FILE

A COMPARATIVE ANALYSIS

OF THE

MAINE WORKERS' COMPENSATION LAW

JOHN H. LEWIS
P.O. BOX 330550
COCONUT GROVE, FLORIDA
33233

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The Cost of Workers' Compensation

Any attempt to compare workers' compensation costs among states must be accompanied by a warning. That is, the data necessary to provide a high level of confidence in the results do not exist. As a result, such comparisons should be considered as guides only, and not as accurate indications of what is happening now, or what may happen in the future. The following comparisons are offered in the spirit of that warning.

There are two types of costs associated with workers' compensation comparisons-- insurance costs and benefit costs. Insurance costs are simply the net rates that are paid by employers for workers compensation insurance coverage. There are insurance rate manuals in existence in most states, and it might appear to be a simple exercise to compare the rates for any type of employment. However, manual rates are only the starting point in arriving at the net rates that are actually paid by employers.

The basic manual rate is modified through experience rating, premium discounts, schedule credits, dividends, and other mechanisms to arrive at what can be termed adjusted manual rates. Professor John Burton, Jr., of Rutgers University has developed and updated comparative rates for 47 states, which take these factors into consideration. They are based upon a combination of 44 insurance classifications that account for 61% of the national payroll among employers who purchase workers' compensation insurance. They are calculated by using a representative sample of employers to measure the costs of workers' compensation insurance in each state. This procedure insures that interstate cost differences are not due to interstate differences in industry mix. This method of comparison was used to provide the information contained in Exhibit 1.

EXHIBIT 1

	7/1/86		7/1/87		7/1/88		7/1/89	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
MAINE	1.796	15	2.102	11	2.632	8	3.380	5
MICHIGAN	1.777	16	2.064	12	1.971	19	1.995	23
NAT. AV.	1.660		1.812		2.006		2.225	

The rate is the weighted average for the 41 classes, per $100 of payroll. 1989 is the most recent year for which data are available.

Unfortunately, this comparison is of limited value with regard to Maine, due to the ongoing debate over rate adequacy. There is obviously a great deal of disagreement in Maine over the adequacy of the rates that insurance carriers are permitted to charge, and, of greater importance, the rates that are used in the residual market. As a result, the data may show the rates that Maine employers pay, but do not necessarily indicate the true cost of the system.

No matter where the truth lies, the very fact of that debate seriously reduces the value of the rate comparison. If the rates charged do not reflect the cost of the system, it means little to say that Maine's rates are not the highest in the country, or that they are moderate, or anything else.

A more appropriate comparison is benefit cost. That is, the dollar amount of benefits provided to or on behalf of injured workers. That comparison too is problematical. One reason is the paucity of appropriate data. State workers' compensation programs are only now moving to adopt data collection programs that will permit detailed comparisons among states, through the International Association of Industrial Accident Boards and Commissions.

That leaves primarily one source of data, the information generated by the National Council on Compensation Insurance data base. Without rehashing all of the arguments over the validity of that data, it must be recognized that there is at least some disagreement over their accuracy. Part of the problem has to do with the long-tail nature of workers' compensation claims, which requires that some cost figures

include estimates of future costs. Acknowledging the existence of those debates, without attempting to resolve them, it should also be recognized that for the time being this is the only significant data source available. For this reason the report will utilize the NCCI's Statistical Bulletin data for some indication of comparative cost.

As the Commission members already know, there are a number of factors that affect the dollar volume of benefits that are generated by a workers' compensation system. The data in Exhibit 2 demonstrate how some of these factors combine to affect the cost of benefits in a given state. The data shown are developed by the National Council on Compensation Insurance. They are based primarily upon 1987-1989 policy years, and are published in the NCCI Annual Statistical Bulletin, 1992 Edition.

Average medical costs are divided into two categories. "Medical Only" are those cases in which the injury was not severe enough to result in the payment of any weekly benefits. "Medical LT" are the medical costs in cases that did involve the payment of benefits for lost time. "TTD" costs are the cash benefits costs incurred in cases in which temporary total disability benefits are paid, but not permanent disability benefits are paid. "PPD," "PTD" and "Death" cases include the cost of cash benefits paid in cases which reached that level of severity, permanent partial, permanent total or death. "All claims" frequencies mean exactly that, and include claims from the most trivial, such as a minor cut or bruise involving no lost time, to very serious injuries as well as deaths. "PPD," "PTD" and "Death" frequencies refer to cases that reached the indicated level of severity.

These numbers demonstrate that a primary force behind the high total benefit costs that are found in Maine (assuming one accepts the data) is the frequency of claims, to a greater extent than their dollar value. For example, if Michigan frequencies are substituted for Maine frequencies, and Maine's dollar values retained, the total cost figure becomes $58,363,702. If Maine's frequencies are used, and Michigan's dollar values, the total cost is $89,006,230.

FIGURE 2

AVERAGE BENEFIT COSTS
IN DOLLARS

	MEDICAL ONLY	MEDICAL LT	TTD	PPD	PTD	DEATH
MAINE	294	5,855	2,225	104,798	79,511	146,854
MICH.	261	5,472	2,517	60,359	167,328	80,802
NAT. AV	269	5,495	1,848	30,717	209,698	139,552

FREQUENCY OF CLAIMS PER 100,000 WORKERS

	ALL CLAIMS	TTD	PPD	PTD	DEATH
MAINE	14,169	3,498	773	41	6
MICH.	12,542	2,115	378	5	7
NAT AV.	10.814	1,971	676	9	8

TOTAL COST PER 100,000 WORKERS

MAINE	$121,111,063
MICHIGAN	$ 45,867,978
NAT. AV.	$ 42,333,822

43 states
Source: NCCI

The high frequencies can be interpreted in a number of ways. First and foremost is the question of safety. Obviously one of the most important things that a state, its employers and employees can do to reduce workers' compensation costs is to improve safety performance, and we do not know how good a job is being done in Maine. The NCCI data indicate that the frequency of death claims is slightly higher in Michigan than in Maine. Some will argue that this is a good indication of true safety or injury rates, because other types of claims are subject to factors that can be manipulated, while death claims cannot. If one accepts this proposition, than Maine is somewhat less hazardous than Michigan. However, there are

data to the contrary.

National Institute of Safety and Health (NIOSH) data show an average fatality rate for Maine of 7.8 per 100,000 workers for the period 1980-1988, 23rd in the nation, and a rate of 5.3 for Michigan, 10th in the nation. The injury rate per 100 workers reported by the Bureau of Labor Statistics for 1990 is 14.3 for Maine, and 10.8 for Michigan.

Another possible factor is industry mix. It might be argued that Maine has a higher proportion of hazardous employments than do Michigan and the rest of the country. This paper cannot respond to that question in a detailed manner. Once again the information does not appear to be readily available. However, there are some indications. According to the NCCI, Maine has a greater proportion of its premiums in contracting classifications, 31%, than does Michigan, at 21%. Michigan has a higher proportion in manufacturing, 33%, than Maine, which has 24%. Since construction is recognized as the more hazardous of the two, this may provide some indication of a industry mix that biases Maine in the direction of higher hazard employments. We do not know the impact of self insurance on these figures. That is, the extent to which certain types of employers may be self insured or belong to group self insurance programs, whose data are not included in the NCCI figures, resulting in an inaccurate statistical picture of the system as a whole.

However, there are factors in addition to safety and industry mix that must be noted when evaluating frequency and severity issues. There is a large number of forces at work which can affect the frequency and severity data that are generated. These can have a significant impact on the numbers, and on what happens in any given state. As noted, frequencies and severities can be affected by safety programs and by industry mix. Wage levels vary state by state, as do weekly benefit maximums, and the general cost of medical care. Experience is affected by the willingness and ability of workers to access the workers' compensation system. The reasons for their actions can include personal choice, economic incentives, the rules that establish compensability in a given state, the knowledge that people have of the system, their access to assistance, their fear of retribution for filing a claim, and their chances of recovering benefits. A higher frequency may also mean that a state is more willing to provide benefits than another under a given set of facts, for the right or wrong reasons. The quality of safety and claims services provided by insurance carriers is another obvious source of influence.

The same holds true for severity. The fact that one state has a greater proportion of its cases receiving weekly benefits, as compared to cases involving medical benefits only, will have something to do with the rules of the system governing

when and how an employee can claim weekly benefits, and the tendencies of adjudicators to award or deny benefits. Benefit payments in many systems are affected by the willingness and ability of employers to bring people back to work. Some states may find permanent disability where others would not, or might award more money for the same degree of permanency. Some systems place more reliance on actual loss of income than do others, and may be affected to a greater extent by economic cycles.

The existence of all of these factors makes it difficult under the best of circumstances to evaluate the reasons for one state's cost rankings versus another. For Maine, there is an additional problem. That is, the numerous changes that have occurred in its workers' compensation system during the past ten years. All of the comparisons that are shown reflect little or none of the impact of the most recent changes in the statutory law. For all we know, the cost of Maine's current system may be considerably lower than the data indicate. It may not be the law that Maine wants, but it may not be as expensive as the laws that generated the results shown above.

Securing the Payment of Benefits

States permit employers to secure their workers' compensation obligations in the following ways:

- Commercial insurance
- Individual self insurance
- Group self insurance
- Competitive state funds
- Exclusive state funds

Commercial insurance is permitted in 44 states. In most of those there are large numbers of carriers, with no individual carrier dominating the market.

Most states also permit individual self insurance. The financial requirements for self-insuring vary greatly from state to state. The purpose of these requirement is to limit self-insurance to employers who are relatively large and have the financial strength to pay their own workers' compensation claims to conclusion. Some states have large numbers of self insurers, others relatively few. Factors such as the criteria for self insuring, the nature and cost of the bonds, excess insurance, and other security devices that are required, and the attractiveness of the insured market all affect the decisions to self insure, and the prevalence of self insurance in a given state. Many of the states that permit self

insurance have established guarantee funds, to assure the payment of benefits should a self insurer lose the ability to respond to its workers' compensation obligations. These funds are financed, usually on an as-needed basis, through assessments on all self insurers.

Thirty two states permit what is known as group self insurance, which is more a form of mutual insurance than it is self insurance. The employers in the group pledge their assets to assure the financial security of the program, and operate in the same basic manner as an insurance company. The rules for the establishment and operation of groups are quite similar in most states, and are usually based upon the model legislation developed by the National Association of Insurance Commissioners.

Twenty-four states have state funds. Eighteen of these states utilize competitive state funds, which co-exist with private insurance carriers. Several of these are newly authorized, and not yet in operation. Some are simply mutual insurance companies chartered by the state, with the intent that they make special efforts to provide coverage for accounts that the commercial market may not want, such as smaller employers. In others they have closer ties to government, and may actually be considered a state agency. The remaining six states do not permit private insurance, and operate "exclusive" or "monopolistic" state funds. For both types of funds, the operating results are mixed, in terms of both financial performance and quality of service, as is true for each of the other mechanisms.

In addition to this "voluntary" market, most states have what is known as a residual market. This is the market of last resort for employers who cannot obtain coverage elsewhere. In a few states the competitive state fund must take all applicants, and becomes the market of last resort. In most, the residual market consists of a pool that is serviced by a few insurance companies and service companies, by contract. If the pool operates at a deficit, as most do, the losses are paid by all carriers writing voluntary business, in proportion to their share of the voluntary market.

The residual market has become a significant factor in many states. For the pools administered by the NCCI, the proportion of direct premiums written in them nationally increased from 6.2% in 1983 to 25.0% in 1991. In three states the residual market is the primary source of coverage for employers.

MAINE

Three of the voluntary mechanisms described above are available in Maine-- commercial insurance, individual self

insurance, and group self insurance. As is well known, there is almost no voluntary commercial insurance market. Most coverage is provided by the two forms of self insurance and the residual market. Self insurance accounts for approximately 40% of premium or equivalent premium volume, and is expanding.

There is nothing particularly unusual about either self insurance mechanisms in Maine. They are both regulated by the Superintendent of Insurance, under rules which are within the mainstream. The minimum bond for individual self insurers is $50,000. Both specific and aggregate excess insurance are generally required, but in most instances the aggregate requirement has been waived, due to market problems. In its place, some self insurers are establishing trust funds. Excess insurance utilized by a self insurer must be written by a carrier admitted in Maine, or by Lloyd's of London. Self insurers must have their authority renewed each year, and the Superintendent can require an actuarial examination every three years.

There is a guarantee fund for individual self insurers, known as the Maine Self-Insurance Guarantee Association. It covers all individual self insurers, except the larger public employers. Its role is to provide benefits in any instance in which an individual self insurer is unable to pay its worker's compensation benefits, and the various security devices that it was required to furnish are insufficient to meet those obligations. Funding is through an assessment formula. The recent financial record of self insurers has been good, with only one small insolvency in recent years.

MICHIGAN

Michigan utilizes four of the voluntary mechanisms. They are commercial insurance, a competitive state fund, individual self insurance and group self insurance. The commercial market has a large number of carriers providing coverage, and has been recognized as a competitive market for many years.

There are approximately 650 individual self insurers, of all sizes. There is no specific formula for approving self insurers, or for establishing the required package of security devices and excess insurance. Each is required to post a $100,000 bond or letter of credit, and to provide specific excess insurance. Aggregate excess insurance is not always required of employers with a net worth greater than $20,000,000.

The Michigan law on group self insurance is basically the same as those used in other states. The law applies to both public and private sector groups, with somewhat different rules for each. The funds must be homogeneous, which means

that the members of the group must be in the same type of business. Private sector funds must have combined employer assets of at least $1,000,000.00. All groups must have gross annual premiums of at least $250,000. Because of the absence of uniform manual rates in Michigan's competitive rating environment, each fund must actuarily establish its own rates, at a 90% confidence level.

Specific excess insurance is generally required. It can be written by surplus lines carriers as well as admitted carriers. Aggregate excess is often required, and must be provided by a carrier authorized to do business in Michigan, or by the state accident fund. A recent statutory change permits the use of bonds and letters of credit in lieu of aggregate excess insurance. A group can also utilize an irrevocable letter of credit to meet some of the other security requirements.

There are currently 31 groups in operation. A total of 10 groups have gone out of business over the years. In each case their assets and security were sufficient to pay all claims.

There is a guarantee fund to protect the employees of all group and individual self insurers. The assessment rate is presently capped at 3% of indemnity payments. It is reported that approximately 90% of the guarantee fund's obligations over the years resulted from the failure of one large foundry operation. Even with that failure, assessments rates are usually 0 or less than 1%.

The state fund, known as the Accident Fund, has been in operation since 1912. It's 32,000 policies account for about 20% of the voluntary market. It also is the largest service carrier for the residual market, handling about 5,000 assigned risk policies.

Starting in the 1970s, there was a long-running legal dispute over the status of the Fund, in terms of its relationship to state government. It is now considered to be an autonomous independent form of state government. Its CEO is appointed by the Governor, but all other employees are civil service. At times this close relationship with the state has led to political decisions affecting the Fund's rate setting policies, with adverse results for the Fund.

The Fund is not the insurer of last resort. There is a residual market mechanism in Michigan. However, the Fund does make special efforts to provide voluntary coverage for small employers, and feels that it has been successful with that business. It also competes for the large accounts as well. It is very careful in its underwriting practices, and utilizes a very sophisticated expert system to assist in its underwriting. It is also very aggressive in its use of the various claim control tools provided by the law, such as

mediation, anti-fraud activity, and medical utilization review.

There are no financial guarantees between the state and the fund, nor does the Fund does belong to the guarantee mechanism that is required for private insurance carriers. The current governor is a supporter of the privatization concept. As a result, efforts are now underway to explore the possibility of making the Fund a private mutual insurance company.

The Fund is the largest servicing carrier for the residual market. It is paid a 30% fee for those services. The Fund reports that this percentage is approximately the same as the cost of providing services for its voluntary policies.

Investments are handled through the state's investment program and through the use of private investment counselors. The investment policies are quite conservative.

The Michigan residual market is about 11% of the total insurance market, despite the fact that Michigan has a very competitive insurance environment, and a competitive rating scheme. The greatest need for the residual market is among smaller employers.

The residual market is divided into three classes. One is for accounts that are basically good, and ought to be in the voluntary market. The rates they pay are based 80% on the experience of the voluntary market statewide, and 20% on the experience of the residual market.

The second class of accounts consists of those who have adverse records. They pay the basic rate plus a surcharge of from 10% to 40%, on top of experience rating. The final class is for self insurers that move into the insured market through the pool. This class was established due to concerns over the potential impact of a large self insurer having to give up its self insured status.

The assigned risk pool operates at close to break even. Its deficit is the equivalent of an assessment level of about 2.7%.

COMMENT

The major differences in insuring mechanisms between Maine and Michigan are the existence of a state fund and a very competitive insurance market in Michigan. The Accident Fund helps assure that rates are kept at appropriate levels, since it offers an alternative to the private carriers. The other aide of the coin is that neither the Accident Fund or the residual market charge rates that are unrealistically low. If they did, they would get all or most of the business, since private carriers would not or could not compete for it.

It should also be noted that based on Michigan's experience, there is no reason to believe that the movement of large numbers of accounts from the residual market into a state fund would not automatically translate into significant administrative savings. The Accident Fund believes that the cost of providing service to its voluntary accounts is at least 30%, and Maine currently pays 25.6% for servicing. Of course it is quite possible that bringing employers into voluntary relationships with their insurers, private or state fund, might well result in improved operating results for everyone.

The Establishment of Workers' Compensation Insurance Rates

States are usually placed in one of two broad categories to describe the manner in which they set insurance rates--- competitive rating or regulated rates. However, the differences among states are far greater than these two categories imply.

In the regulated markets, the state must approve the rates that are set. However, individual carriers can usually apply for and receive permission to vary their rates through mechanisms such as deviations and schedule rating. They also compete through the dividends that they pay to policyholders.

In competitive rating states, there is usually some degree of regulation. For example, the state may have to approve the basic "pure premium" rate, which is the rate that is based on benefits paid, and which does not include consideration of other factors, such as administrative expenses, acquisition expense, overhead and profit. Individual carriers are then required to set their own rates, using the pure premium rate as a starting point. Even in competitive rating states, the laws require that rates not be excessive, inadequate or unfairly discriminatory. Carriers may be required, for instance, to get permission to charge rates that are lower than the pure premium rate, because of concerns that in the absence of special circumstances, a carrier that charges less than the pure premium rate is likely to develop financial problems.

MAINE

Maine is a regulated insurance market, and for all intents and purposes has always been regulated. The Superintendent of Insurance is responsible for rate approval. The proceedings are extremely active, which is not true in many states. A public advocate participates on behalf of employers, an

approach which is used in a few other states. There is greater statutory direction or control established over the rate approval process in the Maine law that is typically found in other states.

MICHIGAN

Michigan is a competitive rating state. Individual carriers file their own rates, based on a pure premium rate that is approved by the state. The rates are basically file and use, as long as there is a competitive market. The rates cannot be excessive, inadequate or unfairly discriminatory, but carriers have been given a great deal of leeway, because the market is in good shape. There have been no instances of rates being held improper over the past nine years.

The state has established the Data Collection Agency, which oversees rate setting activity. It has one representative from the state Bureau of Insurance, three carrier representatives, one public member, one insurance agent, one employer representative and one representative from the executive branch of state government. Its job is to see to it that the proper elements and formulae are used for rate setting. The rating bureau has a contract with NCCI to do most of the actuarial work. The pure premium rate that is developed excludes consideration of administrative expenses, profit considerations and trending.

COMMENT

Michigan is a competitive rating state, Maine is a regulated rate state. Adoption of the Michigan approach, in both substance and style, would result in carriers being free to charge the rates that they believe are necessary to make a profit. The possibility would exist that rates would increase, at least in the short term. The competition offered by self insurance, particularly group self insurance, a state fund and the residual market mechanism would help prevent inordinate rate increases. There is also the danger that two of the mechanisms, the state fund and the residual market, might operate under inadequate rates, resulting in financial problems for the fund, and a residual market deficit, both of which would require a response from the state.

Coverage of Employers and Employees

In the formative years of workers' compensation in the U.S., many state laws had limited applicability. Some only covered hazardous employments. Others excluded smaller employers

through numerical exemptions, which might be quite high. Certain types of employments, such as agriculture, professional sports, and domestic work were often excluded. In a number of states coverage was voluntary on the part of both employer and employee, each having the right to opt out of the system.

For the most part the broader exceptions to coverage have disappeared. Three states still do not mandate coverage. A majority of states either exempt agricultural employers and employees, or have special provisions for them. Most do not cover part-time domestic employment in the home and limit coverage of casual labor by employers not otherwise covered by the law. Many do not require coverage for corporate officers. There are also some that exempt professional athletes, or have special provisions for them. Numerical exemptions still exist in 14 states, most of these requiring at least three employees.

MAINE

Maine's workers' compensation law is applicable to most employers and employees. It is specifically applicable to every private employer, with some exceptions, and to all officials and employees of the state.

The major exceptions are similar to those found in other states, although the specific details of these exceptions are, in some instances, somewhat different. Employers of employees engaged in domestic service are excluded. Employers of employees engaged in agriculture or aquaculture as seasonal or casual laborers are excluded if the employer has an employer's liability policy that meets specified policy limits. Casual is defined as occasional or incidental, and 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.

The law also excludes employers of six or fewer agricultural or aquacultural laborers if the employer has an employer's liability insurance policy, and if the employer did not have more than 6 agricultural or aquacultural laborers in regular and concurrent employment at any time during the 52 weeks preceding the injury. In determining the number of such employees, those employees who are immediate family members of unincorporated employers and immediate family members who are bona fide owners of at least 20% of the outstanding voting stock of an incorporated agricultural employer are not counted. Agricultural employers are exempted when harvesting 150 chords of wood or less each year from farm wood lots, but only if the employer provides employer's liability insurance.

The law excludes from mandatory coverage the executive officer of a charitable, religious, educational or non-profit corporation, although the corporation can elect to provide coverage. Employees who are owners of 20% of the voting stock of a corporation or who are stockholders in professional corporations are permitted to elect out of coverage, as can a parent, spouse or child of a sole proprietor, if employed by that proprietor.

Real estate brokers and salespersons are excluded from coverage if they are paid by commission only, and if they have a signed contract with the real estate agency indicating that the relationship is one of independent contractor.

The law also excludes prisoners who are incarcerated for a criminal offense, unless the prisoner is in a county jail under final sentence of 72 hours or less and is assigned to work outside of the county jail, is employed by a private employer participating in a work release program, sentenced to imprisonment with intensive supervision, or is employed in a program established under a certification issued by the United States Department of Justice under the United States Code, Title 18, Section 1761.

As is true in most states, independent contractors are not considered to be employees of whoever contracts with them. However, as a general rule a contractor that utilizes subcontractors is responsible for workers' compensation benefits for the subcontractors' employees, if a sub fails to provide coverage. In Maine no such responsibility exists. In the states that create that responsibility, the general contractor will, under circumstances which vary from state to state, have immunity from tort suits brought by injured employees of subcontractors. In Maine the general contractor does not have immunity, since no workers' compensation responsibility exists.

Maine is unique in its establishment of a process for determining the existence of independent contractor status prior to the occurrence of an injury. The determination is not binding in future claims, but creates a rebuttable presumption. Its purpose is to assist in the assessment of insurance premiums.

MICHIGAN

The Michigan law provides coverage for almost every employer and employee, with a few exceptions. The major one involves small employers. Private employers, other than agricultural employers, are not required to provide coverage unless they regularly employ three or more employees at one time, or have at least one employee regularly employed for 35 hours or more per week for 13 weeks or longer during the preceding 52 weeks,

must provide workers' compensation coverage. All public employers are covered irrespective of the number of employees.

All agricultural employers must at least provide medical and hospital insurance coverage, but not workers' compensation coverage, for employees who are employed 35 or more hours per week for 5 or more consecutive weeks. All agricultural employers with three or more employees who are paid hourly wages or salaries, and were employed 35 hours or more per week by the same employer for 13 or more consecutive weeks during the preceding 52 weeks, must provide workers' compensation coverage, but only for the employees who meet those criteria. The law contains a long, detailed definition of agricultural employer.

Household domestic employees are excluded from coverage if they did not work for the employer for at least 35 hours per week during a minimum of 13 weeks during the preceding 52 weeks. A household domestic servant is defined as a person who engages in work or activity relating to the operation of a household and its surroundings whether or not they reside there. A person cannot be considered an employee in a domestic employment context if that person is a wife, child or other member of the employer's family residing in the home.

Licensed real estate sales persons and associate real estate brokers are not considered to be employees if not less than 75% of their remuneration is directly related to their sales volume and not hours worked and if they have a written agreement with the broker who employs them which states that the person is not considered an employee for tax purposes.

If an employer covered by the act utilizes a contractor who is not subject to the workers' compensation act or is subject to it but has not obtained insurance coverage or self insurance authorization, the employer must provide workers' compensation benefits to the contractor's employees. If the employer pays workers' compensation benefits to an employee of the contractor, the employer has a right to be indemnified by the contractor and is entitled to immunity from suit by the employee.

COMMENT

The coverage differences between Michigan and Maine are more in the details than in the general approach. A few small employers with irregular employment patterns might be excluded from coverage under the Michigan approach, no specific provision would exist for aquaculture, and the details of other exclusions would impact on a few employers. The major change would be the treatment of contractors, who would become responsible for workers' compensation coverage for the employees of all subcontractors, unless the subs provided their own coverage.

Coverage of Injury and Disease

Most states provide broad coverage of injuries and diseases that occur as the result of job activity or job exposure. They often do so through language which states that coverage is provided for "personal injury or death arising out of and in the course of employment." This language is found in many state laws. Each state has its own rules to determine how this general language is to be applied in particular cases. The rules are usually developed through court decisions. The two phrases "arising out of" and "in the course of" represent two relatively distinct issues, the first having to do with the causal connection between the employment and the injury, and the second dealing with the time-frame within which the injury occurred.

For example, travel to and from work is generally held to be outside the course of employment, unless there are special circumstances involved, such as payment for the time and expense of travel, or a special errand being carried out. Once the employee is on the business premises, including adjacent facilities such as a parking lot, injuries that occur are generally held to be within the course of employment. Again, there are special circumstances to be considered, such as whether the employee was on a lunch-break or in an off-limits area, or clearly deviating from any employment-related activity.

At the present time, the major areas of attention in states which are struggling with their workers' compensation laws have to do with the compensability of conditions such as the following:

- Those that occur gradually over time
- Situations in which the individual is pre-disposed to the injury, as with a back already weakened by age, or a heart damaged by years of an inappropriate lifestyle
- Physical problems that are brought about by emotional stress, emotional problems arising from physical injury, and emotional problems caused by stress

For the most part, states routinely compensate for injuries that occur over time, and for those that involve pre-existing conditions or weaknesses. There has been recent movement in a

few states towards restricting compensability, by requiring significant contribution by the work activity, or requiring that the work injury be the predominant cause of the disability.

There have also been efforts to restrict the compensability of cases involving stress-caused psychological problems. These attempts include the denial of compensation if the source of the stress had to do with routine personnel matters, or requiring that the stress be a significant cause or the result of unusual or extraordinary stress, or represent a certain percentage of the cause. In some states psychological disability unrelated to a physical injury is not compensable at all. A few states also attempt to restrict the amount of benefits that are paid in cases involving stress.

MAINE

The basic language establishing compensability is the same in the Maine law as is found in most other states. That is, compensation is provided for an employee who receives a personal injury arising out of and in the course of his employment or is disabled by occupational disease.

Occupational disease is defined as a disease which is due to causes and conditions which are characteristic of a particular trade, occupation, process or employment and which arises out of and in the course of employment. When an occupational disease is aggravated by a non-compensable disease or infirmity, or aggravates another non-compensable condition resulting in disability or death, benefits are apportioned to reflect the percentage contribution only by the compensable occupational disease.

The law requires that incapacity for occupational disease occur within three years after the last injurious exposure on the job in order for it to be compensable, except for asbestos-related diseases. As a result, no compensation is payable for other long latency diseases which do not develop until many years after the exposure. Presumably such diseases could become the subject of tort actions, since the employer would not have immunity to suit.

The law provides a very detailed mechanism for the evaluation and compensation of hearing loss. The maximum compensation is 50 weeks for total loss of hearing in one ear, and 200 weeks of compensation for total loss of hearing in both ears, in additional to any total disability benefits which may be payable.

As is true in every state, there are in Maine a number of special statutory rules which either help in applying the general compensability language, or deal with specific

circumstances. Injuries sustained as the result of voluntary participation in an employer-sponsored athletic event or athletic team are not compensable, by virtue of a provision which excludes from the definition of employee a person who is ordinarily an employee, but is participating in such activities. Injuries occurring during ride share programs are not compensable, unless the employee is a driver, mechanic or similar employee receiving remuneration for participation in the program.

Mental injuries from work-related stress are not compensable unless the claimant can demonstrate by clear and convincing evidence that the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee and that the stress was the predominant cause of the mental injury. The stress must be measured by objective standards and actual events and cannot be the result of disciplinary action, work evaluation, job transfer, layoff, demotion, termination or any similar action, taken in good faith by the employer.

A subsequent non-work related injury or disease that is not causally connected to a previous compensable injury is not compensable. This provision is an unusual one, apparently brought about by concerns that an employee with a compensable disability who suffered a later, non-compensable injury might have the claim reopened to have compensable disability determined on the basis of all existing factors, including the new, non-compensable injury.

The law denies benefits to employees (and their dependents if death results) who are guilty of a specified level of misconduct. Benefits are denied if the injury or death was "occasioned" by the employee's willful intention to bring about his injury or death, or the injury or death of another. It is also denied if the injury or death resulted from intoxication while on duty, unless the employer knew that the employee was intoxicated or that he was in the habit of becoming intoxicated while on duty.

MICHIGAN

Once again, the basic coverage provided by Michigan law is the same as is found in most other states. The law applies to personal injury, including occupational disease, arising out of and in the course of employment. Occupational disease is defined as a disease or disability which is due to causes and conditions which are characteristic of and peculiar to the business of the employer and which arises out of and in the course of the employment. Ordinary diseases of life to which the public is generally exposed outside the employment are not compensable.

There are also several provisions which deal with specific situations. Injuries sustained while coming to and going from work are presumed compensable when they occur on the premises where work is to be performed and within a reasonable time before or after working hours. This statutory provision is basically the same as the case law in most states.

If the major purpose of the activity engaged in at the time of injury is social or recreational, it is not compensable. If the injury results from the employee's intentional and willful misconduct, it is not compensable. Defenses based upon intoxication and drug use are dealt with under this provision, on a case by case basis.

Mental disabilities and conditions of the aging process, including heart conditions, are compensable only if contributed to or aggravated or accelerated by the employment in a significant manner. Mental disabilities are compensable only when they arise out of actual events of employment not unfounded perceptions of events.

COMMENT

There are several significant differences between Maine and Michigan regarding compensability. Since Michigan has no "last injurious exposure" rule, long latency diseases that are not covered under Maine law would be covered under the Michigan law. The Maine language limiting the compensability of stress-related mental conditions is more stringent than Michigan's. The Michigan requirements for conditions related to the aging process are at least on paper more stringent than the Maine law, but are not necessarily of great impact when applied in individual cases.

Indemnity Benefits

The majority of states use a standard pattern for providing compensation for disability. The four components of the system are:

- Temporary total disability
- Temporary partial disability
- Permanent partial disability
- Permanent total disability

Under the typical program, the first two categories of benefits are provided during the healing period, before the injured employee has reached the highest level of recovery that can reasonably be expected. This plateau is usually

referred to as maximum medical improvement, or permanent and stationary.

Both Maine and Michigan are somewhat different than this basic model, in that the dividing line between temporary benefits and permanent benefits is not as distinct. For that reason the report will discuss indemnity benefits in only two categories, total and partial disability benefits.

Total Disability Benefits

The essential elements of the total disability benefit system are the same for almost all states, and include:

- A calculation of the claimant's weekly income, usually based upon pre-injury earnings, which will be used in determining benefit payments.

- An initial waiting period, from three to seven days, depending upon the state, during which the injured worker will be responsible for dealing with lost income caused by the injury.

- A retroactive period, from seven to 21 days, after which benefits for the initial waiting period will be paid.

- The percentage of weekly income that will be replaced during disability.

- The maximum and minimum weekly benefits that will be paid.

- The maximum duration, if any, of the benefit. In 14 states, temporary total disability benefits are subject to a durational maximum, or are in some other way limited. In almost all states permanent total disability benefits are paid for the duration of the disability or for life.

MAINE

The right to total disability benefits begins after a three-day waiting period, during which no compensation is payable, except to firemen. If disability continues for more than 14 days, the employee receives compensation for the first three days.

Benefits for total disability are paid at the rate of 66 2/3% of the employee's average weekly wage, subject to a maximum weekly benefit which is currently $518.42, about 135% of the state's average weekly wage (SAWW). It will increase to $536.00 effective July 1 of this year. Benefits are also subject to a minimum of $25 per week, even if the employee earned less prior to injury. The maximum is adjusted each year to reflect changes in the statewide average weekly wage for all employees, but for the most part the new maximums only affect new cases. However, on the third anniversary of the injury, every total disability benefit recipient's weekly total disability benefits are adjusted to reflect any increase or decrease in the statewide average weekly wage, not to exceed 5% in any year.

If the employee is able to perform full-time remunerative work in the ordinary competitive labor market in the state, irrespective of the availability of such work in the employee's community, he or she is not eligible for compensation under the total disability benefit section but may be entitled to compensation for partial disability. Under certain circumstances the weekly benefit for partial disability may be the same as for total disability. The entitlement to total disability benefits will continue for life, if total disability continues.

The law establishes a conclusive presumption of permanent and total incapacity for multiple serious injuries. These are the total and irrevocable loss of sight of both eyes, the loss of both hands at or above the wrist, the loss of both feet at or above the ankle, the loss of one hand and one foot, an injury to the spine resulting in permanent and complete paralysis of the arms or legs and an injury to the skull resulting in incurable imbecility or insanity. Employees with these injuries receive total disability benefits for life, irrespective of actual earnings.

As in other states, there is a series of provisions which provide the rules for calculating the individual employee's pre-injury average weekly wage (AWW). If the employee worked for the employer at least 200 full working days during the year immediately preceding the injury, the AWW is calculated on the basis of the hours and days constituting a regular full working week, excluding allowances for the use of chain saws or skidders.

If the employee was not employed by the employer for 200 full working days, AWW is determined by taking the entire amount of wages or salary with that employer during the immediately preceding year and dividing by the total number of weeks the employee worked for that employer during the year.

For seasonal workers, AWW is determined by taking the total wages during the prior calendar year divided by 52.

There is an alternative method used in cases in which the other methods cannot be reasonably and fairly applied. It relies on the earnings of similar workers.

If the employee has more than one job at the time of injury, the earnings of all employments are combined to arrive at the employee's AWW. Fringe benefits are not included in the calculation of AWW.

MICHIGAN

The structure of the Michigan total disability benefit package is basically the same as Maine's, but with some significant differences in the benefit levels and in its application.

The injury must incapacitate the employee from earning full wages for at least one week before compensation benefits are payable. Benefits for the first seven days are payable if the incapacity continues for two weeks or longer or if death results from the injury.

Total disability benefits are payable at the rate of eighty percent of the employee's after tax weekly wage, subject to the maximum weekly benefit, for the duration of the disability. The maximum weekly benefit for all classes of benefits is equal to 90% of the statewide average weekly wage, as determined by the Employment Security Commission. The maximum for 1992 is $441.

There is no distinction between temporary and permanent total disability with regard to the basic weekly benefit. However, if the employee meets the definition of permanent and total disability, which requires blindness, paralysis, or loss of multiple extremities, certain supplemental benefits may be available. If the employee is permanently and totally disabled and receiving a benefit that is less that 25% of the current statewide average weekly wage, a supplemental benefit is paid to bring benefits up to the 25% level. Benefits will continue to increase as the state's average weekly wage increases.

If the employee is permanently and totally disabled and the weekly benefit is less than 80% of the employee's after tax income at the time of injury, due to the cap established by the maximum weekly benefit, benefits will be increased in each year that the maximum weekly benefit increases, until the employee's weekly benefit is equal to 80% of after tax earnings at the time of injury.

In addition, some benefit coordination provisions may not apply to someone who is permanently and totally disabled. In a somewhat related provision, after two years of continuous

disability Michigan permits an injured employee whose weekly compensation rate is less than 50% of the state's average weekly wage at the time of injury present evidence to show that earnings would have increased during that time. The weekly benefit rate can then be increased to a level of up to 50% of the SAWW for the year of injury.

There is a conclusive presumption of total disability for a period of 800 weeks if the employee loses both eyes, both legs or feet, both arms or hands, or a combination of any two, or sustains complete paralysis of any two of the body parts listed. The presumption also exists for incurable insanity, and applies if there is permanent and total industrial use of both legs or both hands or both arms or one leg and one arm. After 800 weeks, the employee must prove total disability in accordance with the economic reality of his or her situation.

The Michigan law provides for a period of presumed total disability for employees who suffer the amputation of certain body parts. This means that irrespective of actual post-injury work experience, total disability benefits will be paid for at least the number of weeks set forth in the law for each body part, starting with the day of amputation. This provision applies only in cases of actual loss, and not loss of industrial use.

Included in the calculation of AWW are overtime, premium pay and cost of living adjustments. Fringe and other benefits which continue after injury are not included. If they are not continued, they can be used in the AWW calculation to the extent that their inclusion does not result in a weekly benefit that is greater than 66 2/3% of the statewide average weekly wage.

The employee's AWW is calculated by computing total wages paid in the highest 39 weeks of the 52 weeks immediately preceding injury and dividing by 39. If the employee worked for less than 39 weeks during the preceding 52, AWW is calculated by taking the total wages earned during the 52 weeks and dividing by the total number of weeks actually worked. If the employee is injured before completing the first week of employment, AWW is determined by taking the number of hours per week contracted for multiplied by the hourly rate, or by using the weekly salary contracted for.

If the hourly earnings rate cannot be ascertained or has not been designated, the AWW is determined by using the usual wage for similar services rendered by paid employees.

If there are special circumstances which make the use of these provisions unjust, AWW can be determined by dividing the aggregate earnings during the year immediately preceding the injury by the number of days when work was performed and multiplying by the number of working days customary in the employment but not less than five.

If the employee has more than one job, the employer in whose service the injury occurs pays all medical, rehabilitation and burial benefits, but there are special rules for paying indemnity benefits. If the employer in whose service the injured occurred provided more than 80% of the employee's combined wages, it pays all of the indemnity benefits. If that employer paid less than 80% of the combined wages, it pays a proportionate share of the indemnity benefits, and the Second Injury Fund pays the rest. When using this apportionment mechanism, only wages reported to the IRS are considered.

Agricultural employees who are paid hourly wages or salaries have their AWW computed by taking the total wages earned from all agricultural occupations during the preceding 12 calendar months and dividing by the number of week's worked in agricultural employment during that same time period.

COMMENT

Most of the differences regarding total disability benefits should result in lower costs under the Michigan approach. The waiting period is a few days longer. The use of 80% of after tax income increases benefits for some low wage employees and some others, but reduces them for most. It also reduces the chances for the payment of compensation benefits that are greater than or even close to the employee's pre-injury after-tax earnings, something that can and does occur fairly often in states with high weekly benefit maximums.

Inclusion of fringe benefits in the AWW calculation can result in higher benefits, but the impact of this provision is likely to be limited, since it cannot be used to bring the weekly benefit above 66 2/3% of the state's average weekly wage. The use of the highest 39 weeks of income out of the last 52 is also likely to increase the average weekly wage figure. Once again the impact will probably be the greatest with lower paid workers, since the maximum weekly benefit will minimize its value to high paid workers.

The Michigan maximum weekly benefit is substantially lower than Maine's in its relationship to wages in the state. It should be noted that at least some employees have these benefits supplemented, or their full wages continued, as the result of collective bargaining agreements or similar arrangements with their employers.

There is no annual adjustment under the Michigan law, other than the more limited adjustments for statutory permanent and total disability cases.

Partial Disability

States take a number of different approaches in determining how benefits for partial disability are to be paid. When an employee is able to return to limited employment prior to reaching maximum medical improvement, most states provide what is known as temporary partial disability, which is typically 66 2/3% of the difference between the pre-injury average weekly wage, and the amount the employee earns during the period of reduced employment.

When maximum medical improvement is attained, another benefit mechanism takes over, providing permanent partial disability benefits for those who are found to have permanent injuries that do not cause total disability. The three basic types of PPD systems are:

- Actual loss of income, sometimes referred to as "wage loss" systems;
- loss of wage earning capacity systems; and
- impairment systems.

The income replacement or "wage loss" approach involves the monitoring of post-injury earnings and the replacement of all or part of the income loss attributable to the permanent injury.

Systems that are based on loss of wage earning capacity attempt to predict who will suffer income loss in the future as the result of their permanent injuries, or, in some states, compensate for the worker's loss of ability to compete for jobs.

The impairment approach utilizes an evaluation of the permanent loss of physical (and in some instances mental) function resulting from the permanent injury. It does not take into consideration the actual or even potential economic impact of the injury. Under an impairment approach, a lawyer and a carpenter would receive the same amount of benefits for a 50% loss of use of the arm (assuming the same basic compensation rate), even though the economic impact is likely to be far greater for the carpenter.

MAINE

Maine utilizes the wage loss theory in providing compensation for partial disability. Benefits for partial disability are

paid at the rate of 66 2/3% of the difference between the employee's pre-injury average weekly wage and the earnings that the employee is able to earn after the injury. The weekly benefit cannot exceed the maximum weekly benefit previously described. Partial disability benefits cannot exceed a total of 520 weeks of payments, including the weeks during which benefits were paid for total disability.

During the first 40 weeks after injury, the determination of the extent of partial disability takes into consideration work that is actually available in the employee's community. "Community" is defined as 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. After 40 weeks, the employer has the burden of producing evidence regarding the employee's capacity to perform work and of producing a list of suitable and available job positions within the state. The employee has the burden of showing a good faith exploration of the positions. The employee bears the ultimate burden of proof to show that he was not hired for one of the positions. The employer has to pay for the cost of the job search. There is also a provision for relocation expense of up to $1,000 if the employee accepts one of the jobs, and is required to changes residences.

Maine also provides for the payment of permanent impairment benefits. Unlike the benefits previously described, the amount of the impairment benefit is not related to the employee's work status. It is payable whether the individual returns to full employment, partial employment or no employment. In addition, impairment benefits are paid at the rate of 66 2/3% of the statewide average weekly wage, with no relationship to the individual's average weekly wage, under a sliding scale:

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> One week for each percent of permanent impairment to the body as a whole from 0 to 14%;
>
> Three weeks for each percent of permanent impairment to the body as a whole from 15% to 50%;
>
> Four and 1/2 weeks for each percent of permanent impairment to the body as a whole from 51% to 85%; and
>
> Eight weeks for each percent of permanent impairment to the body as a whole greater than 85%.

Similar benefits are also provided for serious facial or head disfigurement. The maximum amount that can be paid for disfigurement is 50 times 2/3 of the state's average weekly wage.

The dollar amount of compensation that is payable for impairment under this provision is reduced by the amount of any total or partial compensation received by the employee for total or partial disability. As a result, the effect of the impairment benefit is to provide a floor, or minimum aggregate amount of compensation that will be paid for any given impairment, even if the income loss suffered by the employee is minimal. The law requires the adoption of schedules to assist in the evaluation of impairment. The Commission has adopted a rule that requires the use of either the American Medical Association's Guides to the Evaluation of Permanent Impairment, First, Second or Third Edition, or the American Academy of Orthopaedic Surgeons' Manual for Orthopaedic Surgeons in Evaluating Permanent Physical Impairment.

MICHIGAN

Michigan is also a wage loss state. Partial disability benefits are paid at a rate equal to the difference between 80% of the after-tax, pre-injury AWW, and 80% of the after-tax AWW which the employee is able to earn after the personal injury, for the duration of the disability.

There is a set of rules established to help in the determination of post-injury earning capacity. If the employee has returned to work, but for less than 100 weeks and loses his job through no fault of his own, benefits are paid at the total disability benefit rate, until he returns to other employment.

If the employee has returned to work for more than 100 weeks and then loses his job, he must first apply for unemployment compensation benefits. When eligibility for unemployment compensation is exhausted, a determination is made as to whether the post-injury employment has established a new earning capacity. If it has, when comparing pre- and post-injury earnings for benefit purposes the post-injury earnings will be considered to be not less than the new earning capacity, even if the employee is not working, or working for lower wages. If the employment has not established a new earning capacity, benefits are based upon the difference between wages at the time of injury and current wages. After 250 weeks of post-injury employment, there is a presumption of earning capacity based upon that employment. There is currently a dispute, which must be decided by the courts, over whether any type of post-injury employment can be used to establish a new earning capacity, or whether it must be the same type of work being done at the time of injury.

In a similar vein, insurance carriers and self insured employers are to provide the Unemployment Security Commission with the names of unemployed injured employees who are

receiving workers compensation benefits. The Commission is to give priority to finding them employment and is to notify the bureau of worker's compensation of any employee who refuses a bona fide offer of reasonable employment. If an employee rejects a bona fide offer of reasonable employment, benefits are terminated during the period of refusal. Reasonable employment is defined as employment within the employee's capacity to perform and which poses no clear and proximate threat to his health and safety. It must also be a reasonable distance from the employee's residence. It is not limited to jobs and work suitable to his or her qualifications and training. Benefits are also suspended if the employee is imprisoned.

COMMENT

There are major differences in both the style and substance of the Maine and Michigan approaches to compensation for partial disability. The Michigan benefit maximum is lower, and the replacement rate is based on 80% of after tax income. Both of these factors will reduce compensation for most recipients.

The unlimited duration of partial benefits in Michigan can lead to higher benefit costs in individual cases, but its actual impact is not easy to judge. The Michigan law compares pre- and post-injury income without adjustment for wage inflation. As a result, it is possible, and under some economic conditions likely, that over time inflated post-injury earnings or earning capacity will equal or exceed pre-injury earnings. If the law is permitted to work in this manner, the impact of the longer duration of benefit entitlement will be lessened.

In addition, the use of lump sum settlements also clouds the picture. Some workers' compensation professional assert that in many cases, when settlements are negotiated, the insurance carrier only considers its exposure for the next five or six years, and not over the claimant's lifetime. If true, the impact of the extended duration entitlement might again be lessened. However, no one really knows what will actually happen.

The rules that the two states use in determining earning capacity are different, but it is speculative as to whether either one produces substantially different results in actual practice.

Every workers' compensation system provides for the payment of death benefits. They are usually provided to members of the immediate family irrespective of actual dependency, and to other family members who can establish partial or total dependency on the earnings of the deceased employee. There are numerous details that differ among the states, in terms of who receives the benefits, in what amounts, and for how long. A wife, and in some states a husband, will usually receive full benefits for life or until remarriage, although some states provide a maximum duration. Children are typically entitled to benefits until age 18, or higher if in school, and for life if mentally or physically incapacitated.

MAINE

Death benefits are payable at the rate of 66 2/3% of the employee's average weekly wage subject to the maximum weekly benefit, but not less than $25.00 per week. The death benefits paid in individual cases are adjusted annually so that they continue to bear the same percentage relationship to the statewide average weekly wage, but the increase cannot exceed 5% per year.

Death benefits are paid to dependents of the deceased employee. These are defined as members of the employee's family or the next of kin who are wholly or partly dependent upon the earnings of the employee for support at the time of injury.

Conclusive total dependency is established for the wife under most circumstances, and for a husband living with the wife or actually dependent upon her, for children under the age of 18 (up to age 23 if a student), and over 18 if physically or mentally incapacitated. A detailed definition of "student" is provided. In all other cases, dependency must be determined in accordance with the facts.

If the widow or widower dies or becomes a dependent of another person, their right to benefits terminates, and the remaining benefits are paid to any children who would otherwise be entitled to benefits.

As is the case in about 2/3 of the states, there is no maximum duration of death benefits, other than the events previously described.

Burial benefits cannot exceed $4,000. In addition, the law requires the payment of an "incidental" death benefit of $3,000 to the decedent's estate.

MICHIGAN

Death benefits, like all other indemnity benefits, are based on the employee's after-tax income. Family members deemed to be wholly dependent on a deceased employee are entitled to weekly benefits equal to 80% of the employee's weekly wage, subject to the maximum weekly compensation rate, for a period of not more than 500 weeks. However, if, after 500 weeks, any of the dependents is less than 21 years of age, a magistrate may order continued payments of some portion of the benefit until the dependents reach age 21.

Those who are conclusively presumed to be wholly dependent are:

> A wife living with her husband at the time of his death or separated for justifiable cause.
>
> A child under 16 living with the decedent at the time of death, or, if over 16, physically or mentally incapacitated.

The law also contains detailed provisions for providing death benefits to similar beneficiaries, such as children living apart from the decedent at the time of death.

For other dependents, if they were partially dependent only, weekly compensation benefits are equal to the same proportion of the weekly payments for total dependents as the amount contributed by the deceased employee to the partial dependent bears to the annual earnings of the deceased at the time of injury.

Upon remarriage, benefit payments to the wife or husband terminate. The rest of the benefits which would have been paid to them are paid in a lump sum which cannot exceed $500. Further compensation is payable to other persons either wholly or partially dependent. In most instances these terminate at age 18.

Burial benefits cannot exceed $1,500.00.

If the employee dies as a proximate cause of the compensable injury while still entitled to weekly compensation benefits, those benefit payments are terminated and the dependents become entitled to death benefits. The death benefits to be paid are those which, when added to the disability benefits previously paid, equal the total amount of death benefits which would have been paid if the employee died immediately as the result of the injury.

If no benefits had been paid and a claim is pending at the time of death and is later held to be compensable, and death

is due to unrelated causes, the benefits payable up to the time of death are to 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.

COMMENT

Once again the major differences between the two states are found in the weekly benefit maximum, the replacement rate and the duration of benefits. All of these differences tend to result in lower benefit payments under the Michigan law.

Medical Benefits

Medical benefits account for approximately 45% of workers' compensation benefit costs nationwide. Almost every workers' compensation system provides full medical care, without limits on duration or aggregate cost, and without deductibles or coinsurance.

The single major issue that has dominated this subject until recently has been choice of physician. About half of the states permit initial employee choice of physician, and relatively free ability to change treating physician at least a few times. About 1/3 of the states provide employer choice, and the rest use some combination of the two.

Recently, more attention has been directed to other forms of control over medical costs. Thirty one states now have fee schedules or are implementing them. About a dozen are implementing programs such as utilization review, managed care, treatment protocols and other methods that are used in the general health care system.

MAINE

In Maine, the employee has the initial choice of physician and can change treating physician once. Subsequent changes can only be made with the consent of the employer or carrier, or under the direction of the Commission.

The law contains specific authority for chiropractors to provide services and to testify, if the injury is within the scope of a chiropractor's practice. The same authority is provided for podiatrists if the injury is to the foot. Although in most states there is a great deal of controversy over the involvement of certain medical providers, such as chiropractors, in workers' compensation, almost every state permits involvement in basically the same manner as Maine.

The Maine law contains special provisions to deal with services rendered by a socialized medicine program, due to its proximity to Canada. The law also provides for treatment by prayer or spiritual means by an accredited practitioner under a program established by the employer or carrier. This is somewhat unusual but not unique.

The Maine law contains several interesting provisions which are intended to help deal with the flow of medical information. First, the employer does not need a medical authorization from the employee to obtain medical reports dealing with the initial treatment of a compensable injury and all treatments provided within five days of the initial treatment. This helps get medical information to the employer quickly, so that decisions can be made regarding the compensability of a claim. However, an authorization is required for subsequent medical information, something that many states do not require.

In addition, each party must provide the other with copies of the medical reports they receive, within seven days of receipt. This helps deal with the information flow, but only to the extent that the medical provider actually furnishes reports. The law states that health care providers must furnish a detailed report within five days of initial treatment, and if continuing treatment is provided, every thirty days thereafter, and five days after termination.

The Maine law provides broad authority for the Commission to establish programs which are intended to control medical costs. The Office of Medical Coordination has been established, to help implement and monitor these programs. The medical coordinator is appointed by the Governor, from a list of names developed by the commission chairman with the consultation of the Commissioner of Human Services and the Commissioner of Professional and Financial Regulation.

Maximum charges for health care services are controlled through the adoption of standards, fee schedules, and procedures for the course of treatment. The standards are to be adjusted annually to reflect any appropriate changes in levels of reimbursement. A fee schedule is also provided for preparation of reports and for testimony.

The Medical Coordinator is directed to propose rules establishing protocols for the treatment of specific injuries and illnesses. These may be adopted by the chair of the commission. The law provides for the use of generic drugs, if prescribed by the physician and available.

In an attempt to minimize the costs associated with the us of more than one medical provider in individual cases, if an employee is sent to another provider, all reports and X-rays from prior treatment and examinations dealing with the injury are to be furnished to the new provider.

The law provides for a medical utilization review and case management program, with considerable detail as to how this will be done. The program contains penalties for providers that demonstrate a pattern of overcharging, rendering services that are inappropriate, and similar misdeeds.

As of this date, the only program that has been implemented is the fee schedule, which does not apply to hospitals. It was put in place in 1989, and is based on the Oregon Relative Value Study. The schedule is intended to approximate usual and customary fees in the state. A gap in the fee schedule is due to the fact that it does not cover the services typically provided by chiropractors and physical therapists. When the fee schedule was in the development process, it was determined that the statutorily-required statistics to identify usual and customary rates had not been developed for some procedures. As a result, they were removed from the schedule. For those procedures, the carrier either pays what is billed, arrives at an agreed amount with the provider, or litigates.

None of the other programs has been implemented. Three are in the design stage. The first is the Independent Medical Examiner program. A list of IMEs will soon be released, which will contain virtually any provider that wants to be on it. In other states that have recently adopted IME programs, the direction has been to utilize a limited list of IMEs, consisting of those providers who the agency or other appointing authority believes are the most qualified in their filed.

The IME system is statutorily intended to serve two roles. First, IMEs are to be used in virtually all instances of disputes involving medical issues. The commissioner hearing a case is required to adopt the medical findings of the independent medical examiner unless there is substantial evidence in the record that does not support the medical findings. Substantial evidence means at least a preponderance of evidence. It does not include medical evidence not considered by the independent medical examiner. The commissioner must state in writing the reasons for not accepting the medical findings of the independent.

The second use is in conjunction with the utilization review program that is being developed. It is intended to provide second opinions for surgery, as well as after the fact review of services provided. This will be done through the medical coordinator, who will assign an IME to do a paper review. By

law the IME has to be in the same discipline as the provider being reviewed. If the process results in disagreement that cannot be resolved, it will enter the normal litigation mechanism.

The case management program required by law is also being designed, to deal with long-term and chronic cases, as well as those involving catastrophic injuries. Upon request, the medical coordinator will assign a case manager or team, to meet with all of the parties and physicians, and will make recommendations. If the physician does not agree, he or she must explain their disagreement in writing. The purpose of this process is to work things out through cooperative efforts, but if disagreements continue, they will have to go to the litigation mechanism.

The medical office is also developing treatment guidelines or protocols for the five most common diagnoses. Providers will be aware that should they exceed these guidelines, they will probably be looking at utilization review. There are also reporting forms have been developed, which are now going to the printer.

A unique provision goes into effect November 1, 1995. On and after that date, health care providers must complete a course in occupational health training in order to be reimbursed for services provided in workers' compensation cases.

Maine law also provides for experimental programs to provide 24-hour health care coverage, with deductibles and coinsurance permitted for workers' compensation-related medical care. The maximum deductible is $50 per injury and coinsurance cannot exceed $5 per treatment.

MICHIGAN

The employer has initial choice of treating physician, but ten days after the inception of medical care the employee may switch to a doctor of his or her own choice simply by providing the employer with the name of the new doctor. The employer can object to the change, and if so, the issue is resolved by a magistrate. It is reported that there are very few changes in treating physician, and even fewer objections. If there were an objection which had to be litigated, it would take from two months to over a year to get it resolved.

All medical fees are subject to a schedule promulgated by the Bureau of Worker's Disability, with the assistance of an advisory council appointed by the Director of the Department of Labor. The schedule is based primarily upon the Blue Cross/Blue Shield schedule, with some modifications. The Bureau is hoping to move to the Harvard Relative Value Schedule in the future.

The Bureau is in the process of developing a utilization review system, which is implemented by insurance carriers and self insurers. It will also provide a certification process, to ensure that they comply with the criteria and standards. By accepting payment under workers' compensation, health care providers are deemed to consent to the submission of all records and other information necessary for review. In addition, if a medical provider goes beyond the norms that are established, it may be required by the carrier to explain in writing why it did so.

If the employer or carrier believes that a medical service provider's charges are not appropriate, and refuses to pay, the provider may appeal to the Bureau.

Attendant or nursing care is limited to 56 hours per week if it is provided by family members.

Medical authorizations from the employee are not required. The employer is entitled to copies of all medical reports relating to the compensable injury, directly from the physicians involved.

COMMENT

It is extremely difficult to evaluate or predict the possible impact of a change from the Maine medical delivery system to Michigan's. The fee schedule amounts tend to be lower in Michigan for each service, but we do not know whether it is even possible to gain access to the same type of data that are used in Michigan to establish the schedule, and to what extent the use of that data would change the fee levels in the Maine system.

There is not a great deal of difference in the intent of the two laws with regard to the other types of medical cost containment, other than choice of physician. Both states are developing a series of programs, and their success will depend more upon implementation than on differences in the statutory enabling language. The impact of the loss of the IME provision, which is not contained in the Michigan law, cannot be predicted. Maine has yet to implement the aspect of its law, and it is not clear that it can or will be implemented in a manner that will have a significant effect on case outcomes.

It might appear that the change in choice of physician would have a significant impact on the delivery of medical services. This would be true only if the system operated in the same manner in Maine as it does in Michigan. That is, with very few instances of employees changing treating physicians after ten days. There is no guarantee that this would hold true in Maine.

The basic pattern of benefit delivery in this country's workers' compensation systems is simple. The employee is required to give the employer notice of the injury. Within a relatively short time the employer or its insurance carrier is supposed to start paying benefits. When the employer decides that benefit payments are no longer appropriate, or that they should be modified, it acts accordingly. If the employee disagrees, a claim is filed, and the parties proceed down the litigation path.

State laws often provide for the imposition of penalties if benefits are not paid when they should be, and in the correct amount, but in most instances these penalties are not imposed unless there is litigation. There are very few states in which the worker's compensation agency actively attempts to oversee benefit delivery.

A minority of states limits the employer's ability to terminate or modify benefits, either requiring agreement between the parties or an order from the workers' compensation agency. The employer may also be permitted to terminate unilaterally under certain factual situations, such as actual return to work.

MAINE

The benefit delivery pattern in Maine is relatively straightforward. When an employee is injured, he or she must give notice to the employer within 30 days. Assuming that the injury is one that entitles the employee to indemnity benefits, the employer or insurance carrier has 14 days to either begin payments or file a notice of controversy. If benefits are paid voluntarily, without any disagreements arising, the employee need do nothing else. When benefit entitlement ends, such as with return to full employment, the employee has six years from the last payment of either indemnity or medical benefits to reopen the case by claiming additional benefits. If, after benefits have been paid, six years pass without any benefits being provided, the case is closed, once and for all.

From the employer or carrier's standpoint, there are a number of options to be considered. As previously noted, a decision as to whether to pay or contest the claim must be made within 14 days after notice "of an event that gives rise to an obligation to make payments under subsection 3," which is the section that triggers payment of benefits for total or partial disability. Medical and related expenses must be paid within 75 days of request, and impairment benefits are to be paid

within 90 days after notice. If payments are not started, and a notice of controversy is not filed, the employer must begin paying the benefits that are required.

Simply starting to pay indemnity benefits does not amount to an acceptance of a claim. The employer has 60 days from the date of the event to make that decision, and can deny the claim by filing a notice of controversy. The employer has the right to terminate benefits unilaterally during that time, and in fact if a notice of controversy is filed within the 60 days, the employer can continue to pay benefits, and then unilaterally terminate at any time up to the date of the formal hearing.

If the employer fails to contest the claim within 60 days, it is deemed to have accepted the compensability of the claim. The meaning of this phrase has not yet been defined by the courts. Based on the experiences of other states, it should not mean that the employer becomes bound to pay benefits in accordance with every aspect of the employee's demands as the claim progresses.

Once benefits have been paid for sixty days, without a notice of controversy being filed, the employer is no longer free to discontinue or modify benefit payments at will. A hearing is required, except under circumstances set forth in the law.

The employer may discontinue or reduce benefits 21 days after sending a certificate of intent to the employee. The grounds for discontinuance are:

> Refusal of an offer of reinstatement to a position that is suitable to the employee's medical condition, age, education, skills and prior work experience when the employee's physician or an independent medical examiner has determined that the employee is medically able to perform the employment being offered.
>
> The employee's physician or the independent medical examiner has determined that the employee is able to perform actually available employment and there is employment suitable to the employee's medical condition, age, education, skills and prior work experience actually available within the community, or after 40 weeks from the date of the injury, within the State, if the employer demonstrates by affidavit that the position is actually available for the employee by required age, education, skills and prior work experience. If the employee demonstrates by affidavit that the employee applied for up to 3 of the identified positions within 10 days of being

notified of availability and, through no fault of the employee, was not employed, the employee must be automatically reinstated.

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

The employee refuses to submit to a medical examination pursuant to subsection 5.

The employer and the employee file an agreement with the commission.

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

The employee's whereabouts are unknown and the employer has completed a diligent search for the employee.

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

The standard for review of a discontinuance changes, depending upon the status of the case. On the first petition for review brought by a party to an action, the commissioner determines the appropriate relief, if any, by determining the employee's present degree of incapacity. Once a party has sought and obtained a determination, it has the burden in all proceedings on subsequent petitions to prove that the employee's earning incapacity attributable to the work-related injury has changed since that determination. When an order has been issued denying the employee's petition for reinstatement of benefits, the commissioner may not reinstate benefits after a hearing if any of the conditions listed above are met.

MICHIGAN

The Michigan procedure is even simpler. When an employee is injured, notice must be given to the employer within 90 days. Benefit payments are to begin within 14 days of notice. Once benefit payments are begun, the employer or carrier

unilaterally terminate or modify payments. The only time that the employer must go through a formal process to terminate benefits is after an award has been made. This must be done even if the employee has returned to work. Once benefits have been paid, the employee can reopen the claim at any time, although as a practical matter it may be difficult to establish the right to additional benefits when many years have gone since the last payment of benefits.

COMMENT

The obvious major difference between the delivery systems in the two states is the employer's ability to control benefit payments. There are two major changes that may occur when that right exists. Some employers and insurance carriers may use it to attempt to force claimants to settle their claims inappropriately, by withholding benefits, knowing that it will take months to get to a hearing. On the other hand, employees who can and should return to work may do so sooner, if they cannot extend the receipt of benefits through procedural means. Which of these outcomes will predominate, and what impact it will have on the operation and cost of the system, cannot be predicted.

Dispute Resolution

There are as many models for dispute resolution in workers' compensation as there are states. The most common approach is the use of a single hearing officer, who takes the testimony and makes findings of fact and conclusions of law. There is then an appeal to a review body within the compensation agency. It may consists of a number of the hearing officers peers, or, in larger systems, a separate body. The appeal is usually limited to questions of law and a determination of whether there was any factual basis for the decision. In some states the appellate body may make its own findings of fact. Further review is by the court system, on issues of law only.

If there is an identifiable trend in dispute resolution, it can be found in the use of relatively informal processes early in the course of the claim. The purpose behind most of these efforts is to bring the parties together as quickly as possible, and resolve those issues that should not require actual litigation. Most states that use this approach report around a 50% success rate, no matter what specific format is used.

The major problem is most litigation systems is delay. There are very few states in which workers' compensation cases can be heard at a formal level in less than six months. In most the average time for a hearing is considerably higher.

MAINE

When a Notice of Controversy is filed, the case is assigned to both an employee assistant and to a commissioner. By law an informal conference should be held not later than three weeks from the date of filing, but in most cases it is 30-60 days. The parties may agree to waive the informal conference. Attorney involvement at the informal conference is discouraged. The claimant has to pay his own attorney unless the employer or carrier has its own attorney. The employer may at any time file a memorandum of payment indicating that it has begun making benefit payments. If it does so, it is not responsible for the employee's attorneys' fees for services rendered Within seven days of the conference.

About 50% of the controversies resolve themselves at some point before the informal conference. Nothing of a binding nature occurs at the informal conference, which is intended to bring the parties together, in an attempt to resolve their disagreements. If the informal conference does not resolve the disagreement, it is then up to the parties to take the next step, which is to bring the case to a formal hearing, by filing a petition.

The time necessary to get to a formal hearing, once a petition is filed, varies by commissioner. If the case has had an informal conference, the hearing is supposed to be held within 30 days of the filing of the petition. Some commissioners can set a hearing in three to four weeks, others take seven months or more. The case may not be resolved until many months after the initial hearing, because of the need for additional witnesses and hearings. The commission is required to provide an expedited process for the scheduling and hearing of petitions for review in cases in which benefits have been unilaterally discontinued or reduced.

The decision must be rendered not later than 30 days after each party has completed presenting its case. A commissioner who fails to comply with this requirement forfeits his or her pay during the period of delay, unless there is just cause for the delay.

If a party is dissatisfied with the commissioner's decision, it can appeal to a panel of at least two commissioners, appointed by the chairman on a rotation basis. The appeal must be filed within 20 days after receipt of the single commissioner's decision. There is no appeal on questions of fact except to correct manifest error or injustice. About 75%

of the decisions are affirmed. Effective June 30, 1993, the provision regarding manifest error or injustice is removed from the statute, narrowing the scope of review. It should be noted that there is some uncertainty as to the actual scope of review.

Review by the court system is discretionary on the part of the Law Court. Three or more members of a five justice panel of the Law Court must agree to hear an appeal.

If an employee is awarded benefits after a hearing, they must be paid during the pendency of an appeal. If the employer prevails, it is entitled to have the employee return the benefits that were paid during the time of the appellate process.

MICHIGAN

The Michigan administration is somewhat less aggressive than in Maine. Its involvement in a contested case is triggered by an application for mediation or hearing. The law provides that in certain circumstances mediation must be used first. The case must involve a claim for benefits due for a specific period of time and in which the employee has returned to work, or be a claim for medical benefits only, or involve an unrepresented claimant. The bureau may refer any other case to mediation if it determines that the claim may be settled by mediation. Mediation cannot be used for a claim involving an employer's petition to stop or reduce the payment of compensation or an employee's attempt to reinstate benefits after the employer or carrier terminates benefits that had been voluntarily paid. The mediators have no real power, other than in vocational rehabilitation matters, but the system is able to resolve a significant proportion of the cases that are brought into the dispute resolution process, because it brings about communication and cooperation between the parties. It takes approximately two months to get to mediation.

In a routine case that is not resolved through mediation, the next step is a pretrial conference and then a formal hearing. It takes about three months to get to a pretrial hearing, and may take as much as 18 months for a formal hearing.

The findings of fact made by a magistrate are conclusive if they are supported by competent, material and substantial evidence on the whole record. This means such evidence considering the whole record as a reasonable mind will accept as adequate to justify the conclusion. Appeal is to a three-member panel of the appellate commission, a separate part of the litigation structure. If the employer appeals an award,

70% of the weekly benefits payable under the award must be paid while the appeal is pending, beginning with the date of the award. If the employer wins on appeal, it is reimbursed from the second injury fund.

There is currently litigation going on to determine the true scope of review authority. At the present time the commission's powers are viewed as de novo. That is, it can ignore the magistrate's findings of fact. The findings of fact made by the commission are conclusive, except for fraud. The Court of Appeals and the Supreme Court have the power to review questions of law only.

There are some alternatives to this process. A dispute goes to the small claims division if the claimant requests that it go there, and if it involves $2,000.00 or less in medical benefits or $2,000.00 or less with regard to any dispute or controversy, or $2,000.00 or less as determined by the bureau. and concerns a definite period of time and the employee has returned to work. The carrier can object and require that the matter be resolved through the regular hearing process. No attorneys are permitted in the small claims division. The decisions are non-appealable. This process is seldom used, primarily because employers believe that if they agree to it, some issues, such as their liability for a claim, may be resolved with finality, and without the opportunity for appeal. It is reported that it has probably been used less than 20 times.

The parties may stipulate that the case be heard by an arbitrator selected by them. The arbitrator must be an attorney or an arbitrator of the American Arbitration Association. The parties may also stipulate for an Arbitrator to be used in place of review by the appellate commission. This is a two-step process, with one arbitrator for the "magistrate hearings," and another for the "appellate commission hearing." Findings of fact made by the arbitrator are conclusive in the absence of fraud. The Court of Appeals and Supreme Court have the power to review questions of law involving an arbitration decisions if application is made within 30 days. The use of arbitration is not currently encouraged by the Bureau, because of the fact that it has budget limitations, and is required to pay the arbitrator's fee.

COMMENT

There is nothing inherent in the litigation processes of the two states that should provide better results in one as opposed to the other. In fact, in actual practice they have many similarities. For the most part the differences that exist are due to the existence of greater resources in the Maine system.

There are two basic attorney fee mechanisms that are used in workers' compensation systems. The majority rule is that each party pays its own attorneys, win or lose. The other approach uses attorneys' fees as a form of penalty. Under certain circumstances, the employer or carrier can be required to pay the claimant's attorneys' fees. The circumstances may require unreasonable behavior on the part of the carrier, or merely that the claimant "prevail."

The method of calculating the fee in individual cases is usually a matter of statute, or at least rule. Most often there is are percentages established, either as guidelines or as the controlling factor. Only a small number of states actually pay fees on the basis of the hours spent on the case, although in some the hours may be taken into consideration, particularly in an unusual case. The percentages used run from a low of about 12% of benefits obtained to a high of approximately 35%. Some laws call for a decrease in the percentage as the amount of the recovery increases. A few states place aggregate maximums on attorney fees.

These comments all relate to claimants' attorneys' fees. There are only a very few states in which defense fees are subject to any controls. One example is New Mexico, in which fees for both parties are subject to an aggregate maximum.

MAINE

The attorneys' fee provisions of the Maine law are somewhat different than those in the majority of states, in that they provide for payment of the employee's fees by the employer or insurance carrier in most cases. The statute provides that if the employee prevails, the costs of a reasonable attorneys' fee and witness fees for the employee are assessed against the employer. However, the employer cannot be assessed the costs of an attorney fee attributable to services rendered prior to one week after the informal conference or for services rendered prior to the date of the waiver of informal conference, unless a party adverse to the employee was also represented by an attorney at that stage. This gives the employer the opportunity to investigate and take a position without incurring liability for fees.

The amount of the fee is set by the commissioner hearing the case. The rules contain a series of factors, such as time spent, complexity, amount involved, skill of the attorney in setting the fee. In most cases the number of hours spent on the case is the primary determinant of the fee, with the hourly rate varying from attorney to attorney.

A percentage fee is used in the case of a lump sum settlement. Although the statute states that fees payable as the result of such a settlement may be assessed against the employer, it is reported that they are always paid by the employer. The statute provides a fee schedule for settlements. The fees start at 10% of the first $50,000.00 and scale down to 5% for over amounts over $100,000.00.

MICHIGAN

Fees for attorneys are subject to the approval of a magistrate. There is a schedule prescribed by the Director which establishes the maximum fees that can be charged. In determining the amount of benefits obtained, which provides the basis for the fee, weekly benefits, after benefit coordination, which are higher than 66 2/3% of the statewide average weekly wage at the time of injury cannot be considered.

If the case is tried to completion, the maximum fee is 30% of the net recovery, after the deduction of expenses. If the case is settled with a redemption of liability (a lump sum settlement that closes the cases), the maximum fee is 15% of the first $25,000.00, and 10% of any amount above that. If the case is settled during trial, but not on a redemption basis, the fee is 30%. The claimant always pays his or her own attorneys fees and witness fees.

COMMENT

It might be assumed that a change to the Michigan approach to the payment of attorneys' fees, requiring that employees pay their own, would have a significant impact on attorney involvement and litigation. While it is possible that this will occur, it must be noted that some of the states with the highest levels of workers' compensation litigation are states in which the employee pays the fee. Behavior may change, but there is no guarantee that it will.

Lump Sum Settlements

Although workers' compensation laws all provide for the periodic payment of benefits, and the right of the claimant to reopen the case at even after the passage of some time, most also provide for the lump sum settlement of claims. This

process typically involves the complete closure of all aspects of the case, in exchange for a lump sum payment to the claimant. Only a few states still do not permit this type of settlement.

The circumstances under which settlements can occur vary. Virtually every state that permits them requires some degree of administrative approval, but quite often this is merely a rubber-stamp process. A few recent enactments have slowed down the process somewhat, requiring that the employee return to work, or undergo rehabilitation before a settlement is permitted. Some states also forbid the inclusion of medical benefits, and occasionally vocational rehabilitation benefits, in a settlement. There is also a wide variation in the frequency with which lump sum settlements are used, from sparingly to almost always in cases involving permanent disability.

MAINE

Under Maine law, the parties can agree to a settlement which includes the complete discharge of the employer's liability for any future benefits in the case. The statute states that this type of settlement should not include future medical benefits unless 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. The all-inclusive type of settlement has always been the norm in Maine, and remains so even with this provision.

The settlement must be approved by a commissioner, after a review of a number of factors, to insure that the settlement is in the best interests of the employee. The insurance carrier is required to inform the employer of any proposed settlement. If the employer is in the residual market and the proposed settlement agreement is in excess of $10,000 the employer may object to the settlement agreement, by giving the carrier notice within 7 days of receipt of the agreement.

If the settlement goes forward and is approved over the employer's objection, the employer may appeal inclusion of all or part of the settlement payment in the calculation of its experience modification factor. A procedure is provided through the Superintendent of Insurance. Employers in the voluntary market do not have the same right, presumably because they can deal with their carrier directly.

MICHIGAN

Lump sum settlements, referred to as redemptions, are permitted subject to the approval of a magistrate. There is a detailed statutory provision setting forth the criteria that

the magistrate must use in determining whether approval should be granted. Settlements virtually always include the closure of the right to future medical benefits.

The insurance carrier must notify the employer of a proposed lump sum redemption settlement, and the employer has the right to object to it. If the employer does object, the settlement cannot be approved.

Each party to lump sum redemption must pay a $100.00 fee which is deposited in the administrative fund.

COMMENT

It is unlikely that the use of either the Maine lump sum settlement provision or Michigan's would produce substantially different results.

The Administrative Structure

As in the case of litigation systems, there many different types of administrative structures used in the 50 state workers' compensation programs. They include a few courts, a larger number of commission, and a majority of administrative agencies. However, the activities that they undertake, the quality of the services that they provide, and the results they obtain appear to have little to do with the choice of structure.

The level of activity ranges from passive entities, which merely provide a forum for litigation, to agencies that undertake to manage and control virtually every aspect of the system. They aggressively enforce the provisions of the law, assess penalties when there are failures, and collect large amounts of data. How well they do all of this, and to what end, is often a matter of debate.

For most workers' compensation agencies, the major problems involve resources. Most have a real need to improve their data handling abilities, but lack the financial resources to do so. Many are experiencing budget constraints and reductions which make it extremely difficult for them to do their jobs. This is true despite the fact that about half of the state agencies are funded through assessments on employers and insurance carriers, and in most of these states the money goes directly to the agency, rather than to the general fund.

MAINE

The Maine administrative structure is that of a commission. The law establishes the workers' compensation commission as an independent entity. The twelve commissioners, who must be lawyers, are appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over judiciary and to confirmation by the Legislature. The Governor appoints one of the Commissioners to serve as chairman.

The chairman has responsibility for the administration of the commission. The chairman can appoint an assistant, who serves a the chairman's pleasure. All other employees of the commission are civil service.

The commission's operations are supported by an assessment on insurers and self-insured employers equal to 1/2% on gross premiums, and 1% of benefits paid for self insurers. The assessments may not produce more than $2,500,000 in revenues annually in the 1991-92 fiscal year and more than $3,000,000 in revenues annually beginning in the 1992-93 fiscal year. The money goes into the General Fund, and must be appropriated by the legislature.

MICHIGAN

The workers' compensation agency is the Bureau of Worker's Disability Compensation. It exists within the Department of Labor. The Director of the Bureau is appointed by the Governor with the advice and consent of the senate, for a three year term. All other employees, except Magistrates and members of the appellate commission, are civil service employees.

The agency is financed from two sources. Approximately 2/3 of the budget comes from general revenues. The remainder is from fees that are paid to the agency as part of lump sum redemption settlements.

Appointment and retention of magistrates and members of the appellate commission is accomplished with the involvement of a six member qualifications advisory committee, appointed by the governor, with equal representation of employer and employee interests.

Persons interested in becoming magistrates are first given a written examination, in order to determine the applicant's knowledge of the workers' compensation law, rules of evidence, human anatomy and physiology, as well as their fact finding skills. If an applicant passes the test, he or she is interviewed by the advisory committee, which then ranks the applicants. Names of the most qualified applicants are

forwarded to the governor, the number depending upon the number of vacancies. Appointments are for four year terms, with a twelve year aggregate maximum.

The Committee also evaluates each magistrate at least once every two years. It makes recommendations to the governor, and the governor responds in writing to the committee, indicating the action taken in response to the committee's report.

The appellate commission is also appointed by the governor with the advice and consent of the senate. It is an autonomous entity existing in the department of labor. It has seven members, who serve four year terms, with no aggregate maximum. An appointee to the commission must be recommended by the qualifications advisory committee.

COMMENT

Once again there is no real guarantee that adoption of the Michigan administrative system, along with its methods of appointment and retention, funding, staffing and structure would bring about real change in Maine. Although some people may prefer the separation of administration from adjudication, the results will depend more upon personnel than on structure. With regard to the appointment and retention process, it is fairly easy to undermine its good intentions, unless they are fully supported by the community and by the political process.

It is also clear that Michigan does not fund and staff its agency as well as Maine does, and that it takes longer to get things done. The Michigan system is under increasing pressure, with funding and staffing cutbacks being undertaken, which may totally undermine the ability of the agency to meet its obligations.

Coordination of Benefits

When workers' compensation was first implemented in this country, it were one of the few social benefit programs around. Now, things are quite different, with a myriad of programs that deal with medical disability and income replacement. In some instances the availability of multiple programs leads to situations in which an injured worker may receive as much or more in benefits than in pre-injury earnings, a situation that some find inappropriate at best, and possible harmful from an economic standpoint.

About half of the state laws contain some coordination provisions, directed primarily at unemployment compensation benefits and social security retirement benefits. A few laws now contain very specific provisions which attempt to coordinate benefit payments from many sources.

MAINE

Maine is one of the states that attempts to coordinate workers' compensation benefits with those received under other programs. This is done in several ways. First, workers' compensation benefits are reduced by the amount of any unemployment benefits paid for the same period of time. This applies to both partial and total disability benefits, but not to impairment benefits or lump sum settlements.

Next, total or partial disability benefits are reduced by 50% of the old age social security benefits paid for the same period of time, and by the after tax amount of the payments received from a benefit plan paid for by the same employer. If the employee contributed to the plan, the reduction is limited to a proportional amount of the benefits received from the plan, based upon the ratio of the employer's contributions. No reduction is made in response to cost of living adjustment benefits received from social security. Finally, benefits cannot be reduced to less 10% of the amount due for total or partial disability, or $7.00, which ever is greater.

MICHIGAN

Michigan law contains a similar series of provisions which are intended to coordinate workers' compensation benefits with those provided under other programs. Workers' compensation benefits are reduced by the amount of unemployment benefits paid under the Michigan Employment Security Act for identical periods of time and chargeable to the same employer.

Next, for each year after age 65, weekly benefits are reduced by 5%, but not less than 50% of the normal weekly benefit, or below the minimum weekly benefit. This provision does not apply to someone who is not entitled to social security benefits or whose workers' compensation benefits are coordinated under another section of the law, which provides a more comprehensive coordination plan.

That section of the law provides for reduction of workers' compensation benefits by 50% of the amount of old age insurance benefits received by the employee, and by 100% of the after-tax amount of payments received or being received under a self-insurance plan, wage continuation plan, or

disability insurance policy paid for by the same employer, and with proportional reduction if the employee contributed to the plan. The same scheme is applicable to a pension or retirement payment, or a 401(a) profit sharing plan. Note: There is a lot of language in this section, most of it has to do with making the section work.

Under another provision of the law, if the employee terminates active employment and receives a non-disability pension or retirement benefits that were paid for by or on behalf of an employer from whom weekly workers' compensation benefits are sought, it is presumed that the employee does not have a loss of earnings or loss of earning capacity. The presumption can be rebutted only by a preponderance of the evidence that the employee is unable, because of a work related disability, to perform work suitable to the employee's qualifications, including training and experience. The question of whether the employee's ability to perform work is limited to the work done at the time of injury, or any work at all, is currently being litigated.

COMMENT

Michigan provides somewhat greater coordination of benefit than does Maine, although the programs are quite similar. Some cost reductions should be expected, but they cannot be accurately predicted without a considerable amount of information regarding the benefit packages that are provided to workers in Maine.

Special Funds

Most states utilize what are referred to as special funds in order to deal with situations that the normal insurance mechanism cannot handle. A few states use funds to provide benefits to employees whose employers are required to provide workers' compensation coverage but fail to do so. Others use them to provide compensation for conditions caused by specific occupational diseases. They may also be used to provide supplemental benefits in some types of cases.

The most common special fund is what is usually referred to as the second injury fund. Its purpose is to reduce barriers to the employment of the disabled. This is done by removing from the employer some of the liability for compensation payable as a result of a subsequent injury, if the injury combines with the pre-existing condition to cause substantially greater disability than would have occurred in the absence of the previous condition. States use a wide variety of rules to establish the kinds of pre-existing and subsequent conditions that will result in fund involvement.

MAINE

Maine has one special funds, the Employment Rehabilitation Fund. It has three distinct functions. First, it acts in the same manner as a second injury fund, with regard to employees who have completed a rehabilitation program under Section 83 of the law. If an employee who has completed a program returns to work and suffers a compensable injury, resulting in a reduction in earning capacity which is substantially greater in duration or degree, or both, than that which would have resulted from the second injury alone, the employer gets reimbursed for a portion of the benefits that have to be paid. This provision does not apply if the employee returned to the same job with the same employer as at the time of the first injury, unless the rehabilitation program involved significant rehabilitation services or significant modification of the workplace.

The fund also provides wage credits for an employer who hires an injured worker after the worker completes a vocational rehabilitation program, but once again the provision does not apply to the same employer for whom an employee was working at the time of injury.

Finally, the fund is used to pay the direct cost of implementing vocational rehabilitation plans when the employer refuses to do so. If the plan is successful, the employer must repay its costs, plus an 80% penalty.

The source of funding for the Employment Rehabilitation Fund is payments in death cases in which there are no statutory dependents.

MICHIGAN

There are three special funds provided for in the Michigan statute. They are:

- The Second Injury Fund
- The Silicosis, Dust Disease and Logging Industry Compensation Fund
- The Workplace, Health and Safety Fund

The Second Injury Fund is used for several purposes. One is to provide some of the compensation in cases involving pre-existing loss or industrial loss of use of a hand, arm, foot, leg or eye. If the employee then loses another one of those body parts as the result of a compensable injury, he or she is conclusively presumed to be permanently and totally disabled.

The employer pays the minimum amount of compensation set forth in the law for that body part, and the Fund pays the remaining indemnity benefits.

The Fund also provides benefits in cases involving what the laws refers to as the vocationally handicapped. These are people who have a medically certifiable impairment of the back or heart or are subject to epilepsy, or have diabetes, and the impairment is a substantial obstacle to employment.

A person must be unemployed to become certified as vocationally handicapped. They apply to the division of vocational rehabilitation for certification, and must reapply every two years. If they are injured while certified, the employer's payments are limited to the benefits, including medical, accruing during the first 52 weeks after the injury. Thereafter, the second injury fund pays the benefits.

The Fund is also used to repay employers and carriers who have been required to pay benefits during an appeal, and then win the appeal.

The Second Injury Fund is financed through as assessment on self insured employers and insurance carriers. The current assessment rate is 3.091% of indemnity benefits paid in the prior year.

A Workplace Health and Safety Fund is provided for by the law, but has never been implemented, because it has never been funded. The intent is that one half of the money deposited in the fund each year, and appropriated by the legislature, is to be used to fund workplace safety improvement programs. The other half is to be used to pay benefits to employees of employers who have failed to secure the payment of compensation through an insurance policy or authorized self insurance program.

The Silicosis, Dust Disease and Logging Industry Compensation Fund serves several purposes. The primary one is to provide a subsidy to employers in the logging industry and to employers of employees who suffer injury or death from silicosis or other dust diseases. The Fund caps their liability at $25,000 or 104 weeks of weekly benefits, whichever is greater. A similar subsidy is provided for cases involving the same conditions, but contributed to by other factors as well. This fund also provides reimbursement for benefits paid in cases caused, contributed or aggravated by polybrominated biphenyl with exposures occurring prior to July 24th, 1979.

This fund is also financed through assessments. The current rate is .432% of indemnity benefits paid.

COMMENT

The Michigan approach to the second injury fund is broader than Maine's, and in some respects is like the fund that Maine recently removed from its law. The impact of either the Michigan law or the current Maine law on employer behavior is yet to be established.

The real difference between the two states lies in the subsidy provided to the logging industry under the Michigan law. The adoption of its provisions would reduce costs for similar employers in Maine.

Vocational Rehabilitation

In recent years vocational rehabilitation has become a major focus of many workers' compensation programs. Some states have established major programs, in at least one instance accounting for almost 15% of all benefit costs. A few have repealed their programs, after years of disagreement and questionable results.

There are basically two types of programs that are utilized. One is the informal, assistance-based approach. In these systems the workers' compensation agency's role is directed towards bringing the parties together in an attempt to obtain agreement on an appropriate plan, and to identify and coordinate the various sources of services that exist in the community.

The other approach is to provide a structured mandatory program. These typically contain detailed provisions as to how and when cases must be identified as possibly requiring vocational rehabilitation assistance, how evaluations are to be conducted, what types of plans are to be utilized, which providers can be involved in the program, and so on.

Programs are also classified as mandatory or voluntary. Usually these designations have reference to whether an employee can reject a vocational rehabilitation program without penalty, such as suspension of reduction of compensation benefits.

MAINE

The Maine statute contains very detailed provisions establishing the vocational rehabilitation program through the Office of Employment Rehabilitation. The law requires

identification of all cases involving time loss of at least 120 days, and provides a process for evaluation of these cases, and the development and implementation of appropriate programs.

As a general rule rehabilitation plans cannot continue for more than two years or cost more than $5,000. However, under special circumstances these limitations can be exceeded.

The law also contains a provision which permits the Office to mandate a program in cases in which the employer or carrier refuse to provide one. Mandated programs are initially paid for by the Employment Rehabilitation Fund. If the plan is successful, the employer must pay an amount equal to 180% of the cost of the plan.

MICHIGAN

The law provides for vocational rehabilitation as reasonably necessary to restore the employee to useful employment. The program is not to exceed 52 weeks, except by special order of the director, who can provide for an additional 52 weeks. The claimant's unjustifiable refusal to accept rehabilitation ordered pursuant to a decision of the director will result in a loss or reduction of compensation. Any dispute over vocational rehabilitation is resolved through the normal litigation process.

The vocational rehabilitation program is controlled by one paragraph in the statute. No regulations have been adopted. Due to budget cuts, the staff of the rehabilitation unit has recently been reduced from seven to two. This unit has been quite active, and is perceived as having obtained good results, although there are also reports that when attempts are made to utilize vocational rehabilitation in contested cases, the program tends to get manipulated in the parties' attempt to gain a litigation advantage.

COMMENT

Once again, there is little difference in actual practice between the Maine and Michigan vocational rehabilitation programs. Although the Maine law has considerably more detail in both statute and regulation, they operate in a very similar manner. However, there appear to be substantial differences between the employment markets in the two states, which make it more difficult to return disabled workers to substantial gainful employment in Maine.

Workers compensation programs have traditionally been involved in safety in one of several ways. The fact that for many employers there is a direct connection between experience and workers' compensation costs is believed to provide a safety incentive. Some laws contain statutory provisions which increase or decrease benefits if an injury is caused by violation of safety rules by the employee or employer. In addition, some workers' compensation agencies have provided assistance to employers who are interested in implementing safety programs, by furnishing expertise and in some instance equipment. A few have also mandated that all insurance companies and self insurers develop and implement approved safety plans.

The most recent safety efforts utilize the workers' compensation system, sometimes in conjunction with other state agencies, to identify high hazard employers. Those that are identified in this manner are then required to implement safety programs, usually with penalties imposed for nonperformance.

MAINE

The Maine law provides for work place health and safety training programs, under rules established by the Commissioner of Labor or his designee. The Superintendent of Insurance is required to notify the Department of Labor of all employers with experience modification factors of 2.0 or more. The Department of Labor then notifies each such employer that they are required to undertake a safe work place health and safety program. There is a penalty equal to 5% of premium imposed for failure to complete the safety program. The program is under the direction of the Department of Labor.

There is also the Commission on Safety and Health in the Maine Workplace, outside the workers' compensation agency. Its role is to promote and improve safety and health programs, and to advise the Commissioner of Labor in the distribution of loan money that is used to assist employers with their safety programs.

MICHIGAN

A Workplace Health and Safety Board consisting of nine members from various sources is supposed to look at needed improvements to health and safety programs in Michigan workplaces. This provision of the law has never been implemented. It should also be noted that Michigan has a state OSHA program.

COMMENT

For all intents and purposes Michigan has nothing within its workers' compensation law that can be considered a safety and health program. Adoption of its law would require that Maine take steps to preserve what it now has, or perhaps improve on it.