilize any employment agency that the employer knows or has reasonable cause to know discriminates against individuals because of their race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of their previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions that are protected under Title 26, chapter 7, subchapter V-B;

(1) This paragraph does not apply to discrimination governed by Title ~~39~~ 39-A, section ~~111~~ 353;

B. For any employment agency to fail or refuse to classify properly, refer for employment or otherwise discriminate against any individual because of race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of the individual's previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions taken by the individual that are protected under Title 26, chapter 7, subchapter V-B; or to comply with an employer's request for the referral of job applicants if a request indicates either directly or indirectly that the employer will not afford full and equal employment opportunities to individuals regardless of their race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions that are protected under Title 26, chapter 7, subchapter V-B;

C. For any labor organization to exclude from apprenticeship or membership or to deny full and equal membership rights to any applicant for membership because of race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of the applicant's previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions taken by the applicant that are protected under Title 26, chapter 7, subchapter V-B; or, because of those reasons, to deny a member full and equal membership rights, expel from membership, penalize or otherwise discriminate with respect to hire, tenure, promotion, transfer, compensation, terms, conditions or privileges of employment, representation, grievances or any other matter directly or indirectly related to membership or employment, whether or not authorized or required by the constitution or bylaws of that labor organization or by a collective labor agreement or other contract; to fail or refuse to classify properly or refer for employment or otherwise discriminate against any member because of race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of the member's previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions taken by the member that are protected under Title 26, chapter 7, subchapter V-B; or to cause or attempt to cause an employer to discriminate against an individual in violation of this section, except that it is lawful for labor organizations and employers to adopt a maximum age limitation in apprenticeship programs, if the employer or labor organization obtains prior approval from the Maine Human Rights Commission of any maximum age limitation employed in an apprenticeship program. The commission shall approve the age limitation if a reasonable relationship exists between the maximum age limitation employed and a legitimate expecta-

tion of the employer in receiving a reasonable return upon the employer's investment in an apprenticeship program. The employer or labor organization bears the burden of demonstrating that such a relationship exists;

D. For any employer, employment agency or labor organization, prior to employment or admission to membership of any individual, to:

(1) Elicit or attempt to elicit information directly or indirectly pertaining to race or color, sex, physical or mental disability, religion, age, ancestry or national origin, any previous assertion of a claim or right under former Title 39 or Title 39-A or any previous actions that are protected under Title 26, chapter 7, subchapter V-B, except when a physical or mental disability is determined by the employer, employment agency or labor organization to be job related or when some privileged information is necessary for an employment agency or labor organization to make a suitable job referral;

(2) Make or keep a record of race or color, sex, physical or mental disability, religion, age, ancestry or national origin, any previous assertion of a claim or right under former Title 39 or Title 39-A or any previous actions that are protected under Title 26, chapter 7, subchapter V-B, except under physical or mental disability when an employer requires a physical or mental examination prior to employment, a privileged record of that examination is permissible;

(3) Use any form of application for employment, or personnel or membership blank containing questions or entries directly or indirectly pertaining to race or color, sex, physical or mental disability, religion, age, ancestry or national origin, any previous assertion of a claim or right under former Title 39 or Title 39-A or any previous actions that are protected under Title 26, chapter 7, subchapter V-B, except under physical or mental disability when it can be determined by the employer that the job or jobs to be filled require that information for the well-being and safety of the individual. This section does not prohibit any officially recognized agency from keeping necessary records in order to provide free services to individuals requiring rehabilitation or employment assistance;

(4) Print, publish or cause to be printed or published any notice or advertisement relating to employment or membership indicating any preference, limitation, specification or discrimination based upon race or color, sex, physical or mental disability, religion, age, ancestry or national origin, any previous assertion of a claim or right under former Title 39 or Title 39-A or any previous actions that are protected under Title 26, chapter 7, subchapter V-B, except under physical or mental disability when the text of printed or published material strictly adheres to this Act; or

(5) Establish, announce or follow a policy of denying or limiting, through a quota system or otherwise, employment or membership opportunities of any group because of the race or color, sex, physical or mental disability, religion, age, ancestry or national origin, the previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions that are protected under Title 26, chapter 7, subchapter V-B, of that group; or

E. For an employer, employment agency or labor organization to discriminate in any manner against individuals because they have opposed a practice that would be a violation of this Act or because they have made a charge, testified or assisted in any investigation, proceeding or hearing under this Act.

Sec. E-8. 5 MRSA §17906, sub-§2, ¶A, as amended by PL 1987, c. 560, §1, is further amended to read:

A. The amount of any disability retirement benefit payable under this article ~~shall~~ must be reduced by any amount received by the beneficiary for the same disability under either or both of the following:

(1) The worker's compensation or similar law, except amounts ~~which~~ that may be paid or payable under former Title 39, section 56-B or Title 39-A, section 212, subsection 3; or

(2) The United States Social Security Act, if the employment for which creditable service with the employer is allowed was also covered under that ~~act~~ Act at the date of disability retirement.

Sec. E-9. 5 MRSA §17906, sub-§2, ¶D, as amended by PL 1987, c. 560, §1, is further amended to read:

D. Lump-sum settlements of benefits that would reduce the disability retirement benefit under this subsection ~~shall~~ must be prorated on a monthly

basis in an equitable manner prescribed by the board.

(1) These prorated lump-sum settlements may not include any part of the lump-sum settlement attributable to vocational rehabilitation, attorneys' fees, physicians, nurses, hospital, medical, surgical or related fees or charges or any amount paid or payable under former Title 39, section 56-B or Title 39-A, section 212, subsection 3.

(2) These prorated lump-sum settlements ~~shall~~ must reduce the disability retirement benefit in the same manner and amount as monthly benefits under this subsection.

Sec. E-10. 5 MRSA §17906, sub-§2, ¶E, as amended by PL 1989, c. 78, §3, is further amended to read:

E. Any dispute about amounts paid or payable under ~~worker's~~ workers' compensation, or about the amount of the lump-sum settlement and its attributions ~~shall~~ must be determined on petition, by a single member of the Workers' Compensation ~~Commission~~ Board, in accordance with Title ~~39~~ 39-A. These determinations may be appealed under Title ~~39~~ 39-A, section ~~103-B~~ 322.

Sec. E-11. 5 MRSA §17930, sub-§4, ¶¶A, D and E, as enacted by PL 1989, c. 409, §§8 and 12, are amended to read:

A. The amount of any disability retirement benefit payable under this article ~~shall~~ must be reduced by any amount received by the person for the same disability under either or both of the following:

(1) The workers' compensation or similar laws, except amounts ~~which~~ that may be paid or payable under former Title 39, section 56-B or Title 39-A, section 212, subsection 3; or

(2) The United States Social Security Act, if the employment for which creditable service with the employer is allowed was also covered under that Act at the date of disability retirement.

D. Lump-sum settlements of benefits that reduce the disability retirement benefit under this subsection ~~shall~~ must be prorated on a monthly basis in an equitable manner prescribed by the board.

(1) These prorated lump-sum settlements may not include any part of the lump-sum settlement attributable to rehabilitation, attorneys', physicians', nurses', hospital, medical, surgical or related fees or charges or any amount paid or payable under former Title 39, section 56-B or Title 39-A, section 212, subsection 3.

(2) These prorated lump-sum settlements ~~shall~~ must reduce the disability retirement benefit in the same manner and amount as monthly benefits under this subsection.

E. Any dispute about amounts paid or payable under workers' compensation or the amount of the lump-sum settlement and its attributions ~~shall~~ must be determined on petition by a single member of the Workers' Compensation ~~Commission~~ Board in accordance with Title ~~39~~ 39-A. These determinations may be appealed under Title ~~39~~ 39-A, section ~~103-B~~ 322.

Sec. E-12. 5 MRSA §18005, sub-§2, as enacted by PL 1985, c. 801, §§5 and 7, is amended to read:

2. Workers' compensation or similar law. The amount payable under this article ~~shall~~ must be reduced by any amount received by the surviving spouse and dependent child or dependent children under former Title 39, the Workers' Compensation Act or Title 39-A, Part 1, the Maine Workers' Compensation Act of 1992, or a similar law.

A. Lump-sum settlements of benefits that would reduce the accidental death benefits under this subsection ~~shall~~ must be prorated on a monthly basis in an equitable manner prescribed by the board.

B. The prorated lump-sum settlement amounts ~~shall~~ must reduce the accidental death benefits payable monthly under this article.

Sec. E-13. 5 MRSA §18506, sub-§2, ¶¶A and D, as enacted by PL 1985, c. 801, §§5 and 7, are amended to read:

A. The amount of any disability retirement benefit payable under this article ~~shall~~ must be reduced by any amount received by the beneficiary for the same disability under either or both of the following:

(1) The workers' compensation or similar law, except amounts ~~which~~ that may be paid or payable under former Title 39, section 56 or 56-A or Title 39-A, section 212, subsection 3; or

(2) The United States Social Security Act, if the employment for which creditable service with the employer is allowed was also covered under that Act at the date of disability retirement.

D. Lump-sum settlements of benefits that would reduce the disability retirement benefit under this subsection ~~shall~~ must be prorated on a monthly basis in an equitable manner prescribed by the board.

(1) These prorated lump-sum settlements may not include any part of the lump-sum settlement attributable to vocational rehabilitation, attorneys' fees, physicians, nurses, hospital, medical, surgical or related fees or charges or any amount paid or payable under former Title 39, section 56 or 56-A or Title 39-A, section 212, subsection 3.

(2) These prorated lump-sum settlements ~~shall~~ must reduce the disability retirement benefit in the same manner and amount as monthly benefits under this subsection.

Sec. E-14. 5 MRSA §18506, sub-§2, ¶E, as amended by PL 1989, c. 78, §8, is further amended to read:

E. Any dispute about amounts paid or payable under workers' compensation or about the amount of the lump-sum settlement and its attributions ~~shall~~ must be determined, on petition, by a single member of the Workers' Compensation ~~Commission~~ Board, in accordance with Title ~~39~~ 39-A. These determinations may be appealed under Title ~~39~~ 39-A, section ~~103-B~~ 322.

Sec. E-15. 5 MRSA §18530, sub-§4, ¶¶A, D and E, as enacted by PL 1989, c. 409, §§11 and 12, are amended to read:

A. The amount of any disability retirement benefit payable under this article ~~shall~~ must be reduced by any amount received by the person for the same disability under either or both of the following:

(1) The workers' compensation or similar laws, except amounts ~~which~~ that may be paid or payable under former Title 39, section 56-B or Title 39-A, section 212, subsection 3; or

(2) The United States Social Security Act, if the employment for which creditable service with the employer is allowed was also covered under that Act at the date of disability retirement.

D. Lump-sum settlements of benefits that reduce the disability retirement benefit under this subsection ~~shall~~ must be prorated on a monthly basis in an equitable manner prescribed by the board.

(1) These prorated lump-sum settlements may not include any part of the lump-sum settlement attributable to rehabilitation, attorneys', physicians', nurses', hospital, medical, surgical or related fees or charges or any amount paid or payable under former Title 39, section 56-B or Title 39-A, section 212, subsection 3.

(2) These prorated lump-sum settlements ~~shall~~ must reduce the disability retirement benefit in the same manner and amount as monthly benefits under this subsection.

E. Any dispute about amounts paid or payable under workers' compensation or the amount of the lump-sum settlement and its attributions ~~shall~~ must be determined on petition by a single member of the Workers' Compensation ~~Commission~~ Board in accordance with Title ~~39~~ 39-A. These determinations may be appealed under Title ~~39~~ 39-A, section ~~103-B~~ 322.

Sec. E-16. 5 MRSA §18605, sub-§2, as enacted by PL 1985, c. 801, §§5 and 7, is amended to read:

2. Workers' compensation or similar law. The amount payable under this article ~~shall~~ must be reduced by any amount received by the surviving spouse and dependent child or dependent children under former Title 39, the Workers' Compensation Act or Title 39-A, Part 1, the Maine Workers' Compensation Act of 1992, or a similar law.

A. Lump-sum settlements of benefits that would reduce the accidental death benefits under this subsection ~~shall~~ must be prorated on a monthly basis in an equitable manner prescribed by the board.

B. The prorated lump-sum settlement amounts ~~shall~~ must reduce the accidental death benefits payable monthly under this article.

Sec. E-17. 15 MRSA §3314, sub-§1, ¶B, as amended by PL 1979, c. 233, §3, is further amended to read:

B. The court may require a juvenile to participate in a supervised work or service program. Such a program may provide restitution to the victim by requiring the juvenile to work or provide a service for the victim, or to make monetary restitution to the victim from money earned from such a program. Such a supervised work or service program may be required as a condition of probation if:

(1) The juvenile is not deprived of the schooling ~~which~~ that is appropriate to his age, needs and specific rehabilitative goals;

(2) The supervised work program is of a constructive nature designed to promote re-

habilitation and is appropriate to the age level and physical ability of the juvenile; and

(3) The supervised work program assignment is made for a period of time not exceeding 180 days.

A juvenile referred to a supervised work or service program under this paragraph or section 3301, subsection 5, paragraphs A and B, ~~shall~~ may not be subject to ~~Title 39, the Workers' Compensation Act~~ Title 39-A, Part 1, the Maine Workers' Compensation Act of 1992.

Sec. E-18. 17 MRSA §3964, as amended by PL 1977, c. 696, §366, is further amended to read:

§3964. Settlements or releases from injured persons

Except as provided in this section, no settlement or general release or statement either oral, in writing, or electronically recorded made by any person confined in a hospital or sanitarium as a patient with reference to any personal injuries for which ~~said~~ that person is confined in ~~said~~ that hospital or sanitarium ~~shall be~~ is admissible in evidence, used or referred to in any manner at the trial of any action to recover damages for personal injuries or consequential damages, so called, resulting therefrom, which statement, settlement or general release was obtained within 30 days after the injuries were sustained and such settlement or release ~~shall be~~ is null and void. This section ~~shall~~ does not apply to statements or releases obtained by police officers or inspectors of motor vehicles in the performance of their duty, members of the family of ~~such~~ that person or by or on behalf of ~~his~~ that person's attorney. This section ~~shall~~ does not apply to agreements entered into pursuant to former Title 39 and approved by the former Workers' Compensation Commission or Title 39-A and approved by the Workers' Compensation Board.

Sec. E-19. 19 MRSA §212, as amended by PL 1987, c. 769, Pt. A, §57, is further amended to read:

§212. Actions for loss of services

The parents of a minor child jointly may maintain an action for loss of the services or earnings of that child when that loss is caused by the negligent or wrongful act of another, but where one parent refuses to sue, the other may sue alone. Nothing contained in this section may be deemed to limit, amend, supersede or affect Title 39, the Workers' Compensation Act or Title 39-A, Part 1, the Maine Workers' Compensation Act of 1992.

Sec. E-20. 20-A MRSA §1001, sub-§5-B, as enacted by PL 1989, c. 425, §2, is amended to read:

5-B. Workers' compensation self-insurance. Notwithstanding any other provision of this section, they may participate in or cause their school administrative unit to participate in a self-insurance program or plan for workers' compensation established under and operated in accordance with the ~~Workers' Compensation Act, Title 39, chapter 1, as amended~~ Maine Workers' Compensation Act of 1992, Title 39-A, chapter 9.

Sec. E-21. 24 MRSA §2330, sub-§10, as enacted by PL 1983, c. 91, §1, is amended to read:

10. Additional conversion period for injured workers. Any employee whose group health coverage ceases because of termination of employment resulting from an injury for which compensation is claimed under former Title 39 or Title 39-A, and who has not begun to receive that compensation within the 31-day period prescribed in subsection 1, ~~shall have~~ has an additional 30-day period in which to exercise the conversion privilege provided in this section. In cases where the injury results in the employee's death, the additional conversion period ~~shall~~ must also be available to the employee's surviving spouse and children, as provided in subsection 2, paragraph A.

Sec. E-22. 24 MRSA §2330, sub-§11, as amended by PL 1989, c. 447, §1, is further amended to read:

11. Continued group coverage; certain circumstances. Notwithstanding this section, if the termination of an individual's group insurance coverage is a result of the member or employee being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under former Title 39 or Title 39-A, the insurer shall allow the member or employee to elect, within the time period prescribed by paragraph B, to continue coverage under the group policy at no higher level than the level of benefits or coverage received by the employee immediately before termination and at the member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section.

A. For the purposes of this subsection, the term "member or employee" includes only those persons who have been a member or employee for at least 6 months.

B-1. The member or employee ~~shall have~~ has 31 days from the termination of coverage in which to elect and make the initial payment under this subsection.

C. An insurer is not required to continue coverage under a group policy if the member or employee meets the conditions set out in subsection 3, paragraph A.

D. The payment amount for continued group coverage under this subsection may not exceed 102%

of the group rate in effect for a group member, including an employer's contribution, if any.

E. At the option of the member or employee, the continued group coverage may cover the member or employee, the member or employee and any dependents or only the dependents of the member or employee; provided that, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependents were not eligible for coverage until after the beginning of the 3-month period.

F. Except as provided in paragraph G, coverage provided under this section ~~shall continue~~ continues and may not be terminated until one year from the last day of work.

G. Coverage provided under this section may be terminated sooner than provided under paragraph F if:

(1) The member or employee fails to make timely payment of a required premium amount;

(2) The member or employee becomes eligible for coverage under another group policy; or

(3) The Workers' Compensation ~~Commission~~ Board determines that the injury or disease ~~which~~ that entitled the employee to continue coverage under this section is not compensable under Title ~~39~~ 39-A.

Sec. E-23. 24-A MRSA §212, as amended by PL 1989, c. 269, §4, is further amended to read:

§212. Rules and regulations

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may make, promulgate, amend and rescind reasonable rules and regulations to aid the administration or effectuation of any provisions of this Title or of the following statutes to the extent administered or enforced by the superintendent: Title 5, chapter 501; Title 32, section 13773; and Title ~~39~~ 39-A, sections ~~23, 23A and 107~~ 357, 403 and 404.

Sec. E-24. 24-A MRSA §604, sub-§2, ¶F, as enacted by PL 1985, c. 446, §3, is amended to read:

F. Amounts assessed by the superintendent under Title ~~39~~ 39-A, section ~~29~~ 409; and

Sec. E-25. 24-A MRSA §1901, sub-§1, as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, is amended by amending the first paragraph to read:

1. "Administrator" means any person who, on behalf of a plan sponsor, health care service plan, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State in connection with any type of life, annuity, health or workers' compensation benefit provided in or as an alternative to insurance as defined by sections 702 to 704, ~~or~~ former Title 39 or Title 39-A, other than any of the following:

Sec. E-26. 24-A MRSA §1901, sub-§7, as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, is amended to read:

7. "Plan" means any plan, fund or program established or maintained by a plan sponsor, health care service plan, health maintenance organization or insurer to the extent that the plan, fund or program was established or is maintained to provide through insurance or alternatives to insurance any type of life, annuity, health or workers' compensation benefit within the scope of sections 702 to 704 ~~or~~, former Title 39 or Title 39-A.

Sec. E-27. 24-A MRSA §2176, as amended by PL 1989, c. 206, §2, is further amended to read:

§2176. Funeral and burial service contracts prohibited

No insurer may contract or agree with any funeral director, funeral establishment, mortuary establishment, cemetery, cemetery corporation or association, crematorium, mausoleum or columbarium or any representative of any of these directors or establishments to the effect that the director or establishment shall conduct the funeral, burial, or cremation or other disposal of the remains of any individual insured by the insurer. Nothing in this section prevents compliance with Title ~~39~~ 39-A, section ~~59~~ 216, or the use of an insurance policy to provide security for the payment for a funeral, burial or cremation.

Sec. E-28. 24-A MRSA §2323, sub-§5, ¶B, as enacted by PL 1979, c. 658, §2, is amended to read:

B. Group self-insurer as defined in Title ~~39~~ 39-A, section ~~23~~ 403.

Sec. E-29. 24-A MRSA §2809-A, sub-§10, as enacted by PL 1983, c. 91, §2, is amended to read:

10. Additional conversion period for injured workers. Any employee whose group insurance coverage ceases because of termination of employment resulting from an injury for which compensation is claimed under former Title 39 or Title 39-A, and who has not begun to receive that compensation within the 31-day period prescribed in subsection 1, ~~shall have~~ has an additional 30-day period in which to exercise the conversion privilege provided in this section. In cases where the injury results in the employee's death, the additional conversion period

~~shall~~ is also ~~be~~ available to the employee's surviving spouse and children, as provided in subsection 2, paragraph A.

Sec. E-30. 24-A MRSA §2809-A, sub-§11, as amended by PL 1989, c. 447, §2, is further amended to read:

11. Continued group coverage; certain circumstances. Notwithstanding this section, if the termination of an individual's group insurance coverage is a result of the member or employee being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under former Title 39 or Title 39-A, the insurer shall allow the member or employee to elect, within the time period prescribed by paragraph B, to continue coverage under the group policy at no higher level than the level of benefits or coverage received by the employee immediately before termination and at the member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section.

A. For the purposes of this subsection, the term "member or employee" includes only those persons who have been a member or employee for at least 6 months.

B-1. The member or employee ~~shall have~~ has 31 days from the termination of coverage in which to elect and make the initial payment under this subsection.

C. An insurer is not required to continue coverage under a group policy if the member or employee meets the conditions set out in subsection 3, paragraph A.

D. The payment amount for continued group coverage under this subsection may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any.

E. At the option of the member or employee, the continued group coverage may cover the member or employee, the member or employee and any dependents or only the dependents of the member or employee; provided that, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependents were not eligible for coverage until after the beginning of the 3-month period.

F. Except as provided in paragraph G, coverage provided under this section ~~shall continue~~ continues and may not be terminated until one year from the last day of work.

G. Coverage provided under this section may be terminated sooner than provided under paragraph F if:

(1) The member or employee fails to make timely payment of a required premium amount;

(2) The member or employee becomes eligible for coverage under another group policy; or

(3) The Workers' Compensation ~~Commission~~ Board determines that the injury or disease ~~which entitle~~ that entitles the employee to continue coverage under this section is not compensable under Title ~~39~~ 39-A.

H. At the expiration of any continued group coverage obtained under this subsection, the member or employee has the same conversion privileges as otherwise granted under this section.

I. This subsection ~~shall~~ may not be construed to:

(1) Prevent members or employees from negotiating for or receiving greater continued coverage of group insurance than is provided in this subsection;

(2) Require coverage beyond the time limit set in paragraph F; or

(3) Permit an employee to increase the level of benefits or coverage that the employee received immediately before the termination of the employee's coverage.

J. This subsection does not apply to any group policy subject to the United States Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003.

Sec. E-31. 24-A MRSA §2908, sub-§5, ¶A, as amended by PL 1989, c. 172, §2, is further amended to read:

A. Except for workers' compensation insurance, cancellation ~~shall~~ may not be effective prior to 10 days after receipt by the insured of a notice of cancellation. Notice of cancellation of workers' compensation insurance ~~shall be~~ is subject to Title ~~39~~ 39-A, section ~~23~~ 403, subsection 1. The notice ~~shall~~ must state the effective date of and the reason or reasons for cancellation.

Sec. E-32. 24-A MRSA §4433, sub-§2, ¶G, as enacted by PL 1989, c. 67, §1, is amended to read:

G. Contracts of workers' compensation excess insurance issued to workers' compensation self-insurers approved under former Title 39, section 23 or under Title 39-A, section 403 by any insurer after the effective date of this paragraph, or in the case of a contract ~~which~~ that automatically renews, not later than one year after the effective date of this paragraph.

Sec. E-33. 24-A MRSA §4435, sub-§7, as amended by PL 1989, c. 67, §3, is further amended to read:

7. Net direct written premiums. "Net direct written premiums" means direct gross premiums written on insurance policies to which this subchapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers or premiums written through the United States Government Flood Insurance Program. For purposes of assessment against insurers pursuant to section 4440-B, "net direct written premium" means the average for the 5 calendar years prior to the year of assessment of premiums written on contracts of excess workers' compensation insurance issued to workers' compensation self-insurers approved under former Title 39, section 23 or Title 39-A, section 403.

Sec. E-34. 26 MRSA §61, sub-§2, as amended by PL 1987, c. 660, §2, is further amended to read:

2. Source of funds. The commissioner shall annually assess a levy based on actual annual workers' compensation paid losses, excluding medical payments, paid in the previous calendar year by employers under former Title 39, the Workers' Compensation Act or Title 39-A, Part 1, the Maine Workers' Compensation Act of 1992. As soon as practicable after July 1st of each year, the commissioner shall assess upon and collect from each insurance carrier licensed to do workers' compensation business in the State, and each group and individual self-insured employer authorized to make workers' compensation payments directly to their employees, a sum equal to that proportion of the current fiscal year's appropriation, exclusive of any federal funds, for the safety education and training division ~~which~~ that the total workers' compensation benefits, exclusive of medical payments, paid by each carrier or each group or individual self-insured employer, bear to the total of the benefits paid by all carriers, and group and individual self-insured employers, during the previous calendar year, except that the total amount levied annually may not exceed 1% of the total of the compensation benefits paid by all carriers, and group and individual self-insured employers during the previous calendar year. Assessments under this section ~~shall~~ must include sufficient funds to provide for training and information activities relating to pesticides as required by section 1720, subsection 5.

Sec. E-35. 26 MRSA §62, sub-§3, ¶C, as enacted by PL 1985, c. 372, Pt. A, §7, is amended to read:

C. Payments pursuant to subparagraph (1).

(1) The commissioner shall assess a levy based on the total actual workers' compensation premiums paid in 1984 by employers under former Title 39, the Workers' Compensation Act or under Title 39-A, Part 1, the Maine Workers' Compensation Act of 1992. As soon as practicable after July 1, 1985, the commissioner shall assess upon and collect from each insurance carrier licensed to do workers' compensation business in the State an amount equal to 1/2 of 1% of the total workers' compensation insurance premiums paid to that insurance carrier during 1984 by employers in the State. The levy assessment ~~shall constitute~~ constitutes an element of loss for the purpose of establishing rates for workers' compensation insurance.

(a) The Commissioner of Labor shall send notice of the assessments by certified mail to each carrier and self-insured employer. Payment of assessments must be received in the principal office of the Department of Labor before a date specified in the notice, but not more than 90 days after the date of the mailing.

Sec. E-36. 26 MRSA §1047, as amended by PL 1987, c. 77, §1, is further amended to read:

§1047. Information privileged

All information transmitted to the bureau, the commission or its duly authorized representatives pursuant to this chapter ~~shall be~~ is absolutely privileged and ~~shall~~ may not be made the subject matter or basis in any action of slander or libel in any court in this State. The privileged nature of any such information ~~shall~~ may not limit or affect the use of that information in any prosecution or action to enforce Title ~~39~~ 39-A, section ~~104-A~~ 324.

Sec. E-37. 26 MRSA §1082, sub-§13-A, as enacted by PL 1987, c. 77, §2, is amended to read:

13-A. Certificate of records of payroll reports as evidence. Notwithstanding any other provision of law or rule of evidence, for purposes of any prosecution or action to enforce Title ~~39~~ 39-A, section ~~104-A~~ 324, a certificate signed by the Director of Unemployment Compensation or a representative of the commissioner duly authorized by the commissioner stating what the payroll

report records show ~~shall~~ must be received in any court in this State as prima facie evidence of any fact stated in the certificate or the records attached to the certificate.

Sec. E-38. 26 MRSA §1191, sub-§6, as amended by PL 1989, c. 363, §1, is further amended to read:

6. Supplemental benefit for dependents. An individual in total or partial unemployment and otherwise eligible for benefits ~~shall~~ must be paid for each week of that unemployment, in addition to the amounts payable under subsections 2 and 3, the sum of $10 for each unemancipated child of the individual who in any part of the benefit year and during any part of the individual's period of eligibility is, in fact, dependent upon and is being wholly or mainly supported by the individual, and who is under the age of 18, or who is 18 years of age or over and incapable of earning wages because of mental or physical incapacity, or who is a full-time student as defined in Title ~~39~~ 39-A, section ~~2~~ 102, subsection ~~4~~ 9, paragraph C, or who is in that individual's custody pending the adjudication of a petition filed by the individual for the adoption of the child in a court of competent jurisdiction and for each such child for whom that individual is under a decree or order from a court of competent jurisdiction to contribute to that child's support and for whom no other person is receiving allowances hereunder. In no instance may the dependency benefits as provided in this subsection be more than 50% of the individual's weekly benefit amount.

The commission shall prescribe regulations as to who may receive a dependency allowance when both spouses are eligible to receive unemployment compensation benefits.

No individual may be eligible to receive dependency allowances as provided in this subsection for any week during which that individual's spouse is employed full time provided that the spouse is contributing some support to their dependent or dependents. For purposes of this subsection, "employed full time" means the receipt of any wages, earnings, salary or other income equivalent to that amount ~~which~~ that would be received for a 40-hour work week.

Sec. E-39. 26 MRSA §1192, sub-§5, as amended by PL 1985, c. 348, §5, is further amended to read:

5. Has earned wages. For each eligible individual establishing a benefit year on or after January 1, 1980, ~~he~~ the individual has been paid wages equal to or exceeding 2 times the annual average weekly wage for insured work in each of 2 different quarters in ~~his~~ the individual's base period and has been paid total wages equal to or exceeding 6 times the annual average weekly wage in ~~his~~ the individual's base period for insured work. The annual average weekly wage amount to be used for purposes of this subsection ~~shall be~~ is that which is applicable at the time the individual files a request for determination of ~~his~~ insured status. For the purpose of this subsection, wages ~~shall be~~ are counted as "wages for insured work" for benefit purposes with respect to any benefit year only if such benefit year begins subsequent to the date on which the employer by whom such wages were paid has satisfied the conditions of section 1043, subsection 9, or section 1222, subsection 3, with respect to becoming an employer; provided that no individual may receive benefits in a benefit year, unless, subsequent to the beginning of the next preceding benefit year during which ~~he~~ that individual received benefits, ~~he~~ that individual performed services and earned remuneration for such service in an amount equal to not less than 8 times ~~his~~ that individual's weekly benefit amount in employment by an employer in the benefit year being established. This subsection applies only to any individual requesting determination of insured status on and after January 1, 1972. In determining a claimant's qualification under this subsection, payments pursuant to former Title 39, sections 54 and 55, the Workers' Compensation Act, and former Title 39, sections 188 and 189, Title 39-A, sections 608 and 609, the Occupational Disease Law, ~~shall be~~ are considered wages for insured work.

Sec. E-40. 30-A MRSA §2253, sub-§1, ¶A, as amended by PL 1989, c. 104, Pt. C, §§8 and 10, is further amended to read:

A. Casualty insurance, including general and professional liabilities coverage, but excluding workers' compensation insurance provided under Title ~~39~~ 39-A;

Sec. E-41. 32 MRSA §3113-A, last ¶, as enacted by PL 1991, c. 178, §3, is amended to read:

An employer is not liable under Title ~~39~~ 39-A, section ~~52~~ 206 for charges for services of a physical therapist or physical therapist assistant unless the employee has been referred to that practitioner by a licensed doctor of medicine, surgery, osteopathy, chiropractic, podiatry or dentistry.

Sec. E-42. 32 MRSA §14055, sub-§1, ¶B, as enacted by PL 1991, c. 468, §4, is amended to read:

B. The superintendent shall adopt rules governing the provision of workers' compensation insurance as required by Title ~~39~~ 39-A, chapter ~~1~~ 9 for workers provided by an employee leasing company to any client company. These rules must be consistent with subsection 2 and reflect consideration of the needs and operational efficiencies of employee leasing companies and the costs to the workers' compensation system. If either the employee leasing company or the client company has secured the payment of compensation in conformity with former Title 39, chapter 1 or Title 39-A, chapter 9,

the immunity from liability described in that chapter extends to and is binding on the client company, the employee leasing company, all employees leased to any client company and any other employees of the employee leasing company or the client company. An employee leasing company is not responsible for securing the payment of compensation in conformity with Title ~~39~~ 39-A nor deprived of the defenses listed in Title ~~39~~ 39-A, section ~~3~~ 103 with respect to those persons for whom the provision of benefits is not required under Title ~~39~~ 39-A in the absence of an employee leasing arrangement.

Sec. E-43. 32 MRSA §14055, sub-§2, ¶A, as enacted by PL 1991, c. 468, §4, is amended to read:

A. Under rules adopted pursuant to subsection 1, paragraph B, the superintendent may provide a determination of the circumstances and conditions, if any, under which an employee leasing company may be the policyholder of a workers' compensation insurance policy providing coverage to employees leased to client companies. Additionally or alternatively, the superintendent may require by rule that:

(1) The employee leasing company purchase separate policies through the ~~residual market mechanism~~ Maine Employers' Mutual Insurance Company, established pursuant to Title 24-A, section ~~2366~~ 3703, for client companies subject to Title ~~39~~ 39-A; and

(2) The policies be assigned to one servicing carrier and, to the extent practical, administered on a unified basis. The superintendent also may provide by rule that the employee leasing company or the ~~residual market manager~~ President of the Maine Employers' Mutual Insurance Company request from the superintendent a waiver of a rule adopted pursuant to this subparagraph if it is impractical for one servicing carrier to service all the client companies of an employee leasing company.

Sec. E-44. 37-B MRSA §186, sub-§1, as amended by PL 1987, c. 769, Pt. A, §§162 and 163, is further amended to read:

1. Compensation as state employee. A member of the state military forces ~~shall receive~~ receives compensation as a state employee according to the provisions of former Title 39, Title 39-A and this section.

A. Duty status is as follows.

(1) The types of duty ~~which~~ that are covered are:

(a) Active state duty by order of the Governor under this subchapter;

(b) Inactive duty training, with or without pay, under the United States Code, Title 32, Section 502;

(c) Annual training under the United States Code, Title 32, Sections 502 and 503;

(d) Full-time training duty for 30 days or less under the United States Code, Title 32, Section 502; and

(e) Other training duties or schools under the United States Code, Title 32, with status of less than 30 days' duration;

(2) The types of duty ~~which~~ that are not covered are:

(a) Annual training or any other types of duty under the United States Code, Title 10, including Section 672, Subsections (b) and (d);

(b) Initial active duty for training, such as initial active duty service schools;

(c) Full-time training duty for over 30 days under the United States Code, Title 32, Section 502, Subsection (f); and

(d) Federal technician civilian duty under the United States Code, Title 32, Section 709;

B. Types of injuries cognizable are as follows:

(1) The injury, disability or disease must have been received, incurred or contracted as a result of qualified duty;

(2) Service members must be under the control and supervision of the military. Incidents occurring during periods of leave or pass are not compensable; and

(3) An injury, disability or disease received not incident to duty or contracted with willful negligence or misconduct is not compensable;

C. Preconditions for benefits under former Title 39 or Title 39-A are as follows:

(1) Federal income maintenance benefits must be applied for and, if they exceed comparable former Title 39 or Title 39-A benefits, must be exhausted by the member before receiving weekly compensation benefits under former Title 39 or Title 39-A. Medical care at military or Veterans' Administration facilities, civilian care paid for by the military forces and other benefits furnished by the military force or the Veterans' Administration, including military schools offered to retrain or occupationally rehabilitate the service member, must be used by the service member before entitlement to medical care benefits under former Title 39 or Title 39-A. Military schools are fully creditable under former Title 39 or Title 39-A in an approved plan of rehabilitation; and

(2) Former Title 39 or Title 39-A benefits are based on inability to perform the usual civilian occupation;

D. For the purpose of calculation of compensation, average weekly wage ~~shall~~ must be computed solely on the earning capacity of the injured member in the civilian occupation in which ~~he~~ that member is regularly engaged. In case of death, dependents ~~shall be~~ are entitled to compensation as provided in former Title 39 or Title 39-A and any amendments to that Title;

E. If the member remains in a federal pay status or continues to receive pay in accordance with section 143, the member's medical care ~~shall~~ must be through the military or Veterans' Administration unless the member is referred to civilian care. If, the member is eligible for military or Veterans' Administration care and knowingly declines or through ~~his~~ the member's actions forfeits ~~his~~ rights to the benefits of section 143 or to federal care benefits, this declination or conduct serves to waive ~~his~~ the member's rights to seek compensation for civilian care under former Title 39 or Title 39-A;

F. For the purpose of former Title 39, section 62, all federal benefits received by the member as a result of an injury, disability or disease ~~shall be~~ are considered to be derived from the employer and ~~shall~~ constitute a setoff to compensation awarded as a result of this section. A dollar-for-dollar setoff is authorized for all federal benefits to include continuation of pay under section 143, continuation of federal pay and allowances, incapacitation pay, severance pay, disability retirement pay, Veterans' Administration disability payments and military and Veterans' Administration death benefits; and

G. Reporting under the early pay provisions of former Title 39 or Title 39-A, section 205 do not have to be initiated until a final decision is reached on the injured service member's entitlement to federal benefits or while military or veterans' disability benefits are received in lieu of compensation under former Title 39 or Title 39-A, whichever ceases first. Veterans' disability benefits provided in this subsection include state military duty pay received under section 143, federal continuation pay or incapacitation pay in lieu of ~~Title 39~~ benefits under former Title 39 or Title 39-A. The time provisions of former Title 39 or Title 39-A are effective upon notification to the service member that federal benefits are not authorized, or the gross monetary federal benefits are determined to be less than the entitlements under former Title 39 or Title 39-A without taking into account the setoff prescribed in paragraph E.

Sec. E-45. 38 MRSA §1310-C, sub-§7, ¶A, as enacted by PL 1989, c. 870, §2, is amended to read:

A. For its employees under former Title 39 or Title 39-A; or

Sec. E-46. 38 MRSA §1310-F, sub-§4, as enacted by PL 1991, c. 66, Pt. A, §37, is amended to read:

4. Insurance. Notwithstanding subsection 1, the commissioner may not issue a grant under this section to a municipality for the costs of closure unless the municipality demonstrates to the commissioner that each person who performs work to implement the closure plan is self-insured or is covered by a workers' compensation insurance policy in accordance with Title ~~39~~ 39-A.

Sec. E-47. Effective date. This Part takes effect January 1, 1993.

PART F

Sec. F-1. Additional assessment. Notwithstanding the Maine Revised Statutes, Title 24-A, section 237 and Title 39, section 29, the Superintendent of Insurance may exceed the limits on the assessments authorized by those sections by the amount allocated in section 2 for the fiscal year ending June 30, 1993 only.

Sec. F-2. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

1992-93

PROFESSIONAL AND FINANCIAL SERVICES, DEPARTMENT OF

Bureau of Insurance

Positions	(5.0)
Personal Services	$123,366

All Other	33,333
Capital Expenditures	25,000
TOTAL	$181,699

Provides funding for 2 Managing Examiners, one Workers' Compensation Specialist, one Senior Rate Analyst and one Clerk Steno III; additional actuarial contracting; computer equipment; and other general operating expenses to administer the new rating law and the expected increase in the number of filings by self-insurers.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved, except as otherwise indicated.

Effective October 7, 1992, unless otherwise indicated.

CHAPTER 886

H.P. 1785 - L.D. 2465

An Act to Create Jobs for the State

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

Sec. 1. 30-A MRSA c. 208 is enacted to read:

CHAPTER 208

DEFENSE FINANCE AND ACCOUNTING SERVICE FINANCIAL ASSISTANCE ACT

§5271. Definitions

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

1. Commissioner. "Commissioner" means the Commissioner of Economic and Community Development.

2. Department. "Department" means the Department of Economic and Community Development.

3. DFAS. "DFAS" means the Defense Finance and Accounting Service of the United States Department of Defense.

4. DFAS development program. "DFAS development program" means a statement of the means and objectives designed to design, acquire, construct and operate a DFAS project.

5. DFAS project. "DFAS project" means the facility provided in response to the Defense Finance and Accounting Service's Opportunity for Economic Growth announcement issued March 2, 1992, including all real property, personal property and other improvements, rights and interests in or to real, personal or other property relating to, associated with or used in connection with that facility, as identified by the municipality providing that facility.

6. DFAS project area. "DFAS project area" means a specified area within the corporate limits of a municipality that will be developed in accordance with a DFAS development program adopted pursuant to section 5273.

7. DFAS revenues. "DFAS revenues" means the additional sales and individual income taxes generated as a result of the implementation of a DFAS development program.

8. Eligible municipality. "Eligible municipality" means any municipality in the State that responded on or before June 1, 1992 to the Defense Finance and Accounting Service's Opportunity for Economic Growth announcement issued March 2, 1992.

9. Financial plan. "Financial plan" means a statement of the costs and sources of revenue required to implement the DFAS development program.

10. Project costs. "Project costs" means any expenditures made or estimated to be made or monetary obligations incurred or estimated to be incurred by a municipality that are listed in a DFAS development program as costs of improvements, including public works, acquisition, construction or rehabilitation of land or improvements for sale or lease to commercial or industrial users within a DFAS project area, plus any costs incidental to those improvements, reduced by any income, special assessments or other revenues, other than DFAS revenues, received or reasonably expected to be received by the municipality in connection with the implementation of this plan.

A. "Project costs" does not include the cost of buildings or portions of buildings used predominantly for the general conduct of local government. These buildings include, but are not limited to, city halls and other headquarters of government where the governing body meets regularly, courthouses, jails, police stations and other State Government and local government office buildings.

B. "Project costs" includes, but is not limited to:

(1) Capital costs, including, but not limited to: