



Government Evaluation Act Program Evaluation Report

Maine Workers' Compensation Board

November 1, 2017

Maine Workers' Compensation Board

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TITLE 3 §956. PROGRAM EVALUATION REPORT

§956. PROGRAM EVALUATION REPORT

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

[1995, c. 488, §2 (NEW) .]

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

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

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

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

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

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

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

D. [2013, c. 307, §3 (RP) .]

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

F. [2013, c. 307, §4 (RP) .]

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

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

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

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

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

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

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

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

- (1) The statutory authority for each filing requirement;
- (2) The date each filing requirement was adopted or last amended by the agency;
- (3) The frequency that filing is required;
- (4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and
- (5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication; [2013, c. 588, Pt. A, §1 (RPR).]

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

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

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

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

[2013, c. 588, Pt. A, §1 (AMD) .]

SECTION HISTORY

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

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Organizational Units and Programs

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

Administration (unit 2001)

Represented as a single unit and program

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

Information Management (unit 2002)

Represented as a single unit and program

A single unit that provides support for the Board's technology resources.

Dispute Resolution (unit 2003)

Represented as a single unit and program

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

Advocate Division (unit 2004)

Represented as a single unit and program

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

Monitoring, Audit & Enforcement Division (unit 2005)

Represented as a single unit and program

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

Enabling Legislation and History of Maine Workers' Compensation

ENABLING LEGISLATION

39-A M.R.S. § 101, et seq. (Maine Workers' Compensation Act of 1992)

On January 1, 1993, Title 39, which contained the Workers' Compensation Act of 1991 and all prior workers' compensation acts, was repealed and replaced with Title 39-A, the Workers' Compensation Act of 1992.

REVISIONS TO ENABLING LEGISLATION

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

- **§ 102(11)(B-1).** Tightened the criteria for wood harvesters to obtain a predetermination of independent contractor status.
- **§ 102(13-A).** Tightened definition of independent contractor and made it the same as the definition used by Department of Labor.
- **§ 113.** Permits reciprocal agreements to exempt certain nonresident employees from coverage under the Act.
- **§§ 151, Sub-§1.** Established the Executive Director as a gubernatorial appointment and member and Chair of the Board of Directors. Changed the composition of the Board from eight to seven members.
- **§ 151-A.** Added the Board's mission statement.
- **§ 153(9).** Established the monitoring, audit & enforcement (MAE) program.
- **§ 153-A.** Established the worker advocate program.

- **§ 201(6)**. Clarified rights and benefits in cases which post-1993 work injuries aggravate, accelerate, or combine with work-injuries that occurred prior to January 1, 1993.
- **§§ 212 and 213**. Changed benefit determination to 2/3 of gross average weekly wages from 80% of after-tax wages for dates of injury on and after January 1, 2013.
- **§ 213**. Eliminates the permanent impairment threshold for dates of injury on and after January 1, 2013 and establishes 520 weeks as the maximum duration for partial incapacity benefits with certain exceptions.
- **§ 213(1-A)**. Defines “permanent impairment” for the purpose of determining entitlement to partial incapacity benefits.
- **§ 217(9)**. Establishes that an injured worker participating in employment rehabilitation is protected from having his case reviewed except under three circumstances involving either a return to work, an increase in pay or because the employee reached the durational limitation for partial incapacity benefits.
- **§ 224**. Clarified annual adjustments made pursuant to former Title 39, §§ 55 and 55-A.
- **§ 301**. Notice changed to 30 days from 90 days for injuries on and after January 1, 2013.
- **§§ 321-A & 321-B**. Reestablished the Appellate Division within the Board.
- **§ 328-A**. Created rebuttable presumption of work-relatedness for emergency rescue or public safety workers who contract certain communicable diseases.
- **§§ 355-A, 355-B, 355-C, and 356**. Created the Supplemental Benefits Oversight Committee.

STATE AGENCY HISTORY

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

The Early Years of Workers' Compensation

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

Adjudicators as Fact Finders

In 1929, the Maine Federation of Labor and an early employer group called "Associated Industries" opposed Commissioner William Hall's re-nomination. Testimony from both groups referred to reversals of his decisions by the Maine Supreme Court. This early feature of Maine's system, review of decisions by the Supreme Court, still exists, although today these appeals are discretionary. The Supreme Court decides legal issues; it does not conduct de novo hearings. In Maine, our state agency adjudicator, today an Administrative Law Judge (ALJ) is the final fact finder.

Until 1993, Commissioners, (those who now are ALJs), were gubernatorial appointments, subject to confirmation by the legislative committee on judiciary. The need for

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

Transition to the Modern Era

Before 1974, workers' compensation coverage in Maine was voluntary for most employers. In 1974 it became mandatory. This and other significant changes to our Act were passed without an increased appropriation for the Industrial Accident Board. In 1964, insurance carriers reported about \$3 million in direct losses paid. By 1974, that number grew to about \$14 million in direct paid losses. By 1979, direct losses paid by carriers totaled a little over \$55 million. By 1984, this number grew to almost \$128 million. These figures are only part of the benefit picture because they do not reflect benefits paid by employers who self-insure. The exponential growth of the system resulted from legislative changes during the 1970s and set the stage for a series of workers' compensation crises that occurred throughout the 1980s, into the early 1990s with some of the vestiges still being felt today.

In the early 1970s, the durational limits were removed for both total and partial wage loss benefits. Inflation adjustments or cost of living adjustments (COLAs) were introduced. The maximum weekly benefit was set at 200% of the state average weekly wage. Legislation was enacted making it easier for injured workers to secure legal services. The availability of legal representation greatly improved an injured worker's likelihood of receiving benefits, especially in a complex case. Statutory changes and evolving medical knowledge brought a new type of claim into the system. The law no longer required an injury happen "by accident." Doctors began to connect repetitive overuse conditions to a claimant's work and thus brought these conditions within the workers' compensation coverage.

Gradual, overuse injuries frequently have slower recovery periods requiring benefit payments for longer periods than many accidental injuries. These claims were also more likely to involve litigation. Over the course of time, rising costs transformed workers' compensation into a contentious political issue in the 1980s and early 1990s.

In the 1980s, Commissioners became full time and an informal conference process was introduced in an attempt to resolve disputes early in the claim cycle, before a formal hearing.

Additionally, the agency expanded its physical presence, opening regional offices in Augusta, Bangor, Caribou, Lewiston, and Portland all supported by the central administrative office in Augusta.

In 1987, three full-time Commissioners were added, bringing the total from 8 to 11, in addition to a Chair. Today, the Board has reduced the number of staff hearing claims to nine, from a high of 11.

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

In 1992, a Blue Ribbon Commission was created to examine our system and recommend much needed changes. The Commission's report made a series of proposals which were ultimately enacted. Inflation adjustments for both partial and total wage loss benefits were eliminated. The maximum benefit was set at 90% of state average weekly wage. A limit of 260 weeks of benefits was established for partial incapacity. These changes represented benefit reductions for injured workers, particularly those with long term incapacity. Additionally, the provision of the statute concerning access to legal representation was changed making it more difficult for injured workers to secure the services of private attorneys.

Maine Employers' Mutual Insurance Company (MEMIC) was established. It replaced the assigned risk pool and offered a permanent coverage source. Despite differing views on the nature of the problems within the system, virtually all observers agree MEMIC has played a critical role in stabilizing Maine's workers' compensation environment.

Based on a recommendation of the Blue Ribbon Commission, the Workers' Compensation Board was created directly involving labor and management members in the administration of the agency.

The Board of Directors was initially comprised of four Labor and four Management members, appointed by the Governor based on nomination lists submitted by the Maine AFL-CIO and the Maine Chamber of Commerce. The eight Directors hired an Executive Director who ran the agency. In 2004, legislation was enacted reducing the Board to three Labor and three Management members. The Executive Director became a gubernatorial appointment, confirmed by the Senate and serving at the pleasure of the Governor.

The Board appoints Administrative Law Judges (f/k/a Commissioners, then Hearing Officers) who hear and decide formal claims. A two-step process replaced informal conferences: troubleshooting, and mediation.

In 1997, legislation was passed providing more structure to the claims monitoring operations of the Board and created the Monitoring, Audit, and Enforcement (MAE) program. Also in 1997, a worker advocate program, a pilot project created by the Board, was expanded by the Legislature. This program provides injured workers with legal counsel who provide guidance, legal advice, and prosecute claims.

In recent years, both the regulatory and dispute resolution operations of the Board have experienced significant accomplishments. The dispute resolution function has evolved into an efficient informal process. Between troubleshooting and mediation, approximately 69% of initial disputes that were filed and resolved in 2016 were resolved within 80 days from the date a denial was filed. An efficient formal hearing process has reduced timelines to an acceptable 11 months for processing average claims.

The Board of Directors was gridlocked when appointing Hearing Officers in 2003 and 2004 resulting in slower claims processing at the formal level. This problem was further exacerbated when the Law Court decided *Lydon v. Sprinkler Systems*. This decision significantly reduced the number of independent medical examiners (IME) available under 39-A M.R.S.A. §312. As reported earlier, the pool went from 30 to 11. We now have 25 active examiners and are constantly recruiting. The Hearing Officer gridlock was

broken when the Board agreed to appoint them to seven year terms. The IME problem has improved through the addition of better compensation for independent medical examiners and making it easier to qualify as an IME doctor.

In an apples-to-apples comparison, matching the complexity of the dispute and the type of litigation, the Board's average processing time for formal hearings is reasonable compared to other states, and is quite good if compared to the civil court systems for comparable personal injury claims.

The agency was criticized for not doing more with its data gathering and regulatory operations during the late 1980s and early 1990s. The Board installed a relational database in 1996, with modern programming language; the result was an improvement in data collection. Today, filings of First Reports and first payment documents are systematically tracked. Significant administrative penalties have been pursued in some cases. Better computer applications and the Abuse Unit have improved the task of identifying employers, typically small employers, with no insurance coverage. Now coverage hearings are regularly scheduled. The Board mandated the electronic filing of First Reports beginning on July 1, 2005. The Board has also mandated the electronic filing of claim denials; this became effective in June 2006. We are presently working on other areas where electronic filing would be appropriate.

During the late 1990s, the Board of Directors deadlocked on important issues such as the appointment of Hearing Officers, adjustments to the partial benefit structure under § 213, and the agency budget. By 2002, this became a matter of legislative concern. Finally, in 2004, legislation was proposed and enacted to make the Board's Executive Director a tie-breaking member of the Board and its Chair. The Executive Director became a gubernatorial appointment, subject to confirmation by a legislative committee and Senate. With the new arrangement, gridlock due to tie votes is no longer an issue. The Executive Director casts deciding votes when necessary. However, the objective is still to foster cooperation and consensus between the Labor and Management caucuses. This now occurs regularly.

Chapter 208, A Resolve to Appoint Members To and Establish Terms for the Workers' Compensation Board, was enacted during the second session (2008) of the 123rd

Legislature. The purpose of the Resolve was to change the membership on the Board while maintaining continuity. The Governor appointed new members during the first session (2009) of the 124th Legislature. The Governor's appointments were confirmed by the Legislature.

On October 15, 2015, per LD 1119, the title “Hearing Officer” was changed to “Administrative Law Judge” to reflect the role and duties of the position.

Program Descriptions

Executive Summary

The State Government Evaluation Act “provides for a system of periodic review of agencies and independent agencies of State Government in order to evaluate their efficiency and performance. The financial and programmatic review must include, but is not limited to, a review of agency management and organization, program delivery, agency goals and objectives, statutory mandates and fiscal accountability.”

WORKERS' COMPENSATION BOARD

The Maine Workers' Compensation Board has adopted an approach to managing the Workers' Compensation Act that strives to provide quality service, system stability, and procedural simplicity. Overall, dispute resolution continues to perform well; compliance with the Workers' Compensation Act is generally high, however, claim frequency is slightly higher; compensation rates are stable, but overall have been reduced more than 50 percent since 1993; MEMIC, the largest private workers' compensation insurer in the State, has repeatedly declared an multi-million dollar annual dividends for Maine policy holders; and the Board has kept the employers' assessment under control in recent years. All of these contribute to our continuing effort to keep the Maine workers' compensation system viable, which in turn creates a stable and productive market.

Although said before, we believe it is worth repeating, the Workers' Compensation Board, in recent years, has transitioned from an agency whose focus was mainly on dispute resolution to one which provides effective regulation, improved compliance, and functions as an advocate for both injured workers and the employers for whom they work. We endeavor to control medical costs through a comprehensive medical fee schedule that was thoroughly reviewed and updated last year, and updated again this year. With our limited resources, we continue to vigorously address the problem of

employee misclassification, and we are monitoring the national and state problem of opioids in medical treatment.

We believe it is critical the system maintain the positive and proactive momentum engendered by the Board in recent years. Our political landscape is ever changing. In spite of this reality, it is important for the Board to have a clear vision, one that reassures the Governor and Legislature we are fulfilling our mission “to serve the employees and employers of the State fairly and expeditiously.”

Staffing has been stable in recent years. We have had staff retire and others leave. We quickly filled these positions with very qualified individuals. We relocated two of our offices. These moves caused temporary disruptions, but ultimately were positive for improved agency functioning.

This report should provide the Governor and the Legislature with a foundation from which to analyze the Board’s workings and assess the effect our efforts have made.

To put the Board’s present functioning in context: the seeds of administrative changes at the Board were initially sown more than 13 years ago. At that time, the Governor worked with both labor and management to ensure the passage of legislation designed to eliminate Board gridlock and normalize operations. The legislation changed the Board structure from eight to seven members. Since the changes, three members represent labor and three represent management. The seventh is the Executive Director, who serves as Chair of the Board and at the pleasure of the Governor. Since 2004, the Board has worked to resolve the issues that formally caused gridlock and now focuses on setting meaningful policy. Some of the difficult issues the Board has, and continues to address, are: administrative law judge appointments; budgetary and assessment matters; electronic filing mandates; rule revisions; form revisions; legislation; compliance issues; independent medical examiner recruitment and retention; worker advocate resources and reclassifications; dispute resolution; increases in compliance benchmarks; independent contractor predeterminations and assessment; medical fee schedule updates; data gathering; and employee misclassification.

The importance of the 2004 legislation cannot be overly emphasized. Maine has gradually improved its national workers' compensation fiscal standing. An effective, efficient and well managed Board helps to facilitate this positive trend. Policy decisions are less regularly made by the Chair which means, in large part, the parties in interest are reaching consensus more often on decisions that impact the system.

It was not too long ago that Maine was one of the costliest workers' compensation states in the nation. Reports comparing Maine workers' compensation costs to other states demonstrate Maine has improved significantly. Maine is approaching the national average for indemnity and medical benefits; our status has improved when compared to the other jurisdictions requiring workers' compensation.

As we have reported in recent years, we have moved from one of the most expensive states in the nation to one that is in the average range for both premiums and benefits and have positioned ourselves to continue this trend. Maine is working towards a balance between reasonable costs and reasonable benefits, all within the Governor's policy of keeping Maine fair-minded and competitive.¹

The Workers' Compensation Board made significant progress on controlling medical costs when it adopted a medical facility fee schedule in 2011, and in updating all medical fees each year thereafter. The Legislature in 1992 mandated the adoption of a fee schedule to help contain health care costs within the system. It was not until 2011 one was adopted and implemented. Last year, Board staff conducted a comprehensive review of our schedule and updated it to accurately reflect trends in the medical marketplace. This year we again updated the schedule.

The objectives of the fee schedule include: providing access to quality care for all injured workers, ensuring providers are fairly paid, reducing and containing health care costs, and creating certainty and simplicity in this complex area.

¹ Some of the national reports comparing Maine to other jurisdictions repeatedly fail to consider the very high percentage of Maine employers who are self-insured. Approximately 40% of our market is self-insured. This is significantly higher than most other states. When national comparisons are made, they do not consider the self-insured community, thus these comparisons fail to give an accurate picture of the health of our workers' compensation market. In addition, the largest private carrier in the state, MEMIC, has in recent years returned substantial dividends to its policy holders. These dividends work to reduce employers' workers' compensation costs. This is yet another factor not considered in national cost comparisons.

This year, as has been the case over the past six years, the Board reached consensus on a number of issues and has moved forward on matters that have hindered its efficiency and effectiveness in the past.

We can still do more to improve Maine's workers' compensation system. We continue to work on employee misclassification, injured employees are being encouraged to explore vocational rehabilitation when appropriate, we are encouraging cooperative job placement efforts with the Bureau of Employment Services, and we are working to ensure system reporting compliance.

In recent years, the Maine Workers' Compensation Board has transitioned from an agency whose energies were mainly focused on dispute resolution to one which provides effective regulation, improved compliance, strong advocacy for injured workers, and open and equal treatment of the business community.

Introduction

To best understand the Maine Workers' Compensation Board, a background context is helpful. The original agency, known as the Industrial Accident Board, began operations more than 100 years ago on January 1, 1916. There was a name change in 1978 when it became the Workers' Compensation Commission. On January 1, 1993, there was another name change when it became the Maine Workers' Compensation Board.

The functions of the Board fit into seven broad areas: (1) Dispute Resolution; (2) Compliance – Monitoring, Auditing, and Enforcement (MAE); (3) Worker Advocacy; (4) Medical/Rehabilitation Services; (5) Technology; (6) Central and Regional Office support; and (7) the Appellate Division.

With the implementation of Standard Operating Procedures (SOPs), our claims management process has experienced a reduction and, in some cases, an elimination of backlogs. Dispute resolution has become more efficient. A Law Court decision in 2004 on our Independent Medical Examiner (IME) program reversed some of our early progress in this area. The Court's holding in *Lydon v. Sprinkler Systems* resulted in a reduction in the number of health care providers who were eligible and willing to become independent medical examiners. This caused delays in our formal hearing process. The effects of this decision can still be felt. Cases without need for an IME are processed more quickly than those involving a Board-appointed independent examination. In addition, the Board's ability to attract doctors in certain sub-specialties willing to serve as independent medical examiners is difficult, and in order to ameliorate the problem the Board has raised the fees payable to the IME doctors. The Legislature helped by enacting legislation in 2011, *An Act to Increase the Availability of Independent Medical Examiners*. The number of IME physicians was 30 pre- *Lydon*; 11 post- *Lydon*; and 25 currently. A concerted effort has been made in recent years to expand the pool of IME doctors. We have contacted specialty societies and sought to have information posted on sub-specialty websites. Through these efforts, we have modestly increased the number of IME providers.

The MAE Program has improved payment and filing compliance. MAE's goals are to (1) provide timely and reliable data to the Board and other policy-makers; (2) monitor and audit payments and filings; and (3) identify insurers, self-insurers and third-party administrators who are not complying with minimum standards. Compliance is at or near 90% in almost all reported categories, a major improvement since the inception of MAE.

The Worker Advocate Program gives injured workers access to trained representation. This improves the likelihood of receiving statutory benefits. Nearly 56% of injured workers are represented by advocates at mediation and about 34% are represented by advocates at formal hearings.

The Board is not a General Fund agency, that is, it receives no General Fund money. We are financed through an assessment on Maine's employers and their carriers. The Legislature established this assessment as the Board's revenue source. Our assessment is capped by statute. Recently, the Legislature prospectively increased our cap to ensure adequate funding for all future Board obligations.

The Board is working to improve efficiency and lower costs through administrative efforts ranging from mandating electronic data interchange (EDI), enforcing performance standards in the dispute resolution process, and enforcing compliance through the MAE program and the Abuse Investigation Unit.

Prior to the inception of the Maine Workers' Compensation Act of 1992, Maine was one of the costliest states in the nation for workers' compensation coverage. Recent national evaluations demonstrate an improvement in comparison to other states. Maine has moved from being known for its high costs, to a state that is approaching average premium costs while providing meaningful benefits. In recent years, we reported these reductions fit within the Governor's goal of making the system fair and competitive for the employees and employers of Maine. We strive to control costs for employers, and at the same time are working to provide benefits in an efficient manner to injured workers.

Dispute Resolution

INTRODUCTION

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

THREE TIERS OF DISPUTE RESOLUTION

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

Troubleshooting

Troubleshooting represents the initial stage of the Dispute Resolution process. At troubleshooting, a Claims Resolution Specialist informally attempts to resolve controversies by contacting the employer and the employee. Many times, additional information, often medical reports, must be obtained in order to facilitate a resolution. The Claims Resolution Specialist functions as a neutral in the system providing assistance and information. If the parties are not able to resolve the dispute at this stage, the claim is referred to the next step, mediation.

Mediation

At mediation, a case is scheduled with one of the Board's regional mediators. The parties attend in person or teleconference the mediation at a regional office. The favored and typical mediation is in person. The Board has seen an increasing number of requests for telephonic mediations in recent years. The agency is evaluating whether the increasing number of mediations conducted by telephone is impacting the effectiveness of the mediation process. In the typical case, a mediator requests the party seeking benefits provide an explanation and rationale for the benefits being sought. The mediator then

requests the other parties explain their concerns and identify what benefits they are willing to pay and/or why they are not prepared to pay benefits. The mediator seeks resolution proposals from the parties and the mediator may propose resolutions in an attempt to find an acceptable compromise. If the case is resolved at this stage, the mediator completes a formal agreement that is signed by the parties. The terms of the agreement are binding on those involved. If the case is not resolved at mediation, it could be referred to our formal processing. If a voluntary resolution is not reached at mediation, participation at mediation often benefits the parties by assisting them in identifying concerns that need further exploration and narrowing the issues that need to be addressed at formal hearing.

Formal Hearing

A formal hearing is scheduled after a petition is filed. At the hearing stage, the parties are required to exchange information, including medical reports, and answer Board discovery questions pertaining to the claim. After required discovery has been completed, the parties file a “Joint Scheduling Memorandum.” This document lists the witnesses who will testify and estimates the hearing time needed. Medical witness depositions are oftentimes scheduled to elicit or dispute expert testimony. At the hearing, witnesses for both sides testify and other, usually documentary, evidence is submitted. In most cases, the parties are represented either by an attorney or a worker advocate. Following the hearing, position papers are submitted and the Administrative Law Judge thereafter issues a final written decision.

Appellate Division

After the Administrative Law Judge issues a final decision, parties may file an appeal to the Board’s Appellate Division. On appeal, a panel of three Administrative Law Judges, or, if warranted, the entire panel of Administrative Law Judges (except the judge whose decision is being appealed) is assigned to hear the appeal. Parties file a record, briefs, and, in some cases, provide oral argument to the panel. After considering the issue, the Appellate Division will issue a decision affirming, reversing, modifying the decision or it will remand the case for further proceedings.

The number of cases entering each phase for the period 2006 through 2016 are shown in the table below:

Cases Entering Dispute Resolution			
Year	Trouble-Shooting	Mediation	Formal Hearing
2006	8,962	2,652	1,915
2007	8,749	2,499	1,765
2008	8,384	2,428	1,680
2009	7,960	2,220	1,602
2010	8,546	2,928	1,561
*2011	13,660	2,362	1,440
2012	14,526	2,766	1,398
2013	13,351	2,522	1,321
2014	14,035	2,755	1,333
2015	14,663	2,534	1,272
2016	14,936	2,449	1,424

*Beginning in 2011, the Board changed the way cases are counted. In the past, our count was based on the number of parties. In 2011, we started counting the "disputed issues." This change was made to more accurately report on the work of the Board, not just the number of participants within our system.

This chart shows that in recent years approximately one-fifth of disputed issues entering troubleshooting proceed to mediation. Of those going to mediation, just over half will continue to the formal hearing stage.

TROUBLESHOOTING STATISTICAL SUMMARY

The following table shows the number of filings and dispositions at troubleshooting, the average timeframes, and number of filings pending at the end of each year for the period 2006 through 2016.

Troubleshooting				
Filings Assigned, Disposed, and Pending				
Year	Assigned	Disposed	Pending 12/31	Av Days at TS
2006	8,962	8,927	701	27
2007	8,749	8,719	731	27
2008	8,439	8,439	676	30
2009	7,960	7,913	723	29
2010	8,546	8,303	919	27
* 2011	13,660	13,438	697	28
2012	14,526	14,514	685	24
2013	13,351	13,358	678	26
2014	14,035	14,067	646	32
2015	14,663	14,819	490	32
2016	14,936	14,741	685	25

* Beginning in 2011, the Board changed the way cases are counted. In the past, our count was based on the number of parties. In 2011, we started counting the "disputed issues." This change was made to more accurately report on the work of the Board, not just the number of participants within our system.

MEDIATION STATISTICAL SUMMARY

The following table shows the number of filings and dispositions at mediation, the average timeframes, and number of cases pending at the end of each year for the period 2006 through 2016.

Mediations				
Cases Assigned, Disposed, and Pending				
Year	Assigned	Disposed	Pending 12/31	Av Days at MDN
2006	2,652	2,741	496	61
2007	2,499	2,532	463	58
2008	2,428	2,488	443	55
2009	2,220	2,239	424	57
2010	2,928	2,868	452	59
2011	2,231	2,362	583	66
2012	2,766	2,738	555	50
2013	2,522	2,556	521	61
2014	2,755	2,789	487	57
2015	2,534	2,513	487	48
2016	2,449	2,509	406	55

FORMAL HEARING STATISTICAL SUMMARY

The following table shows the number of filings, dispositions, and lump sum settlements at formal hearing, the average timeframes, and number of cases pending at the end of each year for the period 2006 through 2016.

Formal Hearing					
Cases Assigned, Disposed, and Pending					
Year	Assigned	Disposed	†Lump Sum Settlements	Pending 12/31	Av Months to Decree
2006	1,915	2,173		1,270	11.7
2007	1,765	1,907		1,128	10.7
2008	1,680	1,728		1,080	8.4
2009	1,602	1,546		1,136	9.1
2010	1,561	1,486		1,211	8.5
2011	1,440	1,445		1,206	*10.8
2012	1,398	1,427	667	1,144	*12.1
2013	1,321	1,311	702	1,154	*9.7
2014	1,333	1,376	734	1,111	*10
2015	1,272	1,281	556	1,102	*10.9
2016	1,424	1,299	600	977	*10.7

* This figure represents all cases within the system. In prior years, certain cases were excluded. Claims processing has been slowed by a shortage of IME physicians in certain specialties, awaiting Medicare approval, and staff retirements.

† These figures were not recorded in prior years, but they are a significant part of the formal hearing process, so they will be included going forward.

APPELLATE DIVISION

As of December 31, 2016, 254 notices of intent to appeal have been filed since August 2012; 55 were filed in 2016. The Division has held oral argument in 61 cases, including five before *en banc* panels, and has issued written decisions in 136 cases, with 49 issued in 2016. Fifty-three appeals (11 in 2016) have been dismissed as a result of a post-appeal settlement, withdrawal by the parties, or procedural default.

OTHER

The number of cases entering the dispute resolution process declined steadily until 2010, when an increase was experienced. Because we are now attempting to provide a more accurate picture of this process, it is difficult to compare figures pre-2011 to those post-2011. Our new numbers demonstrate claim frequency is up slightly, a trend that is consistent with what is happening in workers' compensation nationally.

Office of Monitoring, Audit, and Enforcement

HISTORY

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

TRAINING

Our Board today believes a key compliance component is education. In early 2012, the Board confirmed this commitment by dedicating additional human and other resources to this training program for insurers, self-insured employers, claim adjusters, and administrators who manage Maine workers’ compensation claims.

The Board offers a two day “open training” four times a year in January, April, June, and October. These sessions provide a general overview of the Board and its divisions, as well as specific training in claims- handling techniques such as form filing, average weekly wage (AWW) calculations, and calculation of benefits due in a wide variety of scenarios a claim handler is likely to encounter. These sessions are very popular, both for those new to Maine claims, and as a review and update for the seasoned claims handler. For example, in our most recent full year, 78 adjusters, employers, providers, and others involved in workers’ compensation attended sessions. In addition, open training modules are available on the Board’s website. Quarterly training newsletters are emailed to approximately 800 subscribers. The newsletter is also available on the Board’s website. These writings address a broad range of claims-handling topics and report on Board activities that impact claims management.

The Board offers on-site training sessions which provide those being trained the opportunity to experience customized and specific-to-their-needs education. The six hour session focuses on the core of the open training sessions – form filing, AWW calculation, and benefit calculation. These presentations provide the opportunity to review the entity’s recent compliance and audit results, and address specific problems and issues they may have encountered. One hundred ten individuals from thirteen different insurers/administrator groups received on-site training in 2016.

Three special programs were held on proper claims handling and payments using the Board’s medical fee schedule. Seventy- one claim administrators and providers attended.

The Board participated in a training session held by the State Workers’ Compensation Division (WCD). Thirty WCD designees attended.

The Board participates in the annual Human Resources Convention where more than 800 are in attendance.

The Board provides training at the annual meeting of the Maine Workers’ Compensation community, the Comp Summit, which includes participation in the “Comp 101” session held each year for those new to our system. The Board also maintains a booth at the Summit where it provides information on training and other Board resources to attendees. Comp Summit 2017 was attended by more than 300 members of the workers’ compensation community.

Finally, the Board continues to provide access and assistance by telephone and email to claim handlers who have specific questions on difficult or unusual claims. The Board receives an average of a dozen such calls/emails a week through which it provides guidance on proper claims-handling techniques.

MONITORING

This section of the report, because of a data collection lag, traditionally provides information from the prior calendar year. This report is no exception. On July 12, 2016, the Maine Workers' Compensation Board of Directors approved the 2015 Annual Compliance Report (January 1, 2015 through December 31, 2015):

Lost Time First Report Filings

- There is compliance with the lost time first report filing obligation when a lost time first report is filed (accepted Electronic Data Interchange (EDI) transaction, with or without errors) within seven days of the employer receiving notice or knowledge of an injury causing an employee to lose a day's work.
- When a medical-only first report is received and later the claim is converted to a lost time first report, if the date received minus the date of the employer's notice or knowledge of incapacity is less than zero, the filing is considered compliant.
- The Board's benchmark for lost time first report (FROI) filings within seven days is 85%.
- Benchmark Not Met. Eighty-three percent (83%) of lost time FROI filings were within seven days.

Initial Indemnity Payments

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

Initial Memorandum of Payment Filings

- Compliance with the Initial Memorandum of Payment (MOP) filing obligation occurs when the MOP is received within 17 days of the employer's notice or knowledge of incapacity.
- The Board's benchmark for initial Memorandum of Payment filings within 17 days is 85%.
- Benchmark Exceeded. Eighty-six percent (86%) of initial MOP filings were within 17 days.

Initial Indemnity Notice of Controversy Filings

- Measurement excludes filings submitted with full denial reason codes 3A-3H (No Coverage).
- Compliance with the Initial Indemnity Notice of Controversy filing obligation occurs when the NOC is filed (accepted EDI transaction, with or without errors) within 14 days of the employer receiving notice or knowledge of the incapacity or death.
- The Board's benchmark for initial indemnity Notice of Controversy (NOC) filings within 14 days is 90%.
- Benchmark Exceeded. Ninety-four percent (94%) of initial indemnity NOC filings were within 14 days.

Wage Information

- Seventy-two percent (72%) of Wage Statement(s) and seventy-two percent (72%) of the Fringe Benefit Worksheet(s) were filed within 30 days.
- The Board has not adopted benchmarks for these filings.

AUDIT

The Board conducts compliance audits of insurers, self-insurers and third-party administrators to ensure all obligations under the Workers' Compensation Act are met. The functions of the audit program include, but are not limited to: ensuring that all Board reporting requirements are met, auditing the timeliness of benefit payments, auditing the accuracy of indemnity payments, evaluating claims-handling techniques, and determining whether claims are unreasonably contested.

A. Compliance Audits

The following audits were completed in 2016:

Auditee (alpha order)	Penalties
Allianz Insurance Group	\$ 4,600.00
AmTrust North America, Inc.	\$ 10,125.00
Broadspire Services, Inc.	\$ 4,500.00
Church Mutual Insurance Company	\$ 3,500.00
Frankenmuth (Patriot)	\$ 3,000.00
Hartford Insurance	\$ 1,500.00
Lumbermen's Underwritings	\$ 1,200.00*
Maine Automobile Dealers Association Workers' Compensation Trust	\$ 4,550.00
Matrix Absence Management	\$ 800.00
MS & AD Insurance Group	\$ 1,700.00
Ryder Services Corporation	\$ 00.00
SeaBright Insurance Company	\$ 5,000.00
Sentry Insurance	\$ 25,000.00
Zurich Insurance Group	\$ 13,350.00

*penalties negotiated, but not collected because the insurer became insolvent

B. Complaints for Audit

The audit program also has a complaint process. When a formal complaint is received, the Board conducts an investigation to determine if the insurer, self-administered employer or third-party administrator violated 39-A M.R.S.A. §359 by engaging in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims and/or has violated §360(2) by committing a willful violation of the Act, committing fraud, or making intentional misrepresentations. The complainant also asks that the Board assess all applicable penalties. In 2016, the Board received ten audit complaints. Though up slightly from 2015, the overall number is down significantly from previous years and is seen as a sign of a workers' compensation system that is working as designed.

C. Employee Misclassification

The misclassification of an employee as something other than an employee, such as an independent contractor, presents a serious problem for affected employees, employers, and our state economy. Misclassified employees are often denied access to the critical benefits and protections to which they are entitled under our Act. Employee misclassification also generates substantial losses to our state Treasury, Social Security and Medicare, as well as to state unemployment insurance.

In 2009, our Legislature established an allocation of funds to enhance the enforcement of laws prohibiting the misclassification of workers. In 2016, the MAE program completed 20 employee misclassification audits. The audits covered 257 employees, \$1,249,032.73 in payroll, \$1,988,864.28 in "subcontractor" wages shown on 1099's, and \$10,911.86 in "casual labor" wages that resulted in \$2,456,919.17 in potentially misclassified wages, which may result in \$162,798.07 in unpaid workers' compensation premiums.

Eight of the misclassification audits resulted in consent agreements between the Board and the audited employer finding a violation of the Act's coverage requirement, four audits led to investigations that are still underway, and eight

audits did not result in further action either because the employer had the required coverage or because the Board did not have the statutory authority to proceed at the time the audit was concluded. A legislative change in 2016, LD 1553, has given the Board the needed authority to address this problem through the assessment of penalties.

During 2015-2016, several employee misclassification investigations were placed on hold as a result of the Law Court's decision in the *Holyoke v. The Workers' Compensation Board*, 2015 ME 99. In its decision, the Court held an employer can comply with the Act's coverage requirements by purchasing a policy on an individual employee. The Court held the Board could not enforce the Act's coverage requirements in cases where an employer has misclassified its employees as independent contractors when there is a policy in place.

Employee misclassification was, and continues to be, a significant problem for employers that comply with the Act by covering all employees from the inception of a policy. The Board receives complaints from employers who think they are at a major competitive disadvantage because they, as opposed to their competitors, have complied with the law. The *Holyoke* decision eliminated the only recourse the Board had to ensure compliance by all employers. The Board introduced legislation to address this problem. The Board's bill was ultimately enacted into law (P.L. 2015, c. 469; LD 1553).

Chapter 469 resolved this problem by giving the Board authority to pursue penalties against employers who purchase a policy but misclassify some workers as independent contractors. The available penalties include civil monetary fines, criminal charges, and, revocation of corporate status or professional license. The latter penalties have traditionally been reserved for the most egregious offenders (e.g. – employers that are found to have multiple violations) and, with respect to revocation of corporate status, etc., for those employers that fail to pay fines that have been imposed by the Board.

Chapter 469 includes language that reflects this practice. Specifically, criminal charges, and, revocation of corporate status or professional licenses are reserved

for cases involving knowing violations. Chapter 469 defines knowing violations as follows:

For purposes of this subsection, a violation is considered a knowing violation if the employer has previously obtained workers' compensation insurance and that insurance has been cancelled or that insurance has not been continued or renewed, unless the cancellation, failure to continue or nonrenewal is due to a substantial change in the employer's operations that is unrelated to the classification of individuals as employees or independent contractors; the employer has been notified in writing by the board of the need for workers' compensation insurance; the employer has had one or more previous violations of the requirement to secure the payment of the compensation provided for by this Act; or the employer misclassifies an employee as an independent contractor despite a contrary determination by the board.

Penalties assessed on employees not properly covered by workers' compensation insurance are credited to the Employment Rehabilitation Fund, a fund that provides access to employment rehabilitation services such as vocational assessment, retraining and job placement.

ENFORCEMENT

The Board's Abuse Investigation Unit handles enforcement of the Workers' Compensation Act. The report of the Abuse Investigation Unit appears at page 47 of this report.

Office of Medical/Rehabilitation Services

MEDICAL FEE SCHEDULE

A. Background

The Maine Workers' Compensation Act provides, the goal of a medical fee schedule is "to ensure appropriate limitations on the cost of health care services while maintaining broad access for employees to health care providers in the State." 39-A M.R.S.A. § 209-A(2). The Board was tasked with establishing a medical fee schedule in 1993 and again in 2011. See, 39-A M.R.S.A. § 209 and § 209-A(4). The Board satisfied the latter requirement with the adoption of a medical fee rule effective December 11, 2011. The Board has, since the fee schedule adoption, kept the Rule current and consistent with its statutory obligation through annual and periodic updates.

B. Methodology

The Board's medical fee schedule reflects the methodologies underlying the federal Centers for Medicare and Medicaid Services' ("CMS") inpatient, outpatient and professional services payment systems. In particular, the fee schedule uses procedure codes, relative weights or values (together "relative weights") and conversion factors or base rates (together "conversion factors") to establish maximum reimbursements.

In the case of both procedure codes and relative weights, the Board does not exercise discretion in assigning codes to procedures or relative weights to coded services. The Board, in an effort to simplify our Rule, incorporated the codes and weights underlying the federal CMS inpatient facility, outpatient facility and professional services payment systems.

The Board's rule contains the final element of the equation to determine the maximum reimbursement for a service, i.e. the applicable conversion factor. Separate conversion factors exist for anesthesia, all other professional services,

inpatient and outpatient acute care facilities, inpatient and outpatient critical access facilities and ambulatory surgical centers.

C. Annual and Periodic Updates

The Act requires two types of updates: annual updates by the Executive Director and periodic, more comprehensive, updates undertaken by the Board. Annual updates are completed during the last quarter of each calendar year. Periodic updates are required every three years. The Board satisfied the second requirement with the adoption of the current iteration of the medical fee rule effective on October 1, 2015. A second periodic review is in process as this report is being written.

MEDICAL UTILIZATION REVIEW

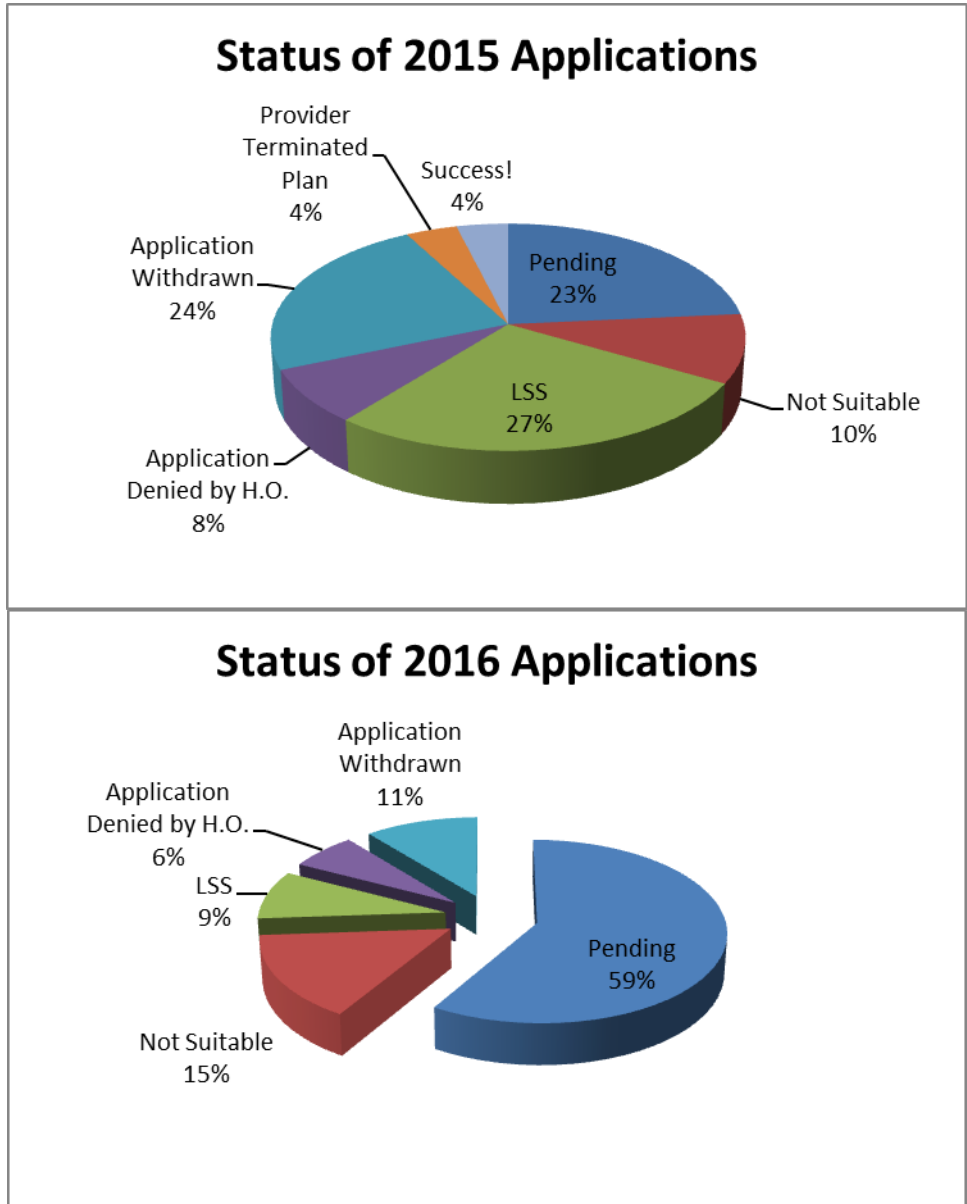
The issue of opioid use and misuse by injured workers is a major concern in the workers' compensation community as well as to society in general. The Board continues to discuss opioid use and misuse in Maine's workers' compensation; however, the Board does not currently have approved treatment guidelines. The legislature, in 2016, passed LD 1646, *An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program*. This legislation applies to all opioid prescribing in Maine. The Board is informally monitoring the legislation's impact on opioid prescribing in workers' compensation. In addition, it has secured the help of the National Council on Compensation Insurance (NCCI) to produce an annual opioid utilization supplement to its annual Medical Data Report.

EMPLOYMENT REHABILITATION

The Board has 21 approved employment rehabilitation providers pursuant to Title 39-A M.R.S.A. §217 and Board Rules Chapter 6. These rehabilitation professionals provide service, treatment or training necessary and appropriate to return an employee to suitable employment. In 2016, the Board received 47 applications for employment rehabilitation services, which represents a slight decrease compared to recent years. Of the requests, 40 were from injured workers, five from employers/insurers, and two were from our

Administrative Law Judges. The charts below show the status of 2015 and 2016 applications as of December 31, 2016.

New Legislation passed in 2017, LD 612: *An Act to Improve Vocational Rehabilitation under the Maine Workers' Compensation Act of 1992*, should increase vocational rehabilitation within our system.



The Board is in the process of drafting Rules that should help to encourage and facilitate vocational rehabilitation as a return-to-work option.

INDEPENDENT MEDICAL EXAMINERS

There were 510 requests for independent medical exams in 2016. Of the 510 requests, 294 were from injured workers, 200 from employers/insurers, 1 from an administrative law judge, and 15 by agreement of the parties.

The §312 Independent Medical Examiner System is critical to the Board's mission. Despite recent law changes and the recruitment efforts of the Board's Executive Director, the Board still lacks a sufficient number of health care providers willing and able to serve as independent medical examiners. At present, the Board has 25 independent medical examiners pursuant to Title 39-A M.R.S.A. §312 and Board Rules Chapter 4.

The Executive Director continues his efforts to recruit physicians to serve as independent medical examiners. In addition, with the assistance of the International Association of Industrial Accident Boards and Commissions (IAIABC), he is in the process of evaluating the Board's annual review process designed to measure the quality of the performance and the timeliness of the submission of the medical findings by the independent medical examiners.

The following health care providers currently serve as independent medical examiners:

CHIROPRACTIC

Ballew, David M., D.C.

FAMILY MEDICINE

Antonucci, Jean, M.D.

INTERNAL MEDICINE

Brett, Craig, M.D.

Medrano, Renato, M.D.

Nass, Meryl, M.D.

Teufel, Edward J., M.D.

ORTHOPEDIC SURGERY

Bradford, John A., M.D.

Donovan, Matthew J., M.D.

Graf, Frank A., M.D.

Mazzei, Richard J., M.D.

OSTEOPATHY

Findlay, James, D.O.

PHYSICAL MEDICINE &

REHABILITATION/PHYSIATRY

Bamberger, Stephan, M.D.

Guernelli, Gianelia F., M.D.

Hall, Genevieve, M.D.

Hall, John, M.D.

PODIATRY

Muca, Eric, D.P.M.

PSYCHIATRY & NEUROLOGY

Barkin, Jeffrey S., M.D. (psych)

Bridgman, Peter, M.D. (neuro)

Burke, David M., M.D. (neuro)

Robinson, Carl D., M.D. (neuro)

PSYCHOLOGY & NEUROPSYCHOLOGY

Bryant, Kendra L., Ph.D. (neuro)

Matranga, Jeff, Ph.D. (psych)

Merrin, Jason, Ph.D., Psy.D. (psych)

Riley, Robert, Psy.D. (psych)

PULMONOLOGY

Fuhrmann, Calvin P., M.D.

Worker Advocate Program

INTRODUCTION

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

Traditional legal representation is the core of the program; the Advocate staff have broad responsibilities to injured workers, which include: attending mediations and hearings; conducting negotiations; acting as an information resource; advocating for and assisting workers to obtain rehabilitation, return to work and employment security services; and communicating with insurers, employers and health care providers on behalf of the injured worker.

HISTORY

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

These changes made it difficult in many instances for injured workers to obtain legal counsel—unless they had a serious injury with substantial accrued benefits or a high average weekly wage. Estimates suggest upwards of 40% of injured workers did not have legal representation after this statutory change was enacted. This presented dramatic challenges for the administration of the workers’ compensation system. By 1995, recognition there was a problem prompted the Workers’ Compensation Board of Directors to establish a pilot “Worker Advocate” program.

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

The 1997 legislation resulted in a substantial expansion of the existing operation. Most significantly, the new program required Advocates to provide representation at mediation and formal hearings. The additional responsibilities associated with this representation require greater skill and more work than previously required. Some of the new responsibilities include: participation in depositions, attendance at hearings, drafting required joint scheduling memorandums, drafting motions, drafting post-hearing position letters, working with complex medical reports, conducting settlement negotiations, and analysis and utilization of the statute, our Rules, and case law.

THE CURRENT WORKER ADVOCATE PROGRAM

At present, the Board has 12 Advocates working in five regional offices. Advocates are generally required to represent all qualified employees who apply to the program. This contrasts with private attorneys who can pick and choose who they represent. The statute provides exceptions to this requirement where the program may decline to provide assistance. In 2014, the Board adopted a new Rule on Advocate representation allowing advocates to cease representation in cases where injured workers are uncooperative; e.g., refusing to respond to requests for meetings, information, etc. The Rule is based on the

Maine Bar Rules. While not frequently used, in the situations the Rule does apply, it helps advocates better manage their caseloads and spend time more productively with employees who need assistance, and less time chasing uncooperative clients. However, the reality is relatively few cases are rejected.

Cases are referred to the Advocate Program when there is a dispute—as indicated by the employee, employer, insurer, or a health care provider. When the Board is notified of a dispute, a Claims Resolution Specialist (commonly referred to as a “troubleshooter”) works to facilitate a voluntary resolution. If not successful, the Board determines if the employee qualifies for the assistance of the Advocate Program, and if so, a referral is made.

As reported in the dispute resolution section of this report, if troubleshooting is unsuccessful, cases are forwarded to mediation. Advocates representing an injured worker at mediation must first obtain medical records and other evidence related to the injury and the worker’s employment. Advocates meet with the injured worker, where they explore the claim and review issues. They also gather information from health care providers and others. Advocates are often called upon to explain the legal process (including the Act and Board Rules) to injured workers. They frequently discuss medical issues, review work restrictions and assist workers with unemployment and health insurance matters. Advocates provide injured workers with other forms of interim support, as needed. Many of these interactions produce evidence and information necessary for subsequent formal litigation, if the case proceeds to formal hearing.

At mediation, the parties appear before a Mediator, discuss the claim specifics, present the issues, and work to secure a resolution. The Mediator facilitates, but has no authority to require the parties to reach a resolution or to set the terms of an agreement. If the parties resolve the claim, the agreement is reduced to writing in a binding record. A significant number of cases are resolved before, at, and after mediation; of every 100 disputes reported to the Board, approximately 75 are resolved by the end of the mediation stage of dispute resolution, and thus avoid formal hearings.

Cases not resolved at mediation typically involve factual and/or legally complex disputes. These claims usually concern situations where facts are unclear or there are differing

interpretations of the Act and case law. If a voluntary resolution of the dispute fails at mediation, the case frequently proceeds to the formal hearing process.

The hearing process is initiated by an Advocate filing petitions (after assuring there is adequate medical and other evidence to support a claim). Before a hearing, the parties exchange information through voluntary requests and formal discovery. Preparation for hearing involves filing and responding to motions, preparing the employee and other witnesses, preparation of exhibits, analysis of applicable law and review of medical and other evidence. At a hearing, Advocates, like any lawyer, must elicit direct and cross examination testimony from the witnesses, introduce exhibits, make objections and motions, and, at the conclusion of the evidence, file position papers that summarize the facts and credibly argue the law in the way most favorable to the injured worker. Along the way, the Advocates also often attend depositions of medical providers, private investigators, and labor market experts. Eventually, a decision is issued or the parties agree on either a voluntary resolution of the issues or a lump sum settlement. In recent years, the average timeframe for the entire process is about 11 months, although it can be significantly shorter or longer depending on the complexity of medical evidence and the need for independent medical evaluations.

CASELOAD STATISTICS

Injured workers in Maine have made substantial utilization of the Advocate Program. Advocates represented injured workers at approximately 56% of the mediations held in 2016. Given the relatively large number of mediations handled by Advocates, it bears noting that from 1998 through 2008, the program consistently cleared a majority of the cases assigned in a given year for mediation. The following table reflects the number of Advocate cases mediated from 2005 through 2015. In 2016, the Advocate Division upgraded its case management and statistics software.

Advocate Cases at Mediation*

Year	Assigned	Disposed	Pending 12/31	% of All Pending
2006	1,522	1,533	280	56%
2007	1,397	1,434	243	52%
2008	1,405	1,437	211	48%
2009	1,205	1,195	221	52%
2010	1,006	1,156	271	60%
2011	975	896	246	42%
2012	1,703	982	294	53%
2013	1,465	1,540	270	55%
2014	1,688	1,486	307	64%
2015	1,621	1,410	326	66%
2016	1,608	1,089	228	56%

*The Advocate Division started using new software this year. This software allows us to capture data unavailable to us in the past. We anticipate revising this table in next year's report to provide more detailed data.

In 2016, the number of cases handled by Advocates at mediation represents a slight decrease as compared to the number of cases taken to mediation in 2015. The Advocate Division handled 56% of all mediations in our system in 2016.

Since becoming fully staffed, the Advocate Program has represented injured workers in approximately 29% of all Board formal hearings. In some years, Advocates clear more formal cases than were pending at the start of the year. Given the much greater scope of responsibility inherent in formal hearing cases, Advocates have performed well in their expanded role. The following table represents the number of cases handled by Advocates at formal hearing from 2006 through 2016.

Advocate Cases at Formal Hearing*

	Assigned	Disposed	Pending 12/31	% of All Pending
2006	628	715	361	29%
2007	632	673	320	28%
2008	599	610	309	29%
2009	564	511	362	32%
2010	463	515	306	26%
2011	438	374	242	20%
2012	444	289	338	29%
2013	476	281	377	31%
2014	461	293	305	26%
2015	503	275	326	29%
2016	693	382	333	34%

*The Advocate Division started using new software this year. This software allows us to capture data unavailable to us in the past. We anticipate revising this table in next year's report to provide more detailed data.

The Advocates handled more formal hearings in 2016 than in 2015. It should be noted that the Advocates continue to be responsible for 34% of the formal hearings held across the state in 2016.

SUMMARY

The Advocate Program was created to meet a significant need in the administration of the workers' compensation system. The statutory expansion of program duties in 1997 created unmet needs in the program. In order to meet the obligations in the statute, the Workers' Compensation Board has diverted resources from other work to the Advocate Program. Currently the program has 12 Advocates with a support staff of 16 (two of whom are part-time) and a supervising Senior Staff Attorney. Services are provided in five regional offices: Augusta, Bangor, Caribou, Lewiston, and Portland.

Over the years, the Program has proven its value by providing much-needed assistance to Maine's injured workers. As a result of limited resources, the Advocate Program has experienced periods of high caseloads which has led to staff turnover. In one 12-month period, (2006–2007) 42% of existing Advocate Program positions were vacant. Nothing has greater potential to impact the quality of the services rendered to injured workers than insufficient staff. In response to ongoing concerns, the 123rd Legislature provided additional support for the Advocate Program. Qualifications for Advocates and paralegals were increased and, in conjunction, pay ranges were upgraded. The changes, which went into effect in September 2007, were intended to attract and retain staff and to bolster stability of this program—which is an integral part of the workers' compensation system in Maine. We believe these goals are being met.

Technology

In recent years, the Board has implemented a number of significant changes within our information management systems and their delivery. By statute, many of the information delivery platforms and applications are centralized into the Maine Office of Information Technology (OIT). We work with OIT to improve the service quality and support needed.

The following represents a list of functional areas within the Board that have seen new development, upgrades, or enhancements to the systems used regularly:

- The EDI Payments initiative was the primary focus for the majority of development. Our goal was to be a position to offer to our trading partners the ability to send payment information via EDI thus reducing about 75% of the paper they are sending the Workers' Compensation Board. The initial plan was to offer submission of payment reports using the IAIABC Claims Rel 3.0 in a voluntary basis only and to then mandate Claims Release 3.1 in July 2017. The time frame for production of Claims Rel 3.1 was rescheduled to August of 2018 due the extensive number of changes submitted to the IAIABC by jurisdictions for inclusion into Release 3.1. We determined there would be less difficulty for the Trading Partners to wait until Release 3.1 and abandon the voluntary use of Release 3.0. We will continue testing for the changes to 3.0 and will incorporate the changes included in Release 3.1 as they are finalized.
- There was a Claims 3.0 change for the Claim Type Code that all jurisdictions must adopt within a two-year time frame. Maine has elected to have this modification implemented in the 3rd Phase, which must be in production by November 6, 2017. Along with this change, we also need to cease usage of the UR and CO transactions. Most of this work has been completed but implementation requires Rule writing.
- We completed the programming and introduced to our trading partners the ability for the Board to send back to claim administrators (CA) claim denial forms (NOC)

in a .pdf format. Providing the CA community the forms will ensure all parties to the dispute have the same information as the Board. All too often, when parties arrive at a mediation there are various versions of Board documents. This causes confusion and complicates the mediation process. We have also completed programming to return the FROI to the CA community for distribution to the employee and employer involved in the claim. These efforts have paved the way for sending additional forms to all parties in the future.

- In July 2016, the WCB replaced our law office client tracking software, Abacus. The Advocate Division had been using the application since 1997 and was comfortable with the product. The change was necessitated by the product supplier's decision to move all clients holding a lifetime license to change the application at an annual cost of \$36k. When the lifetime license was in place, they advised they were no longer going to honor the license. It would have been far more costly to litigate our contract rights than to purchase a new product. The Advocate program now uses the law office package, Practice Master. Advocate staff is credited with the project success due to their work reviewing functional needs, testing the new product, and continuing their current workload.
- The network infrastructure for the two WCB office relocations in 2016 allowed for an upgrade to the bandwidth in both the Portland and Augusta Central locations. Additionally all internal and security wiring was upgraded at the time we moved.
- The project known as the Progress Upgrade was plagued with false starts, poor planning and oversight, and basic failure. What should have been an eight-month to one year project is now in its fourth year. We have just begun testing to identify issues with the migration from Progress Release 9 to Progress Release 11. In addition to the time delay on this project, OIT has been unable to provide cost documentation and unable to tie the costs to specific project milestones. This has been disconcerting because the project has taken so long and the costs keep mounting.
- The WCB also replaced the enterprise search application known and ISYS Search Software due to a company buyout and the new owner's discontinuation of their desktop product. This left the Board with a decision to either use the Cloud version of the application with a \$33k yearly subscription cost or find an alternative

product. The Board went with the latter and selected dtSearch for initial investment of \$5k. Staff was trained and is currently working with the new product.

Future Challenges:

- Computer upgrades to Microsoft Windows 7 32-bit operating system were completed in July 2013. This work did not enhance performance of our computers due to the 3 GB memory limitation. Our operating system needs to be upgraded to a 64-bit version so additional memory can be installed for better system performance.
- OIT also informed the WCB the Progress database is not in their long-term plan and it is not a going-forward strategy for the State. There are options that may be available to the WCB that will be investigated over the next few years. Hosting and application development support are major topics that will need to be evaluated in the upcoming years.

Abuse Investigation Unit

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

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

The Unit's legal work is focused on enforcement of the insurance coverage obligations in the Act. The AIU staff investigates whether businesses have workers' compensation insurance; files complaints against businesses that are out of compliance; represents the Unit in administrative penalty hearings; and, when able, negotiates consent agreements resolving violations. The Unit is also responsible for defending appeals of "coverage" penalty decisions to the Board's Appellate Division.

AIU coordinates its work with the Board's Coverage Division and the Monitoring, Audit and Enforcement Program (MAE). It represents the MAE unit when a dispute arises as a result of one of an audit. AIU works with the Attorney General's office to enforce subpoenas, and to identify and refer cases for criminal prosecutions against employees and employers who have committed egregious or repeated violations of the Workers' Compensation Act.

Following is a list of the statutory provisions for which AIU is responsible.

- **Section 205(3):** when there is no ongoing dispute lost time benefits must be paid within 30 days of becoming due. Penalties of \$50 per day to a maximum of \$1,500 are payable to the injured worker for violations.
- **Section 205(4):** when there is no ongoing dispute medical bills are payable within 30 days of becoming due. Penalties of \$50 per day up to a maximum of \$1,500 are payable to a health care provider or the injured worker if there is a violation.
- **Section 324(2):** payments pursuant to a board order or agreement of the parties must be made within 10 days. Violations of this section may be penalized up to \$200 per day for each day of violation. The employee receives up to \$50 per day of any penalty assessed with the balance, if any, payable to the Board's Administrative Fund.
- **Section 360(1):** employers and insurers must provide information and/or file certain forms within deadlines specified. Penalties of up to \$100 per instance are payable to the General Fund.
- **Section 324(3):** entities conducting business in Maine, regardless of where they are based, must have workers' compensation insurance for any employees. Failure to carry coverage can result in penalties of up to \$10,000.00 or an amount equal to 108% of the unpaid premiums, *whichever is greater*. Violators are also subject to loss of corporate status, suspension of a state-issued license, and/or referral to the Attorney General for criminal prosecution. Penalties are paid to the Board's Employment Rehabilitation Fund.
- **Section 356(2):** benefits due to the work-related death of an employee are payable to the state when there are no surviving dependents as defined by the Act. An amount equal to 100 times the state average weekly wage is payable. AIU investigates possible cases and negotiates with insurers or litigates claims for payment.
- **Section 359(2):** any employer, insurer or third-party administrator found, after a hearing, to have a pattern of questionable claims-handling techniques or to have repeatedly unreasonably contested claims for compensation is liable for fines of up to \$25,000. Penalties are payable to the General Fund and violations are certified to the Superintendent of Insurance for further action.

➤ **Section 360(2):** individuals or businesses that commit a willful violation of the Workers' Compensation Act, fraud or intentional misrepresentation may be penalized. Individuals may be fined up to \$1,000 and businesses up to \$10,000 per violation and they may be ordered to pay compensation wrongfully withheld or repay benefits received. Penalties are payable to the General Fund.

Claims Management Unit

The Claims Management Unit (CMU) operates using a “case management” system. Individual claim managers process a file from start to finish, handling all filings for a given date of injury. The insurance carriers, claims administrators, and self-insured employers benefit from having a single contact in the unit. The Unit coordinates with the Monitoring section of the MAE Program to identify carriers who frequently file late forms or may be consistently late in making required payments to injured workers. Case managers in CMU review carrier’s filings to ensure payments to injured workers are accurate and that the proper forms are completed and filed with the Board. The Unit participates in compliance and payment training workshops quarterly with the MAE Program and as requested.

Electronic Data Interchange (EDI) has created efficiencies in this department. It allows managers to increase their claims management efforts through the electronic filing of the First Reports of Injury and Notices of Controversy. The EDI system has shifted the CMU workload, allowing a sizeable portion of mandatory filing information to be transmitted electronically. As a result, CMU staff can focus on troubleshooting more complex questions, verification of information in cases of dispute and investigate more serious problems. This shift in focus benefits the entire workers’ compensation community and assists carriers to identify potential problems early in the life of a claim.

Currently the Employer’s First Report of Occupational Injury or Disease and an initial Notice of Controversy are the only two forms that can be filed by EDI (corrections to a Notice of Controversy cannot be made electronically and must be filed by a paper form). All other Board forms are filed in paper form and are manually entered into our system.

For each paper form received, Claims staff searches the database for a matching claim, checking initially by Social Security number, then by Board claim number, employee name, and date of injury. CMU staff verifies the accuracy of payment information on each claim with a date of injury after 1966. Cost of Living Adjustments (COLA) are

calculated on claims with dates of injury from January 1, 1972 through December 31, 1992.

The Unit is also responsible for annually producing the “State Average Weekly Wage Notice (SAWW).” This notice contains information needed to calculate COLA’s on claims, to calculate permanent impairment payments, and determine whether to include fringe benefits when calculating compensation rates. The SAWW is determined by the Department of Labor each year. Using the SAWW, Claim staff calculates the COLA multiplier and maximum benefit in effect for the upcoming year.

Following is a brief description of the processing for the most often used forms.

Petitions – staff search to match the date of injury on the Petition to an existing claim. The file for the claim is located and the form information is entered in the Board’s database. The file is sent to the assigned Claims Resolution Specialist in the appropriate regional office for dispute resolution. If there is no claim matching the date of injury on the Petition, CMU contacts the person who filed the form and requests they file an Employer’s First Report of Occupational Injury or Disease so a claim file can be started.

Notices of Controversy - The initial form is filed electronically. Corrections to the form are submitted to the Board on paper forms and the changes are entered by Claims staff into the Board’s database of claims.

Answers to Petitions - The file for the claim is located, the information in the Answer is entered into the database and the Answer is filed or sent to regional office processing the claim.

Wage Statements - The average weekly wage is calculated by Claims staff in accordance with the Statute, Board Rules and Law Court decisions. The average weekly wage is entered into the database and the form put in the paper file.

Schedule of Dependent(s) and Filing Status Statements - The information on this form is entered into the database and the form is placed in the physical file.

Fringe Benefit Worksheets- The form is logged in as received and sent to the file.

Memorandum of Payment, Discontinuance or Modification of Compensation, Consent between Employer and Employee - The form is checked for accuracy; dates, the compensation rate, and the wage are compared to information previously filed. The information is entered into the database and the form is sent to the file. If there is any discrepancy, a telephone call or e-mail message is directed to the person who filed the form. Explanations or amended forms are requested when necessary.

21-Day Certificate or Reduction of Compensation - The form is checked for accuracy; dates, the compensation rate and the wage are compared to information previously filed. Information from the form is entered in the database. If the Claims staff determines there has been an improper suspension or reduction, they contact the person who prepared the form and request a correction. The file and form are sent to a Claims Resolution Specialist in a regional office if the form is not corrected promptly.

Lump Sum Settlement - The information on the form is entered into the database and the form filed.

Statement of Compensation Paid - The information on this form is compared to information previously reported, the form is entered into the database, and the form is filed. A large number of these forms have errors and staff must then research the file, contact the person who filed the form, and request corrected or missing forms.

BREAKDOWN OF CLAIM FORMS FILED WITH THE WORKERS' COMPENSATION BOARD

Information filed from November 1, 2015 - October 31, 2016

Information/Form	EDI	CMU	TOTAL
Employer's First Report of Occupational Injury or Disease	30,186	69	30,255
Notice of Controversy	10,757	52	10,809
Petitions		4,889	4,889
Answers to Petitions		821	821
Wage Statement		9,467	9,467
Schedule of Dependent(s) and Filing Status Statements		61	61
Fringe Benefits Worksheet		8,769	8,769
Memorandum of Payment		5,899	5,899
All other payment forms, including:		15,473	15,473
• Discontinuance or Modification of Compensation			
• Consent Between Employer and Employee			
• 21-Day Certificate of Discontinuance or Reduction of Compensation			
• Lump Sum Settlement			
Statement of Compensation Paid		15,236	15,236

Insurance Coverage Unit

The Insurance Coverage Unit is responsible for filings and records concerning workers' compensation insurance coverage. Board rules require employers doing business in Maine file proof of a workers' compensation policy (known as "coverage") with the Board. When an injured worker makes a claim for benefits, the claim must be linked to that employer's policy.

The Coverage staff provides information to insurers, employers, insurance adjusters and the public on insurance coverage requirements. Staff matches insurance coverage to employers, update employer records, and research the history of an employer's insurance coverage when there is a question what insurer is liable for paying benefits. Part of matching coverage to specific employers involves resolving instances of "no recorded coverage." Employers identified as needing but not having workers' compensation coverage are notified by letter and asked to contact the Coverage Unit. Coverage staff responds to these calls and, when possible, resolves the matter. The Unit is also responsible for processing applications to waive the workers' compensation coverage requirement, maintaining waiver records and rescinding waivers when applicants no longer meet the statutory requirements.

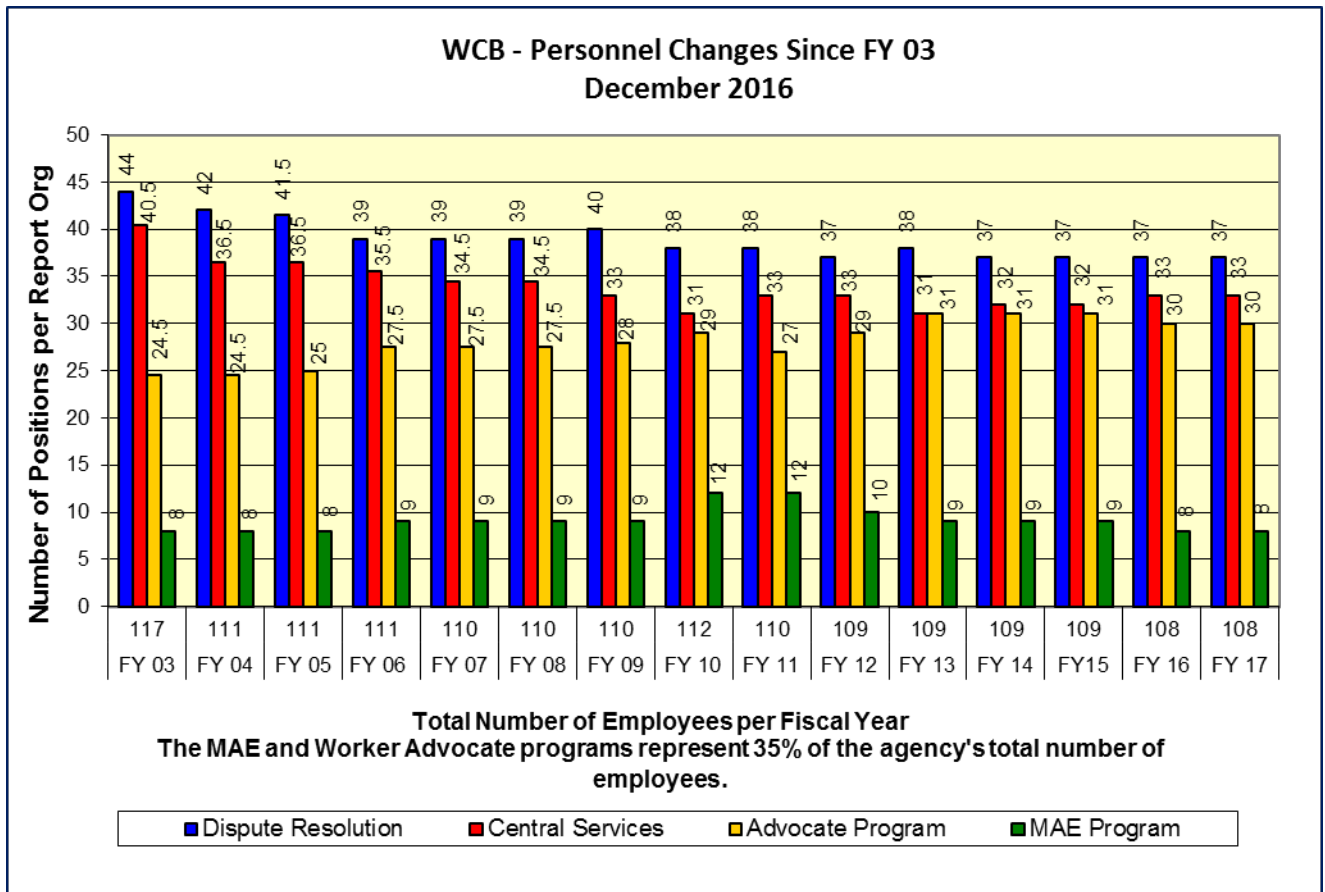
For the twelve (12) month period November 2015 through October 2016, the Board received and processed 55,348 filings providing employers' proof of workers' compensation insurance coverage. 5,462 "no record of coverage" letters were sent to employers requesting information to verify if they were subject to the coverage requirement, and if so, whether they had workers' compensation insurance. Information received in response to these letters allowed the Unit to determine 645 employers fell under one of the exemptions to the requirement for workers' compensation insurance. The Unit also received and processed 1,355 applications to waive the coverage requirement.

The Coverage staff works closely with the Abuse Investigation Unit on problems associated with coverage enforcement. The Unit Cooperates with the MAE program to identify carriers and self-insureds who consistently fail to file required information in a timely manner. They also assist the Bureau of Labor Standards in maintaining an accurate, up-to-date employer database utilized by both agencies.

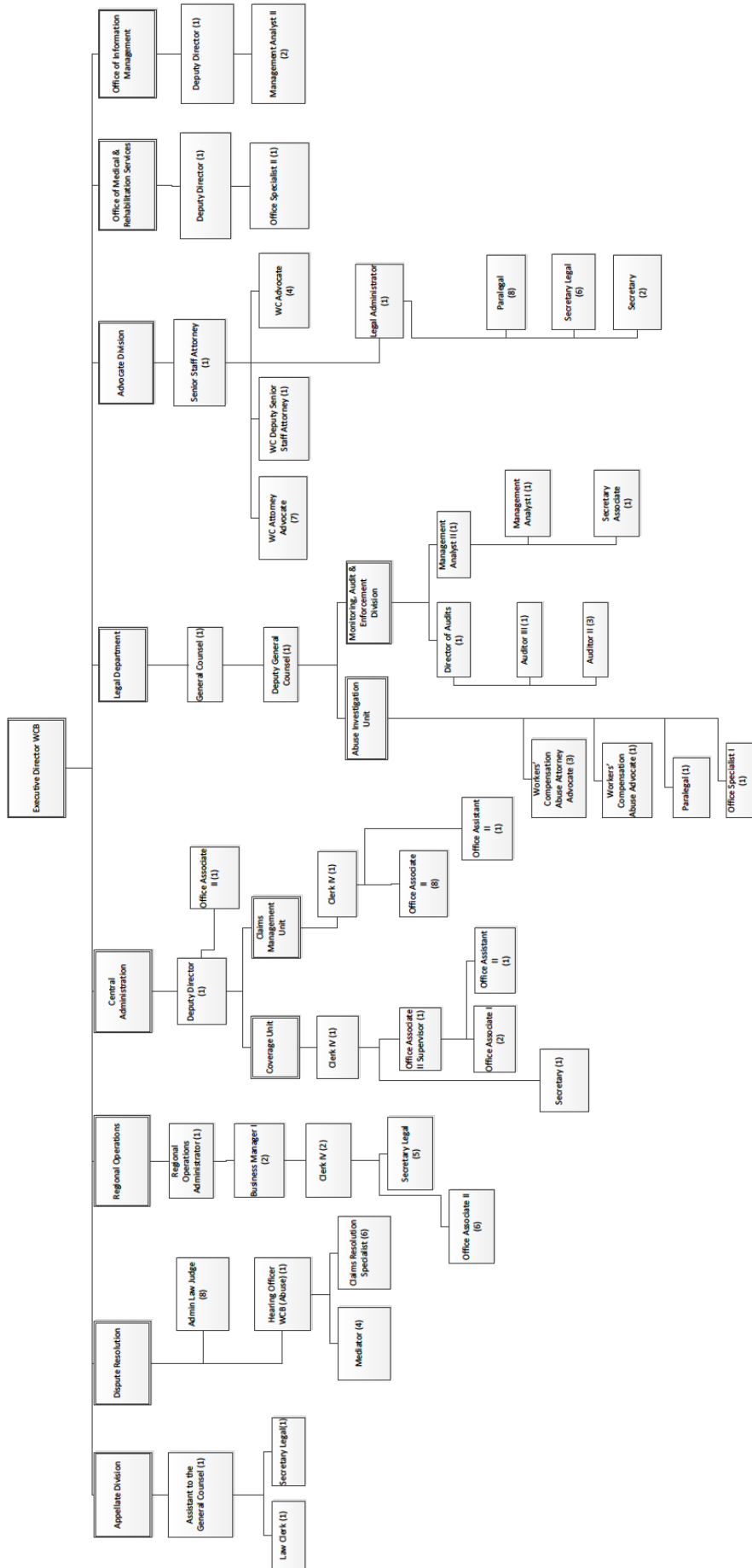
Organizational Structure, Position Count, Job Classifications

The Workers' Compensation Board's position count is 108. The Board's organizational structure and job classifications are detailed on the next page.

Note: The Board's position count is down from 122.5 in 2001.



Workers' Compensation Board Organizational Chart October 2017



Budget and Assessment

(Ten-Year Financial Summary)

The Workers' Compensation Board has two accounts: The Administrative Fund and the Employment Rehabilitation Fund. The Administrative Fund is the account from which the Board pays its expenses. It will be discussed more extensively than the Employment Rehabilitation Fund which, as a result of a legislative change, does not figure as prominently in the Board's operations.

ADMINISTRATIVE FUND

As a result of sweeping changes enacted in 1992, the Workers' Compensation Board replaced the Workers' Compensation Commission. As the Legislature and Governor debated the proposed changes to the Workers' Compensation Act, they also considered how to fund the new agency (i.e. the Board) which was being created.

The Board received an appropriation from the General Fund for fiscal year ("FY") 93. However, the Legislature and Governor decided, in the context of the economic slowdown in the late 1980s and early 1990s, that the Board should have an independent funding source. Therefore, the Board became and is an independent agency and receives no General Fund money. Instead, the Legislature and the Governor created an assessment on Maine's employers that supports the Board's operations.

The Workers' Compensation Board receives virtually all of its revenue from this assessment. The maximum annual assessment is set by statute. 39-A M.R.S.A. § 154(6).

The process for issuing and collecting the annual assessment is also in the Workers' Compensation Act. 39-A M.R.S.A. § 154. The statute requires the Board to divide the assessment between self-insured employers and insured employers. The division is based on the pro rata share of disabling cases that each employer category experienced. 39-A M.R.S.A. § 154(5).

Once the distribution of disabling cases is determined, the Board must then determine an assessment amount. In calculating the amount to be assessed, the Board first projects its expenditures. The Board then projects a prior budget surplus. The surplus is defined as the money in the Administrative Fund that exceeds the allowed reserve.² The surplus must be returned to Maine's employers in the form of a reduced assessment.

The Board has reduced its annual assessment in each of the last ten fiscal years (2007-2017). These reductions total \$21,387,500.

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

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

As indicated, in 1992, the Legislature established a statutory assessment of insurers and self-insurers to fund Board operations. Previously the agency received a General Fund appropriation. Assessments are paid by Maine's employers, both self-insured and those with insurance. By adopting a funding assessment, the Legislature intended the entities using the workers' compensation system pay the system costs. At the same time, the

² The Board is required to have a reserve equal to one-quarter of its annual budget. 39-A M.R.S.A. § 154(6). Currently, the Board's reserve account can be funded to a maximum of \$2,819,350. The reserve account is discussed more fully below.

Legislature placed an annual cap on the dollar amount allowed to be assessed, limiting the amount of revenue we could generate. The current Administrative Fund assessment cap of \$11,200,000 has been in place since 2012. The Legislature voted in 2016 to increase the assessment cap to \$13,000,000 annually starting in Fiscal Year 2018 (July 1, 2017 – June 30, 2018).

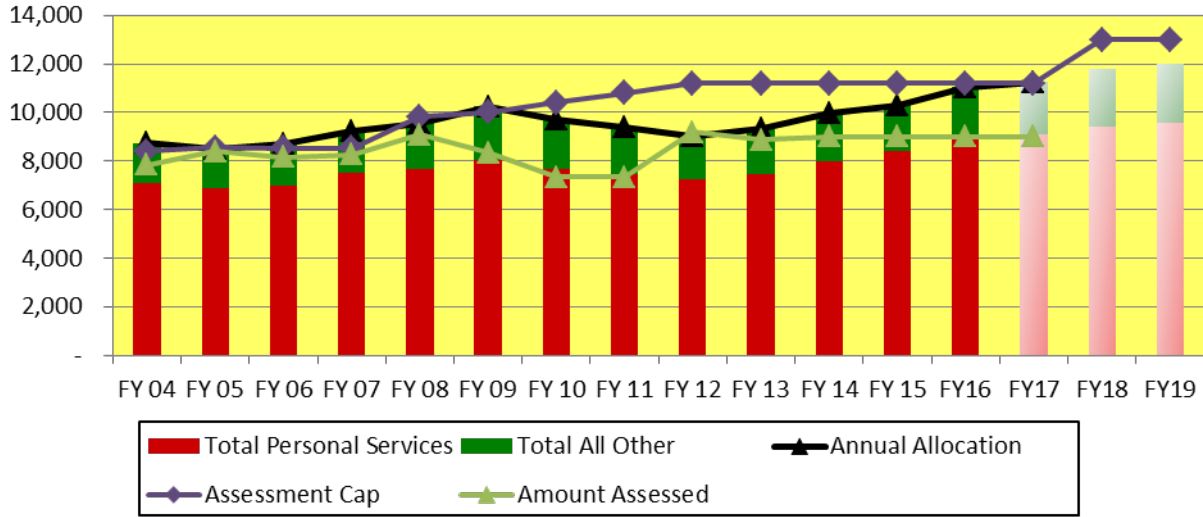
The Board cannot budget more than it can raise in revenue from the annual assessment, we do have other minor revenues collected from the sale of publications and some fines and penalties. The majority of the fines and penalties, however, are paid into the Rehabilitation Fund or the General Fund and are not available for Board expenses. The Board-approved budget for fiscal year 2017 ending on June 30, 2017 is \$11,256,581. The budget for fiscal year 2018, ending June 30, 2018, is \$11,819,123 and the budget for fiscal year 2019, ending June 30, 2019, is \$12,000,871.

The Board's funding mechanism also includes a reserve account. The Board may vote to use funds from the reserve account to assist in funding "Personal Services," "All Other" expenditures, and other reasonable costs incurred to administer the Act. The Bureau of the Budget and Governor approve all reserve fund requests via the financial order process. The bar chart entitled "WCB – 15 Year Schedule of Actual and Projected Expenditures" shows actual expenditures through FY16 and projected expenditures for FY 2017 through FY 2019. The chart also shows the amounts actually assessed through FY17 and the assessment cap through FY 19.

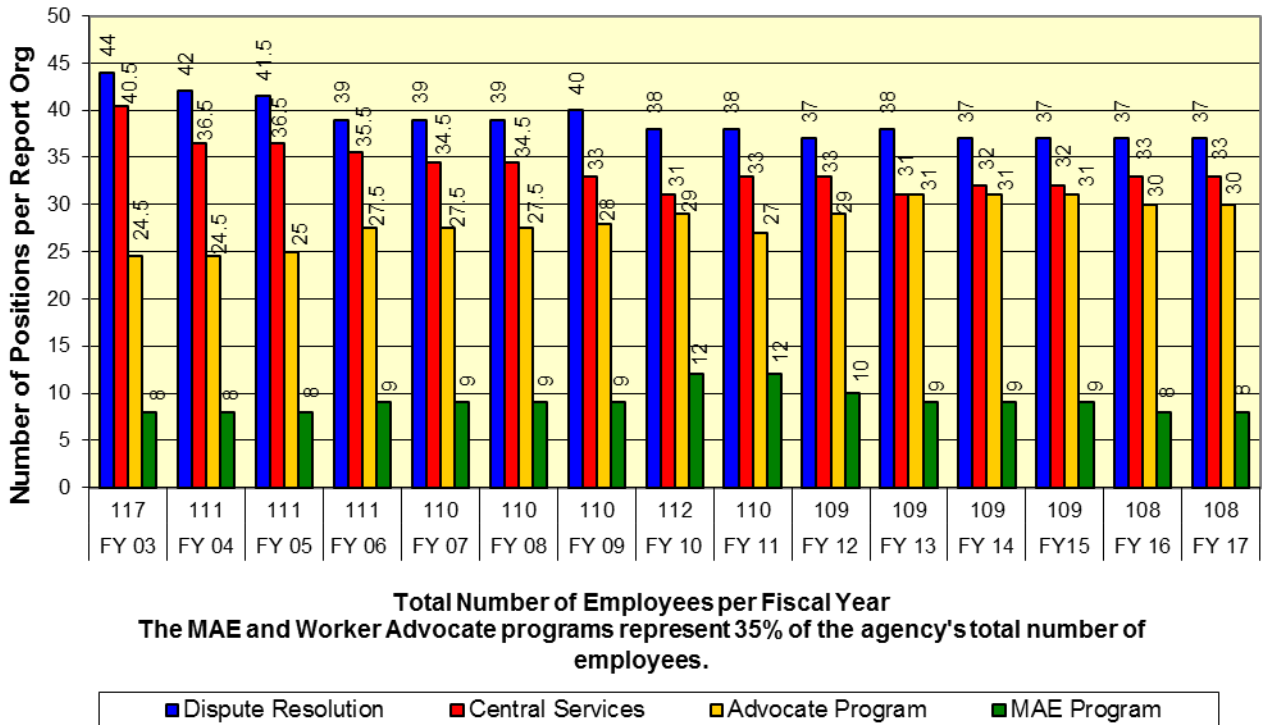
Since 2003, the Board has reduced staff by 9 positions from 117 to the FY17 level of 108. Despite the decrease during this period, the Board has accommodated staffing for new divisions created by the Legislature: the Monitoring, Audit & Enforcement (MAE) program, and the Advocate Division; and the Appellate Division created in 2012. The bar chart entitled "WCB – Personnel Changes Since FY03" illustrates the Board's efficient use of personnel.

**WCB - 15 Year Schedule of Actual and Projected Expenditures
Workers' Compensation Administrative Fund - 0183
December 2016**

(figures for FY 17, FY 18 and FY 19 are budget projections)



**WCB - Personnel Changes Since FY 03
December 2016**



Coordination with Other Agencies

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

DEPARTMENT OF LABOR

For years, the Board and the Department of Labor (DOL) maintained separate employer databases. The separate databases contained information unique to the needs of each agency, but there was also a significant overlap. Maintaining the two systems proved to be inefficient and resulted in unnecessary work. Information updated on one system, for example, would not always be updated on the other, causing confusion between the agencies. The Board and DOL worked together to merge their information into a single database. Today, the Board can more accurately determine whether employers are complying with the obligation to secure workers' compensation coverage for their employees.

The Board, DOL and other interested parties worked together to create a single, uniform "independent contractor" definition used for both workers' compensation and DOL purposes. The new definition has been in effect since January 2013 and is working well. In an effort to improve the overall effectiveness of the new definition, the Board is reviewing the application process for requesting a predetermination of an individual's employment status. Concerns have been raised it may be too easy to receive an independent contractor predetermination, thus, potentially, undermining the goal of ensuring all employees are covered by required workers' compensation insurance. We are evaluating this concern.

The Board also works with DOL’s vocational rehabilitation staff. In order to return injured workers to suitable employment as quickly as possible, the Board refers injured workers to qualified employment rehabilitation specialists, who evaluate the workers and develop rehabilitation plans. Some of these referrals are made to DOL staff. DOL’s staff does well ensuring plans for injured workers are tailored to the individual workers’ abilities and needs. The Board and DOL continue to monitor how effective the plans are at returning injured workers to suitable employment.

The Bureau of Labor Standards (BLS), a division within DOL, uses claim information gathered by the Board to produce statistical reports on workplace safety in Maine. These reports are used by the Board, policy makers, and others to understand how well the system is working and where there is room for improvement. BLS is currently working with the Board to develop and define procedures for filing claim information electronically.

BUREAU OF INSURANCE

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

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

OTHER AGENCIES

As the Board continues to shrink, it has entered into agreements with other agencies to provide services that used to be provided in-house. Several of these agencies are within the Department of Administrative and Financial Services (DAFS).

For instance, the Board's human resources needs are managed in conjunction with the Bureau of Human Resources. The Board and BHR have worked well together to address a number of personnel related issues.

A coordinated effort is also underway with the Office of Information Technology (OIT), another DAFS Bureau, to upgrade the Board's computer hardware and software. Upgrades include desktops, network servers, a database server, network hubs, and a routed network. Major programming changes are underway. We anticipate these will continue into the foreseeable future.

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

The Board works with the Maine Health Data Organization to gather information regarding payments for medical services made by private 3rd-party payors. The Board uses this data to evaluate whether its medical fee schedule sets appropriate limits on payments for health care services while maintaining broad access to care for injured workers.

Finally, the Board works with the Attorney General's office on matters ranging from employee misclassification to representation on collection matters when penalties are assessed and not readily paid.

Constituency Served by the Board

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

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

39-A M.R.S.A. § 151-A

Since its inception in 1916, the Board (then the Industrial Accident Commission) has existed to serve the employers and employees of Maine. No changes to the Board's constituency are imminent or anticipated.

Alternative Delivery Systems

The Board has implemented an electronic filing system that requires certain information be filed electronically. First Reports of Injury, Notices of Controversy and Proof of Coverage documents are all filed electronically now.

The Board has also expended the ability to file pleadings and other case related documents electronically in its regional offices.

Emerging Issues for the Board

OPIOIDS

Workers' compensation has been broadly characterized by members of the medical community as a medically-driven legal system. Because the work we do involves injuries sustained by employees, the workers' compensation system is subjected to the same problems which are inherent in all medical treatment in our state and society at large.

Opioids, beginning in 1996, crept into our cases. As time passed, they evolved from being a solution to a problem, to becoming a problem themselves. The Board had an informal taskforce working with occupational physicians to address the problem of opioids in our system. The Legislature, in 2016, enacted LD 1646, *An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program*. This legislation has had an impact on the use of opioids in this state and because the Workers' Compensation Board is a microcosm of the state, it has impacted the workers' compensation system.

In an effort to fully understand opioid use in our system, the Board has contacted the National Council on Compensation Insurance (NCCI), an organization that has in recent years been preparing a Medical Data Report for the Board. This Medical Data Report captures information on medical usage within our system and is able to best describe what is happening from a medical perspective. The Medical Data Report has been modified to add an Opioid Utilization Supplement. With this supplement, something we have specifically requested and have received over the last two years, we are able to monitor the use of opioids. Although we identify this as a problem, we think it is a problem in the process of slowly being solved. Time will tell what happens with this issue going forward.

MEDICAL MARIJUANA

On November 2, 1999, a ballot question provided for the removal of state level criminal penalties for the use, possession and cultivation of marijuana by patients who possess an oral or written “professional opinion” from a physician stating the patient might benefit from the medical use of marijuana. Initially, this legislation limited the amount of marijuana that could be used and required specific diagnoses. Our medical marijuana statute was amended several times and in 2009 diagnosed conditions or symptoms for which marijuana could be certified were expanded. The expansion included some we typically see as a result of work-related injuries. It was believed at that time it was only a matter of time before medical marijuana surfaced in workers’ compensation. In 2015, we had our first case.

Our Workers’ Compensation Act allows for payment of reasonable, proper, and necessary medical treatment. It was determined in the initial case the use of medical marijuana was appropriate given the nature and extent of the employee’s injury and his reliance on massive doses of opioids. Since that original decision, 11 other cases have been processed. Some of them allowed for the reimbursement of medical marijuana expenses because the claim fit within the Maine Medical Use of Marijuana Act, 22 M.R.S.A. §§2421 et seq. Others were denied because they did not fit within the Medical Use of Marijuana Act.

One case is presently before our State Supreme Court. The case has been briefed and the Court has heard oral argument. It is anticipated a decision will be rendered in this matter sometime in the foreseeable future.

OTHER NATIONAL TRENDS

Opioids and medical marijuana are national trends that are impacting our state. The other national trend we are carefully monitoring pertains to the number of constitutional challenges to state Workers’ Compensation Acts. Pennsylvania, Florida, New Mexico, Oklahoma, and Utah have all had provisions of their Workers’ Compensation Acts challenged. Some of the provisions in these states’ Acts are similar, but not identical to ours. We have had no constitutional challenges, but there is no reason to believe we are immune from having one or more going forward.

Other Information Specifically Requested by the Committee of Jurisdiction

No other information was specifically requested by the Labor, Commerce, Research and Economic Development Committee.

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

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

The LHWCA covers some workers in Maine who are also covered by Maine's Act. This is, therefore, concurrent jurisdiction. Injured workers can elect into what system they will elect benefits. Even though the programs are similar, most comparisons, in Maine and elsewhere, are directed at workers' compensation acts in other states. Maine is a member of the IAIABC and tries to keep abreast of trends in other states that may impact Maine.

The Board has adopted a medical fee schedule that reflects the system established by the Centers for Medicare and Medicaid Services.

Agency Policies for Collecting, Managing and Using Personal Information

Access to Workers' Compensation Board records, which are stored on a secure server, concerning individual employees is strictly limited by both statute and regulation.

Pursuant to 39-A M.R.S. § 152(2):

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

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

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

List of Reports, Applications and Paperwork Required of Public

The list must include:

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

A. First Reports of Injury

- (1) Required pursuant to 39-A M.R.S.A. § 303.
- (2) Last substantive regulatory amendment: December 27, 2010
- (3) Per statute, First Reports of Injury must be filed within 7 days of notice or knowledge of an injury that causes an employee to lose a day's work.
- (4) (a) Filings previous two years:
 - (i) 2016: 30,255
 - (ii) 2015: 29,434(b) Anticipated filings next two years: Approximately 30,000
- (5) The Board has implemented electronic filing of First Reports of Injury in an effort to minimize the paperwork associated with these reports.

B. Notices of Controversy

- (1) Notices of Controversy are required pursuant to 39-A M.R.S.A. § 205 which requires payment of incapacity within 14 days unless there is a dispute as to an employee's entitlement to benefits.
- (2) Last amendment to the filing requirement: April 12, 2012.

- (3) Pursuant to 39-A M.R.S.A. § 205(2) and Board Rule Ch. 1, section 1, Notices of Controversy must be filed within 14 days after notice or knowledge of a claim for incapacity.
- (4) (a) Filings previous two years:
 - (i) 2016: 10,809
 - (ii) 2015: 9,900(b) Anticipated filings next two years: Approximately 10,000
- (5) The Board has implemented electronic filing of Notices of Controversy in an effort to minimize the paperwork associated with these reports.

C. Memorandum of Payment

- (1) Memoranda of Payment are required by 39-A M.R.S.A. § 205(7).
- (2) The Board adopted a rule pertaining to Memoranda of payment in March of 1995.
- (3) Pursuant to 39-A M.R.S.A. § 205(7), Memoranda of Payment must be filed immediately upon the first payment of benefits.
- (4) (a) Filings previous two years:
 - (i) 2016: 5,899
 - (ii) 2015: 6,049(b) Anticipated filings next two years: Approximately 6,000
- (5) The Board is working on a rule/process for filing Memoranda of Payment electronically.

D. Forms Reporting Changes to Benefit Payments

- (1) Pursuant to 39-A M.R.S.A. § 205(9), benefits may be reduced either by the filing of a discontinuance or the filing of a Certificate of Discontinuance. Pursuant to Board rule Ch. 8, § 18, parties may use a consent form to change benefit payments. A discontinuance must be filed after a case is lump sum settled pursuant to 39-A M.R.S.A. § 352 to end any open payment schemes.
- (2) Last substantive regulatory amendment: December 27, 2010

- (3) The aforementioned forms must be filed whenever an employee's benefit payments are changed; either increased, decreased or terminated.
 - (a) Discontinuance filings previous two years:
 - (i) 2016: 15,473
 - (ii) 2015: 15,695
 - (b) Anticipated filings next two years: Approximately 15,500
- (4) The Board is working on a rule/process for filing these documents electronically.

E. Proof of Coverage

- (1) Required pursuant to 39-A M.R.S.A. § 403(1).
- (2) The most recent amendment was adopted on August 22, 2009.
- (3) By rule, proof of coverage must be filed within 14 days after the issuance, renewal or endorsement of a policy.
- (4) (a) Filings previous two years:
 - (i) 2016: 55,348
 - (ii) 2015: 44,720
- (b) Anticipated filings next two years: Approximately 50,000
- (5) The Board has implemented electronic filing of Proof of Coverage in an effort to minimize the paperwork associated with these reports.

F. Statement of Compensation Paid

- (1) Required pursuant to 39-A M.R.S.A. §§ 152(2), 152(7), 152(10), 153(1), 153(4) and 357(1).
- (2) The last amendment was adopted on March 4, 2001.
- (3) The First Statement of Compensation paid form must be filed within 195 days of an injury if incapacity payments are made, and then within 15 days of each anniversary date of the injury.
- (4) (a) Filings previous two calendar years:
 - (i) 2016: 15,236
 - (ii) 2015: 18,281

- (b) Anticipated filings next two years: Approximately 16,000
- (5) The Board is working on a rule/process for filing Statement of Compensation Paid forms electronically.

G. Wage Statements

- (1) Required pursuant to 39-A M.R.S.A. § 303.
- (2) The last amendment was adopted on March 4, 2001.
- (3) Wage Statements must be filed within 30 days of notice or knowledge of a claim for incapacity.
- (4) a) Filings previous two calendar years:
 - (i) 2016: 9,467
 - (ii) 2015: 9,408
- (b) Anticipated filings next two years: Approximately 9,400
- (5) The language enacted by the Legislature in section 303 was proposed by the Board several years ago in an effort to strike a balance between minimizing filing requirements while ensuring that sufficient information is available to adjust and monitor claims for incapacity.

List of Reports Required by Legislature

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

(2) Pursuant to 39-A M.R.S.A. § 153(10), the board shall collect and analyze data from Maine cases on permanent impairment ratings and costs to employers associated with the compensation for partial incapacity pursuant to section 213. The board shall provide annually by January 31st a report to the joint standing committee of the Legislature having jurisdiction over labor matters regarding the data collected.

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

- A. The number of individual cases monitored to ensure the provision of benefits in accordance with law, pursuant to section 152, subsection 10;
- B. The number of cases monitored to ensure the payments are initiated within the time limits of sections 205 and 324 and the adequacy of compensation provided pursuant to section 153, subsection 1;
- C. The number of investigations performed pursuant to section 153, subsection 7;
- D. The number of lump-sum settlements cases monitored and a summary of post-settlement employment experience pursuant to section 352, subsection 6;
- E. The number of audits performed and an assessment of compliance with this Act based on audit results pursuant to section 359, subsection 1;

- F. The number of penalties assessed and the reasons for the assessments pursuant to section 205, subsection 3; section 313, subsection 4; section 324, subsections 2 and 3; section 359, subsection 2; and section 360;
- G. The results of the monitoring program giving side-by-side information compilations for the past 5 years pursuant to section 359, subsection 3; and
- H. The timeliness of examinations conducted pursuant to section 312 and any other data regarding independent medical examiners and examinations.

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

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

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