MAINE STATE LEGISLATURE

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July 13, 1992

The Hon. William Hathaway
Co-Chair, Maine Blue Ribbon Commission
on Workers' Compensation
Danton Towers
207 E. Grand Ave.
Apt. 6D
Old Orchard Beach, ME 04064

Mr. Richard Dalbeck
17 Spoondrift Lane
Cape Elizabeth, ME 04107

Dear Chairs Hathaway and Dalbeck:

President O'Leary of the Maine AFL-CIO has asked that you be provided copies of Federal EEOC's Technical Assistance Manual on the Employment Provisions (Title I) of the Americans with Disabilities Act, Chapter IX, entitled "Workers' Compensation and Work-Related Injury".

A review of this recently issued publication indicates the need for correction of the June 26, 1992 Maine AFL-CIO position letter to the Blue Ribbon Commission in that at page 3, para. 3, stated that:

> "But the Americans with Disabilities Act is not particularly focused on workers' compensation and may not even apply to a worker who suffers a workplace injury followed by a period of disability and full recovery... ."

The underlined word "may" was employed improvidently and may be misleading. The sentence should be corrected to read:

> "But the Americans with Disabilities Act is not particularly focused on workers' compensation and DOES not even apply to a worker who suffers a workplace injury followed by a period of disability and full recovery... ."

The Maine AFL again encourages the Blue Ribbon Commission to give strong and favorable consideration in regard to reemployment by:

1. Applying the Maine Family Leave Law to workplace injury disability subject to the existing exception for employers of under 25.

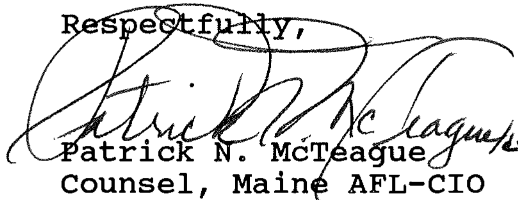
2. Enacting a Maine specific and Maine administered "Mainers with Disabilities Act" patterned exactly on the Americans with Disabilities Act and providing for identical procedures and remedies.

3. Vesting jurisdiction under the Mainers with Disabilities Act, the Family Leave Act, and all reemployment and anti-discrimination rights under the workers' compensation law in the Maine Human Rights Commission rather the Maine Workers' Compensation Commission.

4. Provide that workers' compensation insurance and group self-insurance may not apply to violations of the anti-discrimination provisions, the reemployment provisions of the Maine Workers' Compensation Act and the suggested Mainers with Disabilities Act and the Maine Family Leave Law amended to include protection for workers on leave because of workplace injury or disability.

The Maine AFL-CIO regrets any misunderstanding caused by its inadvertent misstatement.

Respectfully,



Patrick N. McTeague
Counsel, Maine AFL-CIO

PNM:cw
Enclosure
cc: The Hon. Emilien Levesque
Dr. Harvey Picker
Charles J. O'Leary, President
Maine AFL-CIO

Dictated But Not Read

PRETI, FLAHERTY, BELIVEAU & PACHIOS

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July 14, 1992

Hon. William D. Hathaway
BLUE RIBBON COMMISSION
c/o University of Maine Law School
246 Deering
Portland, ME 04101

Dear Bill:

When we appeared before your panel, we promised to send along information that we have regarding problems (and solutions) in workers compensation systems in other states. Enclosed are a variety of materials which you can scan in a few minutes, and which will give you an overview of some things happening around the country. Some of it you may have already seen.

I am also enclosing under separate cover to Michelle Bushey copies of the New Hampshire workers comp task force report and the Connecticut task force report.

Sincerely,

HAROLD C. PACHIOS

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encs.
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July 14, 1992

Ms. Michelle Bushey
BLUE RIBBON COMMISSION
c/o University of Maine Law School
246 Deering
Portland, ME 04101

Dear Michelle:

Enclosed please find copies of the task force reports on workers compensation from both New Hampshire and Connecticut.

Sincerely,

HAROLD C. PACHIOS

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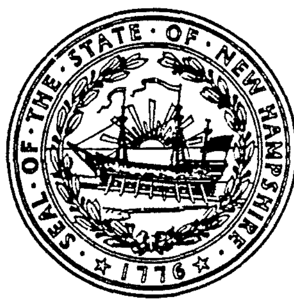
encs.
55330.bl3

REPORT OF THE TASK FORCE ON WORKERS' COMPENSATION IN NEW HAMPSHIRE

AUGUST 31, 1989



TASK FORCE MEMBERS:

David G. Hampson, Chairman
KENDALL INSURANCE, INC.

Peter M. Burton
NATIONAL COUNCIL ON COMPENSATION INSURANCE

James D. Casey
NEW HAMPSHIRE AFL/CIO

Glenn L. Rondeau
JAMES RIVER CORPORATION

James G. Scott
SHAW'S SUPERMARKETS, INC.

STATE OF NEW HAMPSHIRE

CONCORD 03301

EXECUTIVE ORDER NUMBER 89-4

an order establishing a
Governor's Task Force on Workers' Compensation.

WHEREAS, there is an urgent and substantial need to review and evaluate the performance of the State's workers' compensation system in order to ensure the system's consistent, affordable, and equitable operation; and

WHEREAS, it is necessary to provide an effective long-term solution which acknowledges growth and its effect on the varied interests involved in the system; and

WHEREAS, a thorough analysis of the workers' compensation system necessitates consideration of all components involved in the system, including insurance, medical, legal, employer and labor practices and concerns, and review of statutory provisions and administrative rules and regulations; and

WHEREAS, the State government's responsibility and mission is to evaluate the performance of the workers' compensation system in the achievement of its purposes; to anticipate and prepare for future needs and demands on the system; and, to make recommendations to meet current problems and future needs;

NOW, THEREFORE, I, JUDD GREGG, Governor of the State of New Hampshire, by the authority vested in me by Part II, Article 41 of the New Hampshire Constitution, do hereby establish a Governor's Task Force on Workers' Compensation for a one-year term.

Said task force will examine and analyze all aspects of the workers' compensation system. Data and information from the State's departments of labor and insurance, private sector, insurance practitioners, labor organizations, medical and legal communities will be collected and reviewed and resultant existing and potential needs shall be addressed to assure the health and viability of the State's workers compensation system and promotes efficiency and equity to the benefit of the citizens of New Hampshire. A coordinated planning and action effort shall be made in the public and private sector.

The task force shall submit periodic updates to the Governor with a final report and recommendations being completed no later than August 15, 1989.

Given under my hand and seal at the Executive Chambers in Concord this 27th day of February, in the year of Our Lord, one thousand nine hundred and eighty-nine.

Governor of New Hampshire

ACKNOWLEDGEMENTS

On January 26, 1989, Governor Judd Gregg appointed a Task Force to conduct a thorough review of the New Hampshire Workers' Compensation system. This report is the result of the work of the Task Force.

First and foremost the Task Force wishes to thank Governor Judd Gregg for the opportunity to participate in such a worthwhile task and for his foresight in recognizing the need to study New Hampshire's Workers' Compensation system.

The following people were or are part of the Task Force: David Hampson, Chairman, Peter Burton, James Casey, Glenn Rondeau, James Scott (who replaced Scott Ramsay, who resigned due to a job relocation) and Gerry Balch, who resigned due to a job relocation.

The Task Force retained a consultant, Ms. Mary Ann Stiles (of Stiles, Allen & Taylor, P.A.), to conduct a study of actual case files at the Department of Labor. Ms. Stiles' fees have been paid for with private funds that were raised from various individuals and organizations. In addition, the Task Force has utilized the Workers' Compensation Research Institute, a Cambridge, Massachusetts based non-profit entity that conducts research on workers' compensation. The Workers' Compensation Research Institute conducted an income replacement ratio study for the Task Force. Also, Medata, a for-profit medical information service organization, conducted a review of actual medical bills submitted to two major insurers and compared them to medical fee allowances in the States of Massachusetts and New York.

Numerous other persons provided invaluable assistance in conducting the study. We wish to thank them and any others who aided our efforts, whether specifically named or not. Special thanks go to the New Hampshire Department of Labor, including Richard Flynn, Commissioner; Anne Eaton, Director Workers' Compensation and Caroline Verity for her clerical support. Additional thanks go to the New Hampshire Insurance Department, including Louis Bergeron, Commissioner and the Attorney General's office, especially Charles Putnam, for their counsel.

MISSION STATEMENT*

Conduct a comprehensive study of the New Hampshire Worker's Compensation system. Upon completion of the study, present the 1990 session of the New Hampshire Legislature with a comprehensive set of recommendations for keeping workers' compensation costs under control.

*This mission statement is based on the language contained in the January 26, 1989 Press Release appointing the Task Force.

HIGHLIGHTS OF THE TASK FORCE ACTIVITIES

-Task Force members reviewed the entire New Hampshire Workers' Compensation statute and administrative rules as a group, one sentence at a time, in order to gain a complete understanding of all aspects of the statute.

-Task Force retained the services of a consultant, Ms. Mary Ann Stiles, in order to conduct a review of case files at the Department of Labor. This type of study reveals many intimate aspects of the "system at work".

-An income replacement ratio study was conducted with the assistance of the Workers' Compensation Research Institute.

- The Task Force conducted a review of actual medical bills in comparison with the allowable payments for these services under the medical fee schedules of Massachusetts and New York. This review was completed with the assistance of Medata.

-Specific meetings were held with Richard Flynn, Labor Commissioner; Louis Bergeron Commissioner of Insurance; Robert Duval and Dennis Murphy, former Labor Commissioners; and Anne Crane, former Director of Workers' Compensation at the Department of Labor.

-Open public hearings were held at three different locations around the state, two in Concord, one each in Conway and Nashua.

-A public session was held in Concord in June to present the summary findings of the Task Force Consultant's review of case files at the Department of Labor. Written testimony concerning the findings was actively solicited from any and all individuals and participant groups.

-A special day-long meeting was held with invited participant groups consisting of the following:

Alliance of American Insurers
American Insurance Association
NH Association of Domestic Insurance Companies
NH Hospital Association
NH Medical Society
Teamsters
State Employees Association
AFL/CIO
NH Bar Association - Defense Counsel
NH Bar Association - Plaintiff Counsel
NH Association of Commerce and Industry
Business and Industry Association

-General research on the subject of workers' compensation was conducted, including visitations to the Insurance Library in Boston and telephone inquires of other states that have or are studying workers' compensation.

-Task Force members were assigned special areas of concentration based on background research. These areas included rehabilitation, permanent partial injuries, medical fee schedules and workers' compensation in the State of Michigan.

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I. INTRODUCTION:

Workers' compensation has been functioning in the United States for close to seventy-eight (78) years. In most states, the workers' compensation system has either already broken down or is on the verge of breaking down.

Workers' compensation as originally conceived was based on the concept of "liability without fault". Under this concept, the fundamental purpose is a swift, certain and assured remedy for litigation. The system was never meant to create adversarial relationships between employer and employee. A system that was so simple in concept has become highly complex in its application. This in turn has created numerous inefficiencies that burden the system and contribute to escalating costs.

The system has many participants beyond the employer and employee. The other major participants in the system include the insurers, medical care providers, attorneys, and rehabilitation specialists.

To quote from the annual report of the Workers' Compensation Research Institute "the pace of change in Workers' Compensation systems has accelerated over the last two decades. Stimulated in part by the report in 1972 of the National Commission on State Workmen's Compensation Laws, state systems broadened coverage and liberalized benefits. As a result, workers' compensation costs to employers have risen, far exceeding anticipated costs of reform. Increased litigiousness has also raised the cost of what were intended to be efficient benefit-delivery systems."

The Task force has attempted, in its study of the Workers' Compensation System in New Hampshire, to address each and every issue in this complex system. Basic research has been utilized where possible in order to gain a factual understanding of the issues and pressure points in the system. There are no quick fixes in a workers' compensation system. Quite the contrary, a system must be viewed in its entirety with the impact of each change analyzed as to its overall impact on other aspects of the system. Furthermore, the dynamic nature of a workers' compensation system requires constant monitoring for needed modifications. As such, no one set of changes will provide the total answer forever.

We, the members of the Task Force, are proud to present the extensive package of recommendations for reform contained in this report. In deciding on the many issues, we have taken the facts known to us and have made decisions based on those facts. It is our collective feelings that implementation of the recommendations contained in this report will allow the New Hampshire Workers' Compensation System to reassume the leadership position that has been its trademark in the past.

II. OVERVIEW OF WORKERS' COMPENSATION INSURANCE COSTS IN NEW HAMPSHIRE:

In order to understand the current state of affairs concerning the cost of workers' compensation in New Hampshire, the following basic measures are presented:

- Incurred Losses - this represents the sum of both paid losses and future payments estimated to be paid on current cases.

- Earned premiums - this represents the premiums paid by employers and earned by insurers in New Hampshire for the period covered i.e. calendar year.

TABLE 1 INCURRED LOSSES*

Year	Amount
1978	$ 54 million
1983	$ 64 million
1987	$143 million

*Source - Best's Executive Data Service (A.M. Best is an insurance information and publication service), Exhibit 1

% increase 1978-83 = 19%
% increase 1983-87 = 123%
% increase 1978-87 = 165%

TABLE 2 EARNED PREMIUMS*

Year	Amount
1978	$ 61 million
1983	$ 93 million
1987	$179 million

*Source - Best's Executive Data Service, Exhibit 1

% increase 1978-83 = 52%
% increase 1983-87 = 92%
% increase 1978-87 = 193%

On an absolute basis, these numbers show the significant upward growth experienced in New Hampshire Workers' Compensation losses and premiums. These numbers show a rather alarming growth during the period of 1983-87, especially in the area of incurred losses, realizing that administered pricing can artificially limit earned premiums. For a discussion on administered pricing, see Section VII.

Another measure of New Hampshire's growth in workers' compensation can be seen by reviewing total payments which include cash indemnity payments for income replacement and medical payments.

TABLE 3 TOTAL CASH INDEMNITY AND MEDICAL PAYMENTS*

Year	Amount
1977	$ 26.3 million
1982	$ 60.5 million
1986	$107.7 million

*Source - May 1989 Bulletin National Foundation for Unemployment Compensation & Workers' Compensation Exhibit 2

	NH	Total U.S.
% increase 1977-82 =	130%	94%
% increase 1982-86 =	78%	62%
% increase 1977-86 =	309%	214%

The total cash indemnity and medical payments in New Hampshire for the period 1977 through 1986 were up 309 percent while during 1978 through 1987, incurred losses were up 165 percent and earned premiums were up 193 percent. This appears to provide some confirmation in the overall upward trend in workers' compensation costs for New Hampshire. As can be seen from Table 3, the growth in the cost of indemnity and medical payments in New Hampshire exceeded the national average for the ten year period by ninety-five (95) percent (309 percent vs. 214 percent). New Hampshire's growth of 309 percent during this period placed New Hampshire as the seventh highest in the nation.

How did the growth in New Hampshire's economy during these same periods impact the growth rates? The following measures are used to adjust for the changing exposure levels (covered employment) and claim activity.

-Average cost per claim - this is computed by dividing the incurred losses in a given year, by the total number of claims that year.

-Average premium per covered employee - this is computed by dividing the earned premium in a given year, by the number of covered employees that year.

TABLE 4 AVERAGE COST PER CLAIM*

Year	Amount
1978	$ 994
1983	$1,236
1987	$2,062

*Source - Incurred Losses Best's Executive Data Service Exhibit 1 and NH Department of Labor Statistics on Reported Injuries Exhibit 3

% increase 1978-83 = 24%
% increase 1983-87 = 67%
% increase 1978-87 = 107%

TABLE 5 AVERAGE PREMIUM PER COVERED EMPLOYEE*

Year	Amount
1978	$167
1983	$235
1987	$362

*Source - Earned Pemiums Best's Executive Data Service Exhibit 1 and NH Department of Labor Statistics on Covered Employees Exhibit 3

% increase 1978-83 = 41%
% increase 1983-87 = 54%
% increase 1978-83 = 117%

Table 4 and table 5 indicate that after allowing for the growth in covered employment and resulting injury rates, New Hampshire still shows a rather significant upward trend line in claim costs and premiums paid.

This trend is further supported by comparing the average benefit cost per covered employee (benefits paid divided by covered employment) published for all states by the National Council for Unemployment Compensation & Workers' Compensation. Table 6 shows New Hampshire and its growth compared to the other fifty (50) states.

TABLE 6 AVERAGE BENEFIT COST PER COVERED EMPLOYEE*

Year	Amount
1977	$ 84
1982	$173
1986	$249

*Source - May 1989 Bulletin National Foundation for Unemployment Compensation and Workers' Compensation Exhibit 2

	NH	Total U.S.
% increase 1977-82 =	106%	82%
% increase 1982-86 =	44%	45%
% increase 1977-86 =	196%	164%

New Hampshire ranks eighteenth (18th) highest in the nation for growth in average benefit cost per covered employee for the period 1977-1986. New Hampshire's overall growth rate in average benefit cost per covered employee is thirty-two (32) percent higher (196 percent versus 164 percent) than the average for all states during this period.

The next comparison pertains to the growth in reported injuries and compensable disabilities compared with the growth in covered employment. In other words, is New Hampshire producing more injuries and disabilities per hundred in employment?

TABLE 7 INCIDENCE RATES PER HUNDRED IN COVERED EMPLOYMENT FOR REPORTED INJURIES AND COMPENSABLE INJURIES*

Year	Incidence Rate Reported Injuries	Incidence Rate Compensable Injuries
1978	14.9	3.3
1979	16.1	3.8
1980	15.4	3.7
1981	15.0	3.1
1982	14.8	3.0
1983	13.1	2.5
1984	14.1	3.6
1985	13.3	3.2
1986	13.6	3.1
1987	14.0	3.1
1988	13.7	3.8

*Source - NH Department of Labor Statistics Exhibit 3 and Exhibit 4

In reviewing Table 7, it is apparent that the incidence rate for reported injuries has remained relatively stable with a downward bias and the incidence rate for compensable injuries has also remained relatively stable with a recent upward bias. Therefore, the significant growth in workers' compensation costs cannot be directly attributable to a significant increase in reported injuries and compensable injuries per hundred in covered employment.

Additional statistics that collaborate the trends in New Hampshire include the following:

-According to the National Council on Compensation Insurance (NCCI), during the period 1980-84 medical costs in workers' compensation for New Hampshire were up eighty-five (85) percent vs. fifty-nine (59) percent for the other NCCI states and for this same period indemnity costs (lost wages) in workers' compensation for New Hampshire were up fifty-seven (57) percent vs. thirty-three (33) percent for the other NCCI states.

-According to the National Council on Compensation Insurance (NCCI), New Hampshire has the ninth highest level of assigned risk premiums as a percent of total premiums. New Hampshire's assigned risk premiums through 1988 stand at 26.4 percent of total premiums in the state. The National average in 1988 for all NCCI states was 19.6 percent. Assigned Risk Pools are basically mechanisms of last resort in that when an employer can't find an insurance company willing to underwrite their workers' compensation insurance on a voluntary basis, they can submit their application to the Assigned Risk Pool for coverage. A high level of assigned risk premiums is an indicator of the general unwillingness of insurers to voluntarily write workers' compensation in the state, which is often the result of the insurers perception that rates are inadequate.

-During the period 12/1/83 - 1/1/89, the National Council on Compensation Insurance (NCCI) has requested five rate increases that totalled 100.3 percent. They were granted five rate increases totalling 44.5 percent.

New Hampshire
Rate Filing Activity*

Proposed Effective Date	Approved Effective Date	Amount Requested	Amount Granted
12/01/83	12/01/83	+ 8.7%**	+ 8.7%
04/01/84	05/01/84	+ 5.1%	+ 5.1%
12/01/85	05/01/86	+24.2%	+ 9.6%
12/01/86	05/01/87	+24.6%	+ 7.0%
01/01/88	01/01/89	+37.7%	+14.1%
		+100.3%	+44.5%

*Source: National Council on Compensation Insurance (NCCI)
**Law Changes Only

According to a report this past Spring in the publication *Business Insurance*, the NCCI has targeted New Hampshire for an additional rate increase of twenty (20) to thirty (30) percent.

-According to A.M. Best (an insurance information and publication service), for the five year period 1983-1987, New Hampshire had the twentieth (20th) highest five year direct/incurred loss ratio out of the fifty (50) states. (see exhibit 5)

New Hampshire's workers' compensation costs have shown high levels of growth during the past ten years with no end in sight. This upward spiral appears to have accelerated during the past five years which is no surprise, given the major changes to the system since 1983. It is difficult to put the brakes on escalating workers' compensation costs given the complexity of the system, coupled with the relatively long-term nature i.e. costs paid out over many years. However, if meaningful reform is ignored, there is a degree of certainty that the "worse is yet to come" in high workers' compensation insurance costs in the State of New Hampshire.

III. REFORM IN THE ADMINISTRATION OF THE SYSTEM:

The Department of Labor has the overall responsibility for the administration of New Hampshire's workers' compensation laws. If one considers the growth in employment in the State of New Hampshire over the past ten years and the resulting number of injuries and disabilities, coupled with the increasing complexity of New Hampshire's workers' compensation system, it is amazing that the Department of Labor has been able to perform as well as they have. Also, consider that the Department has had four changes in management, i.e., commissioners over this ten year horizon.

As a result of the additional administrative burdens, lack of sufficient staff, increasing complexity of the system and lack of management consistency, many inefficiencies and lack of attention to detail problems exist in the overall administration of the workers' compensation system. An example is the improper administration of the Special Fund for Active Cases that was established in 1975. This error produced improper assessments of significant magnitude. The following is an excerpt from a memo from Commissioner Flynn dated May 26, 1989, correcting the error as soon as it was made known to Commissioner Flynn (see exhibit 6 and Exhibit 7):

> "It has been brought to our attention by the Governor's Task Force on Workers' Compensation that the department's administrative handling of the Special Fund for Active Cases has been in error. It has been the department's practice to reimburse carriers from this fund for cost of living adjustments as required by RSA 281:23-a.
>
> The Task Force, however, has pointed out that the first sentence of RSA 281:23-b provides for reimbursement by the Special Fund for Active Cases for "payments made pursuant to RSA 281:23-a for compensable injuries occurring on or before June 30, 1975....". Therefore, the fund will no longer reimburse carriers for cost of living adjustments made in claims which occurred after June 30, 1975; adjustments for claims which occurred prior to July 1, 1975 will continue to be reimbursed by the special fund."

Therefore, a multitude of recommendations have been made to improve and/or correct these inefficiencies and managememt issues.

There appears to be widespread agreement among participants in the system that the current New Hampshire Workers' Compensation System is much too adversarial and does not provide for prompt hearings. The consultant's study (exhibit 8) revealed that "sixty-nine (69) percent of the cases initially scheduled were rescheduled for an average of 273 days from the date that the hearing was originally requested and were held 9.2 months later." Delays of this nature cannot be tolerated in a workers'

compensation system. The system should allow for a swift resolution of all disputes realizing that the central issue underlying all disputes is the awarding of benefits - their duration and amount. Lengthy delays of the hearings process are a major factor in the upward cost spiral and are unfair to both injured employees and their employers.

RECOMMENDATIONS FOR STATUTORY REFORM:

1. Redesign the hearings process as follows:

Process	Structure/Forum	Criteria
Step 1	Hearings Officer: informal hearings held in Concord and at other locations throughout the State	Case Merits and Facts: require all available evidence known be disclosed
Step 2	Compensation Review Commission: Appeals Board comprised of Director of Workers' Compensation or Deputy Commissioner plus 2 Hearings Officers new to the case being appealed	Case Merits and Facts: plus record from Step 1 hearing. Can only present evidence that was unknown at the date of Step 1 hearing
Step 3	Superior Court	Questions of Law only

This redesign involves adding a new appeals board (step 2), conducting hearings at other locations in the State, requires that all known evidence be disclosed at the hearing and allows appeals to Superior Court on questions of law only. This redesign is similar in concept to the structure recommended in The Report of the National Commission on State Workmen's Compensation Laws (see exhibit 9).

2. Modify the hearings officer position as follows:

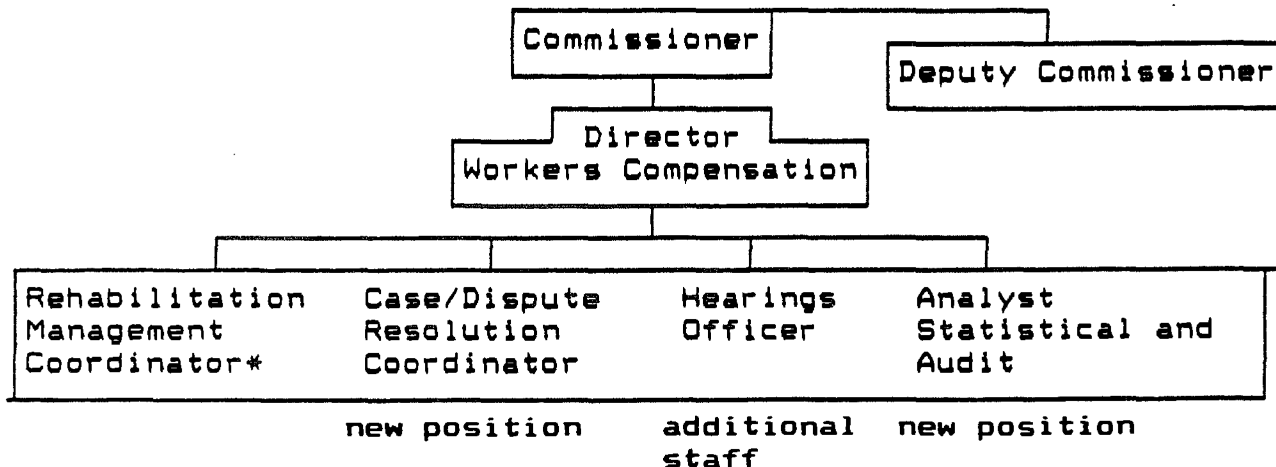
-increase job qualifications
-increase salary level
-strengthen the reporting structure and role
-develop a code of ethics for hearings and hearings officers
-develop and require at least fifteen (15) hours of continuing education each year
-require a minimum of an additional fifteen (15) hours of annual training and briefing with Attorney General's staff

3. Require timely hearings with a specific requirement that all hearings be held no later than six weeks from the date of request. Require that once hearings are scheduled they can only be continued by filing a written petition with the Department of Labor. Such written petition must be delivered to the Department seven days prior to the hearing, otherwise the hearing is not continued. Require that decisions will be rendered no later than thirty (30) days from the date of hearing. Require that when appropriate, based on the facts and merits of the case, decisions shall be rendered at the hearing. To the extent additional hearings officers are required to meet the required six week hearing turnaround they should be added. The Department of Labor will need to closely monitor performance against this standard and maintain an adequate staff of hearings officers and clerical support.

4. Allow for special expedited hearings, i.e., sooner than six weeks when requested and deemed appropriate. Require that such request shall be in writing and in sufficient detail to support the request. All requests for expedited hearings shall be reviewed periodically through case management at the Department of Labor to ensure requests are being given the proper attention and to identify any over-utilization by requesting parties.

5. Restructure the Department of Labor Workers' Compensation Unit as follows:

RESTRUCTURE OF DEPARTMENT OF LABOR
WORKERS' COMPENSATION UNIT



*Review current position to assure job description/qualifications are being met.

This restructure is vital to allow the Department to operate in an efficient and professional manner. The Report of the National Commission on State Workmen's Compensation Laws contained an example of the flow of information through a workers' compensation agency (see exhibit 10). In reviewing this flow chart and discussing the many functions of the Department of Labor in the area of workers' compensation, it is obvious that new positions are necessary to perform the overall functions of monitoring, feedback and control, all of which are the foundation of "good" management.

6. Restructure the Advisory Council as follows:

-Eleven (11) member council comprised of:

(1) member of House of Representatives
(1) member of Senate
(1) representing management
(1) representing labor
(1) representing defense bar
(1) representing plaintiff bar
(1) representing physicians
(1) representing chiropractors
(1) representing insurance companies
(1) representing self-insurers
(1) representing rehabilitation providers

The Advisory Council shall meet at least monthly and shall annually review the performance of the workers' compensation system, issuing a report of its findings and conclusions on or before January 1 of each year to the Governor, the Labor Commissioner, the Commissioner of Insurance, and the Speaker of the House of Representatives, President of the Senate, and appropriate committee chairmen of both houses as to the status of the workers' compensation system. In the performance of such responsibility, the Advisory Council shall have the authority to:

a. Make recommendations relating to the adoption of rules and needed legislation.

b. Develop recommendations regarding the method and form of statistical data collection.

c. Monitor the performance of the workers' compensation system in the implementation of legislative directives.

d. Perform other duties and responsibilities outlined in the current statute (see exhibit 11).

The department and other state agencies shall cooperate with the Advisory Council and shall provide information and staff support as reasonably necessary and required by the Advisory Council.

7. Modify the Special Disability Trust Fund to allow the following:

a. If an employee, who has a pre-existing permanent physical impairment, incurs a subsequent permanent physical impairment from a second job related injury, the employer can recover from the Special Disability Trust Fund for the cost of the second injury in excess of a specified threshold.

b. Allow employers to obtain payments on a cooperative basis (50/50 sharing of the costs subject to a maximum per employer) from the Special Disability Trust Fund for job modification costs for the purpose of retaining injured workers. This has been done in the States of Washington and Oregon, and it is recommended that Washington and Oregon be used as models (see exhibit 12).

These changes will help encourage the hiring and/or retaining of the handicapped and will promote the creation of less hazardous job processes.

8. Require the Department of Labor to develop a multi-media education program on safety in the workplace and other specific aspects of workers' compensation, including basic information explaining the workers' compensation system (see exhibits 13 & 14). Also, provide an "800" number answer phone to field questions from employers and employees.

More frequent and higher quality education of the employer and employee may significantly impact the level of litigation in the system. A study by the California Workers' Compensation Institute (see exhibit 15) provides insights into this issue and concludes that "uncertainty creates a fertile atmosphere for litigation". The following are selected findings of this study:

"-For 92 per cent of the sample it was their first work injury.
-85 per cent of the employees felt their injuries were "serious" or "very serious".
-Yet 74 per cent of the sample had no preinjury knowledge of workers' compensation and another 16 per cent knew something "but still had a lot to learn."
-Three of every four employees received little or no information about workers' compensation from the employer.
-20 per cent of the sample claimed no contact with the insurer. Of those who did have contact, more than half said the company representative was "not at all helpful", primarily because of perceived unwillingess to answer questions and explain procedures.
-Union members, half of the total sample, received little assistance or information from their union. Of those who did contact the union, 80 per cent merely were encouraged to see an attorney.
-The typical litigant most frequently contacts the attorney about two weeks after the injury-in most instances after contact with the employer, physician and insurer and after receiving the first payment of benefits."

9. Modify current penalty provisions in the statute as follows:

281:36B Failure to make payment of compensation - increase to $50.00 from $25.00.

281:37II Failure to comply with decisions by employer/insurer - increase to $50.00 from $25.00.

X 281:10I Employer failing to secure compensation - increase civil penalty for each day of noncompliance to $50.00 for each day from $10.00. 100 per day / per employee
1500.

281:46I Failure to report first report of injury - increase civil penalty to $50.00 from $25.00.

281:10 Employer failing to comply with requirement of providing workers' compensation coverage to employees - Subject owners and/or officers to criminal penalties if an employee is injured and it is determined that the employer failed to secure coverage.

Increasing these penalty amounts and putting stiff criminal penalties for failure to secure coverage under the Act will bring an awareness to employers as to the importance of the Act. The Department should make periodic reports on enforcement activities.

10. Implement changes in the area of qualified self-insurers as follows:

Require that all qualified group self-insurers come under the State Guaranty Fund. This would require qualified group self-insurers to pay an assessment, but would provide protection to claimants in the event of the self-insurers inability to pay future claims.

Allow employers from different industry groups to band together and form a qualified self-insurance group. Current regulations require that employers be in the same general industry to form a qualified self-insurance group. Since New Hampshire has such a varied group of industries with a predominance of smaller employers, the opportunities for group self-insurance is somewhat limited. This change would open up new opportunities for employers to consider self insuring their workers' compensation.

RECOMMENDATIONS FOR ADMINISTRATIVE PROCEDURES AND RULES:

1. Require Department of Labor provide Department of Employment Security with a listing of all individuals receiving benefits under workers' compensation. This should help reduce the possibility of collecting under both systems.

2. Penalties - administrative rules covering penalties - Department of Labor shall enforce these consistently and effectively. Require a quarterly report to Advisory Council of all penalties assessed.

3. In order to monitor compliance with securing coverage, develop rules allowing that the Department of Labor will receive from the State, a list of all employers doing business in New Hampshire and cross check this list against those who have registered with the Department of Labor.

4. Employee's Fault - need administrative rules on this subject on definitions, monitoring and enforcing.

5. Hearings and Awards - draft administrative rules to cover subject and follow up enforcement - this enforcement shall include a tracking system that issues a report to the Advisory Council.

6. Self-insured Guaranty Fund/Trust Administrative Rules - monitoring, follow-up, enforcement, with report to Advisory Council.

7. Approval of self-insurers - Department of Labor required to coordinate with Insurance Department for initial and renewal approval.

8. Decisions at hearings shall be periodically and routinely reviewed by the Director, Workers' Compensation, to provide for analysis of the consistency and impartiality of rulings.

9. Department of Labor shall promulgate guidelines that encourage early intervention by employers towards and for the injured employee. This would be an additional aspect of the multi-media program discussed in Recommendation #8 in the previous discussed statutory recomendations section, elements to include communication, transitional early return-to-work programs and safety retraining.

10. Department of Labor shall develop a system of monitoring liens and subrogation activities by insurers.

11. Department of Labor shall study notification compliance on the part of the employee, employer and providers in the system. A special emphasis should be directed to review of RSA 281:16-a notice of injury. This section of the statute allows notice of an injury to be given up to two years from the date of injury, which is an excessive length of time and far in excess of the length of time allowed in other states.

IV. REFORM IN THE AREA OF SAFETY:

The area of safety is the single most important component of a workers' compensation system. If there were no workplace accidents, then there would be no workers' compensation claims. The reality is that workplace accidents can and do occur and can never be totally eliminated. However, the frequency and severity can be greatly reduced by the design, implementation and carrying out of well constructed safety programs. Preventing accidents in the first place will produce savings far in excess of any other single action item.

The Task Force has attempted to create a package of safety related recommendations that will assist in both encouraging safety and rewarding safety.

RECOMMENDATIONS FOR STATUTORY REFORM:

1. Require employers with ten or more full-time employees (excluding financial, insurance, professional office, legal, banking and other similar predominantly clerical office type operations) to have on file with the Department of Labor, a current written copy of their firm's safety program. All such programs to include specific provisions addressing employees non-compliance with safety rules and regulations and failure to use required safety equipment.

   This recommendation will require employers with non-existent or outdated safety programs to consciously review their safety issues and create a safety program or modernize their existing program. It will also provide the vehicle for addressing employee non-compliance with safety rules and procedures, including the process of warnings, job suspensions and job terminations for violations of safety rules and regulations.

2. Require that the Department of Labor, in conjunction with the National Council on Compensation Insurance (NCCI), develop a list of the best and worse performers based on the experience modification factors promulated by the NCCI. These factors are computed from insurance company reports on a firms premiums and losses by job classification and reflect the firms performance relative to the expected levels (see exhibit 16). The list will include the top ten lowest experience modifications and the Commissioner shall be required to publicly recognize these low experience modification employers by presenting them with an award at the annual Department of Labor Workers' Compensation conference. The list of the top ten highest experience modification employers will be provided to the Advisory Council and the Department of Labor shall be responsible for reviewing specific claims against these employers in conjunction with their safety program on file at the Department of Labor. A final aspect of this recommendation is to require that all qualified self-insurers shall be required to develop experience modification factors by submitting the appropriate information to the NCCI. Currently, self-insurers are not required to calculate experience modification factors, however, some self-insurers are voluntarily calculating experience modifications.

This recommendation will help encourage safety in the workplace.

3. Require that a medical and/or indemnity deductible be allowed in all commercial workers' compensation insurance policies. The minimum deductible allowed shall be $500.00 per claim with other options, up to a maximum to be determined by the Commissioner of Insurance. These deductibles are to be available on an optional basis.

The use of deductibles in workers' compensation has become a recent trend with the States of New Mexico, Colorado and Montana recently enacting legislation allowing for deductibles. Basically, the use of deductibles help speed up the payment on small claims, provide premiums savings and provides an awareness factor to the employer on the cost of accidents. This awareness factor should produce a residual safety incentive.

4. Require that both debit and credit schedule rating be allowed on a voluntary basis for workers' compensation insurance policies. The range of debits and credits shall be plus or minus twenty-five (25) percent and shall be based on a firms safety policies and record, along with the firms return to work policies on injured employees. Schedule rating is an insurance pricing mechanism that is commonly used in other forms of casualty and property insurance. Under schedule rating, the insurance company based on the criteria outlined, can either discount or surcharge the current rates to arrive at a new rate. This type of program shall be voluntary on the part of the insurer and the employer. Therefore, insurers would not be required to provide discounts and employers would not be required to accept surcharges. The system would however, allow better use of the free and competitive market theory and thus provide lower cost insurance to the "safer" employers.

The use of schedule rating with the basis being safety and return to work, should provide an incentive for employers to develop positive safety and return to work programs and in doing so, realize immediate insurance premium savings.

5. Require that the premium discount will be eliminated for employers in the workers' compensation assigned risk pool who have experience modification factors of 1.50 or higher. Premium discounts apply on the basis of premium size (see exhibit 17).

This provision would only apply to larger employers since experience modification rating requires either a premium of $9,000 the last year or last two years, or if more than two years, an average annual premium of at least $4,500. This threshold is subject to periodic upwards adjustments (see exhibit 18).

This would effectively provide a disincentive to the employers who allow their modification experience to deteriorate to 1.50 or higher due to the frequency and severity of their workers' compensation claims. Assigned risk pools are meant to be avenues of last resort for obtaining workers' compensation insurance.

As an avenue of last resort, the typical employer in the assigned risk pool should be a firm that due to its prior loss history and/or current safety practices, can't find an insurance company that will voluntarily insure their workers' compensation. A possible exception is the small employer who may be in the Assigned Risk Pool due to size. Focusing on eliminating the premium discount for employers with an experience modification factor of 1.50 or higher may help depopulate the assigned risk pool, as it may help convince some employers to accept voluntary retrospective rating, i.e., cost plus type insurance programs in lieu of going in the pool. Also, as a disincentive mechanism for poor loss experience, it may help convince some employers to pay more attention to their loss experience - hence safety.

6. Redefine language under Employee's Fault to include that the employer shall not be liable for any injury to a worker which is caused in whole or part by the use of controlled substances. Current law uses the word intoxication which is not representative of the modern day issues of drug use.

Previously mentioned recommendations in the area of safety include:

- Expanding the Special Disability Trust Fund to reimburse employers for the cost of job modifications (see Section III Statutory Reform #7).

- Requiring the Department of Labor to develop a multi-media education program on safety (see Section III Statutory Reform #8).

RECOMMENDATIONS FOR ADMINISTRATIVE PROCEDURES AND RULES:

1. Department of Labor shall be required to study what other states have done, such as Oklahoma, or are doing to encourage safety in the workplace and develop a financial incentive program for New Hampshire employers by August, 1991.

2. Department of Labor shall develop sample safety program guidelines to help employers comply with recommendation #1 under Statutory Reform, in this section of the report.

V. REFORM IN THE ADEQUACY AND EQUITY OF BENEFITS:

The fundamental purpose of any workers' compensation system is to provide adequate and equitable benefits to employees injured in the scope of their employment. The dual equation of adequacy and equity is subject to wide interpretations. In order to gain an understanding as to what is adequate and what is equitable to workers' compensation systems one needs to review what other states provide in the way of benefits and couple that review with the recommendations contained in The Report of the National Commission on State Workmen's Compensation Laws. With this combined review as a backdrop, the attributes and requirements of the citizens of the State of New Hampshire must be factored in and judgements made as to adequacy and equity. Adequacy and equity can be defined as suitable, just, impartial and fair.

RECOMMENDATIONS FOR STATUTORY REFORM:

1. Modify the amount paid to an injured employee age sixty-five (65) or older, who is receiving or is eligible to receive benefits under the Social Security Act. The modification shall apply as follows:

   Upon the attainment of age sixty-five (65), the weekly payments for each year following age sixty-five (65) shall be reduced by five percent of the weekly payment paid or payable at age sixty-five (65), such reductions shall continue until age seventy-five (75), at which time payments shall have been reduced by a total of fifty (50) percent (ten years times five percent a year) of the payment payable at age sixty-five (65). The amount payable at age seventy-five (75), fifty (50) percent of the amount originally payable at age sixty-five (65) shall remain for the duration of the injured employee's life.

   The original intent of workers' compensation was to provide for the replacement of wages lost due to the inability to work. The system was never meant to pay employees past their normal work life. For those receiving or eligible for Social Security benefits as an additional source of income at age sixty-five (65), a form of reduction appears to be in order. This concept is modeled after the statutory language in the State of Michigan.

2. Retain the forty (40) percent minimum, but require that an employee may not receive more than 100 percent of their average pre-injury paycheck (prior twenty-six (26) weeks, or actual weeks worked if less), defined as gross pay less federal tax and FICA. This, in essence, removes the inequity of paying an employee in excess of 100 percent of what they were receiving as "take home" pay. To illustrate this recommendation, consider the following example. An individual is earning $100.00 a week as gross pay and is receiving after taxes and FICA "take home" of $77.00 a week. Under current workers' compensation law, this individual would receive $100.00 a week tax-free, or 130 percent of

their pre-injury paycheck. In this case there is little if any incentive for this individual to return to work, especially if they only work part-time and are not the prime wage earner in the household. Using this same example and applying this recommendation, the individual would receive 100 percent of their pre-injury paycheck or $77.00 a week, which appears equitable, all things considered.

The income replacement study that was conducted by the Workers' Compensation Research Institute provides a true picture of the current inequity that surrounds the issue of an injured employee receiving far in excess of their pre-injury gross wages on a tax free basis. The summary findings of this study were (see exhibit 19):

"-Most receive 80-100% of lost income
-Few get less than 80%
-1 in 4 get more than 100%
-High minimum benefit may create disincentives to return to work"

3. Increase death benefits for burial allowance from $3,000 to $5,000. This is viewed as a necessary change to more adequately reflect the current cost of burial.

4. Require that all impairment ratings be in accordance with the most current edition of the "Guides to Evaluation of Permanent Impairment" published by the American Medical Association. This is necessary to assure consistency and uniformity to the finding of impairment ratings. Consider Consultant Stiles findings that "the payment of permanent impairment benefits was sporadic and inconsistent. The impairments given to the same portions of the body were across the board. For instance, the ratings for the leg ranged from six percent to forty-nine (49) percent." Inconsistencies such as this are unconscionable and must be eliminated. The use of the AMA guidelines is a common practice in many states.

5. Redefine injury to ensure that stress without physical trauma is not a compensable condition. Workers' Compensation was not and is not meant to be a source of reimbursement for any and all conditions of life. Allowing stress without physical trauma to be compensable would be a serious mistake. Consider the following excerpt from a study conducted by the California Workers' Compensation Institute entitled "Mental Stress Claims":

> "Many observers attribute the recent increase in mental stress claims, both in workers' compensation and other benefit programs to societal changes: today's faster pace in life and work; unfulfilled expectations for a better quality of life; the belief that every wrong deserves a remedy; and the increasingly litigious nature of society, even in a no-fault compensation system.

At the same time, the sophistication of medical diagnoses and the rapid influx of mental health professionals in practice-up seventy-seven (77) percent in the past ten years-have contributed to a growing acceptance of mental disability. One commentator, a former chairman of the California appeals board, notes: "As people become more aware of psychological forces and their application to the workplace, as they become willing to acknowledge that they too may have a psychiatric disorder...as they become more willing to risk the stigma of emotional disorder and of putting time in on the psychiatrist's couch, then inevitably we begin to see more workers' compensation cases alleging psychiatric injury and disability." That prediction, made five years ago, is today's reality."

6. Redefine injury to ensure those cases that claim to relate to cumulative injury/trauma are, in fact, a result of cumulative injury/trauma and not a result of the aging process. Occupation can be related to cumulative injury/trauma in three basic ways: as a cause, as a contribution factor, or as an aggravating factor. Except in very rare disease cases, a cause-effect relationship between cumulative injury/trauma and the work environment is not so uniquely evident. Generally, the relationship of an injury or illness to an occupation is elusive because many cumulative injuries/traumas are clinically indistinguishable from general, chronic-type conditions of non-occupational origin. Even when occupation is considered to be contributory or aggravating, it is difficult to determine the extent of job influence because, in most cases, the causes of the condition cannot be fully traced; a multiplicity of factors may be involved, including the age of the worker, diet and nutrition, smoking, and general life style, to name a few.

7. Redefine the definition of average weekly wages to be based on earnings during the preceding twenty-six (26) weeks. The current dual system of twelve (12) weeks or fifty-two (52) weeks (if more favorable to the employee) is confusing, often misapplied and not always representative of true earnings capacity, especially among New Hampshire's large seasonal employee population.

8. Provide new language that states that an injury or illness incurred in or resulting from the pursuit of an activity, the major purpose of which is social, recreational or sports is not covered under the Workers' Compensation Act. This Concept, modeled after the State of Michigan, attempts to remove a possibility for abuse.

9. a. Establish a definition of maximum medical improvement which is basically the point at which an injured employee has completed a healing period and no further improvement can be expected.

b. Introduce the concept of maximum medical improvement into the compensation for total disability section of the Act such that upon reaching maximum medical improvement, the injured employee must either return to work or be classified a permanent total or a permanent partial. Under the current system, an injured employee can remain in a temporary total type of status indefinitely, which can make it difficult to bring individuals back to the workplace and difficult to close cases. The statute must be explicit as to ability to close a claim. The following excerpt from a recent New Hampshire Supreme Court case, Vassilios A. Xydias V. Davidson Rubber Company & a., June 28, 1989, provides insight into this problem:

> "Because of our holding, we reject the defendants' further argument that the court erred in failing to rule upon whether the plaintiff was partially disabled. See RSA 281:25. We note, however, that a finding of total disability pursuant to RSA 281:23 entitles a recipient to benefits only so long as the period of total disability continues. Since the repeal of RSA 281:24, providing for "Compensation for Permanent Total Disability," the workers' compensation statute does not distinguish permanent total disability from temporary total disabiltiy. See RSA 281:23, :24."

10. Revise the current retroactive provision of the waiting period from seven days to fourteen (14) days. In other words, in order to be paid for the first three days of a disability an employee must be disabled for fourteen (14) days or longer. Current law only requires being disabled for seven days to collect for the first three days. Therefore, for minor disabilities that occur on a Monday, there is an easy threshold of missing the full work week (five days) and with the addition of the weekend qualifying for payment of the first three days. Out of the other fifty (50) states, only six have retroactive periods of seven days or less.

VI. REFORM CONCERNING PARTICIPANTS/PROVIDERS IN THE SYSTEM:

Workers' Compensation is a system that contains a number of participants beyond the employer-employee. These other participants/providers play a significant role in the success or failure of the system. As such, each participant/provider group has been reviewed in order to determine necessary reform. This section will address each participant/provider group separately.

A. MEDICAL CARE PROVIDERS

RECOMMENDATIONS FOR STATUTORY REFORM:

1. Establish a medical fee schedule to control medical care costs. This schedule should be modeled after the State of Washington, a highly regarded schedule that was selected by the Federal Government as a model for a fee schedule under Federal Workers' Compensation (see exhibit 20). Current law allows payment for reasonable medical care. In today's medical cost control environment, with the Federal DRG (Diagnostic Related Groups) Program for Medicare and Medicaid, Blue Cross & Blue Shield contract rates and the usual, customary and reasonable limitations of commercial health insurers, workers' compensation remains the only unsupervised, unchecked reimbursement system. Many people suspect that cost shifting is occuring against the workers' compensation system. In fact, testimony was received by the Task Force from a provider representative, that cost shifting can and does occur to workers' compensation payors due to reimbursement limitations and cost accounting changes brought about as a result of DRG reimbursements from the Federal Government. Evidence of cost shifting is further supported by a Workers' Compensation Research Institute brief titled Rising Medical Costs: Evidence of Cost Shifting (see exhibit 21). The following is an excerpt from this brief:

    "The Business Week article quotes the CEO of a large California hospital center: "The difference between the quoted rates and the actual amount paid [by preferred customers] is growing." And the experience of at least one large state workers' compensation system reinforces the fear that workers' compensation systems remain vulnerable to cost shifting. A recent study in Florida found, in 1984, that hospitals collected 74 percent of their charges from all payors, but more than ninety-one (91) percent from workers' compensation payors. This disparity reflects, in part, discounts offered to preferred customers-public and private-and the shifting of overhead costs to workers' compensation payors.

    Workers' compensation systems must recognize that their costs are inextricably linked to developments in the medical care marketplace. Unless the systems adapt to these developments in innovative ways, they remain vulnerable to escalating costs that may threaten the broad health care coverage traditionally provided to injured workers."

By a number of measures, New Hampshires' medical costs in the area of workers' compensation has grown at excessive levels. For example, according to the National Council on Compensation Insurance (NCCI), Table 1 (page 24) indicates that the overall average medical costs increased in New Hamsphire by approximately ninety-three (93) percent from 1979 to 1983 going from $364 to $702 per claim. This represents the third largest percent change among the states reported on in Table 2 (page 25) taken from the Workers' Compensation Research Institute research brief entitled Workers' Compensation in Texas (see exhibit 22), trailing only Texas and Colorado. It also represents the third largest annual percent change among the states compared by the NCCI.

Of additional significance is Table 3 (page 26), which illustrates that New Hampshire has experienced a significantly greater percentage change over the 1980 to 1984 policy periods, than the U.S. as a whole (eighty-five (85) percent versus fifty-nine (59) percent for the U.S.).

Additional support for a medical fee schedule is found in a study of a random sample of New Hampshire medical provider billings that was done at the request of the Task Force, by Medata, a California medical information/services firm. This study concluded with Constantine Callas, M.D., Medata Medical Director, stating that "New Hampshire is in need of effective medical cost-containment measures. I would suggest that a good first step would be to effect a medical fee schedule". Dr. Callas concluded his letter with the following statement: "Your state needs help" (see copy of entire letter on pages 27,28 and 29).

Table 1.
New Hampshire *

All Medical

Calendar Year	Number of Claims	Costs Incurred	Average Cost	Percent Change
1979	40444	14741117	364	
1980	39381	15789818	401	10.0
1981	39346	17572704	447	11.4
1982	36889	21055466	571	27.8
1983	33722	23661784	702	22.9
1984	35860	27600016	770	9.7

% Change from 1979 to 1983	92.5
% Change from 1979 to 1984	111.2
Average annual % change from 1979 to 1983	18.0
Average annual % chagne from 1979 to 1984	16.4

Medical Costs for Indemnity Claims

Calendar Year	Number of Claims	Costs Incurred	Average Cost	Percent Change
1979	13127	12886480	982	
1980	12351	13680388	1108	12.8
1981	12197	15023110	1232	11.2
1982	11432	18173177	1590	29.1
1983	10653	20611130	1935	21.7
1984	11478	24203051	2109	9.0

% Change from 1979 to 1983	97.1
% Change from 1979 to 1984	114.8
Average annual % change from 1979 to 1983	18.7
Average annual % change from 1979 to 1984	16.8

Indemnity Losses Incurred

Calendar Year	Number of Claims	Costs Incurred	Average Cost	Percent Change
1979	13127	28702691	2187	
1980	12351	29417189	2382	8.9
1981	12197	31513834	2584	8.5
1982	11432	36252855	3171	22.7
1983	10653	41437178	3890	22.7
1984	11478	49226441	4289	10.3

% Change from 1979 to 1983	77.9
% Change from 1979 to 1984	96.1
Average annual % change from 1979 to 1983	15.7
Average annual % change from 1979 to 1984	14.6

*Table provided by National Council on Compensation Insurance (NCCI)

Table 2.***

Average Medical Claim Costs per Claim (Second Report)

Year	TX	CA	NY	MA	FL	NC	WI	GA	IL	CO	CO (State Fund)	CPI-U Medica
1979	516	625	377	388	515	228	320	400	506	414	336	70.6
1980	598	736	373	415	594	290	377	464	597	474	421	77.6
1981	730	888	486	488	718	326	444	521	639	615	555	87.3
1982	924	1,070	567	519	776	375	489	659	754	694	732	96.9
1983	1,125	1,194	654	595	869	420	556	753	798	805	775	103.1
1984	1,263	1,332	698	659	930	444	611	n/a	n/a	n/a	n/a	109.4
Percent Change 1979-1983*	118.0	91.0	73.5	53.4	68.7	84.2	73.8	88.3	57.7	94.4	103.7	46.0
Average Annual Percent Change 1979-1983*	21.5	17.6	14.8	11.3	14.0	16.5	14.8	17.1	12.1	18.1	23.2	9.9

**Medical component of the consumer price index-urban. The reference base is 1982-1984 = 100.
*Calculated from 1979 through 1983 for consistency with those states where 1984 numbers are not available.
***Source - National Council on Compensation Insurance.

Table 3. *
Average Indemnity and Medical Costs for New Hampshire and the United States On an Ultimate Report Basis

	N.H.	U.S.**	N.H.	U.S.**
Policy Period	Medical Costs	Medical Costs	Indemnity Costs	Indemnity Costs
6/80 - 5/81	507	572	3349	4499
6/81 - 5/82	584	692	3750	5224
6/82 - 5/83	630	671	2894	3938
6/83 - 3/84	877	824	4540	6543
6/84 - 3/85	937	912	5269	5988
% Change from 1980 to 1984	84.8	59.4	57.3	33.1
Avg. Annual % Change from 1980 to 1984	17.3	12.9	15.5	12.3

*Table provided by National Council on Compensation Insurance (NCCI)

**Excludes Massachusetts, Delaware, Pennsylvania and Texas

August 4, 1989

Mr. David G. Hampson
Chairman, Governor's Task
Force on Workers' Compensation
c/o Kendall Insurance
95 South Main
Rochester, New Hampshire, 03867

Re: Review of New Hampshire Medical Provider Billings

Dear Mr. Hampson:

This is in response to your request of July 27, 1989 that I review random samples of New Hampshire medical provider billings.

To analyze the providers' charges on the samples submitted, we elected to compare those charges with the allowances that would have been paid had the services been rendered in New York or Massachusetts. As you know, both of these states do have Workers' Compensation Fee Schedules. We have been reviewing No-Fault and Workers' Compensation billings in New York for 12 years, and have been reviewing Workers' Compensation billings in Massachusetts for 10 years. The New York Schedule of Medical Fees regionalizes the state into 4 separate areas. Each area has its own conversion factors with the area around New York City comprising Region IV. Region IV has the most liberal conversion factor for that state. In other words, we selected the highest paying region of New York in order to provide a fair comparison of New Hampshire medical provider charges.

The following chart will summarize the results of the review of the sample billings by New York's standards:

Number of bills reviewed:	163
Total provider charges	$52,686.00
Total reductions	14,860.13
Total allowances	$37,825.87
Percent reduction:	28.21%

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Legislative Program Review and Investigations Committee

Workers' Compensation System

Staff Recommendations

December 5, 1990

INTRODUCTION

During the last 10 months, the Legislative Program Review and Investigations Committee staff has studied nearly all aspects of workers' compensation in Connecticut from the system's administration to benefit costs. The study revealed a number of serious problems in the organization, operations, and benefit structure of the system, which were discussed in detail in the staff's preliminary findings paper. This document contains staff recommendations for legislative and administrative changes to address the problems.

Overall, it was found that the system's current administrative structure is not responsive to the concerns of either employers, who pay for benefits, or employees, who receive benefits. Management is weak and accountability is lacking. District offices vary significantly in terms of outcomes and efficiency, and their operating policies and procedures are not uniform. Administrative resources for central and district office operations are inadequate, particularly given the dramatic growth in workload, and backlogs and delays in case processing are widespread. Benefit costs are rapidly escalating, with little response from the system to contain them. The methods of calculating compensation rates create inequities in the distribution of wage replacement compensation, as well as in benefit levels for permanent partial disabilities and disfigurements.

In response to these findings, program review committee staff developed recommendations intended to achieve the following goals: stronger management and improved accountability; more efficient processing of disputed claims; a more equitable benefit structure; and better control over rising benefit costs. The staff recommendations are presented below and organized into three sections: 1) system organization; 2) case processing; and 3) benefit costs. Included in each section is a summary of the staff findings that led to the proposed changes as well as a brief discussion of the rationale underlying the recommendations.

I. SYSTEM ORGANIZATION

ADMINISTRATION AND ACCOUNTABILITY

A major problem cited by all parties involved in the workers' compensation system is the lack of accountability. The program review committee staff found administration of the system to be weak and fragmented. In the staff's view, the problem is rooted in structural deficiencies and complicated by an absence of aggressive leadership on the part of either the commissioners acting together as a board or the chairman.

Authority to set direction for the system is ambiguously divided between the chairman and board of commissioners leaving both unclear as to their leadership roles. The committee staff found that the board as an entity seldom takes definitive action largely because it is composed of commissioners with few limitations on their powers when acting individually and little incentive to curb their authority. While the chairman has overall administrative responsibility, clear authority over individual commissioners and certain division directors is lacking. As a result, the chairman appears reluctant to act without the board's concurrence.

It appears to the program review committee staff that the Division of Worker Education and the Division of Workers' Rehabilitation operate without direction from either the board or chairman. These two divisions, which account for nearly one-third of the commission's staff and three-quarters of its financial resources, are funded through statutory formulas and, therefore, are not subject to fiscal review by the board or the chairman.

District offices are operated by individual commissioners with little oversight or performance monitoring. District commissioners, by necessity, focus on handling their caseloads rather than administering their offices. As a result, district offices are, in general terms, poorly managed. The program review committee staff also found that policies, procedures, and outcomes vary significantly among the district offices. The lack of uniformity makes it highly probable that similar cases are handled very differently in different district offices.

Finally, in the committee staff's opinion, existing accountability mechanisms are too external to the system, and

extreme in their application, to be effective. Only the governor and the legislature acting through their roles in the appointment and impeachment processes can hold a commissioner answerable for his or her actions.

To strengthen administration and focus accountability, the program review committee staff recommends a major restructuring of the workers' compensation system. Under the staff proposal the Board of Commissioners would be replaced by a Board of Directors composed of representatives of business and labor. The board would be given the statutory authority to direct the overall operation of the system. Administrative responsibilities now carried out by the chairman would be transferred to a newly created chief administrative officer position.

All commissioners would be appointed by the Board of Directors and answerable to it. The role of the commissioners would be focused on quasi-judicial duties and their administrative responsibilities would be eliminated. The formula funding method now in effect for the divisions of workers' education and rehabilitation would be replaced with a comprehensive budget covering the whole system. The staff's specific recommendations regarding the new board of directors, the chief administrative officer, funding, and the commissioners, along with a discussion of the impact of each proposal follow.

Recommendations: Board of Directors

Establishment. There shall be a Workers' Compensation Board of Directors whose purpose shall be to develop policy and oversee the operation of the workers' compensation system. The board shall consist of eight members, four representing employees and four representing employers. The board shall elect its own chairperson and vice chairperson. Board members shall receive no compensation but shall be reimbursed for necessary expenses.

Terms. The initial employee and employer appointments shall be for one-, two-, three-, or four-year terms and shall be nominated by the governor and confirmed by both houses of the General Assembly on or before March 15, 1992. All appointments to full terms subsequent to the

initial appointments shall be for four years. Vacancies shall be filled for the expiration of the term of the member being replaced in the same manner as original appointments.

Powers and duties. The Workers' Compensation Board shall meet at least monthly. The board may meet at such other times as the chairperson and vice chairperson deem necessary. Any action taken by the board shall require affirmative vote of at least five members to take effect.

The Board shall have the power to:

* adopt such rules as it deems necessary for the conduct of its internal affairs;

* adopt regulations in accordance with Chapter 54 to carry out its responsibilities under this chapter;

* adopt an annual budget and plan of operation;

* prepare and submit an annual report to the governor and the legislature;

* allocate resources within the system as it sees fit;

* establish an organizational structure and such divisions as deemed necessary for efficient and prompt operation of the workers' compensation system;

* establish policy in all areas of the workers' compensation system, including rehabilitation, education, statistical support, and administrative appeals;

* appoint such advisory panels as it deems necessary and helpful;

* **establish standards for the approval and removal of physicians, surgeons, podiatrists, and dentists from a list of persons who may examine and treat employees under provisions of this chapter;**

* **establish standards for approving all fees for services rendered under this chapter by attorneys, physicians, surgeons, podiatrists, dentists, and other persons;**

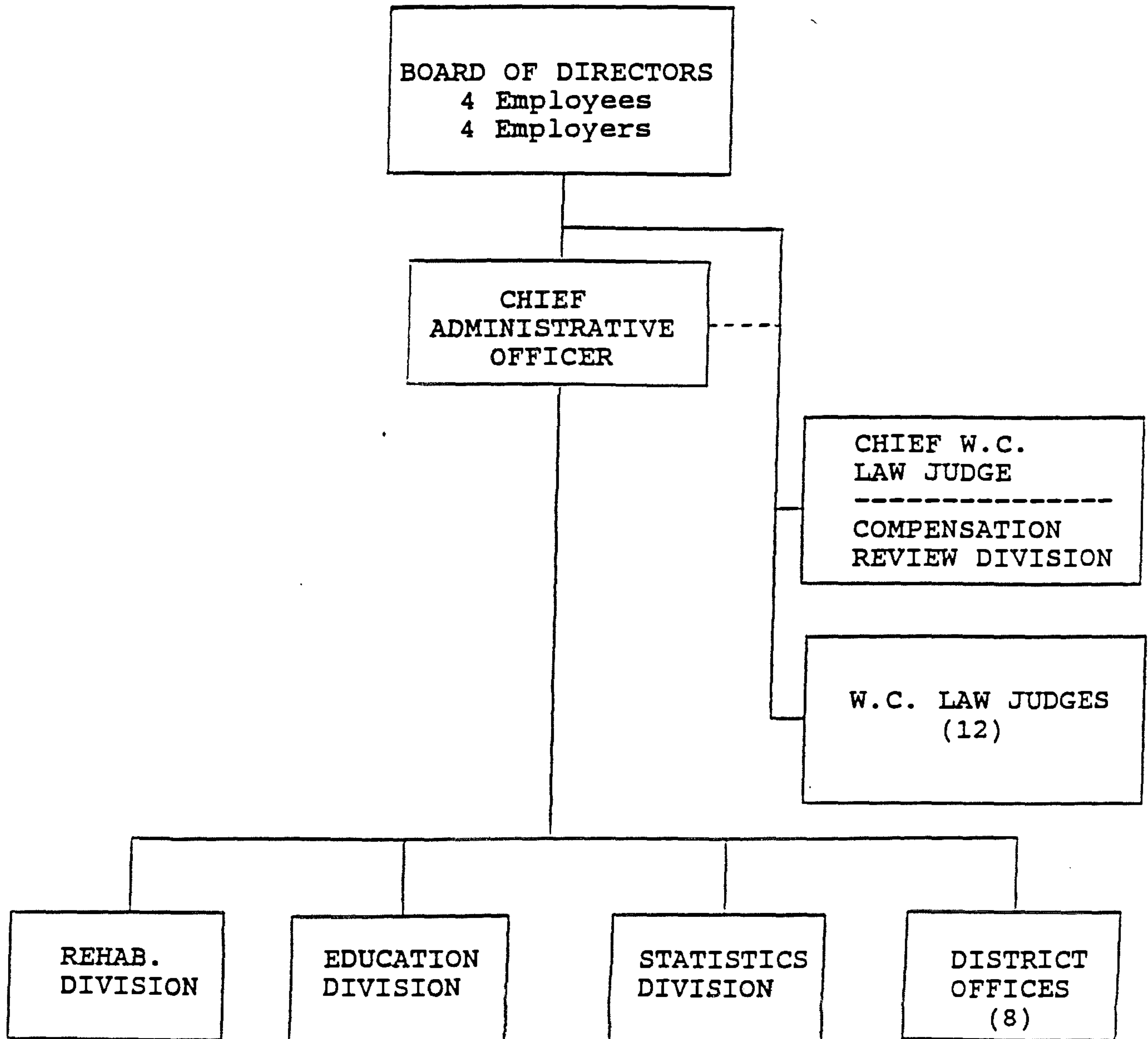
* **approve applications for employer-sponsored medical care plans, based on standards recommended by a medical advisory panel; and**

* **establish procedures to hire, dismiss or otherwise discipline, and promote employees within the workers' compensation system, subject, where appropriate, to provisions of the state's civil service system.**

Discussion. Figure 1 shows the proposed system organization. The committee staff believe the recommended organization will strengthen accountability by placing policy-making and oversight authority in a central body. Further, this body is made up only of employers and employees, the two essential parties in this system, and the ones for which the system was created. Employers are paying all the administrative and benefit costs, while employees have given up their rights to sue their employers in order that they may receive prompt compensation for work-related injuries. All other parties operate in the system because of this basic agreement between employers and employees. Thus, employees and employers are the two groups that have the greatest interest in seeing the system work promptly and efficiently.

The proposed recommendation also establishes clear lines of authority in the workers' compensation system. The board establishes policy and is ultimately accountable for those who work in the system. Unlike the present administrative structure, the

Figure 1. Proposed Workers' Compensation System Organization



proposed board will set policy, while others, under its direction, will implement it.

The four divisions mandated by current law--worker education, workers' rehabilitation, statistics, and compensation review--are retained in the committee staff's proposed administrative structure. However, each division will now be clearly accountable to the central policy body. Control over activities carried out by the divisions is increased by the new board's authority to adopt regulations, hire division personnel, and allocate resources.

The Compensation Review Division would continue to function, without significant procedural changes, as the administrative appeals body for workers' compensation decisions. Its important role in promoting uniformity by building a body of case law and providing accountability for commissioners' judicial activities would not change under the committee staff proposal.

Recommendations: Chief Administrative Officer

Appointment. The board shall on or before July 1, 1992, and every four years thereafter, appoint a full-time Chief Administrative Officer. The Chief Administrative Officer may be removed by the board for cause. Any vacancy in the position shall be filled for the balance of the vacated term. The Chief Administrative Officer shall be exempt from classified service and receive such compensation as determined by the board.

Powers and duties. The Chief Administrative Officer shall be the administrative head of the workers' compensation system, and shall be responsible for the efficient operation of the system and prompt disposition of workers compensation cases. The Chief Administrative Officer shall be responsible for:

* **directing and supervising all administrative affairs of the workers' compensation system in accordance with the directives of the board;**

* attending all board meetings, keeping a record of all board proceedings, and acting as custodian of all board documents, minutes, etc.,

* preparing the budget and annual operating plan for the board's approval;

* reporting monthly to the board on operations in the workers' compensation system;

* assigning and reassigning staff, including workers' compensation law judges, to each of the district offices;

* controlling the hearing calendars of the workers' compensation law judges in order to facilitate timely and efficient processing of cases;

* collecting and analyzing statistical data concerning the administration of the workers' compensation system;

* directing and supervising implementation of a uniform case filing and processing system in each of the district offices;

* entering into contracts with consultants and such other persons as are necessary for the proper functioning of workers' compensation system; and

* establishing staff development, training and education programs designed to improve the quality of service provided in the workers' compensation system.

Discussion. The Chief Administrative Officer (CAO) is responsible for the day-to-day operations and everyone in the system reports to that person. In turn, the CAO reports monthly to the Board of Directors on operations in the system. If the board is unhappy with operations in the system it can require that the CAO implement changes, and if the changes are not forthcoming the board can discipline or dismiss the CAO.

This proposal establishes a clear line of authority from the policy board, through the Chief Administrative Officer, to all workers' compensation divisions and offices, thus eliminating the current problems with fragmented and diffuse accountability.

Recommendations: Compensation Commissioners

Title. Beginning July 1, 1992, the position of workers' compensation commissioner shall be titled workers' compensation law judge. Workers' compensation law judges shall be qualified members of the Connecticut bar, who shall be full-time, not otherwise employed, and sworn to the faithful performance of their duties.

Appointment. Beginning July 1, 1992, the Board of Directors shall on or before the date of expiration of the term of a workers' compensation commissioner or upon the occurrence of a vacancy appoint a person to fill the position. The term of appointment shall be for five years or the unexpired portion of a vacant term. An appointee may be removed or suspended for cause by the board.

The board may appoint acting workers' compensation law judges on a per-diem basis from among former workers' compensation law judges or qualified members of the Connecticut bar.

Jurisdiction. The existing requirement that an appointee reside within the jurisdiction for which he or she is appointed shall be repealed and all appointees shall be granted statewide jurisdiction.

Workers' compensation law judges shall be relieved of their administrative responsibilities related to the operation of a district office.

Chief Compensation Law Judge. The board shall designate one workers' compensation law judge to serve as chief of the Compensation Review Division with complete responsibility for the day-to-day operation of the division. The chief of the Compensation Review Division may, as the board permits, be assigned to other duties by the chief administrative officer.

Discussion. The committee staff believes the direct and immediate accountability provided by having the board appoint and discipline workers' compensation law judges will increase their responsiveness to implementing policies and procedures established by the board. This will result in more administrative control over the system and greater uniformity in its operations.

Under the staff recommendation, workers' compensation law judges would have the same authority to resolve claims and questions of law as the compensation commissioners do now. Current quasi-judicial powers to conduct hearings, impose penalties, award or dismiss claims would not be altered. Similarly, the authority to approve voluntary agreements between parties, stipulated agreements, commutation of benefits, the discontinuance or reduction of benefits, acknowledgements of physical defects, and other legally binding documents and actions would also continue unchanged.

The compensation law judges would no longer be responsible for the day-to-day administration of a district office, but instead would be able to concentrate on matters that require legal expertise and substantive knowledge of the system. With compensation law judges able to devote full time to the resolution of disputes, cases should move more quickly.

In addition, since jurisdiction would not be confined to a single district, the board would be free to rotate all the compensation law judges in order to address workload fluctuations as well as vacancies, vacations, or illnesses.

Under the new administrative structure, the chief of the Compensation Review Division would be designated from among the

compensation law judges by the board. Like other division heads, the chief compensation review judge would report to the chief administrator for administrative purposes. The chief's duties would be those currently performed--assigning panels to hear appeals, receiving and reviewing appeal petitions, and directing division staff regarding legal matters arising from appeals. In addition, the chief would be available for assignment to cases at the district level on an at-large basis.

Recommendations: Funding

> **The Board of Directors shall approve and submit a budget for the operation of the entire workers' compensation system including the central office, district offices, and the divisions of workers' education and rehabilitation to the appropriate budget agencies.**
>
> **There shall be one comprehensive assessment on employers for funding the operation of the entire workers' compensation system. The assessment shall not in any state fiscal year, exceed 5 percent of the amount expended by employers or private insurers on behalf of employers in payment of workers' compensation liability for the prior year. The assessment shall be levied in accordance with the provisions of C.G.S. Section 31-345, as amended by Public Act 90-311. The separate assessments on employers to finance the Division of Worker Education and the Division of Workers' Rehabilitation specified in sections 31-283h and 31-283b, respectively, shall be repealed.**

Discussion. Making one assessment on employers that will pay for the entire administration, rather than having separate statutory formulas for workers' rehabilitation, worker education, and administrative functions, will give the policy board the authority over all system resources. The board can then allocate funds where it believes the need is greatest and where resources will be used most effectively.

DIVISION OF WORKERS' REHABILITATION DIVISION

To date, there has been little oversight or evaluation of Division of Workers' Rehabilitation (DWR) activities although 2 percent of workers' compensation payout--approximately $10.5 million in FY 91--is targeted each year for a broad range of vocational rehabilitation services and financial benefits intended to return injured workers to suitable employment. The program review committee staff found that despite policies that emphasize getting injured workers rehired with the same or similar employers, most division efforts are focused on expensive, formal reeducation programs.

Committee staff research also raised questions about the division's performance. The majority (72 percent) of closed cases end because clients decide not to participate in division programs, indicating that referrals are inappropriate or needs are not being met. Furthermore, between FY 86 and FY 90, job placement rates, a measure of training effectiveness, declined from 77 to 55 percent of those trained.

Greater accountability and stronger central control over funding and policy resulting from the committee staff's proposed reorganization offer opportunities to improve vocational rehabilitation efforts. The board's annual planning process recommended by the committee staff will be especially useful both in setting rehabilitation policy and evaluating performance. Through this process, the rehabilitation director could be required each year to submit to the board specific goals (e.g., the percentage of clients to be trained and reemployed, the portion of clients trained through on-the-job versus academic programs, etc.) and the strategies for achieving them. To monitor performance, the board could also require that program measures such as average cost and placement success of each type of training program, numbers of clients still employed six months after placement, and profiles of workers referred, terminated, and served, be collected and reported annually.

Two areas of particular concern revealed by the committee staff review of DWR can be addressed by the new policy board through its authority to adopt regulations and establish both budgetary and operating policies. First, the committee staff found that large sums--over $7.6 million in FY 90--have been spent on training fees, travel reimbursement, and basic living expenses (subsistence) for clients without formally established policies to

guide the award or denial of rehabilitation benefits. Second, it was found that subsistence benefits, which consistently account for half of the division's annual expenditures, are not equally available to all claimants.

DIVISION OF WORKER EDUCATION

As with the Division of Workers' Rehabilitation, there has been little effort in setting a direction for the Division of Worker Education (DWE) in meeting its statutory mandate to train both employers and employees in preventing workplace accidents, and educating workers about the workers' compensation system and their benefits within it. In the absence of a clear policy focus, the division has initiated a variety of programs without any external input into whether they meet a need, are cost efficient, or are generally effective. Division funding, which is set by a statutory formula, grows as claim payouts grow without any checks to ensure that DWE actually needs the amounts that are assessed to run its operations.

Program review staff findings called into question the effectiveness of the division's prevention activities, citing both a 30 percent rise in the total number of workplace accidents in Connecticut between FY 86 and FY 89, and a 16 percent increase in the accidents per 100 workers during the same period. The division, hampered by a lack of statistics, has been unable to focus its prevention activities on where job accidents are occurring. Instead, the division's prevention efforts are broad-based, such as the distribution of newsletters, and the production of a weekly television program.

The legislature has clearly seen a need for better prevention of occupational diseases and injuries. In 1990, the General Assembly passed Public Act 90-226, aimed at improving the state's ability to detect occupational hazards, assess workplace exposure, and conduct medical surveillance, including the collection and analysis of data on injuries and disease. The act also created a role for both the statistics and education divisions, within the workers' compensation system. The statistics division is responsible for receiving and analyzing the data from the occupational health clinics, hospitals, and other medical facilities specified in the act. Both the statistics and education divisions are required to educate unions, employers and individual workers on the data and how it will be used.

Program review believes that this coordination of efforts in preventing workplace accidents and diseases is an important first step that ought to be strengthened. The General Assembly authorized General Fund revenues of $750,000 to support the legislation through June 30, 1991; however, funding after that date is unclear.

Recommendation

Funding for the occupational health clinics to conduct activities outlined in P.A. 90-226 shall be allocated from the Workers' Compensation Commission budget at the level specified in the act, until June 30, 1992.

Discussion. Under this proposal, the funding for these important prevention activities will be assured for one additional year, until the Board of Directors for Workers' Compensation can examine all prevention and worker education efforts to determine what the objectives of the programs are, how they can best be achieved, and the level of resources needed to accomplish those goals. Committee staff findings point to a clear need to bolster the Division of Worker Education's prevention activities, and in a manner that targets where the potential for injury or disease is greatest. The occupational clinics program can provide the data which DWE can use to focus those efforts. The legislature, through Public Act 90-226, requires that all parties work together to help prevent occupational disease and injuries. The proposal will maintain this consolidated prevention program at least one more year, so that its work can be more accurately evaluated by the board.

Other deficiencies cited can be addressed, similarly to those of the Division of Workers' Rehabilitation, through the staff's proposed system reorganization. Program review staff believes the policy board will establish what it wants accomplished from an education division, set clear goals and objectives for the division, and measure its performance against those.

Coupled with the policy initiatives given the board under this proposal, accountability of the division's operations will also be improved through reporting requirements and board oversight of spending. Under the new central administration, the director of

the education division would be responsible directly to the Chief Administrative Officer, while the budget for the entire administration, including DWE, would be set and controlled by the board.

DISTRICT OFFICES

Workers' compensation cases are processed at district offices, which at present are operated under the direction of a district commissioner. Committee staff found that, other than the commissioner, no position in a district office has overall supervisory authority. Management responsibilities are delegated by district commissioners to a variety of support staff on an ad-hoc basis. While all district offices are staffed by paralegal and clerical support personnel, staffing levels and structures vary widely.

To date, no efforts have been made to determine what type and amount of staffing would best carry out the functions of a district office. Analysis of staff-to-workload ratios indicates inequities in the allocation of personnel resources among district offices. Both clerical and paralegal workers spend most of their time processing paperwork and moving the daily docket of hearings. The case management and legal research duties envisioned for paralegal staff are often superseded by their assignment to clerical activities. Few staff resources are available for working with parties to prevent disputes although the benefits of such efforts in terms of reducing the need for hearings are widely recognized. From these findings, program review committee staff concluded structural and staffing changes are required to improve district office operations.

Recommendations

> **A district manager position shall be established to serve as the administrative head of each district office. The district manager should be a professional position. District managers should report to the chief administrator and be responsible for all office administrative functions related to budget development, purchases, personnel and payroll, equipment, office procedures, and staff supervision. In addition, district**

managers should oversee the management and processing of cases in each office.

Appropriate support staff levels for each district office shall be determined by the chief administrator in accordance with workload and performance standards. Furthermore, the chief administrator shall develop job descriptions, and if necessary, new classifications, to insure that staff resources are appropriately matched with the tasks to be performed.

Discussion. Systematic review of staffing needs will result in the proper allocation of resources to each district. Ideally, each office should have a sufficient number of staff to carry out basic case-processing functions in a timely way and permit more emphasis on dispute prevention as well as better use of paralegal staff skills. Additional support staff positions may be needed to achieve this goal, although the automated case-processing system now being implemented in the districts is expected to reduce the time devoted to clerical functions.

At a minimum, the committee staff recommendation will require 8 new office manager positions at an estimated annual cost of $370,000 to $470,000, including fringe benefits. The committee staff believes stronger management and, ultimately, better service to parties involved in the workers' compensation system justify the additional investment in district staffing. The fact that resources have not kept pace with workload over at least the past five years has contributed to the backlogs and costly delays the system is now experiencing.

In addition to improving accountability for district operations, the proposed administrative restructuring can address two major problems revealed by the committee staff's review: the lack of uniformity in district office policies and procedures and the inefficient use of district staff resources, particularly the commissioner's time. The time commissioners now spend on office management could be devoted to the critical judicial aspects of the system--holding hearings, mediating and arbitrating disputes, and enforcing agreements and awards.

II. CASE PROCESSING

POLICIES AND PROCEDURES

Workers' compensation claims are processed at the district offices where commissioners and support staff review and approve related paperwork, maintain case files, and arrange and conduct hearings to resolve disputes. Prompt processing of benefit claims is critical to an effective workers' compensation system. Delays, particularly in resolving disputes over employer liability or the claimant's ability to return to work, can result in financial hardship to workers and unnecessary expense to businesses. The program review committee staff found the system collects little information on how cases are processed at the district offices and there is virtually no monitoring of district office efficiency.

The committee staff reviewed a sample of case files at the district offices to develop information about case processing. The sample revealed that a significant number of claims take years to finalize. About half of the temporary total disability benefit claims included in the staff sample were resolved within 3 months of the date of injury; however, 10 percent took over 1 year to resolve. The time between date of injury and resolution of permanent partial disability benefits averaged more than 20 months (617 days) and 25 percent of the permanent partial claims in the sample took 2 or more years resolve.

Based on the staff sample data, processing times for claims that involve hearings are substantially longer than cases resolved by parties on their own. On average, temporary total claims settled after an informal hearing took almost three times as long to finalize as claims that were resolved without hearings (428 versus 151 days). For permanent partial disability claims, the average time between date of injury and date resolved for those settled before a hearing was about 18 months while those resolved after an informal hearing took an average of about 24 months to finalize.

The majority of claims are settled voluntarily and require little involvement by either the commissioner or office staff. Approximately 86 percent of the temporary total disability benefits claims and 66 percent of permanent partial claims included in the staff's sample of cases that became active in 1987 were resolved without the need for even an informal hearing.

Cases that require hearings, while small in number, place a considerable demand on district office resources. Formal hearings, which are the most time-consuming case processing activity, were held for very few cases included in the staff sample--just 3 percent. Half of these cases involved only one formal hearing but a quarter required at least two and up to four formal hearings to resolve disputed issues.

In contrast, the sample indicated that about one out of three cases handled at the district offices involves at least one informal hearing. Over half of these cases required from 2 to 13 informal hearings while it appears that disputes were resolved through a single informal hearing for 46 percent. Overall, cases in which multiple informal hearings were held made up only 17 percent of the sample but accounted for 80 percent of all hearings held.

Backlogs in hearing schedules are a serious problem in all offices. As of September 1990, 6 to 7 weeks were required to schedule a routine informal hearing and formal hearings were being scheduled at least 7 to 10 weeks in advance. The staff case sample showed that, on average, 10 weeks elapsed between the time an informal hearing was requested and the date it was held.

The program review committee staff found that postponements and cancellations, which are common, contribute to hearing backlogs. Review of selected daily hearing dockets in six district offices showed that 10 to 20 percent of all hearings scheduled were postponed or canceled. Forty percent of the initial informal hearings scheduled for cases included in the committee staff sample were postponed at least once; 7 percent were rescheduled 2 to 3 times. A total of 109 initial informal hearings were postponed, with claimants responsible for 33 percent of the postponements, respondents 11 percent, and for the remainder (55 percent), responsibility could not be determined. The staff also noted that missing or incomplete medical reports were often cited as a reason for delays in proceedings.

Despite often lengthy processing times and the frequency of last minute cancellations and postponements, there was little evidence in the files reviewed by committee staff that commissioners imposed the penalties available under current law for undue delay. As a formal hearing is necessary to order the payment of fines and dockets are already filled months in advance,

the reluctance of commissioners to impose penalties to speed up cases is due in part to hearing backlogs.

The case processing data gathered by committee staff suggest that district office efforts to screen hearing requests are insufficient and that in a number of cases, hearings are requested unnecessarily. From the staff review of case files, it appeared that hearing requests were often vague. While some offices attempt to determine the nature of the dispute prompting the hearing request and whether parties have made reasonable attempts to resolve the problem prior to adding a hearing to the docket, other districts schedule hearings on demand.

Although all offices have policies for holding hearings for emergency cases within several days of a request, a system that requires parties to wait months for their cases to be heard is not responsive to the interests of either workers or employers. When commissioners cannot intervene early in disputed cases, disagreements between parties may escalate and attempts at mediation are impeded. Given the current backlog, one of the most effective tools for achieving prompt resolution of disputes--the commissioner's ability to immediately schedule a formal hearing to order parties to act when attempts at mediation fail--is unavailable in practical terms.

Recommendations

More efficient case processing is a goal of all involved in the workers' compensation system. The increased district office staffing recommended in the previous section by program review committee staff, along with implementation of the district office automation project, will promote this goal. However, committee staff believes hearing backlogs and processing delays will continue to be a problem unless stronger case management policies and procedures are instituted as well. Therefore, it is recommended that:

- **a standard form for requesting hearings should be developed and standard policies regarding limits on the numbers of informal hearings that will be allowed and the number of hearing postponements that will be accepted before a**

formal hearing is held to resolve a case should be adopted;

- **a central system for monitoring case processing should be established and provide, at a minimum, data on the number of cases with multiple hearings, the numbers of hearings postponed, and hearing schedules, on an office-by-office basis;**

- **guidelines for expediting disputed cases should be developed and district office staff should be trained in techniques for screening hearing requests;**

- **medical providers who fail to submit required reports in a timely manner be subject to removal from the approved workers' compensation provider list; and**

- **by statute, interest at the rate provided for in C.G.S. Section 37-3, currently 10 percent per annum, should be applied automatically to the unpaid amount of benefits due a claimant beginning on the date the employer contested liability or discontinued or reduced payment.**

Discussion. The staff's series of case processing recommendations have two main purposes--to avoid unnecessary hearings and to provide greater incentives for resolving claims quickly. Several offices have been successful in reducing the need for both informal and formal hearings by contacting requesting parties by phone to determine what issues are in dispute and what efforts have been made already to resolve points of disagreement.

In one office, clerical staff have been trained by the paralegal to screen requests; in another, a checklist is used to evaluate the need for hearings. In some cases, follow-up by clerical and paralegal staff resolves the issues in dispute. By developing efforts to reduce the number of hearings scheduled in all offices, the system can be more responsive to cases that can only be resolved with a commissioner's involvement.

At present, there is no set format for requesting hearings, and policies on scheduling and cancellations vary among offices. A standard form that requires details on the reasons a hearing is necessary and what actions parties have taken on their own to resolve disagreements will permit staff to quickly evaluate whether a hearing is needed. Fewer unnecessary hearings will be scheduled and less staff time will be spent gathering information that is missing from letter and phone requests that are received now. The committee staff also believes that strict policies on multiple informal hearings and canceled hearings, uniformly applied in all districts, will result in fewer postponements and more productive hearings overall.

Statistics produced through the proposed case processing monitoring system will enable system administrators to identify problem areas and develop strategies, including reallocation of district resources, for addressing backlogs and delays. District staff will also have more incentive to handle cases efficiently as the monitoring system will permit evaluation of each office's performance.

At present, sanctions that could address late or incomplete medical reporting are lacking although medical information is key to many decisions on claims. Current law permits providers now to be removed for cause from the approved list. The staff recommendation would clearly establish untimely or incomplete reporting of information necessary to the resolution of workers' compensation claim as cause for removal. The possible loss of authorization to treat workers' compensation claimants would be a strong incentive to respond to the needs of the system for prompt and complete medical reports.

Finally, unlike workers who may be without income, employers have little interest in speeding up processing when benefits are in dispute and may, in fact, be earning interest on monies that will eventually be paid to claimants. Under the staff proposal, any economic advantage to delays in payment would be reduced. The interest charge, because it is applied automatically in all cases of delayed benefits, also would be imposed without the need for a formal hearing and order from a commissioner.

ATTORNEY FEES

Another matter of concern raised during the committee staff review of case processing is the monitoring of attorney fees. Fees charged by all service providers including attorneys in workers' compensation cases are subject to the approval of commissioners. For claimants, who frequently pay lawyers on a contingency basis from the benefits they receive, the commissioner's review can insure against excessive or unreasonable charges.

In interviews with committee staff, commissioners reported that, in general, attorney fees are checked in cases settled through awards or stipulated agreements and usually limited to 20 percent. The staff, however, found little evidence in the case files it examined that commissioners are monitoring legal fees. While about half of the claimants in the caseload sample were represented by attorneys, documentation of the commissioner's approval of legal fees existed in only 2 percent of the case files. The program review committee staff believes the interests of workers' compensation claimants would be better protected if commissioners took an active role in monitoring legal fees.

Recommendation

A policy requiring commissioners to approve all attorney fees charged to claimants should be established.

Discussion. Attorney fees, even if limited by informal agreement to 20 percent, can represent a significant portion of a claimant's benefits. Under an earlier recommendation, the committee staff proposed that the new board of directors be authorized to establish standards for fees charged by all service providers including attorneys. Requiring commissioners to monitor legal fees actually charged will promote compliance with standards the board may adopt and will protect claimants from unnecessary expense in the processing of their cases.

III. WORKERS' COMPENSATION BENEFIT COSTS

Connecticut's benefit structure in workers' compensation is extensive. Thirteen different benefit features are offered including dependency allowances, paid group health while on workers' compensation, disfigurement awards, automatic cost-of living adjustments, and additional benefits after permanent partial benefits have run out.

The costs of providing these benefits are growing at an annual double digit rate. Workers' compensation benefits paid in Connecticut for 1989 totalled more than half a billion dollars. Table 1 below shows the total benefit payouts from 1985 to 1989, along with the annual growth rate. As the table indicates, in the past five years benefit costs have almost doubled, and increased almost $100 million in the last year alone.

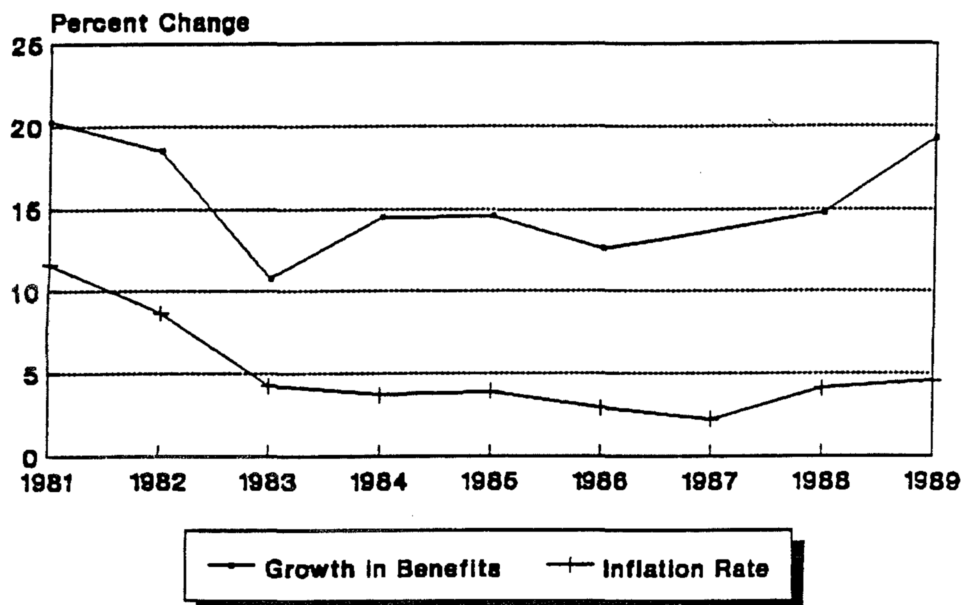
Table 1. Connecticut Workers' Compensation Payouts 1985 - 1989

Year	Total Payouts	Annual % Increase
1985	$303,819,628	
1986	$342,043,718	12.5
1987	$423,687,103	23.8
1988	$486,500,000	14.8
1989	$580,252,719	19.2

Source: Connecticut Workers' Compensation Commission

Total workers' compensation costs have been increasing much faster than the rate of inflation in Connecticut. Figure 1 depicts the growth in the rate of inflation compared with the growth rate in total workers' compensation costs. The results show that, during the 1980s, workers' compensation costs grew at two to four times the rate of inflation.

FIGURE 1. GROWTH RATES
Benefit Payments vs. Inflation



Benefit data for 1987 not comparable

Source: LPR&IC Staff Analysis of WCC Statistics

The growth in benefit costs is also greater than can be attributed solely to growth in the workforce. On a per-worker basis, workers' compensation costs in Connecticut rose from $21.80 in 1986 to $34.50 in 1989. This represents a 58 percent increase in four years.

Program review committee staff believes that efforts must be made to curtail the high growth rate in workers' compensation costs. Staff recommendations contained in this section encompass three major areas -- wage replacement, medical expenses and the second injury fund -- and are aimed at reining in the growth in costs, eliminating any disincentives to return to work, while still providing injured workers with a fair and equitable wage replacement system.

The staff proposals include changing the method of calculating indemnity or wage loss benefits from gross to after-tax income;

eliminating dependency allowances; restricting eligibility for disfigurement benefits, and setting a flat rate for those eligible. Similarly with permanent partial disability benefits, the staff proposes changing the current wage-based method of calculating benefits with a three-tiered flat rate system, based on injury severity. Cost-of-living adjustments would also be altered to more closely reflect actual increases in wages in the state. Finally, committee staff suggests that employer-sponsored medical health plans, with prior board approval, be implemented as a way to contain medical costs, and that eligibility for the Second Injury Fund be limited to those claimants whose employers' knowledge of a preexisting condition is documented.

WAGE REPLACEMENT

The majority of benefit costs go toward directly compensating injured workers, while a lesser amount pays medical expenses on behalf of injured workers. In Connecticut, as with most other states, the compensation rate for totally disabled workers is calculated by taking 66 2/3 percent of a worker's gross wage. However, as reported in the staff's findings, because workers' compensation benefits are not taxed, and because of the nature of the tax structure, 20 percent of the workers in Connecticut receive 100 percent or more of their pre-injury take-home pay, and no one in this state receives less than 80 percent of their disposable income.

The Workers' Compensation Research Institute conducted a study of benefit structures for those workers receiving temporary total benefits in various states, including Connecticut. The table below shows that, depending on the workers' status (e.g., married, single, two-income family and wage level), the percentage of the worker's income that is replaced by compensation benefits varies widely. Even among the same categories of workers, large disparities exist in the percentage of income replaced. For example, an unmarried worker making $20,000 gets 86 percent of his or her spendable income replaced, while another single worker making $35,000 gets 103 percent of his or her take-home pay.

Table 2. Income Replacement Levels in Connecticut				
	Marital Status			
Predisability Annual Income	Single	Married	Married	Married
			Spouse earns $15,000	Spouse earns $25,000
$5,000	87%	87%	103%	103%
$9,347	103%	87%	103%	103%
$10,000	97%	81%	97%	97%
$11,216	86%	81%	97%	97%
$15,000	86%	95%	95%	95%
$20,000	86%	93%	93%	93%
$25,000	86%	92%	92%	110%
$30,000	104%	91%	91%	109%
$35,000	104%	90%	108%	109%
$40,000	104%	90%	108%	109%
$45,000	104%	89%	108%	109%
$50,000	104%	106%	108%	109%

Note: All replacement rates are based on a four-week disability

Source: Workers' Compensation Research Institute, November 1990 Research Brief

The 1972 report of the National Commission on State Workmen's Compensation Laws, generally viewed as the pivotal study of states' workers' compensation benefits systems, established standards for adequacy and equity of benefits. The commission's broad standard for adequacy was that lost earnings should approach the pre-injury standard of living, while also encouraging safety consciousness and return-to-work incentives. The commission defined equity as providing equal benefits or services to workers in identical circumstances.

Measured against these standards, program review committee staff believes that Connecticut's current method of calculating wage replacement creates inequities and reduces incentives to return to work. A more equitable approach would be to calculate a worker's compensation rate on his or her after-tax earnings. In the three states and the District of Columbia where this method is used, the compensation rate is pegged to 80 percent of a workers' take-home pay.

Recommendation

Beginning October 1, 1991, the weekly rate of compensation paid to the employee for total incapacity to work shall be equal to 80 percent of his or her earnings after deducting for federal income tax and FICA (Social Security) taxes. This rate would apply to all workers whose current compensation rate is established at 66 2/3 percent of gross pay.

Discussion. Under this proposal, other components that affect a workers' compensation rate -- the weekly maximum and minimum, the definition of total wages and the time periods for determination and waiting -- as currently specified in C.G.S. Sections 31-295, 31-309, and 31-310 would not be altered. However, the calculation of the compensation rate would require that the amounts deducted for federal income tax withholding and social security payments be subtracted prior to multiplying the remainder by 80 percent.

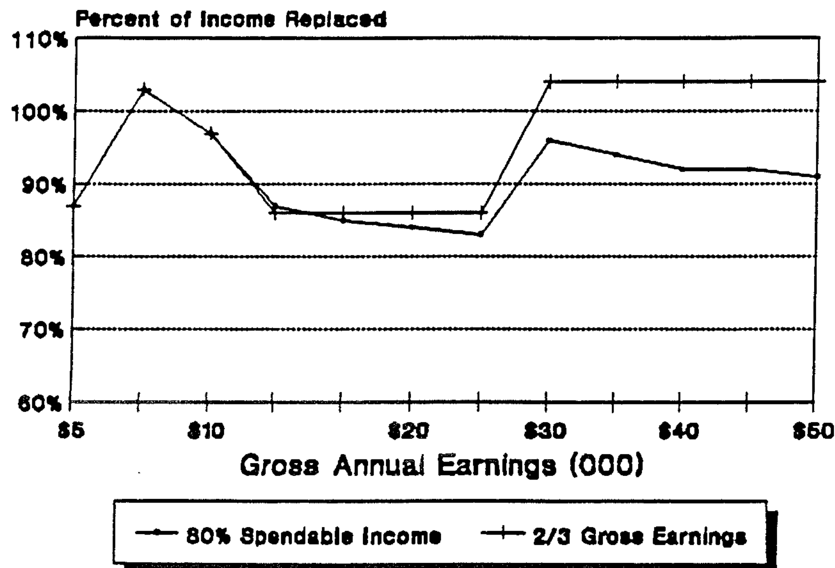
Program review committee staff believes that this proposal will provide for a more equitable system of compensating those who are temporarily totally disabled. First, as Table 3 below indicates, using 80 percent of spendable income as the compensation rate will reduce, by almost half (from 20.9 to 10.9 percent), the percentage of workers who receive more in compensation than they did while working, thereby strengthening the incentive to return to work for those additional ten percent of workers. There are most likely factors, other than monetary ones, that prompt people to return to their jobs, but certainly for those workers who receive the same disposable income from workers' compensation benefits as they would if they were on the job, the incentive is not an economic one. The additional advantage is that by pegging the rate to 80 percent of after-tax income, no one will receive less than the minimum paid under the current system.

Table 3. Income Replacement Levels: A Comparison of Gross and After-Tax Methods		
Percent of Disposable Income Replaced	Present System (66 2/3 of Gross)	Proposed System (80% of Net)
	Percent of Workers	
Above 100%	20.9%	10.9%
Between 80% and 100%	79.1%	89.1%
Below 80%	0.0%	0.0%

Source: Workers' Compensation Research Institute

Another outcome of the recommendation is that it lessens the variation in replacement levels that currently exist as a result of the tax structure. While complete uniformity in replacement levels is not possible, the figure below shows that the gap in replacement rates under the 80 percent of spendable income narrows. This indicates that there is less variation among workers in what portions of their take-home pay compensation benefits replace.

FIGURE 2. INCOME REPLACEMENT



unmarried workers, four week disability

DEPENDENCY ALLOWANCE

Connecticut is one of nine states that provides an additional allowance for dependents of workers' compensation recipients. In general, if a worker in this state is totally disabled, either temporarily or permanently, he or she receives an additional $10 a week for each child under 18, within certain limits (i.e., the total dependency allowance cannot exceed certain percentages of wages or compensation rates). The dependency allowance is considered a supplementary benefit, and is not affected by the statutory weekly maximum benefit rate. For example, a claimant with three children, eligible for the current weekly maximum of $719, would receive an additional $30 per week, bringing the worker's weekly compensation to $749.

The dependency allowance is another benefit that can create an economic disincentive to return to work, when it brings the worker's total compensation benefits close to his pre-injury take-home pay.

Recommendation

The dependency allowance, as contained in Section 31-308b of the Connecticut General Statutes, shall be repealed.

Discussion. Committee staff believes it is important that wage replacement benefits, under workers' compensation, provide sufficient financial support to enable workers to maintain their pre-injury standard of living. In the staff's opinion, Connecticut's system ensures this by statutorily setting weekly high minimums and maximums. However, if workers with families are maintaining a standard of living on their wages while working, it goes beyond the simple wage replacement concept underlying workers' compensation to provide a larger disposable income for that family when the worker is disabled. Removing the dependency allowance will establish a wage replacement system with more definite parameters and, again, one that reduces economic incentives to extend disability beyond what is medically necessary.

COST OF LIVING ADJUSTMENT

Every October 1, workers receiving total disability payments or dependents receiving death benefits are granted an automatic cost-of-living adjustment (COLA). Connecticut's method of

calculating the COLA leads most recipients to receive a greater change in their benefit levels than the actual percentage change in the manufacturing wage upon which the adjustment is based. This occurs because in the calculating the COLA, the annual rate of change in the production workers' wage is applied to the maximum weekly benefit rate in effect for the time period in which the claimant's injury occurred. The dollar amount of any increase this procedure yields is then added to the weekly rate of every recipient in the affected category. Adding a constant dollar amount to the benefit rate of all recipients in that category results in all but those at the maximum, receiving a greater rate change than actually occurs in the production workers' wage.

For example, workers injured in 1986 and collecting total disability benefits between October 1, 1989 and September 30, 1990, were subject to a maximum weekly benefit cap of $462. As a result of the October 1, 1990, COLA the weekly benefit cap was increased to $477. For recipients at the maximum, the additional $17 was equal to the 3.7 increase in the production wage. However, for recipients at half the maximum rate ($231) the increase represented a 7.5 percent gain.

Recommendation

The annual cost-of-living adjustment for workers' compensation benefits shall be an individual's current weekly rate multiplied by the rate of change in the average weekly earnings of production workers in manufacturing in Connecticut, as determined by the labor commissioner.

Discussion. The staff recommendation equates the change in benefits paid to the percentage change in the production wage. The proposal would limit the change in total expenditures on benefits related to cost-of-living adjustments to the actual rate of change in the average production workers wage in Connecticut. Assuming continued growth in the production wage, the result would be a slight decline in total expenditures. Under the staff proposal the ability of all workers' compensation benefit recipients to purchase goods and services would increase proportionally to the increase experienced by the average employed manufacturing worker.

PERMANENT PARTIAL DISABILITY

Most workers' compensation claims, other than medical only, are filed by individuals who are temporarily totally disabled from working. However, data from the National Council on Compensation Insurance (NCCI) indicate that such claims make up only about 10 percent of total workers' compensation payments in Connecticut. The largest portion, slightly over 50 percent, goes to workers who suffer a permanent partial loss of a body part or function. Using NCCI data as a guide, Connecticut's permanent partial disability payments totalled about $200 million in 1987.

A staff analysis of roughly 3 percent of the workers' compensation cases that became active in calendar 1987 found that, through June 30, 1990, a total of 281 out of a possible 745 cases involved a permanent partial disability claim. For 260 cases in which resolution data were available, the amount of money obligated to workers ranged from approximately $200 to $63,650 and averaged just under $10,460.

The 260 cases accounted for nearly $2,720,000 in payment obligations, which if projected to the entire population of cases would total over $90.6 million. The discrepancy between the two data sets is most likely due to the fact that the sample data are limited to the amount of money obligated specifically for the permanent partial disability payments, while NCCI's data include this type of payment amount plus other benefits, such as temporary total and disfigurements, paid to permanent partial disability recipients. The important point is that estimated total payments are large regardless of the data source.

In Connecticut, permanent partial disability benefits are designed to compensate workers for physical impairments and loss of earning capacity. The level of compensation is based on the proportion of the loss of a body part or function as determined by a physician at the point where the worker reaches maximum medical improvement following an injury.

The benefit amount is computed by multiplying two-thirds of a worker's average gross wage in the 26 weeks prior to the onset of the injury or disability, by the number of weeks allowed for loss of the specific body part or function, with a partial loss compensated on a proportional basis. The allowable weekly rate is subject to a maximum, which is set at 150 percent of the wage for production workers in manufacturing, and a minimum that is set at

20 percent of the maximum, provided the resulting amount does not exceed 80 percent of the worker's pre-injury weekly wage.

The number of weeks of benefits varies depending on the body part or function lost. A schedule, setting the maximum number of weeks for 13 specified body parts, is written in state statute. The number of weeks ranges from 13 for loss of a toe to 520 for total incapacity of the back. The number of weeks allowed for all other losses are set by the workers' compensation commissioners on a case by case basis, and can range from 1 to 780 weeks.

The Connecticut system, by including the worker's weekly wages into the formula for calculating his or her permanent partial benefit level, compensates workers more at higher salary levels for an identical loss than those in lower salary ranges. For example, a worker at the maximum compensation rate of $719 who suffers a 10 percent permanent disability of the thumb on his or her master hand will receive $6,830, while a worker at half the compensation rate ($360) will be given only $3,415 for the same injury. The inequity can be compounded if the lower salaried worker's ability to perform his or her previous occupation is affected by the disability, while the other worker's is not.

Fortunately, this inequity can be partially ameliorated by benefits allowable under Section 31-308a of the Connecticut General Statutes. The additional benefits for a permanent partial disability, awarded at the discretion of a commissioner under section 31-308a, are designed to compensate a worker for his or her lost earning capacity. Of course, the existence of section 31-308a benefits raises questions about the need for a permanent partial disability program as generous as the one Connecticut has.

Another question about the compensation program for permanent partial disabilities relates to the substantial amount of benefits received by workers whose injuries, as measured by the number of weeks of compensation provided, may not be severe. This view is supported by data from the committee's sample showing that in 25 percent of the cases the number of weeks of compensation for a permanent partial disability was 13 or less. The cases accounted for about 6 percent of the obligated benefits, which if projected to all cases would amount to approximately $5.5 million.

Recommendation

The high cost of Connecticut's permanent partial disability program, its inequities, and the existence of benefits under Section 31-308a led the committee staff to explore changes in the current system. As a result, the program review committee staff recommends Section 31-308 be amended as follows:

> **the weekly compensation rate for a partial incapacity that is determined to warrant 13 weeks or less of compensation shall be fixed at 25 percent of the average weekly wage of production and related workers in manufacturing;**
>
> **the weekly compensation rate for a partial incapacity that is determined to warrant more than 13 weeks, but not more than 104 weeks of compensation, shall be fixed at 50 percent of the average weekly wage of production and related workers in manufacturing; and**
>
> **the weekly compensation rate for a partial incapacity that is determined to warrant more than 104 weeks of compensation shall be fixed at 100 percent of the average weekly wage of production and related workers in manufacturing.**

Discussion. The staff proposal is designed to decrease overall payments for permanent partial disability benefits. It is also intended to shift benefits from less severely injured workers to those more seriously injured.

Table 4 on the following page shows the effect of the staff recommendation on the sample of permanent partial disability cases contained in the committee's sample of cases that become active in 1987. The column on the left identifies weekly time parameters outlined in the recommendation. The second column cites the number of cases in the sample that fall into each time class. The third and fourth columns show the dollar amount obligated to each time class under the system in effect in 1987 and the staff proposal.

The staff recommendation would reduce overall benefit obligations in the sample data by 11.9 percent. Total payments would decrease by 62.9 percent in the 13 week and under category

and by 24.9 percent in the 14 to 104 week category. Payment obligations in the above 104 week grouping would rise 49.4 percent.

TABLE 4. Effects of Recommendation on Current System			
Weeks	Number in Class	Total Benefits Current System	Total Benefits Recommendation
< 14	66	$154,021	$57,160
14-104	176	$1,920,873	$1,456,864
> 104	13	$512,011	$764,833
Total	255	$2,586,905	$2,278,857

The effect of the proposal on individuals within each group varies depending the relationship of their weekly compensation rate to the applicable fixed rate contained in the staff recommendation. Of the 251 cases in the sample, 181 claimants would have benefits reduced, 68 would receive an increase, and 2 would experience no change. The average benefit per case would fall from $2,334 to $866 in the under 14 week group and decline from $11,167 to $8,273 for the middle group. Average per case payments in the above 104 week category would increase from $42,668 to $58,883.

It should be noted that the recommendation's effect on current cases should result in greater cost savings. First, the maximum weekly rate under this proposal would be limited to 100 percent of the average production worker's wage instead of the current 150 percent. Second, the increase in the overall wage level since 1987 means that workers' compensation rates have also moved upward. Unfortunately, the committee staff has no hard data on current weekly compensation rates being paid, and therefore cannot calculate accurately what the exact savings would be. However, based on the 1987 sample data it is reasonable to estimate savings in benefit payments in the neighborhood of 12 percent.

DISFIGUREMENT AWARDS

Connecticut, like most states, provides benefits to compensate workers for disfigurement and scarring related to on-the-job injuries. The majority of states limit such benefits to permanent

scars on the head, face, or exposed body parts or require that employability be affected by the disfigurement; some states require that both conditions be met. In general, Connecticut only requires that compensable scars be permanent and significant as determined by a commissioner.

Available benefit payout data do not isolate the money awarded for scarring and disfigurement. The committee staff's sample of workers' compensation cases that became active in 1987 indicated that one claimant in four received disfigurement benefits. While individual awards in the sample were relatively small, averaging just over $2,100, total costs were significant. Based on its sample data, the program review committee staff estimates that scarring and disfigurement payouts in 1987 were in the range of $19.5 million.

By statute, the maximum benefit duration for scarring is 208 weeks. The highest number of weeks awarded in the committee staff sample was 51. Workers receiving scarring benefits for four weeks or less accounted for nearly half (49 percent) of the 170 disfigurement award cases in the sample; 75 percent of the cases received disfigurement benefits for 10 weeks or less.

Analysis of the sample data provides evidence that benefits are frequently awarded for scarring from occupational injuries that did not result in any lost work time. Disfigurement awards were the only benefits claimed by about 44 percent of the 175 workers in the sample who received them. The program review committee staff also found that because disfigurement awards, like permanent partial disability benefits, are related to weekly wage rates, those earning high salary levels are compensated more than low wage earners for equally severe scarring.

The inequities in scarring benefits due to disparities in weekly earnings were vividly illustrated by the program review committee staff sample data. Weekly wage rates for disfigurement award cases averaged $281 but ranged from $61 to $690. The largest disfigurement award in the sample --$20,808-- was paid to a worker with a weekly rate of $408 for scarring evaluated at 51 weeks. In contrast, another worker with a 50-week scar award but with a compensation rate of $160 received a total of $8,000 in disfigurement benefits. Of the 29 cases in the sample involving disfigurement awards with a 2-week duration, total benefit amounts ranged from $176 ($88 per week) to $1,390 ($690 per week).

In the opinion of the program review committee staff, the dollars provided for disfigurement benefits should be provided in an equitable manner and aimed at workers who have suffered the most damaging scarring.

Recommendation

Compensation for disfigurement shall be limited to permanent and significant scarring or disfigurement that occurs on the head or face. It is further recommended that the compensation rate be set at 100 percent of the state average production worker wage for all recipients of disfigurement awards.

Discussion. The primary purpose of workers' compensation is to replace lost wages. Linking scar benefits to head and facial disfigurements, which are the most likely to affect employability, is consistent with this intent. Current policy on disfigurement benefits already incorporates the thrust of the recommended restriction. Existing regulations require that commissioners give lesser importance to scars rarely or never visible. Furthermore, under current law, no compensation is given for hernia or spinal surgery scars. In the staff's opinion, the proposed change in how disfigurement benefits are calculated will produce fairness by insuring that scars of equal severity are compensated at the same rate.

Many in the system believe that serious burns are not adequately compensated under the present scarring benefit structure. While under the staff recommendation, only burns on the head or face will be eligible for disfigurement awards, compensation for more extensive burns is not precluded. The committee staff believes that serious burns can and should be recognized as organ (skin) losses under the unscheduled permanent partial disability structure and thus be eligible for up to 780 (rather than 208) weeks of benefits.

Under the staff proposal there will be substantially fewer scarring awards, but the cost per claim paid will be higher since the weekly rate for all recipients would be pegged to the state's production worker wage. Overall, disfigurement compensation that is received will be provided at a higher level and directed at the most serious cases.

The fiscal impact of the recommended changes in disfigurement awards is difficult to estimate since it is not known what portion of the current beneficiaries would be excluded by the new limits. However, in the opinion of the program review committee staff, the reduction in payouts would be substantial and should easily exceed 75 percent. The staff bases this view on its recollection that very few head or facial disfigurement awards were encountered when reviewing files to collect a sample of compensation cases.

MEDICAL COSTS

Nationally, it has been documented that workers' compensation medical costs are growing about 30 percent faster than health care costs in general. Countrywide, workers' compensation medical expenses are approaching 40 percent of all benefit costs in workers' compensation, and are projected to be half of all benefit costs by the year 2000.

Program review committee staff's analysis of workers' compensation medical costs in Connecticut showed that: 1) medical costs in Connecticut are about 30 percent of the state's total workers' compensation costs; 2) of the 42 states that report data through the National Council on Compensation Insurance, only 6 other states had percentages of medical to total costs lower or equal to Connecticut's; but 3) the average per-claim medical costs are growing at a faster rate than are indemnity, or wage loss costs.

Committee staff also found that while total workers' compensation medical costs are proportionately lower than most other states, medical costs are growing faster than wage loss costs in Connecticut. The preliminary findings showed that during the policy years 1982 through 1986, the average per-claim medical costs grew by 71.8 percent, while average indemnity costs grew by only 40.2 percent.

The growth rate in total medical costs in workers' compensation is also more rapid than the increase in actual benefits. Table 5 below shows the total amounts that private insurers expect to pay in wage loss and medical payments for the policy years 1984 through 1988. As the table shows, the annual increases in medical costs outpaced wage loss costs in each of the four years, and in total grew by 107.8 percent, while actual

benefits to claimants grew by 75.7 percent. Expressed another way, for every $100 paid to a worker in wage benefits, almost another $50 is paid for medical services.

Table 5. Annual Growth in Wage Loss and Medical Benefits				
Policy Year	Indemnity Losses	% Annual Growth	Medical Losses	% Annual Growth
1984	$265,534,006	--	$101,530,671	--
1985	$326,791,957	23	$129,697,218	27.7
1986	$359,755,835	10	$147,642,703	13.8
1987	$429,459,632	19.3	$180,021,154	21.9
1988	$466,688,749	8.6	$211,011,022	17.2
Total % Increase		75.7		107.8

Source: NCCI 1991 Rate Filing with CT. Insurance Dept.

Growth in medical costs may be difficult to control in Connecticut because no medical cost-containment measures are in place. As the preliminary findings indicated, the Workers' Compensation Commission has the statutory authority to establish a fee schedule, but has not done so. In addition, Connecticut is one of about 30 states where employees may select a medical provider of their choice, thereby limiting the use of employer-sponsored health maintenance organizations and the like.

With no systemwide external controls on medical costs in workers' compensation, coupled with the lack of deductibles and co-pays that exist in most other medical plans, neither patients nor providers have any incentive to exercise restraint. Many experts even suggest that there may be shifting of medical costs from other sources (e.g. group health, medicaid, and medicare) into workers' compensation because of efforts to control medical costs in those programs. Thus, it is imperative that some efforts be made to contain medical costs in workers' compensation.

Medical cost-containment options. Program review committee staff examined both fee schedules and provider-sponsored medical care as options in containing medical costs. Fee schedules list maximum charges for medical services and products. About 23 states have fee schedules in place. However, there is no conclusive evidence that fee schedules by themselves lower medical costs. A study released by the Workers' Compensation Research Institute (WCRI) in December, 1989, entitled Medical Costs in Workers' Compensation, ranked states by their annual percentage growth in medical costs. The results showed that states with fee schedules in place for at least 15 years during the period between 1965 and 1985 fared no better than those without schedules. In fact, the study found no relationship between the growth rate in medical costs and the use of fee schedules ($r = -0.08$).

One of the basic shortcomings of fee schedules is that they do not control utilization. Additional administrative mechanisms must be put in place to ensure that the quantity of medical services are not increased to make up for the lowered price of the service set in the schedule.

Second, setting a fee schedule creates a dilemma of what the appropriate price for each good or service should be. A level is set too low can severely limit the number of providers willing to offer the service. For example, according to the Connecticut Department of Income Maintenance, only about one-quarter of the 7,000 physicians in Connecticut actively treat medicaid patients, while approximately another 1,000 treat a medicaid patient occasionally.

Massachusetts, which has a workers' compensation fee schedule, had the lowest annual growth in workers' medical costs between 1965 and 1985, according to the WCRI study. However, staff in that state's rate setting commission indicate that they receive complaints that there is a shortage of medical specialists willing to treat workers' compensation patients for the set fee.

If, on the other hand, the scheduled rates are set too high, the new fees often become the ones charged by most medical providers. The use of fee schedules may also lull the system into a sense that medical costs are being contained when they are not. The WCRI study results show this nationally.

Another study, Health Care Costs and Cost Containment in Minnesota Workers' Compensation, was conducted by that state's

Department of Labor and Industry, and released in March 1990. The study's research showed that, despite Minnesota's use of a medical fee schedule in workers' compensation, medical costs for treating injured workers were twice as high, overall, as charges for Blue Cross.

For all the above reasons, program review committee staff concludes that use of medical fee schedules is not the best option to contain medical costs in workers' compensation.

Committee staff also examined another alternative to containing medical costs -- allowing some degree of employer choice in the selection of treating physicians. This would allow employers, or insurers on their behalf, to negotiate with providers to treat their employees, injured on the job, at previously agreed-upon rates. The staff recognizes that there have to be some checks in place to ensure the adequacy of the quality and the quantity of the providers enlisted by the employers; otherwise employees may not receive adequate medical care.

Recommendation

Beginning July 1, 1992, allow employers, or insurers on their behalf, to submit a plan for its workers' compensation medical care to the Workers' Compensation Board of Directors for its approval. The plan must be submitted 120 days before the employer intends to have the plan become effective, and must be resubmitted and receive board approval every two years from its initial effective date. The information required in the submitted plan shall be determined by the board, but shall include: 1) a list of the names of all individuals who will provide services, and appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in Connecticut; 2) a description of the times, places, and manner of providing services; and 3) a description of how the quality and quantity of medical care will be managed.

The approval of such plans shall be based on standards set by the board, with advice from a medical panel established by the board. Standards shall include, but not be limited to: 1) provision of all medical and health care services that may be required under workers' compensation in a manner that is timely, effective, and

convenient for the worker; 2) inclusion of all categories of medical service, with an adequate number of providers for each type of medical service in accessible locations, to ensure that workers are given adequate choice; 3) provision of appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service; 4) some method of fee screening, peer review, service utilization review, and dispute resolution to prevent inappropriate or excessive treatment; and 5) a manner in which information on medical and health care service costs and utilization could be reported to the board, upon its request, so that the plan's effectiveness can be determined.

Section 31-305 of the Connecticut General Statutes, concerning independent medical examinations shall be changed to allow an employee, upon the employee's request or at the direction of a workers' compensation law judge, to be examined by a reputable physician or surgeon, other than one listed in the plan sponsored by the employer or the insurer. The costs of such examination shall be paid by the employer.

Discussion. Program review committee staff believes that if this recommendation is implemented, it will be an essential first step in establishing medical cost containment measures in workers' compensation in Connecticut. The staff recognizes that the approach presented here offers only an opportunity to control costs, not a guarantee. Indeed, the Workers' Compensation Research Institute study cited above showed that states with employer choice of physician had growth rates in workers' compensation medical costs that were both as high and as low as those states with employee choice. However, the most recent data examined were from 1985, before prevalent use of preferred provider organizations and the like.

Committee staff considers this recommendation a balanced approach to controlling costs in that it offers the employers, or their insurers, some latitude in establishing a medical plan that may provide some cost savings, while still allowing employees a reasonable choice of treating physician. Further, since the recommendation would allow either employers, or their insurers, to establish a medical plan it offers opportunities for both large and small businesses to participate. Some employers may realize

additional savings if they are able to negotiate with the same providers for their employees' group health care.

Further, by making the plan, including the physician list, subject to board approval there will an outside check on the integrity of the employer/insurer to establish a medical model with the employee's best interests in mind.

This recommendation should not cause any provider shortages, since provider participation in the employer/insurer plan would be voluntary. Further, the recommendation adds the protection of the board's approval to ensure adequacy of the quantity and quality of those physicians in the plan.

Under the committee staff's proposal, rates for medical goods and services would be negotiated between the provider participants and the employer or insurer, rather than set in a schedule, allowing the parties to the agreement to decide what fees are reasonable. Also, the rates would be adjusted each time the contract was renewed, allowing for some degree of self-regulation.

The recommendation also addresses the need for controlling utilization, requiring that information on usage and costs be kept, and reported to the board upon its request, so that the effectiveness of cost and utilization control can be evaluated.

Finally, program review committee staff believes this recommendation will move toward controlling costs, while still preserving the worker's right to have all medical costs paid, without deductibles or copayments.

SECOND INJURY FUND

Benefit Costs

Program review committee staff's findings on the Second Injury Fund (SIF) focused on its explosive growth. The findings showed that the SIF paid out over $43 million in calendar year 1989, a 130 percent increase in the past five years. The SIF payouts have grown 40 percent more rapidly than workers' compensation overall and payouts now equal about $27 per year for each employed worker in the state.

The findings also indicated that 78 percent of the payouts from the SIF are for subsequent injuries, while the remainder provides benefits such as cost-of-living adjustments (3%), group health benefits (1%), payments to claimants whose cases are being appealed (2%), and benefits to workers where their employers were uninsured (4%). Further, the potential demand for the SIF to pay for subsequent injuries is significant. At present, pending claims are one-and-a-half times the number of claims currently being paid in this category. As mentioned in the staff's preliminary findings report, not all pending claims are transferred, either because they are never acted upon or are denied. However, it is an indication of the potential claims that may have to be picked up by the Second Injury Fund.

Connecticut statutes are broad in their interpretation of who is eligible for transfer to the Second Injury Fund. Connecticut is one of 15 states that requires only that the second injury or disease, when combined with any preexisting condition, results in a permanent disability greater than that which would have occurred from the second injury alone. Such transfers in Connecticut are allowed after the employer has paid benefits to the claimant for two years.

In addition, Connecticut statutes allow immediate transfer to the Second Injury Fund if the worker has signed a document entitled an acknowledgement of physical defect, and the subsequent injury is related to the acknowledged defect.

Other states are more restrictive concerning subsequent injuries in one of two ways: 1) they require the second injury to be a permanent total disability or be the loss of an eye or member part; or 2) they require that the employer be knowledgeable about the preexisting condition or prior injury in order for the second injury claim to be transferrable.

The Second Injury Fund expense data show that the rapid growth in the SIF is due largely to benefits paid to claimants who suffer a second injury. In FY 86, the SIF paid about $15.9 million for subsequent injuries; by FY 90 that payment category had grown to $35.5 million, or 78 percent of all SIF benefit payments.

Program review committee staff believes that this growth in the subsequent injury category of the fund is likely to continue for two reasons. First, eligibility for the SIF is broad, allowing high utilization of the fund. Almost anyone suffering a work-

related injury can be transferred to the fund if a preexisting condition can be found and the injured worker receives benefits for the required 104 weeks. Second, there are no deterrents, like user fees, for employers or carriers to use the fund. In fact, there is an incentive for an individual employer to shift that liability to the SIF, where the payments of benefits for that injury become the responsibility of the pool of employers rather than the individual employer.

Recommendation

Program review committee staff concludes that to limit utilization of the fund the statutes must be changed to restrict eligibility. Therefore, committee staff recommends that:

> **transfer to the Second Injury Fund shall be limited to claimants for whom a signed and approved acknowledgement of physical defect is on file with the workers' compensation commission. Further, any transfer to the SIF due to a second injury would take place after the expiration of 104 weeks of benefits paid by the employer. The current statutory reference allowing immediate transfer where acknowledgements exist would be repealed.**
>
> **The procedure and time limits for application for transfer to the Second Injury Fund, as well as the requirement for all medical reports and a copy of the voluntary agreement or award to be sent to the custodian of the fund, would remain as currently required in statute. However, the employer or insurance carrier would also be required to furnish the signed acknowledgement.**
>
> **The statute shall require that the employer, or insurer on his behalf shall be the respondent party to the claim until the transfer to the Second Injury Fund has been completed.**

Discussion. Program review committee staff believes that this recommendation to limit eligibility to the Second Injury Fund is necessary in order to curtail the fund's tremendous growth, and maintain the long-range viability of the fund. The proposal is in keeping with the original purpose of the Second Injury Fund -- to encourage employers to hire handicapped workers or those who had experienced prior injuries, by diminishing the risk to employers if

the worker experienced a job-related injury. Indeed, staff believes that in order for that purpose to be achieved it is essential that employers at least recognize the employees' handicaps or prior injuries.

Committee staff believes that employers will not be accepting unlimited liability by hiring someone with a prior injury or disease, since the employer will only be responsible for the first two years of paying the claimant's benefits. After that period, the benefits would be paid from the Second Injury Fund.

This recommendation may encourage employers to conduct pre-employment and employment physical examinations to determine any preexisting conditions workers might have. At the same time, these physical examinations may inform workers of conditions they were previously unaware of and that they may be able to control -- e.g., heart disease or diabetes -- contributing to a healthier workforce.

Assessments

To finance the Second Injury Fund, employers are assessed five percent of all workers' compensation benefits paid by them in the preceding year. Each assessment is limited to five percent, but there are no limits on the number of times an employer can be assessed in a one-year period.

Prior to the 1990 legislative session, both the State of Connecticut and municipalities that insured their workers' compensation risks with the Connecticut Interlocal Risk Management Agency (CIRMA) were exempt by statute from the assessment, but neither was excluded from using the fund. Public Act 90-311 required that the municipalities in CIRMA be assessed for their portion of the SIF, but the State of Connecticut currently remains exempt. Based on the total workers' compensation benefits paid by the State in 1989, the State's annual assessment in FY 90 would have been approximately $4 million.

Neither does the State contribute to the administration of the fund. Until recently, the costs of administering the Second Injury Fund came out of the Workers' Compensation Commission budget. However, P.A. 87-277 required that costs incurred by the state treasurer in administering the Second Injury Fund be paid from the fund itself. Thus, other then providing the office space that houses the SIF administrative personnel, the State does not contribute to the Second Injury Fund.

Further, the State's use of the SIF has been growing, according to those in the system. Program review committee staff examined data available on state usage of the SIF as of February, 1990 and found that there were 129 claimants who were receiving benefits for a second job-related injury. However, there were an additional 110 claims pending in this category. As discussed above, all pending cases do not result in transferred cases, but it is an indication of the number that the State considers meet the eligibility criteria.

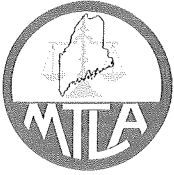
Recommendation

Program review committee staff believes that all employers that pay out workers compensation benefits, including the State of Connecticut, ought to be assessed for use of the Second Injury Fund. Therefore, committee staff recommends that:

> **beginning July 1, 1992, the mandatory assessments for the Second Injury Fund be extended to include the State of Connecticut.**

Discussion. Committee staff believes that having the State pay into the Second Injury Fund will make a fairer assessment system than the one currently in existence. First, the State of Connecticut uses the Second Injury Fund for its eligible claimants like any other employer in the state. Further, the State paid workers' compensation benefits totalling about $40 million during calendar year 1989, which would have translated into a $4 million annual assessment for the Second Injury Fund.

Second, it is difficult to justify why other employers who pay the assessments for the fund must share the burden of the State's portion as well. For example, if the State had been assessed for its portion of the fund's payouts in 1989, it would have saved all other employers about ten percent on their assessments. State responsibility for its use of the fund would spread the costs to all citizens who benefit from the State's services, and not just to those businesses that pay out workers' compensation benefits.



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Re: Blue Ribbon Commission

Gentlemen:

Enclosed is a copy of an article I have done for the newsletter of the Maine Trial Lawyers Association analyzing some of the issues as I have seen them develop in your hearings.

The process has been fascinating; and I wish I had the time to attend more of the proceedings.

If the Commission would like to have feedback or assistance from those of us who practice in this field, please feel free to call upon us.

Yours very truly,

S. Peter Mills, Esquire

SPM/bp

Enclosure

WORKERS COMPENSATION

Having completed a two month crash course on workers' compensation, the Blue Ribbon Commission must now synthesize its recommendations to meet the legislature's summer deadline. Questions from the panel have become increasingly sophisticated as the members have interrogated one witness after another during approximately 60 hours of public testimony supplemented by numerous documents and briefs.

One of the most compelling presentations came from the Workers' Compensation Group, an ad hoc study committee comprised of eight labor and eight business members who recently achieved the remarkable consensus that Maine should look to Michigan for adoption of a new system. As a result, the Blue Ribbon Commission has focused close attention on Michigan law and is likely to recommend that Maine imitate at least some of Michigan's structural or substantive provisions.

To solve Maine's current dilemma, the Commission must consider problems in the following areas:

<u>The Insurance Market</u>

If nothing is done, Maine's insurance market will dry up on 1/1/93. Ninety-two percent of insured employers are assigned to the residual market pool; and there is no means to perpetuate the pool beyond the end of this year.

However, the problem is narrower than it seems. Approximately one-third of Maine's employees now work for large self-insured businesses which no longer depend on the insurance market for comp coverage. This segment of the labor force represents about 40 to 50% of Maine's total payroll and is growing rapidly. Twenty years ago, self insurance was limited to a few paper companies and the State of Maine. But as premiums rose in the 1980's, the smart businesses bailed out of the market and joined a massive and permanent exodus into self-insurance. Now there are seven or eight hundred self-insured employers and a dozen new groups of smaller employers who have formed self insured associations.

These businesses have already saved a lot of money and will save more as they implement safety programs that were previously non-existent, as they develop more creative means of returning injured people to work, and as they achieve familiarity with tactics available under the 1991 law changes. In its position paper, the Maine Council of Self-Insurers has stated:

> The success of self-insurance is measured by lower costs, improving risk management experience and better

claims handling practices. In relation to their share of the risk, self-insurers experience less loss time incidence than insured employers. Furthermore, over time, the experience rating of self-insurers has been declining. Recent testimony in the workers' compensation rate case revealed that self-insurers are paying less than their insured counterparts in legal expenses and administration. That testimony also revealed overcharging of insured employers compared to self insureds due to faulty cost data.

Because a self-insurance program presently requires a special dispensation from the Superintendent of Insurance, it is not an option easily available to many of Maine's 27,000 businesses, particularly the smaller ones which must still depend on the purchase of insurance; but even among these employers, there are reasons to distinguish among different sectors of the market. For instance, for those of us in the clerical and service sectors, the risks and attendant premiums are still so low that it would do no harm simply to throw the market open and remove existing premium controls.

Take an example: In my office, it costs about $200 per year to provide compensation coverage to a secretary. This is only half of what it costs to purchase a long-term disability policy, one-twentieth of what it costs for health insurance, one-fifteenth of social security taxes, and one-half of unemployment taxes. Thus, for the ever expanding service and clerical sectors, workers' comp continues to be what it was for nearly everyone else twenty or thirty years ago, a trivial cost of doing business.

Unfortunately, it is not the same for those employers whose business it is to cut down trees, to make shoes, or to put up buildings. Even with regulated premiums, their rates are in the range between fifteen and forty percent of payroll.

Sen. Judy Kany and Rep. Elizabeth Mitchell, co-chairs of the Committee on Banking and Insurance, have observed that the existing residual market pool is really functioning like a poorly managed mutual fund. They propose that this pool be taken away from the insurance companies and converted into a series of small, self-insured mutual funds owned by the employers themselves and managed by a board representing both employers and employees who would also control safety policies, calculate mutual assessments, and select claim management services through competitive bidding.

Rates outside the pool in the voluntary market would be deregulated; assessments against insurance carriers would be eliminated; and the mutual fund pools would be available to all employers who cannot otherwise obtain coverage. A special pool with special rates would be created for employers with poor safety records.

With help from Bill Black and Martha McCluskey of the Public Advocate's Office, Sen. Kany and Rep. Mitchell have devoted extraordinary time and energy to the refinement of their proposal; and the members of the Blue Ribbon Commission are considering it carefully.

Safety

In Michigan, public regulation of employer safety is closely integrated with administering workers' compensation. This is not so in Maine. Safety is the responsibility of federal OSHA agents and the Maine Department of Labor. The Compensation Commission administers claims and rehabilitation. There is little interchange.

In Michigan, on the other hand, the same department is responsible for safety as well as claims. Employers have access to state safety counselors to help set up programs and there is a parallel enforcement team to see that recommended programs are implemented.

In Maine, the self-insured employers have taught everyone how to reduce costs dramatically through aggressive safety policies. It seems likely that the Blue Ribbon Commission will recommend changes in Maine's administration of safety programs, perhaps following the Michigan example.

Continuing Oversight

Since 1981, Maine's workers' compensation laws have suffered from constant amendment, and have been on the front burner of every legislative session. The law is looked upon as a fluid continuum, subject to constant change analogous to a collective bargaining contract that is under perpetual negotiation with no beginning and no end. It would be one thing if the parties to the debate were limited to labor and management; but in the workers' compensation field, everyone gets a say. The law is riddled with pockets of special protection for such disparate groups as firefighters, asbestosis sufferers, chiropractors, and design professionals. Other parties in interest include segments of the health care industry, insurance companies and agents, attorneys and, recently, specialists in vocational rehabilitation.

Michigan has resolved this cacophony by recognizing that employers and employees are the only two parties that ought to be listened to. There is an oversight committee that is comprised of equal numbers from each camp similar in structure to Maine's Workers' Compensation Group. Law changes are rarely considered by the legislature unless they come with the approval of the oversight committee.

Operating in a similar vein is a Qualifications Advisory Committee comprised of three members each from labor and from

industry appointed by the governor. This balanced committee screens candidates for appointment or reappointment as workers' compensation magistrates and effectively removes these issues from the political arena.

Through the work of these two committees, Michigan has depoliticized its workers' compensation system; and here in Maine, the Blue Ribbon Commission will be looking to the Michigan example.

Benefits

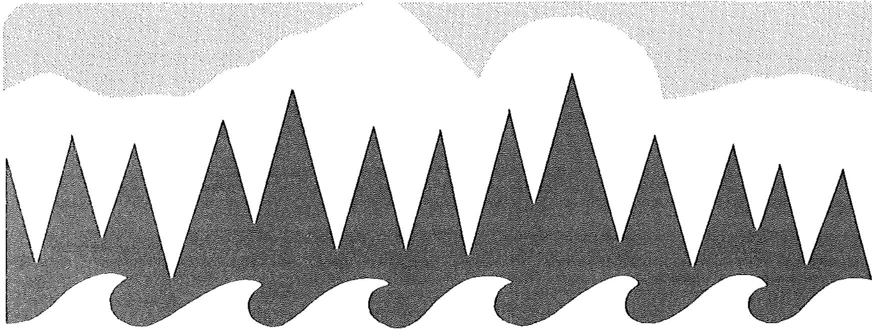
After the cuts made in 1983, 1985, 1987 and 1991, Maine's resultant benefit package is neither better nor worse than that of most other states. To the extent that Maine still experiences an adverse claims experience, consultants suggest that it results from a habit of "over-utilization" or from pent up hostilities in the work place or from other adversities peculiar to Maine's culture.

In fact, it may have more to do with inertia. It takes years for any change to have its impact in the market place. We are only now beginning to see results from the 1987 changes; and it will be years yet before adjusters learn how to use the tactics created by the 1991 law. Self-insured employers responded more quickly and have already begun to see significant savings.

It exceeds the scope of this report to speculate on what the Commission will do with benefits, but there is a general argument afoot that they should either leave Maine's existing package well enough alone or else supplant it completely with the Michigan system as recommended by the Workers Compensation Group. To tinker piecemeal with benefits may give one side or the other a sense of victory that will destroy the tender consensus behind the creation of the Commission and reopen the old Pandora's Box of controversy that has so often disrupted our political scene.

The Commission has one major challenge that exceeds all others: It must create a new market place for purchase of coverage and for spreading of risk among the more hazardous of Maine's small employers. If the Commission accomplishes nothing else, it will have done its job, for it is chaos in this segment of the insurance market that has driven all of the political controversies of the past decade.

S.P. Mills
7/14/92



MAINE CHAPTER
AMERICAN
PHYSICAL THERAPY
ASSOCIATION,
INCORPORATED

July 15, 1992

Commissioner Richard Dalbeck
The Honorable William D. Hathaway
The Honorable Emilien LeVesque
Dr. Harvey Picker
The Blue Ribbon Commission on Workers' Compensation
University of Maine
School of Law
246 Deering Avenue
Portland, ME 04102

Dear Messers Dalbeck, LeVesque, Picker, Hathaway:

I would like to thank you in advance of reading this testimony for your time and consideration. I can appreciate the enormity of your task. Reviewing, analyzing and making recommendations on such a sprawling and complex issue as the workers' compensation system is indeed formidable.

I would like to address the role of physical therapy, its utilization, effectiveness, and delivery to injured Maine workers within the workers' compensation system. Physical therapy is an important profession in the rehabilitation of any physical injury or dysfunction. As a profession, physical therapists are intimate with the multitude of various injuries, symptom complexes, diseases, and pain syndromes associated with the work places. Therapists are often called upon for their expertise in evaluating, assessing, measuring, and documenting the probable cause, status and potential outcomes of these injuries. Additionally, in many cases involving musculoskeletal injuries where surgery is not warranted, physicians will direct their patients to therapists with a request to "evaluate and treat" trusting the therapists to assess the patient's problem, identify any musculoskeletal deficit associated with the injury, devise and implement a treatment program, and restore that patient to as full a functional capacity as possible. Likewise, many patients recovering from back, neck, upper extremity and lower extremity

surgery will be referred. Often times with these patients, it is the therapist who progresses them toward full rehabilitation while maintaining communication with the physician.

Until October of 1991, physical therapists in the State of Maine could legally treat patients only on the referral of a licensed medical doctor, doctor of osteopathy, dentist, or doctor of podiatry. In October, Maine statutes changed allowing for Direct Access; permitting Maine physical therapists to legally treat patients without the written referral of a physician (with certain provisions included in the law as safeguards). Essentially, this change in law enabled injured employees, and non-work related injuries, to gain faster, easier and more timely access to physical therapy without the added cost of seeing a physician first. It is significant to note that a majority of the states have Direct Access. Also, McGinnis and Associates, who underwrite the majority of professional liability insurance for physical therapists nationally, have never had a claim filed as a direct result of therapists seeing patients without a referral.

It is recognized that the evaluation of utilization and therefore over-utilization of any service provided in the workers's compensation system is difficult to objectively measure and analyze. The over-utilization of health care, insurance and legal professionals is complicated due to manifestations including emotional, biopsychosocial, legal and lack of appropriate diagnosis and treatment. A case in point would be to review the complex model and treatment management of low back pain. Below is a list of Industrial, Epidemiological and Clinical Research results which support why over-utilization should be considered throughout the entire system and not directed at any one discipline.

1. Only 10-15% of patients with low back complaints have a certain diagnosed cause of their symptoms.

2. False positive findings have occurred in 37-38% of individuals by radiologists as showing disc protrusions without complaints or clinical findings. The practical application of this information is that spinal radiographs only rarely yield information of major clinical importance.

3. There is extreme difficulty in diagnosing the difference between the natural aging process, degeneration, and the effects of cumulative trauma.

4. RISK MANAGEMENT FACTORS. Research supports the following:
a) Job satisfaction is a strong indicator of workers' compensation claims.
b) Younger and newly employed males have more claims.
c) Employees with poor employment reviews have greater claims.
d) Females in heavy jobs have greater claims.
e) Other cumulative factors which have shown to increase out of work injuries include physically heavy work, static work postures, frequent bending and twisting activities, repetitive work and whole body vibration.
f) Pain itself is not measurable objectively. The severity of pain complaints is not necessarily well correlated with the level of functional impairment. Pain greater than three months probably is not healing by primary intentional but is rather a combination of the chronicity of the injury and mental status of the individual with chronic, multifaceted considerations. The rate of return to work as a function of out of work is approximately 50% at six months, 25% at one year and 0% at two years. A containment of clinical evaluation reliability is a phenomenon referred to as "symptom magnification syndrome". This has been described as "a conscious or unconscious self-destructive socially reinforced behavioral response pattern consisting of reports or displays of symptoms which function to control the life circumstances of the sufferer." (Matheson 1987).
g) Major determinants of disability have been identified as treatment history, perceived control of health, low need for affection, low job employment, poor cardiovascular fitness and smoking.
h) successful rehabilitation has focused far less on psychosocial factors and far more on biological factors, particularly aerobic conditioning and muscle function.

Physical therapists in the State of Maine have taken bold and progressive steps in trying to assure their involvement within the workers' compensation medical management system is efficacious, cost effective, and beneficial. At the present time, The Maine Chapter of American Physical Therapy Association maintains committees on consumer affairs, legislation, public relations, workers' compensation, and quality assessment. Myself and one other physical therapist sit on the Medical Advisory Committee as established by Sandra Hayes in the office of Medical Coordinator of Workers' compensation. We are working closely with the Medical Coordinator in the development of treatment guidelines, fee schedules, documentation, independent medical examination and case management.

The effectiveness of utilization, early intervention, education and ergonomics of physical therapy in the workers' compensation management system have been extensively documented. Examples of physical therapy intervention follows:

1. Between 1982 and 1988 one practice's audit analysis of over 100 patients referred for treatment following lumbar disc excision demonstrated 70% of the patients reported improvement characterized by decreased back pain, decreased leg pain and improved function in terms of flexibility, strength and endurance. The average number of physical therapy visits was eight. Treatment included electrical stimulation for pain modulation, strength and endurance exercises, ultrasound, manipulation, flexibility exercises and postural training.

2. In 1985, the largest employer in the state paid in excess of four million dollars in medical costs and indemnity. On-site physical therapy was instituted in June of 1986. Statistics obtained one year laterin August of 1987 demonstrated the following as compared to 1985.

    a) Total cost decreased from $4,128,545 to $489,255.
    b) Decreased lost work days from 16,929 to 1,871.
    c) Average intervention time decreased from 2.5 months to 3 days.

d) Average number on compensation list decreased from 316 to 231.
e) Average duration in therapy decreased from 3 months to 2 weeks.
f) Average duration of single therapy visit was 30 minutes.
g) Increased cost of therapy services from 1985 to 1987 was $15,000.

3. From June-December 1990 to 1991, LL Bean realized a 41.5% decrease in their lost time claims with the advent of on-site physical therapy. Of the 135 patients referred to physical therapy, 87% have been resolved. This reflects physical therapy involvement in treatment, screening, preventative programs, and ergonomics.
4. A Portland physical therapy clinic helped to reduce medical and compensation costs of Parker-Nichols by as much as two million dollars in two years.
5. Physical therapy has been an integral part of Boise Cascade since May of 1986. They have been instrumental in the training, treatment, and ergonomics of that plant assisting in 2 million safe man hours worked - now approaching their second 2 million safe-man hours.
6. Back injury prevention programs taught by physical therapists in 1989-90 decreased back injuries in two separate departments at BIW by 30 loss time injuries resulting in a net cost savings of $192,362.
7. In the first quarter of 1992, 116 patients were discharged from a Brunswick physical therapy clinic. Seventy-seven percent returned to their regular job. The average number of patient visits was 8.9.

The role of physical therapy is changing. Traditionally, physical therapy has been a "last resort" rather than a primary consideration in the early intervention process of work-related injuries. In more recent times, data such as that collected above bears witness to the benefits of physical therapy intervention. Major industries have apparently noticed these benefits and how to utilize therapists for evaluations, treatment, pre-placement screenings, ergonomics, preventative programs, expert witnesses, independent medical examiners, and injury July

management consultants. A partial list of industries availing themselves of such services include Central Maine Power, Hannaford Brothers, Dexter Shoe, Parker-Nichols, Oakhurst Dairy, Nissen's, LL Bean, Boise Cascade, Saunders Brothers, ArrowHart, International Paper, Bath Iron Works, etc.

Physical therapists have committed themselves to the expedient delivery of appropriate services to Maine's work-related injuries. However, we do harbor concerns of non-professionals within physician and chiropractor offices supplying services that are indicated as physical therapy on billing statements. This along with physician-owned, self-referral clinics causes concern when utilization is scrutinized. Conflicts of interest, profit generation, and non-professional services delivered under the heading of physical therapy must be considered when looking at overall utilization.

I would be more than happy to provide any further information on these issues as you deem necessary. I am enclosing referral letters from a number of companies which have benefited from the services provided by IMPACC, a physical therapy firm specializing in injury prevention and workplace performance. I can be reached at (207) 729-4998. Thank you for your time and consideration.

Respectfully submitted,

Stephen R. Vance /bg

Stephen R. Vance, PT, CHT
Workers' compensation Committee
Maine Chapter
American Physical Therapy Association

Enclosures
APTA/AA4B

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2. WORK RISK ANALYSIS...ergonomic risk evaluation and recommendations

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1. Manager/supervisor training seminars:

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2. Employee WorkSmart prevention training:

   WORKSMART NECK-ARM SCHOOL

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The IMPACC ERGONOMICS PROGRAM:

WorkSmart

Ergonomic injury claims (back, neck, arm/hand) are epidemic. Costs are out of control. Stronger OSHA enforcement looms. IMPACC's WorkSmart ergonomics program offers the most cost-effective answers to your ergonomic claims problems.

WorkSmart identifies your risks for injuries, claims and costs (as three separate but related issues) with an on-site WORK RISK ANALYSIS performed by industrial physical therapists. This documents a problem list, action plan and priorities. The report becomes your written Ergonomics Plan.

WorkSmart then trains managers and supervisors to become experts on the company's injury issues and corrective options, guiding them through the development of prevention actions for each work area. The Employee WorkSmart component motivates workers to accept responsibility for proper care and use of the working body through IMPACC's NECK ARM SCHOOL and BACK SCHOOL.

But the most important prerequisite to success is: creating proper attitudes and commitment among all parties. And this is what IMPACC does best! Managers and workers alike find IMPACC's WorkSmart to be one of the most valuable and motivating program ever seen in the workplace.

NATION'S BUSINESS magazine cited IMPACC for its success in fighting Worker Comp costs for companies around the U.S. Eight years of experience at over 150 companies nationwide has built IMPACC an impressive track record.

Other providers may try to develop their own ergonomic programs, but they have not had the experience, results or cost-recovery of IMPACC. IMPACC's WorkSmart program has demonstrated dramatic reductions in lost-time claims and costs. Without a doubt, WorkSmart can be your most profitable investment!

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1. WORKSMART ERGONOMICS PLAN...a complete procedures manual detailing your comprehensive Ergonomics Plan
2. ERGONOMICS TEAM TRAINING...advanced policies and training for your in-house ergonomics team
3. VDT TRAINING COMPLIANCE...Computer station design and training

IMPACC PERFORMANCE REFERENCES

ANZAC ELECTRONICS: 1987 saw 2-4 claims per month with 30% workers affected. After IMPACC we had no claims for 30 months. Production increased from 85% to 102% of productivity standard. 207-942-7391 (Ron Woodvine)

GATES FORMED FIBRE: 1988 we had five CTS surgeries in six months. After IMPACC we had a year of no claims. 207-784-1182 (Dan Gagne)

GFS MANUFACTURING: 68 lost days the year before IMPACC. Only 28 lost days the year following IMPACC. A 60% decrease. 603-742-4375 (Tim McCabe)

PET GROUP: IMPACC provides CTD & back injury ergonomic programs to our food processing facilities nationwide. 314-622-6139 (Larry Valentine)

WHITMAN'S CHOCOLATES: We had serious ergonomics claims problem in 1989. By 1991 we had 60% decrease in lost time after IMPACC. 215-464-6000 (Joe McGary)

GH BASS SHOE: We have had a 50% decrease in lost-time claims since IMPACC, with no lost time in nine months. 207-645-3131 (Ron Howard)

BANGOR HYDROELECTRIC: Before BACK SCHOOL we had 5-8 back claims per year. After the program we had only one claim in ten months.

WATTS FLUIDAIR: We had serious carpal tunnel and back injury problem. We went 8 months with no lost time claim after IMPACC. 207-439-9511 (Kim Gerard)

DIGITAL EQUIPMENT CORP: CTD and BACK SCHOOL part of three year program. Saw lost days reduced from 590 in 1986 to 75 in 1989, an 87% decrease.

DEXTER SHOE: Controlled study showed 63.7% reduction in lost days, 30% drop in absenteeism and 9.3% increase in productivity. 207-924-7341 (Ted Warren)

MAINE WORKER COMP OFFICE: We had four CTS lost-time cases in 1989 before IMPACC program; no cases the year following. 207-289-3751 (Bonnie Coyne)

GUILFORD INDUSTRIES: BACK SCHOOL resulted in 50% decrease in lifting related injuries with 75% drop in lost days. (207-876-3331 Tom Leonard)

GENERAL ELECTRIC (ED&C DIV.): IMPACC WorkSmart Ergonomics program has been implemented in facilities in Maine, Connecticut and Tennessee. More planned. Great results. (Dick Guimond, GE, Plainville, CT)

SAN ANTONIO SHOE: We saw a 50% decrease in claims and improved productivity after the IMPACC program. 207-487-3252 (Red Dunphy)

NATIONAL SEA PRODUCTS: We had a significant reduction in lost time CTD claims after the School. Very effective!

UNDERWOOD/PROGRESSO: Complete ergonomics program resulted in 54% decrease in lost days to CTD in 1991. 314-221-9420 (Carmen Mazzei)

OLD EL PASO FOODS: BACK and CTD SCHOOL resulted in 88% decrease in lost time claims in 1990-91. 404-482-5092 (Plant Mgr.)

ETHAN ALLEN FURNITURE: IMPACC program led to 47% decrease in all injuries. Employee response was excellent.

BROCKWAY SMITH: BACK SCHOOL resulted in ten months of no injuries in 1989.

OLAMON INDUSTRIES: CTD SCHOOL led to a 75% reduction in CTD claims. Attitudes also much improved. 207-827-8051 (Gerry Pepin)

BRIDGE CONSTRUCTION: BACK SCHOOL resulted in 84% decrease in lost days in 1989.

GEORGIA PACIFIC: BACK SCHOOL in 1985 resulted in only one lost time case for one year after the program for 600 paper workers.

HANNAFORD BROS. WAREHOUSE: We had 72% reduced costs and 63% reduced days for back injuries after 1986 BACK SCHOOL. Spent $3,500. Saved $34,000.

LETTERS

OF

REFERENCE

RAILROAD AVENUE DEXTER MAINE 04930-9422 DUNS 00-110-1435 TELEPHONE (207) 924-7341 FAX (207) 924-7341 EXT 259

WHERE PEOPLE MAKE THE DIFFERENCE

October 8, 1990

Dear Fellow Employee:

More than nine months have passed since our plant was selected to conduct a pilot "WORKSMART" program . We are now pleased to report the highly positive results of your participation.

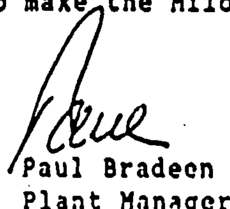
The "Industrial Athletes" who have participated in the exercise/stretching program have produced some very encouraging results. For example, during the period of January 1st through June 30th;

- <u>Lost Time</u> injuries have been reduced by <u>63.7%</u>.
- <u>Absenteeism</u> has been reduced by <u>31.4%</u>
- Milo Plant led the company last quarter with <u>32.7%</u> of all employees receiving the <u>Perfect Attendance Savings Bond</u>.

Obviously, "WORKSMART" participants perform better, miss less time from work and most importantly, feel better. In the case of Stitching Room pieceworkers there is evidence that those who participate in the "WORKSMART" Program earn more money, <u>in fact 9.3% more</u>, than their nonparticipating co-workers.

Our program has been reviewed by area doctors and has received their enthusiastic endorsement. Further, a recent review by Department of Labor OSHA representatives has generated an extremely positive evaluation of our program and their recommendation is not only to continue, but to expand our program.

Thank you for your past, present and future cooperation in "WORKSMART" and for your excellent efforts to make the Milo Plant a safer and healthier place to work.



Paul Bradeen
Plant Manager

June 30, 1989

Mr. Bob Patterson
Impacc
89 Hillside Avenue
Bangor, ME 04401

Dear Mr. Patterson,

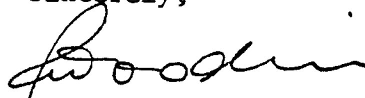
RE: CTD Elimination Program.

The above program was run in the Adams-Russell Bangor Plant just over one year ago with the intent of addressing workmen's compensation claims for ergonomics related injury, which were running at an average rate of two per month.

Since the introduction of the exercise program by your Mr. Lavren Hebert, we are pleased to inform you that workmen's compensation claims related to ergonomics have dropped to zero.

I can heartily endorse your program and would recommend it to any organization interested in employee health and cost reduction.

Sincerely,



Ron Woodvine
Plant Manager

RW/mr

Advanced Signal Processing Technology

448 Griffin Road, Bangor, Maine 04401 (207) 942-7391

digital

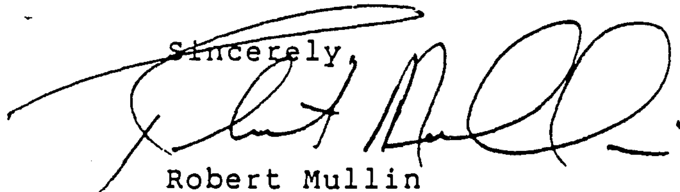
To Whom It May Concern:

Digital Equipment Corporation is committed to the elimination of Cumulative Trauma Disorders (CTD) from the work place. Our Augusta, Maine plant has implemented a comprehensive program for the identification and elimination of CTD. This program has proven successful and IMPACC has played an essential role in this effort.

IMPACC has provided us with CTD prevention training (Neck/Arm School), back injury prevention training (Back School) and work task risk analysis and ergonomic recommendations. These programs have been well received and effective.

Together we have demonstrated that a strong commitment on the part of management and employees to the elimination of CTD can lead to dramatic success. Our facility has experienced a 10 fold reduction in lost time over the last three years of this effort. IMPACC has played a major role in this success.

Sincerely,



Robert Mullin
Mgr. Environmental Health & Safety, Augusta Plant
Corporate Chairperson, CTD Task Force
Digital Equipment Corporation

Gates Formed-Fibre Products,
Washington Street
Auburn, Maine 04210
(207) 784-1118
Telex: 94-4443

October 23, 1989

Gates Formed Fibre had a very serious problem in late 1988 and early 1989 with cumulative trauma disorder. We called Impacc in early January and Lauren Hebert came out to Gates and conducted a plant evaluation of all jobs in our Auburn faculity.

Lauren did Supervisory training in March and Production Operator training in May. The results of the Impacc program have been very successful. We have not had one new case of carpel tunnel syndrome since the Impacc Program. Our Production operators understand what they need to do to prevent serious repetive motion damage that could result in surgery. The Impacc Program does work effectively and I would recommend this program to any Industry.

Sincerely yours,

Daniel R. Gagne
Employee Relations Specialist
Gates Formed Fibre
Auburn, ME 04210

G.H. Bass & Co.
Weld Street · P.O. Box 659 · Wilton, Maine 04294
(207) 645-3131 · Fax (207) 645-3255

October 29, 1991

Impacc
89 Hillside Ave. Suite 4
Bangor, Me. 04401

To Whom It May Concern,

Over the years G.H. Bass & Co. has had a close working relationship with Lauren Hebert and the Impacc organization. Most recently the majority of our employees were involved in the CTD and/or Back School training offered by Impacc.

We had implemented a stretching program within our manufacturing area six years ago but felt that we were not realizing all of the benefits from such a program that were possible. Lauren's training for our management team renewed their commitments and enthusiasm for stretching. The training for our manufacturing and warehouse employees provided them with a broader perspective and understanding of the causes and affects that work activities, home activities, and stretching may provide.

We are very pleased that there was an immediate "renaissance" in our injury prevention program as a result of this program. The renewed interest and commitment contribute towards our realizing a record 9 1/2 month period in which not one of our employees received a work related injury requiring them to collect wages for lost time.

We have been very pleased with the service, professionalism, and quality of the Impacc programs. As such, I would highly recommend their services to any organization that is <u>serious</u> about reducing work related injuries.

Sincerely,

Ron Howard
Personnel Manager

pb/rch91079

the BRIDGE construction corporation

ESTABLISHED 1875
HEAVY AND HIGHWAY CONTRACTORS
AUGUSTA, MAINE

MAILING ADDRESS · P.O. BOX 229
AUGUSTA, MAINE 04330
TELEPHONE: 207/623-3806

March 14, 1989

Mr. Robert Patterson
IMPACC
P.O. Box 2086
Bangor, ME 04401

Dear Bob,

As promised (although slightly late!) here are our back injury statistics for the past two years. These numbers are based on a calendar year. The back classes were conducted in March 1988, but from January - March we work very reduced manhours.

BACK INJURIES	1987	1988
# OSHA Recordable Injuries	16	7
# Lost Time Injuries	10	5
# Days Lost from Work	468	73 ...down 84%

TOTAL INJURIES		1988
# OSHA Recordable Injuries	49	29
# Lost Time Injuries	28	21
# Days Lost from Work	637	338

The numbers really did surprise me! We also conducted a pilot safety program for three months on one of our jobsites, which also helped to reduce these rates. But as far as the reduced back injuries, I do believe that the back classes were primarily responsible.

Our thanks to you, Lauren, and Mark for jobs well done! Feel free to use our back injury statistics for other firms' references. I know that this kind of information was helpful to me before deciding to sign up our firm for the back school.

We have four employees going to the New Employee Back School this month, and hope to schedule your 1 hour refresher for our April training session. I'll be in touch.

Sincerely,

THE BRIDGE CONSTRUCTION CORPORATION

By [signature]
Allison B. Pederson
Human Resources Manager

ABP/cy
cc: Dave Bridge
John Bridge
Lauren Hebert

Ethan Allen® inc.
Beecher Falls Division

MAIN STREET
BEECHER FALLS, VT. 05902-0217
(802) 266-3355

Impacc
89 Hillside Ave.
Bangor, ME 04401

October 6, 1989

Dear Bob,

Just a note to let you know of the positive results we have seen in our injury rate since 500 employees attended the Back School. Below is a table of all reported injuries in 1988 with the corresponding figures for 1989:

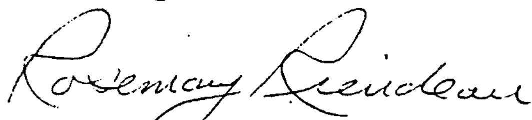
	1988	1989	
Jan	14	21	
Feb	23	20	
Mar	22	22	
Apr	18	15	
May	21	7	
June	30	10	
July	6	10	
Aug	25	12	
Sept	18	14	47% decrease

April begins to show a decline after approximately 140 had attended the classes. The employees thoroughly enjoyed the enthusiastic presentation which directed much of the responsibility for their own health and safety to themselves.

I have had several employees relate to me that since the Back School they are exercising on a routine basis and have had no re-occurence of chronic back problems. I thought you would be interested to know that one of these individuals attended the class given in French.

I sincerely hope that we can discuss the presentation of more programs in the future.

Sincerely,



Rosemary Riendeau
Personnel Manager

Brockway-Smith Company

WHOLESALE

DOORS · SASH · MILLWORK AND MOULDINGS

203 READ STREET
PORTLAND, MAINE 04104-0636
207/774-6201

August 21, 1989

IMPACC
Mr. Bob Patterson
6 Wabon Street
Augusta, Maine 04330

Dear Bob:

Here it is August already...... I wanted to drop you a note and let you know that we have had a very good Summer and we certainly thank "Back School" for contributing to our well-being.

Since all of our employees attended the "Back School" and from that experience developed a morning stretching and exercise program, I am pleased to let you know that we have not had a problem with a back related injury.

We look forward to continuing this beneficial program in the future.

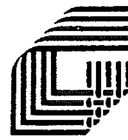
Very truly yours,
BROCKWAY-SMITH COMPANY

Stephen E. Post

Stephen E. Post
Manager

SEP:kg

CENTRAL OFFICE — 146 DASCOMB ROAD • ANDOVER, MASSACHUSETTS 01810


GUILFORD
INDUSTRIES

Guilford, Maine 04443
Telephone: 207-876-3331

January 16, 1989

Impacc
Bob Patterson
6 Wabon Street
Augusta, ME 04330

Dear Bob:

Enclosed are 1987 and 1988 OSHA Logs complete.

I screened the 1987 reports as you and I did, pulling out those claims related to improper lifting techniques.

The results are very favorable and are as follows:

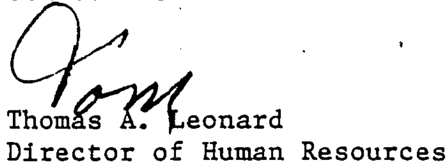
1987 - 10 cases resulting in 269 lost days (before the school)
1988 - 5 cases resulting in 66 lost days

I'm sure that the back school contributed towards this reduction.

We need to get on with the additional training.

Sincerely,

GUILFORD OF MAINE



Thomas A. Leonard
Director of Human Resources

TAL/jh

CC: J. Brownlow
L. Smith

Olamon Industries
Penobscot Indian Nation
25 River Road
Old Town, Maine

0 4 4 6 8

September 27, 1991

Mr. Robert Patterson
IMPACC, Inc.
89 Hillside Avenue
Bangor, Maine 04401

Dear Bob:

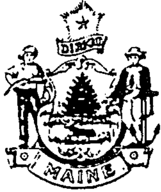
I thought you might be interested in knowing the short-term results of implementing your stretch-exercise program. Since you conducted the training in April, we have only experienced one repetitive motion/sustained posture injury and this one was expected because of a bilateral condition. When I project our injuries over a twelve month period, I expect the results to show better than a 75% reduction over the previous twelve months. This is great news for Olamon.

The stretch-exercise program is working, as you can see. The general attitude towards safety and health has improved because people feel better knowing that Olamon took this positive step for everyones' benefit. IMPACC continues to be good for Olamon and the program will remain mandatory. Thanks for the Program and the follow-up support. I'll be back in contact with you to set up training for new employees coming in.

Sincerely,

Gerry

Gerard L. Pepin,
Personnel Manager



STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE
04333

September 30, 1991

JOHN R. MCKERNAN, JR.
GOVERNOR

Mr. Lauren Hebert
IMPACC
89 Hillside Avenue
Bangor, ME 04401

Dear Mr. Hebert:

Thank you for your letter concerning the effectiveness of prevention programs in lowering workers' compensation costs.

I agree completely that we need to place more emphasis on preventing injuries, particularly musculoskeletal disorders that cause such pain to workers and enormous cost to the system. Programs like yours are certainly valuable in this regard. In fact, I believe that you provided a "Back School" for the Department of Professional and Financial Regulation a few years ago, and the Department was very pleased with the program.

The workers' comp reform legislation that I recently signed into law provides incentives for employers to implement programs such as your organization provides. Preventing injuries should be a high priority for all employers and employees.

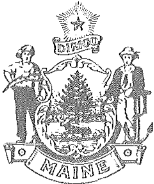
Again, thank you for taking the time to write.

Sincerely,

John R. McKernan, Jr.
Governor

JRM/mag

PRINTED ON RECYCLED PAPER



STATE OF MAINE

MAINE POTATO BOARD

744 Main Street, Room 1 Presque Isle, Maine 04769 (207) 769-5061

July 15, 1992

Ms. Michelle Bushey
Blue Ribbon Commission to Examine Alternatives
to the Workers' Compensation System
University of Maine Law School
246 Deering Avenue
Portland, Maine 04102

Dear Ms. Bushey:

→ called to let him know his letter has been passed on to the Commissioners

Several weeks ago I wrote to you with concerns from the Maine potato industry regarding changes in the Worker's Compensation System in Maine. I asked that the current agricultural exemption, which allows up to six agricultural workers before workers' compensation coverage is required, be left in place. The commission's recent preliminary decision to keep the current agricultural exemption was an important decision and one that I hope is adopted in the final report of the commission.

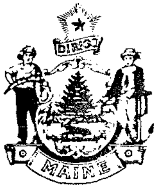
The potential liability of Maine employers for carrier losses retroactive to 1988 is also a major concern. This cost to Maine's potato farmers and processors, who are a part of Maine's workers' compensation system, would drastically affect their being able to compete against areas in the west where rates are much different.

I sincerely ask that these issues be addressed by the Reform Commission and that Maine employers not be penalized for past policy decisions that allowed such losses.

Sincerely,

David R. Lavway
Executive Director

DRL/ca



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July 15, 1992

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Blue Ribbon Commission to Examine Alternatives
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University of Maine Law School
246 Deering Avenue
Portland, Maine 04102

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Sincerely,

David R. Lavway
Executive Director

DRL/ca

The Independent Insurance Agents Association, Inc. (of Maine)

NINETY-THIRD YEAR
432 WESTERN AVENUE, AUGUSTA, MAINE 04330

JOHN W. CLARK
Executive Vice President/Treasurer
207-623-1875 1-800-439-1875
FAX 626-0275

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David W. Smith
Orono - 1994

John F. Ezzy, President
Aroostook County IIAA
Madawaska - 1992

Bradford S. Kirkpatrick
Southern Maine IIAA
Portland - 1992

July 15, 1992

Mr. Richard Dalbeck
17 Spoondrift Lane
Cape Elizabeth, ME
04107

Senator William Hathaway
6707 Wemberly Way
McLean,VA 22101

Dr. Harvey Picker
P.O. Box 677
Camden, ME 04843

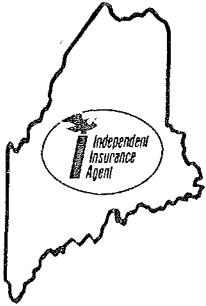
Mr. Emilian Levesque
52 Burke St.
Farmingdale, ME 04344

Dear Blue Ribbon Commission Members:

I took the liberty of sharing Commissioner Dalbeck's proposal for a Maine Mutual Workers Compensation Company with some members of the Independent Insurance Agents Association of Maine. Several of their comments dealt with issues that have already received considerable discussion at commission meetings; subjects such as rate adequacy in any new system. I won't bother to rehash these issues, but there were some comments and questions which I felt were worthy of your consideration if, in the final analysis, you pursue Commissioner Dalbeck's suggestion for the mutual company. These include:

1. While Commissioner Dalbeck's outline stated that the mutual company would exclusively offer workers compensation insurance, the question was asked as to whether it would offer Employer Liability Protection. Although I do not have a great deal of personal expertise in this area, I am informed by independent agents that this protection is needed, for example, in cases where an injured worker would collect workers compensation benefits but sue a manufacturer for a defective machine that injured him. There apparently have been cases where the manufacturer would, in turn, sue the employer, whose liability would not be covered under workers' compensation.

2. Will the mutual company offer coverage for Maine employees who might be injured while working for



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Aroostook County IIAA
Madawaska - 1992

Bradford S. Kirkpatrick
Southern Maine IIAA
Portland - 1992

their employer in another state? The suggestion has been made that the charter of a mutual company should deal with that question.

3. Among the other so-called Coverage "B" items that should be considered is the relationship the new company should have with federal coverage such as that provided under the Longshoremen's Act.

4. Commissioner Dalbeck's proposal recommends a 12-member board of directors with nine of the members coming from policyholder employers. Will employers from within the insurance industry be allowed to serve?

Also, members of IIAAM and PIAM ask that we continue to stress to the Blue Ribbon Commission the role independent agents perform in the workers' compensation system and the importance of that role being protected in any new program or company that is established. Jim Thibodeau, representing IIAAM and the Professional Insurance Agents of Maine, appeared before you on June 19 and you also received a written submission from Clark Associates earlier this month. Mr. Thibodeau's presentation and the materials from Mr. Clark and Mr. Ross of Clark Associations did a good job of outlining the important services performed by independent agents. I won't bother to restate them. However, in view of the mountains of written materials and the countless hours of verbal testimony you have received, I will enclose copies of these earlier presentations so that you may reconsider them in any deliberations regarding the formation of the mutual company.

Independent agents have a deep understanding and appreciation of the critical and complex assignment given the Blue Ribbon Commission and admire it for its efforts to find a solution to a problem that threatens to undermine the foundation of the Maine economy. In that spirit, IIAAM, PIAM or individual member agents of these organizations stand ready to assist on the issues outlined above or others that may confront you as you prepare your report.

The Independent Insurance Agents Association, Inc. (of Maine)

NINETY-THIRD YEAR

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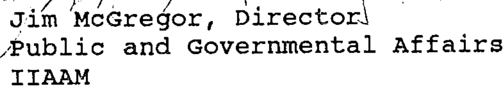
Thank you for this opportunity to comment on what will be a key component of any recommendation you make to the governor and legislature.

Best regards,



Jim McGregor, Director
Public and Governmental Affairs
IIAAM

enc.

6/19/92

James A. Thibodeau
Representing
The Independent Insurance Agents Association of Maine
And
The Professional Insurance Agents of Maine

To: Blue Ribbon Workers' Compensation Commission

Friday June 19, 1992

As representatives of a majority of independent insurance agents in Maine, we appreciate the opportunity to appear before this commission. Our request to appear was prompted by our desire to:

1. Offer our services to the Commission as you continue your deliberations on this issue which is so important to the future of this state, and;

2. Hopefully, we will be able today to give the commission some insight into the role independent insurance agents play in the workers' compensation system and to encourage you .... as you began preparing your recommendations ... to call on us if we can answer any additional questions.

We previously mailed to the commission a position statement approved by the boards of our two organizations. We won't take the commission's time today to restate that position. Suffice to say that our organizations, like most others you have heard from, have concluded that the Maine Workers' Compensation System is broken beyond repair and that this commission needs to reach out and embrace a completely new system.

However, regardless of the system you ultimately choose or whether you opt to combine or modify systems, independent insurance agents and the two associations which represent them would welcome the opportunity to be a part of the implementation of the new system. Our agents have been on the front lines for many years. You have previously heard from associations which represent large companies that are able to self-insure and from insurance carriers. These are valuable and important players in the overall workers' compensation, but very often independent agents represent the small businesses which really need addition help and services and often do not have a voice. Agents play a critical role in the system and that role must be preserved in whatever system is created.

We would like to briefly describe the service we perform for accounts in the system then attempt to answer

any questions you might have.

Independent agents help their clients to better understand the various systems that affect their workers' Compensation costs. We have made investments in people and resources so as to assist our clients to manage, and gain more control over their costs. The better they understand the system, the more effective we can be in working together to gain the best results possible for their companies.

The Experience Rating System plays a major role in determining workers' compensation premiums. We review each company's worksheet as calculated by the National Council on Compensation Insurance to verify the accuracy of the payroll and claims information used to determine their experience modification. Experience has shown us that mistakes are common and usually they work to the detriment of the employer.

The following are examples of what one independent agent has done.

1. A contractor's policy was canceled midterm and placed into the Accident Prevention Account with a 39% premium increase. An independent agent identified incorrect payroll data and had the

contractor reassigned to the Safety Pool.

NET RESULT - A $29,500 PREMIUM SAVINGS

2. A woodworking manufacturer was identified by the agent as being eligible for the Accident Prevention Account upon their forthcoming renewal date. After four months of negotiating and working with claims adjustors, two major claims were closed for about 50% of their previous reserved amounts.

   NET RESULTS - AVOIDANCE OF THE ACCIDENT PREVENTION ACCOUNT AND A $45,000 PREMIUM SAVINGS.

3. A retail store had their experience modifier increased from .98 to 1.09 a $47,000 claim was the culprit. The agent did some research and found that the claim had actually been closed for $9,000. The insurance carrier agreed to refile the lower figure and a new modifier was calculated.

   NET RESULT - A PREMIUM SAVINGS OF $2,700

These are examples from just one agency here in the Portland area.

We also help our clients develop appropriate strategy to provide a safe work environment and train employees to

avoid unsafe work habits.

The independent agent makes certain that the employers payrolls are correctly placed within the various classifications which results in the lowest possible rate.

As you can see the agent does much more than fill out applications and renew policies. We serve as the advocate for the employers - reviewing current experience rating worksheets, monitoring and negotiating within the claims settlement process, assisting with work place safety programs and some of our members even have in-house software programs to predict renewal experience modification from thirty days to as much as eight months in advance.

The Professional and Independent Insurance agents in Maine appreciate the opportunity to testify before this prestigious commission. We have been present at each of your hearings and we commend you for the job you are doing and understand the monumental task you have been charged with. We very much look forward to being in a position to support a new system and to being a player in its implementation.

Thank you.

Lois W. [illegible]
Accounting Manager

Gail [illegible]
Insurance Services Manager

Clark Associates
· Insurance ·

Richard W. Clark
F. Dale Rudson
Paula M. Hamilton
Jean C. Libby
Judy Conley [illegible]
Lee Ramsdell
Kenneth A. Ross
Andrew [illegible] Borglund
Charles [illegible] Smith

David G. Bruneau
Charles S. Clark
David W. May
Life, Health & Group

July 8, 1992

The Honorable William Hathaway, Co-Chair
Mr. Richard Dalbeck, Co-Chair
Mr. Emilian Levesque
Dr. Harvey Picker
The Blue Ribbon Commission on Workers' Compensation
246 Deering Avenue
Portland, ME 04102

Dear Blue Ribbon Commission members:

We wish to commend you for the process being used to research and develop a proposal to improve the Maine Workers' Compensation system. We have been working within four different organizations that we belong to, in an effort to develop a consensus amoung the business community. As you know, the interests represented by business are varied. The one issue upon which most agree is the legislature has been unable to resolve the problems created by our current system, and ideally, the system should be free from political influences in the future.

We agree the solution needs to be found within a forum such as the so called Workers' Compensation Reform Group; a forum of employers and employees, without influence by special interest groups. We support the use of the Michigan law as a base with appropriate changes to assure it's success in Maine and to incorporate some of Maine's recent improvements. We believe the best solutions will be those upon which such a group can reach a unanimous consensus.

The role of the independent agent in the Workers' Compensation system of Maine, is often misunderstood. We believe agents play a vital role by providing the policy holder with an advocate to explain and assist with a wide array of systems and programs which affect the costs they must bear. The enclosed will help you to better understand some of the claims management services available to our policy holders; typically, for those large enough to be experience rated. Regardless of premium size, there are many other issues an agent can help policyholders to deal with. The completion of the application, and understanding the issues therein, can be very confusing to a small business person. There is a need at this early stage of the process to have an agent interpret not only what is on the application form, but also to explain claims reporting and handling issues.

2331 Congress Street • P.O. Box 3543 • Portland, Maine 04104-3543 • (207) 774-6257
FAX – (207) 774-2994

An independent agent can help the employer in understanding the payroll auditing system and will then be better able to assign payrolls, and develop costs based upon appropriate classification usage. The owner of a business must also decide whether or not to have workers' compensation benefits apply to him or her. Agents are able to explain the various issues that need to be understood in order to make this an informed decision, and to be sure their workers' compensation arrangement dovetails with their personal life, medical and disability insurance program. The current system provides for a variety of deductibles which may apply to lost wages or medical payments. Agents play a very valuable role in helping employers determine the feasibility and applicability of these deductibles.

Every workers' compensation policy includes Coverage B, which is referred to as employers liability. Many employers buy commercial umbrella liability policies, which will add a million dollars of protection to the employers liability section of the workers' compensation policy. Depending upon the umbrella liability insurance carrier's requirements, the employers' liability limits often need to be increased beyond the standard limits provided by the policy. It may even be more important to increase those limits if an employer is not purchasing an umbrella liability policy. No one is in a better position than the insurance agent to offer the appropriate advice surrounding this particular issue.

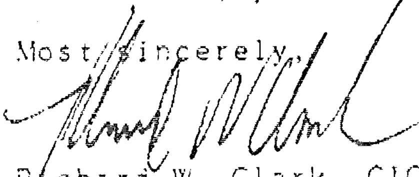
Many employers in Maine have out of state exposures and on the water exposures. These employers need an insurance agent to help them understand and purchase appropriate insurance to cover their employees who are subject to the federal laws, commonly referred to as Admiralty Law (Jones Act) and the United States Longshoremen and Harbor Workers Act. An agent is in the best position to help their customer determine whether or not the Maine Workers' Compensation Policy will respond to the individual needs of the employer and/or if additional policies are necessary.

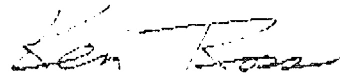
The Maine Self Insurers Council has proposed a series of self-insured groups to replace the residual market. Such a system apparently does not allow the small business person access to Independent Agents. We feel this would be a serious disadvantage, and would rather see a State Competitive Fund with Agents involved to assist the policyholders with issues included herein.

In conclusion, we believe it to be in the best interest of employers for the Maine Workers' Compensation system to have independent insurance agents as the sales force and advocate for policyholders. Agents do play a critical role in the system. Whatever system is created, we encourage you to preserve the independent agents' role.

Thank you for your considerations. If we can be of further assistance, please feel free to contact us.

Most Sincerely,





Richard W. Clark, CIC
President

Kenneth A. Ross, CIC
Vice President

Enc.

Clark Associates

WE, AT CLARK ASSOCIATES, REALIZE THAT WORKERS' COMPENSATION COSTS IN MAINE ARE TOO HIGH.

Do you realize what can be done to reduce them?

Clark Associates' Claims Management Services can help you better understand the various systems that affect your Workers' Compensation costs. We have made an investment in people and resources so as to assist our clients to manage, and gain more control over, their costs. The better you understand the system, the more effective we can be in working together to gain the best result possible for your company.

The Experience Rating System plays a major role in determining your Workers' Compensation premiums. We will review your company's worksheet as calculated by the National Council on Compensation Insurance to verify the accuracy of the payroll and claims information used to determine your experience modification. Experience has shown us that mistakes are common, and usually they work to the detriment of the employer.

The following examples illustrate the value of our service:

1. A contractor's policy was cancelled midterm, and placed into the Accident Prevention Account with a 39% premium increase. Clark Associates identified incorrect payroll data used, and had the contractor reassigned to the Safety Pool.
   NET RESULT – A $29,500 premium savings.
2. A woodworking manufacturer was identified by Clark Associates as eligible for the Accident Prevention Account upon their forthcoming renewal date. After four months of negotiating and working with claims adjustors, two major claims were closed for about 50% of their previous reserved amounts.
   NET RESULT – Avoidance of the Accident Prevention Account and a $45,000 premium savings.
3. A retail store has their experience modifier increased from .98 to 1.09. A $47,000 claim is the culprit. Clark Associates researched it and learned the claim actually had been closed for about $9,000. The insurance carrier agreed to refile using the lower figure, and a new modifier was calculated.
   NET RESULT – A premium savings of $2,700.

Our Claims Management Services are results-oriented and include the following:

- Review of the current experience rating worksheet
- Monitoring of, and negotiating within, the claims settlement process
- Use of our in-house software program to predict your renewal experience modification from thirty days to as much as eight months in advance

As important as these services are, they are responding to claims which have already taken place. Safety and Loss Control efforts are essential to minimize the likelihood of an injury. We can help you develop an appropriate strategy to provide a safe work environment and train your employees to avoid unsafe work habits.

Another area of potential savings is the correct placement of your payrolls within the various classifications. It is important your insurance agent act as your advocate and have you assigned to a class that is appropriate with the lowest possible rate.

Although less tangible, Clark Associates is heavily involved in the process of redefining the Maine Workers' Compensation Act through legislation. We are actively involved through our participation in the Professional Insurance Agents Association, the Chamber of Commerce of the Greater Portland Region and the Associated General Contractors of Maine, Inc.

Clark Associates makes a point of getting to know your business and your business challenges. You can make a difference in the amount you pay for workers' compensation insurance.

Charles P. Pray
President of the Senate

Tel. (207) 289-1500

State of Maine
Senate Chamber
Augusta, Maine 04333

FAX TRANSMITTAL SHEET

DATE 7-15-92

TO: Michelle Bushey

FROM: Senator Pray

NUMBER OF PAGES INCLUDING COVER SHEET: 8

Please contact ____________ at the Senate President's office if you have any questions.

Telephone number: 207/289-1500

Fax number: 207/289-1900

Recommended Specs for Third Party Administrators from 2 very reputable TPAs.

I. CLAIMS ADMINISTRATION

1. The Third Party Administrator will provide the following services:

A. Examine, on behalf of Trust, all reports which are submitted by Trust to TPA of personal injury, sickness, disease or death of employees of Trust for which benefits may be payable under Workers' Compensation laws.

B. Limit the number of lost time (indemnity) claims managed by any one claims examiner to 200 at any one time. Medical only claims will be handled by support staff under the direct supervision of the claims examiner.

C. The claims examiner will personally meet with the claimant in all cases resulting in seven days days or more of disability. The meeting will take place no later than ten working days from the date of loss, or from the date upon which disability begins.

D. Conduct any investigations of the foregoing claims to verify the legitimacy of such claims or to assist in the defense of controverted claims.

E. Recommend to Trust what benefits, if any, should be paid or rendered under the applicable Workers' Compensation laws with respect to each reported claim.

F. Arrange for physical and/or vocational rehabilitation in serious injury cases or where required by applicable laws.

G. Prepare compensation, medical expense, and "Allocated Loss Expense" checks and forward to the payee.

H. Maintain a claim file on each reported claim, which shall be available to Trust at all reasonable times for inspection and audit.

I. Provide forms necessary for the efficient operation of the program and assist Trust in filing of all legally required forms.

J. Recommend reserves on all claims in accordance with accepted industry practices and provide written justification for all reserve adjustments totalling $------- or more.

K. Assist in the preparation of controverted cases for settlement or hearing.

L. Furnish full and complete monthly reports to Trust listing all accidents, including occupational diseases, and tabulate all payments made and reserves set up for benefits and expenses on account of liability and/or reasonably anticipated liability for accidental injuries and/or occupational diseases sustained by employees of Trust.

M. Prepare on behalf of Trust all scheduled hearings and personally attend on behalf of Trust all informal hearings before the Maine Workers' Compensation Commission; but all legal expenses attendant thereto, including attorneys' fees, witness fees for general and expert testimony and costs, shall be paid by Trust.

N. Assist Trust in the selection of a panel of physicians or other providers of health care, to initially treat injured employees and a panel of medical specialists to provide long term or specialty care, where applicable.

O. Assist Trust in the monitoring of treatment programs recommended for employees by physicians, specialists, and other health care providers by reviewing all medical reports so prepared and by assisting Trust in maintaining such contact with those providers as may be appropriate.

P. Meet monthly with Trust to review management objectives on claims or other related issues.

Q. Investigate Workers' Compensation subrogation possibilities, with approval of Trust. All legal expenses incurred in connection with subrogation activities shall be borne by Trust.

2. All claims examiners will be licensed by the State of Maine no later than six months following the date of employment.

3. All claims examiners shall be based at an office maintained by the TPA within the State of Maine, and all claim files shall be available for inspection at this office.

4. One hundred and eighty days (180) following the date of termination of the contract, and at each subsequent anniversary date, a charge will be made on each open tail claim which occurred during the contract. The charge for the first and subsequent tail years will be negotiated prior to termination of the contract.

II. LOSS CONTROL

1. The Third Party Administrator will provide the following services:

A. For all employers with standard premiums of $25,000 or more:

a. Conduct physical survey of each location annually

b. Prepare 12 month Action Plan, incorporating loss control recommendations.

B. Conduct one day group training programs for employers with standard premiums of less than $25,000

C. Provide additional safety consulting to individual employers as requested by the Trust, at a fee to be negotiated.

III. TERM OF SERVICE CONTRACT

Minimum of five years

IV. SERVICE FEE

The fee for all services provided by the Third Party Administrator shall be computed as a percentage of premium contributions.

V. COMPOSITION OF SELF INSURED GROUPS

Heterogeneous, by geographical divisions

VI. COMMISSIONS

Maine licensed insurance agents shall receive servicing commissions consistent with current residual market commission schedule.

I like all of the Third Party Administrators' suggestions except this one. Instead, perhaps the agents who were interested could contract with Third Party Administrators or directly with a Mutual Fund Group to help inform employers about [illegible]. Of course agents will also be [illegible]

WORKER'S COMPENSATION
Current Situation (July 1992)

Sen. Judy Kany (495-3857)
July 15, 1992

100% by premium

40% — Individual and Group Self-Insurance

*Joint & several liability

*Up-front scrutiny of member financials

*Up-front actuarial determinations of funding requirements

*Self-Insurance Guarantee Fund if reserves or "joint & several liability" insufficient

*Servicing is usually done by a TPA (Third Party Administrator), but sometimes by employer itself

Residual Market Liabilities for years prior to 1993

Prior to 1988, insurance carriers paid any deficit. Any deficits applying to 1988 cases are paid entirely by employers -- both those who are now self-insured but were in the voluntary or residual market in 1988 and employers who are currently in the voluntary or residual market. Deficits arising from the years 1989-92 are required by statute to be paid 50% by employers and 50% by insurance carriers. The law is called "Fresh Start", 24A MRSA §2367. The allocation of the insurance carrier's 50% is according to the Superintendent of Insurance's Rules #440, #640, and #650.

6% — Voluntary Market

*Often retrospective rating

*Rate set by Superintendent is ceiling

*If insurance company becomes insolvent, then Maine Insurance Guarantee Association covering insolvencies for all types of insurance takes over claims.

54% — Residual Market/Assigned Risk Pool (involuntary market)

Safety Pool: Mostly very small employers - 78%

Accident Prevention Account: High Risk Pool - 22%

Residual market pool fund: $296 million, December 1991

*Governance determined by Bureau of Insurance Rule #440, not by statute.
- 3 employer members
- up to 12 insurance carrier members
- Board of Governors chooses Plan Manager
- Plan Manager is NCCI, insurance organization

*Rates determined by Superintendent of Insurance. Higher rate for Accident Prevention Account. Rates vary for work classifications. Rates applied to employer's "mod", experience modification factor weighting 3 years' experience.

*Insurance carriers service the residual market and are paid 25.6% of premium. An insurance carrier can contract with a TPA to service.

*Deficit now shared 50-50 between employers and employees under Fresh Start Law. See 24A MRSA §2367.

WORKERS' COMP PROPOSAL
Effective January 1, 1993

Senator Judy Kany
(495-3857)
July 15, 1992

100% by premium

45%

Individual & Group self-insurance

No changes to law.

Residual Market Liabilities for years prior to 1993

Change make-up of Board of Governors to reflect employers' responsibility under Fresh Start Law. Prohibit NCCI from being Plan Manager.

Improve servicing.

Deficits expected to decline immediately due to improved servicing, procedures, laws, and labor/management relations.

No change is recommended in allocation of responsibilty.

5%

Voluntary Market

Allow "file & use", de-regulation of rates.

Regulate only regarding solvency and claims administration.

Eliminate requirement that insurers participate in residual market in any way (servicing or deficits) for years beginning with the year 1993.

50%

Residual Market (Assigned Risk Pool) Maine Employers Mutual Fund

Governing Board to become active immediately upon enactment of the emergency legislation (approximately September 30, 1992). Governing Board to be 50-50 employer/employee. Board to choose Executive Director, select investment manager, select and oversee divisions, administer Guarantee Fund and provide administration and central staffing for divisions to the extent deemed appropriate.

80%

(old Safety Pools) 8-14 geographic or industry divisions

*Governance of each division to be 50-50 employer/employee.

*Separate deficit or surplus determinations for each division. If surplus, surplus to be distributed only to employers within division earning surplus. If deficit, 50% of deficit to be paid by employers in division causing deficit and 50% to be paid by all

20%

(old Accident Prevention Account) High Risk Division

High Risk Division to be governed by the board governing the entire Maine Employer's Mutual Fund and the Employer's Mutual Guarantee Fund.

*Safety plans and committees required. Minutes to governing board. Can be eliminated from High Risk division for safety

WORKERS' COMP
Expected results by January 1996
if proposal effective January 1993

Senator Judy Kany
July 15, 1992

100% by premium

55% Individual & Group Self-Insurance	25% & growing Voluntary Market	20% & getting smaller Residual Market Employers Mutual Fund	
		10%	10%
		8-14 geographic or industry divisions Very small employers with good safety records (old Safety Pool)	High Risk division (old Accident Prevention Account)

Individual divisions take care of deficits and surpluses. Employers Mutual Guarantee Fund only covers claims due to employer insolvencies under Chapter 7 or 11 under the Bankruptcy Code or because employer has gone out of business.

Residual Market Liabilities
from 1988-1992

It is expected that deficits for '88-'92 will cease due to improved servicing, procedures, laws and labor/management relations.

employers in division.	compliance problems or non-payment of assessments.
*Eliminate need for servicing agent to be associated with insurance companies. Servicing can be bid on basis of price and performance. Servicing by insurance carriers, Third Party Administrators and insurance agencies.	*This division must cover own deficits beginning with 1993.
*Flexibility. Division can determine standards for elimination of members for non-payment and safety reasons.	

Employers' Mutual Guarantee Fund
(Pre-funded 2%)

To pay claims only in the case of employer insolvency (chapter 7 or 11 under the bankruptcy code) or upon termination of employer's business. To be governed by the board governing entire Maine Employers' Mutual Fund.

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07-15-92 12:08 PM FROM SENATE PRESIDENT P04

Sen. Judy Kany (495-3857)
July 15, 1992

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P35

WORKERS' COMP PROPOSAL
Effective January 1, 1993

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July 15, 1992

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07-15-92 12:08 PM FROM SENATE PRESIDENT

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July 15, 1992

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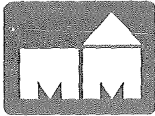
It is expected that deficits for '88-'92 will cease due to improved servicing, procedures, laws and labor/management relations.

employers in division.	compliance problems or non-payment of assessments.
*Eliminate need for servicing agent to be associated with insurance companies. Servicing can be bid on basis of price and performance. Servicing by insurance carriers, Third Party Administrators and insurance agencies.	*This division must cover own deficits beginning with 1993.
*Flexibility. Division can determine standards for elimination of members for non-payment and safety reasons.	

Employers' Mutual Guarantee Fund
(Pre-funded 2%)

To pay claims only in the case of employer insolvency (chapter 7 or 11 under the bankruptcy code) or upon termination of employer's business. To be governed by the board governing entire Maine Employers' Mutual Fund.



Maine Municipal Association

37 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486
(207) 623-8428

July 17, 1992

Michelle Bushey
Blue Ribbon Commission
c/o UM School of Law
246 Deering Avenue
Portland ME 04102

Dear Ms. Bushey:

NCCI recently reported that the projected residual market loss for 1988-1990 has reached the $574 million level. If these projections bear up under review we may be faced with a residual market "collapse" of even more alarming proportions than the 1987 and 1992 crises. Commercial Union, one of the major carriers in Maine has just declared its intent to withdraw from the market, an indication that the possibility of another crisis must be taken seriously.

As self insureds, the members of the MMA Workers' Compensation Trust would not be directly affected by a loss of capacity in the residual and voluntary markets. However, we are greatly concerned that the absence at this late date of a plan for dealing with a potential collapse on January 1, 1993 may result in stop-gap measures which will call upon self insurers to absorb a share of the residual market loss, or to assume financial responsibility for either a state fund or the "management pool" concept.

We believe it would be inappropriate for self insurers to be held responsible for a failure of the commercial market. As permitted in state law, we have chosen to meet our Workers' Compensation responsibilities by retaining our liabilities, rather than by transferring them to other entities. We believe our sole responsibility under these statutes is to responsibly manage our own liabilities.

The separation of insured and self insured employers has been an important principle in the development of the Workers' Compensation system in Maine. For example, the Maine Self Insurance Guarantee Association was created in response to the wishes of both the commercial carriers and self insurers that their liabilities not be commingled.

This concern is particularly acute for self insured public employers. To pass along residual market losses to self insured municipalities, special districts, public schools, the State University, the Maine Technical College system and State Government would amount to appropriating public funds to ensure the profitability of private enterprise. To involve public employers as guarantors of a state fund or management pool would result in the use of public funds to meet the obligations of private sector employers.

In light of these concerns, we urge you to reject any plan which would make self insurers financially responsible for a market in which they do not participate.

On another level, we are concerned that the window of opportunity for averting, or preparing for, a potential residual market collapse is closing rapidly. The Blue Ribbon Commission will be issuing its recommendations on or before September 1, and the Legislature may come in to session in the fall to deal with the Workers' Compensation crisis.

Given this scenario, we are concerned that there will be insufficient time in which to implement an alternative to the residual market in an effective manner. We are concerned that, under pressure of time, administration of either a state fund or management pool may be entrusted to the insurance companies. Given past criticisms of insurance industry performance by the Bureau of Insurance and by members of the Legislature, this is a prospect which must be viewed with concern. It must also be a source of concern that such an arrangement would free the carriers from any responsibility for the experience of the residual market while providing them with guaranteed fees for administering its replacement.

It is our belief that the only effective course of action, given the time available before the anticipated January 1, 1993 collapse, rests on five points:

1. Resolve the most critical problems in the system, including an overly broad compensability statute, and excessive litigation.

2. Deregulate the voluntary market. The existence of responsibly managed individual and group self insurance plans will serve as a check to unwarranted voluntary market rate increases.

3. Reshape the residual market by eliminating the fresh start surcharge and by setting ratios at a level which will cover losses without reliance on post policy period assessments. Consideration should be given to capping the involuntary market as a percent of the total market, as previous attempts to induce depopulation have failed.

4. Provide an hospitable environment for the voluntary formation of group self insurance plans, based on commitments to careful underwriting, safety programs and sound management. Regulation should remain effective, but should be more stream-lined and targeted. The proliferation of assessments on self insurers should be curtailed. Self insurers should not be looked to as guarantors of either private sector or state initiated markets.

5. Encourage improvements in work place safety and light duty job programs through legislation, regulation, and dedication of state financial resources.

The Blue Ribbon Commission has received a number of proposals which address these objectives through a variety of mechanisms. It is our hope that the Commission will find solutions to the numerous and complex problems plaguing the Maine Workers' Compensation system within these proposals, and that they will ultimately be enacted into law this Fall. It will take far reaching and timely reforms to prevent a collapse of the market in 1993.

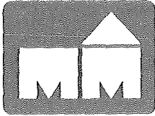
Thank you for the opportunity to express our views and concerns on the Workers' Compensation crisis.

Sincerely,

Martin Hanish
Chief Financial Officer

CC: Senator Judy Kany
Representative Elizabeth Mitchell

MH:jlt



Maine Municipal
Association

37 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486
(207) 623-8428

July 17, 1992

Senator William D. Hathaway
6707 Wemberly Way
McLean VA 22101

Dear Senator Hathaway:

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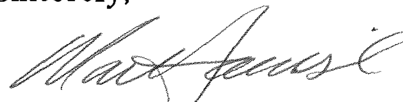

Martin Hanish
Chief Financial Officer

CC: Senator Judy Kany
Representative Elizabeth Mitchell

MH:jlt

National
Council on
Compensation
Insurance

Law Evaluations

Barry I. Llewellyn
Vice President and Actuary

TO: Maine Blue Ribbon Commission Members **DATE:** 07/17/92

FR: Barry Llewellyn, NCCI

We have recently held a series of discussions with Mr. John Herzfeld of Milliman & Robertson regarding NCCI's Maine/Michigan Benefit Cost Analysis provided to the commission under date 7/2/92. As a result of these discussions, we have discovered that the model of Michigan's permanent partial benefit structure was incorrectly represented. In Michigan, scheduled impairment benefits **only** apply to actual physical loss (i.e., amputations) rather than actual physical loss and loss of use. This led to an overstatement of scheduled losses and a subsequent understatement of wage loss benefits. Upon the correct allocation of permanent partial losses, our calculations yield a revised variation of effect of +40% - +60%. This in turn produces an overall variation of effect of +7.8% - +20.2% (see Attachment 1).

Underlying details in support of the +60% permanent partial effect are attached as Exhibit A, Sheets 1-3. An alternative scenario employing a 2% per year wage loss decrement (to account for reductions in wage loss benefits due to increases in post injury wages) yields a permanent partial effect of +45.8%. Details of this calculation are provided in Exhibit B, Sheets, 1-3.

This detail has been provided to your consultant, John Herzfeld of Milliman & Robertson. If you have any further questions, please do not hesitate to call.

Attachments

cc: John Herzfeld

BIL/mic/0322

One Penn Plaza, New York, NY 10119

Attachment 1

MAINE VERSUS MICHIGAN

ESTIMATED EFFECT OF REPLACING MAINE LAW WITH MICHIGAN LAW

TYPE OF INJURY	PERCENT OF LOSSES	VARIATION OF EFFECT	
Fatal	1.6%	-70.0%	-80.0%
Permanent Total	2.7%	-50.0%	-60.0%
Permanent Partial	44.8%	60.0%	40.0%
Temporary Total	10.9%	-20.0%	-30.0%
Medical	40.0%	-5.0%	-10.0%
Total	100.0%	20.2%	7.8%

MAINE VERSUS MICHIGAN LAW (APPLIED TO MAINE)

PERMANENT PARTIAL

1. Effect of Major Permanent Partial (Exhibit 1-A)	1.5645
2. Effect of Minor Permanent Partial (Exhibit 1-B)	2.2650
3. Percent of Losses, Major Permanent Partial	42.1%
4. Percent of Losses, Minor Permanent Partial	2.7%
5. Overall Effect	1.6067

MAINE VERSUS MICHIGAN LAW (APPLIED TO MAINE)

MAJOR PERMANENT PARTIAL

	MAINE	MICHIGAN
1. Healing period (% claims)	100%	100%
2. Cost in weeks of Benefits	120	165
3. Annuity Value	115.37	156.34
4. Average Weekly Benefit	274.48	253.84
5. Cost of Healing Period (1) x (3) x(4)	31,667	39,685
6. Scheduled Impairment (% of claims)	11.3%	2.7%
7. Cost in weeks of benefits	66	211.88
8. Average Weekly Benefit	272.74	253.84
9. Cost of Impairment Benefit (6)x(7)x(8)	2,034	1,452
10. Wage Loss (% claims)	100%	97.3%
11. Cost in weeks of Benefits	345	679.40
12. Annuity Value	281.51	477.58
13. Average Weekly Benefit	111.31	133.56
14. % of Claims affected by SS offset	2.8%	2.8%
15. 100%−(14)	97.2%	97.2%
16. Reduced benefit for claims affected by offset	24.00	46.25
17. Cost of Wage Loss Benefit (10x(12)x[(13)x(15) + (14)x(16)]	30,647	60,927
18. Subtotal, Indemnity	64,348	102,064
19. Effect, Indemnity		1.5861
20. % Indemnity spent on Vocational Rehabilitation	0.9%	0.5%
21. Effect, Vocational Rehabilitation		0.5556
22. Vocational Rehabilitation as a Percent of Major PP losses		2.1%
23. Indemnity as a Percent of Major PP losses 1−(22)		97.9%
24. Effect		1.5645

EXHIBIT A
SHEET 3

MAINE VERSUS MICHIGAN LAW (APPLIED TO MAINE)

MINOR PERMANENT PARTIAL

	MAINE	MICHIGAN
1. Healing period (% claims)	100%	100%
2. Cost in weeks of Benefits	20	20
3. Annuity Value	19.87	19.87
4. Average Weekly Benefit	274.48	253.84
5. Cost of Healing Period (1) x (3) x(4)	5,454	5,044
6. Scheduled Impairment (% of claims)	12.5%	5.85%
7. Cost in weeks of benefits	6.4	30.29
8. Average Weekly Benefit	272.74	253.84
9. Cost of Impairment Benefit (6)x(7)x(8)	218	450
10. Wage Loss (% claims)	89%	94.2%
11. Cost in weeks of Benefits	196	504.75
12. Annuity Value	180.74	418.77
13. Average Weekly Benefit	69.58	83.47
14. % of Claims affected by SS offset	2.8%	2.8%
15. 100%–(14)	97.2%	97.2%
16. Reduced benefit for claims affected by offset	7.00	7.00
17. Cost of Wage Loss Benefit (10x(12)x[(13)x(15) + (14)x(16)]	10,911	32,066
18. Total Cost, Minor Permanent Partial	16,583	37,560
19. Effect		2.2650

EXHIBIT B
SHEET 1

MAINE VERSUS MICHIGAN LAW (APPLIED TO MAINE)

PERMANENT PARTIAL

1. Effect of Major Permanent Partial (Exhibit 1-A)	1.4176
2. Effect of Minor Permanent Partial (Exhibit 1-B)	2.0936
3. Percent of Losses, Major Permanent Partial	42.1%
4. Percent of Losses, Minor Permanent Partial	2.7%
5. Overall Effect	1.4583

EXHIBIT B
SHEET 2

MAINE VERSUS MICHIGAN LAW (APPLIED TO MAINE)

MAJOR PERMANENT PARTIAL

	MAINE	MICHIGAN
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3. Annuity Value	115.37	156.34
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17. Cost of Wage Loss Benefit (10x(12)x[(13)x(15) + (14)x(16)]	30,647	51,276
18. Subtotal, Indemnity	64,348	92,413
19. Effect, Indemnity		1.4361
20. % Indemnity spent on Vocational Rehabilitation	0.9%	0.5%
21. Effect, Vocational Rehabilitation		0.5556
22. Vocational Rehabilitation as a Percent of Major PP losses		2.1%
23. Indemnity as a Percent of Major PP losses 1−(22)		97.9%
24. Effect		1.4176

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16. Reduced benefit for claims affected by offset	7.00	7.00
17. Cost of Wage Loss Benefit (10x(12)x[(13)x(15) + (14)x(16)]	10,911	29,224
18. Total Cost, Minor Permanent Partial	16,583	34,718
19. Effect		2.0936

DATE July 20, 1992 TOTAL # OF PAGES 11

TO Michelle Buckley

FAX # 780-4913

TELEPHONE # 780-4378

FROM: HARVEY PICKER
TELEPHONE # 207-236-6651
FAX # 207 236-3510

Michelle
Copies of this have gone to the other commissioners

HP

Commercial Union Insurance Companies
Executive Offices: One Beacon Street
Boston, Massachusetts 02108
FAX: (617) 725-6702
Telex: 94 0184

SENT VIA FACSIMILE

July 17, 1992

Dr. Harvey Picker
Blue Ribbon Commission To Examine Alternatives
To The Workers' Compensation System

Dear Dr. Picker:

Once again, we appreciate the opportunity to provide our input into your deliberations.

I hope you will find the enclosed useful and thought provoking.

If we can be of any help to you and your committee, please let us know.

Cordially,

Malcolm H. Leggett
Senior Vice President

MHL/ltw
enclosure

MAINE WORKERS' COMPENSATION
DEALING WITH THE INVOLUNTARY MARKET
AND ITS DEFICITS

It is recognized by all parties that major reform is required to prevent the total collapse of the existing workers' compensation system in Maine. A number of proposals have been considered by the Blue Ribbon Commission and the Eight and Eight Committee. Neither group has yet to make its final recommendations.

Solutions clearly must focus on bringing future benefits paid to injured workers in line with what competitive employers can afford to pay. While the cost of benefits is the most important issue to address, there are three funding issues which must also be addressed:

1. Prior Years' Deficits
2. Market of Last Resort
3. Rate Adequacy

This paper explores these three issues and makes suggestions as to how to deal with them.

Regardless of what shape the needed reform takes, most thoughtful people agree that it must include a private insurer market. Over many years private insurers have developed an extensive infrastructure consisting of expertise in the underwriting, risk control and claims handling

disciplines. This expertise and the people it represents should not be discarded as part of the "solution." If allowed to work, a private competitive workers' compensation insurance industry provides the best chance to provide employers with the options and motivation to hold down costs. However, it is unlikely that any viable private workers' compensation insurer will remain in Maine if the funding issues are not addressed.

I. Deficits From Prior Years. A recent estimate by the National Council of Compensation Insurers (NCCI) estimates a staggering $617 million in operating loss from policy years 1988, 1989, 1990 and 1991 (see Exhibit attached). The losses from these four years are expected to grow and additional losses will arise from the 1992 policy year. If these operating losses are to be retired in a reasonable period of time, five years for example, then on average over $125M per year in additional revenues must be raised each year. The revenue need for the 1988 policy year, which must be 100% funded by employers, is $193M (see Exhibit attached). The 1989, 1990 and 1991 years are born by both employers and insurers. The deficit for 1989, 1990 and 1991 is estimated at $424M (see Exhibit attached).

These deficits will result in significant assessments to both Maine workers' compensation insurers and Maine employers for many years to come. Assuming each group on average assumes 50% of the deficit, over $60 million a year will have to be raised from each if the deficit is to be retired in the next five years. The economic consequences on both groups would be crippling.

For workers' compensation insurers, 50% of the deficit is greater than the entire 1992 estimated premium of $247 million. Even spread out over five years, insurers' deficit share would wipe out all the capital currently supporting the workers' compensation insurance line in Maine. The insurer share of the deficit is so great that it would be greater than the estimated profits for all lines of business for all property - casualty carriers for the next five years. Attempts to collect such confiscatory assessments would likely result in many carriers simply pulling out of Maine. For any that remain, rates for other lines would have to be raised significantly to offset the deficit impact.

The impact on employers would be equally devastating and fruitless. Under current law, future insured employers are supposed to pay a surcharge to fund the employer share of the deficit. Who will be left to pay these higher premiums? Many employers, most of whom were insured when the deficit was created, have already left the insurance market and with even higher rates few employers would remain insured. In short, a workers' compensation premium surcharge will not raise the required funds.

In simple terms, the deficit has grown so large that it cannot be funded as anticipated by the framers of the current law. Years of inaction and halfway measures have failed to check a system which has grown so increasingly out of control that it has literally self destructed. The total "fresh start" operating loss is now over twice as large as the annual workers' compensation premium in Maine. Future calculations will undoubtedly reveal that the deficit is even higher. If Maine is to retire the deficit without crippling its

business infrastructure and insurance availability, other financing means must be found. The following are possible solutions to the problem:

- A Sales Tax On All Insurance Premiums In The State. A specific sales tax levied on all insurance policies in Maine could be a major source of funds to help retire the deficit within a reasonable period of time. With approximately $1.2 billion in property and casualty premiums and $650 million in life and health premiums in Maine, a tax on all lines premiums would make a significant contribution to deficit funding. The tax would be added to policy premiums, collected by insurers and remitted to a quasi-governmental body established for the purpose. This body would retire the deficit by distributing the funds as needed.

- A Paid Loss Tax On Workers' Compensation Self Insurers. As the Maine workers' compensation system has deteriorated, many employers have moved to qualified self-insurance programs and others have joined self-insurance groups. This removal of so many risks from the insurance system has exacerbated the problem for those who remain. Because self-insurance represents such a large share of the total workers' compensation market, self-insurers must be part of the funding mechanism. Self-insurers do not collect a conventional policy premium and would not be subject to the sales tax based on premium as described above. Thus, another funding mechanism must be substituted for self-insurers. Because the amount of self-insurance funding is normally based on loss projections, and

because accurate paid loss data is compiled and reported to the Maine Workers' Compensation Commission each year, a tax on paid losses, calculated at a figure which will establish parity with the sales tax collections described above, would be a reasonable substitute for the self-insurer share of the funding mechanism.

- Payroll Tax. A more direct funding of the deficit would be a simple payroll tax on all Maine payroll. This could be paid by employers or employees or shared in some proportion.

- Issue State General Obligation Bonds. The State has a vital interest on behalf of its citizens in the health of the Maine economy. To overcome the crippling consequences of the impact of the deficit, it would be appropriate for Maine to pledge the full faith and credit of the State to remove the threat to the economy that the deficit represents. Bonds are often issued for economic development purposes. Because of the economic consequences of the deficit, it is equally appropriate to issue them to address this critical issue. Revenue from the special bond offering would be paid to the quasi-governmental body and disbursed as described above. The bonds would be retired from general state revenues.

Some combination of these approaches may be required. The important point is to recognize the need to remove the threat of the deficit to the Maine economy by raising funds in a manner that shares the burden equitably across a wide base. Only by

discharging the deficit can the economic climate in Maine again become vibrant. Arguing about why the deficit exists and where the blame should rest may be useful to reform the future, but the fact remains that the old deficit has to be eliminated.

II. The Market Of Last Resort. There is a need to provide an insurance market for those employers who cannot secure coverage in the conventional market. This is certainly a transition problem until a conventional market can be reborn in Maine, but it is also an ongoing need. Without a market of last resort especially during a transition period, employers would either go out of business or become uninsured with the resultant impact on employees. Private insurers are no longer willing to provide the market of last resort. At present, the only way for an insurer to avoid involvement in the current market of last resort, the assigned risk plan, is for a carrier to write no voluntary workers' compensation at all. If a private insurance market is to be re-established, the current linkage between the voluntary and involuntary markets must be broken, and insurers freed from the involuntary burden.

The most common way to break the linkage between voluntary private insurance and involuntary insurance is to form a competitive state fund. The state fund would become the underwriter of last resort. Such funds are not without financial problems. Lacking competitive business forces, some funds have gotten into serious financial difficulties. If a State Fund is created, it should:

- Be a quasi-independent body required to pay its own way.

- Be required to adhere to sound actuarial reserving practices.
- Be subject to the same regulatory control of the insurance department as other insurers.

Another approach, which would be easier to implement, would be a reinsurance entity, run by and guaranteed by the state, which would reinsure private carriers or group self-insurance plans who provide an assigned risk market. The reinsurance facility could be administered by the quasi-governmental body mentioned previously, which would have standby authority to retire any deficits through a payroll tax on employers and employees. The tax would be a subsidy of the assigned risk's costs, and such subsidies should be temporary and tightly controlled. Any such plan should include provisions that an actuarial evaluation is made each year and any deficits would be linked to automatic rate increases, predetermined by law. When triggered, these rate increases would raise the needed funds to return the entity to a sound financial footing.

III. Rate Adequacy. The size of the involuntary market is directly correlated to rate adequacy. Rates in Maine have been kept at grossly inadequate levels for years. As each "reform" package has been passed, it has generated unfounded optimism which was applied to rate making despite industry warnings. If realistic rates are to be achieved, the Bureau of Insurance must exercise its basic obligation to assure that rates are adequate. File and use rating laws, which retain the Bureau's oversight powers but remove it from the actual setting of uniform rates, would be a significant step in

overcoming this problem. Private insurers are in business to write business and will do so if they believe they can charge a profitable rate. Without that confidence, insurers will not return.

CONCLUSION

A viable, effective and efficient workers' compensation system can be crafted for Maine. As a prerequisite, the balance between benefits and revenues must be restored. In the process, the three funding issues described above must be successfully addressed.

If they are, an environment will be created in which a private insurance market can be restored. Experience in other states has shown that a private insurance market is an important contributor to the health of the overall system. The underwriting, risk control and claim skills represented by private insurers and their employees are a valuable asset, which has for many years provided a significant contribution to the Maine compensation system. In a healthy system private carriers provide a check and balance for any return to an inadequately funded system.

MAINE WORKERS' COMPENSATON DEFICITS BY POLICY YEAR AS ESTIMATED BY THE NATIONAL COUNCIL OF COMPENSATION INSURERS AS OF 3-31-92

POLICY YEAR	DEFICIT
1988	$193M
1989	174M
1990	143M
1991 (incomplete)	107M
	$617M

Lois W. Knight
Accounting Manager

Gail E. Lind
Insurance Services Manager

Clark Associates
* Insurance *

Richard W. Clark
F. Dale Hudson
Paula M. Hamilton
Leon D. Libby
Judy Conley Dibble
Lee Ramsdell
Kenneth A. Ross
Andrew N. Berglund
Charles H. Smith

David G. Bruneau
Charles S. Clark
David W. May
Life, Health & Group

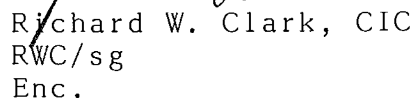
July 20, 1992

The Honorable William Hathaway, Co-Chair
Mr. Richard Dalbeck, Co-Chair
Mr. Emilian Levesque
Dr. Harvey Picker
The Blue Ribbon Commission on Workers' Compensation
246 Deering Avenue
Portland, ME 04102

Dear Blue Ribbon Commission Members:

I found the enclosed article from Nations Business in my file and felt that it would be well worth your reading.

Best regards,

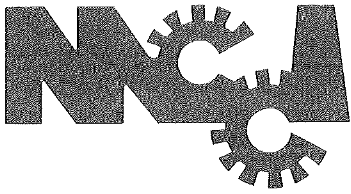


Richard W. Clark, CIC
RWC/sg
Enc.

2331 Congress Street • P.O. Box 3543 • Portland, Maine 04104-3543 • (207) 774-6257
FAX – (207) 774-2994

Fighting the high cost of workers' comp (Thompson, Roger) (Nation's Business, March 1990) ●
(Available on request-please include the following citation: WC115-BRC-08-Pt.C-168.pdf)

To obtain items available on request, or to report errors or omissions in this history, please contact:
Maine State Law and Legislative Reference Library



Maine Chamber of Commerce & Industry

126 Sewall Street ▪ Augusta, Maine 04330 ▪ (207) 623-4568

July 21, 1992

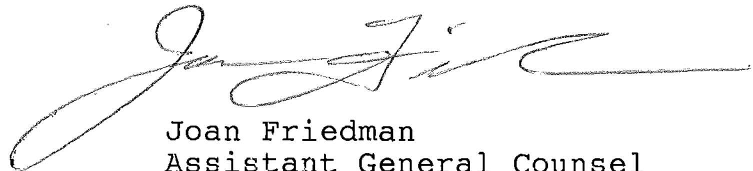
Honorable William D. Hathaway, Co-Chair
Mr. Richard B. Dalbeck, Co-Chair
Honorable Emilian A. Levesque
Dr. Harvey Picker
Blue Ribbon Commission on Worker's Compensation
246 Deering Avenue
Portland, Maine 04102

Dear Blue Ribbon Commission Members:

We understand that you have directed John Lewis to submit proposals that will be used in drafting your preliminary recommendations. We would be very interested in receiving a copy of Lewis's proposals. Additionally, we hope that such proposals are shared widely so that you can receive the comments of all parties with an interest in this very sensitive issue.

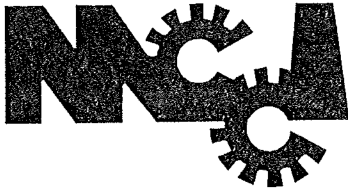
Thank you for your consideration.

Very truly yours,



Joan Friedman
Assistant General Counsel

The Voice of Maine Business



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July 21, 1992

Honorable William D. Hathaway, Co-Chair
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Blue Ribbon Commission on Worker's Compensation
246 Deering Avenue
Portland, Maine 04102

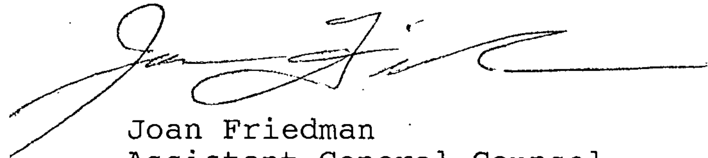
Dear Blue Ribbon Commission Members:

We understand that you have directed John Lewis to submit proposals that will be used in drafting your preliminary recommendations. We would be very interested in receiving a copy of Lewis's proposals. Additionally, we hope that such proposals are shared widely so that you can receive the comments of all parties with an interest in this very sensitive issue.

Thank you for your consideration.

7/27 called to tell her no proposals will be distributed to the public before it goes to Gov. + Leg.

Very truly yours,



Joan Friedman
Assistant General Counsel

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AREA CODE 207
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July 21, 1992

Blue Ribbon Workers' Compensation Commission
c/o Michelle E. Bushey
University of Maine School of Law
Portland ME 04103

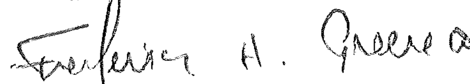
Dear Commissioners:

As you know, the costs of the system would be reduced if any new reforms are made retroactive and applicable to prior dates of injury to the greatest extent constitutionally permissible.

The enclosed case, McDonald v. Rumford School District, (Me., Dec. No. 6227, 6/24/92), suggests that the Law Court will tolerate retroactive application of benefits in apportionment cases where disability is caused in part by a new injury and in part by a prior injury.

I hope this is useful to you.

Very truly yours,



Frederick H. Greene III

lla
Enclosure
cc: Acadia Insurance Company
John H. Lewis

MAINE SUPREME JUDICIAL COURT

Reporter of Decisions
Decision No. 6227
Law Docket No. WCC-91-531

DANIEL McDONALD

v.

RUMFORD SCHOOL DISTRICT, *et al.*

Argued April 28, 1992
Decided June 24, 1992

Before WATHEN, C.J., and ROBERTS, GLASSMAN, CLIFFORD and COLLINS, JJ.

CLIFFORD, J.

The Rumford School District appeals from a decision of the Workers' Compensation Commission Appellate Division affirming a decision of the Commission awarding compensation for total incapacity to Daniel McDonald, Rumford's employee, based on McDonald's average weekly wage at the time of the first of two successive injuries. We agree with Rumford's contention that McDonald's benefits should have been based on his average weekly wage at the time of his second injury, and accordingly, we vacate the decision.

McDonald sustained a compensable injury to his back while working for Rumford School District in 1986. He then returned to full-time work for Rumford. In 1988, McDonald again suffered a compensable injury to his back. He began to receive benefits based on his average weekly wage at the time of his second injury. In 1990, McDonald petitioned the Commission for further compensation requesting that it be based on his average weekly

wage at the time of his first injury rather than his second.[1] The Commission found that the 1986 injury played a "real and actual role" in his present incapacity. Apparently, however, the Commission was unable to determine the exact extent to which each of the two injuries contributed to McDonald's present incapacity.[2] The Commission ordered compensation for total incapacity based on McDonald's 1986 average weekly wage. The Commission rejected Rumford's contention that 39 M.R.S.A. § 2(2)(F) (1989)[3] and our decision in *Warren v. H.T. Winters Co.*, 537 A.2d 583 (Me. 1988), required use of the average weekly wage at the time of the second injury. Rumford appealed to the Appellate Division, *see* 39 M.R.S.A. § 103-B (1989), which likewise rejected Rumford's contentions and affirmed the Commission. This appeal followed. *See* 39 M.R.S.A. § 103-C (1989).

In *Warren*, we held when an employee suffers two successive work-

---

[1] McDonald's average weekly wage at the time of his first injury was $355.84. It was $393.15 at the time of the second injury. Compensation based on the average weekly wage for 1986 is adjusted annually for inflation pursuant to 39 M.R.S.A. § 54-A. In 1987, however, section 54-A was repealed and replaced by section 54-B. P.L. 1987, ch. 559, Pt. B, § 26. That section, which became effective November 20, 1987 and is applicable to McDonald's second injury, delays the application of the inflationary adjustment for the first three years after the injury. *See* P.L. 1987, ch. 559, Pt. B, § 27.

[2] The evidence presented before the Commission was that both the 1986 and the 1988 injuries contributed "probably equally" to McDonald's present incapacity.

[3] 39 M.R.S.A. § 2(2)(F) (1989) states:

> The fact that an employee has suffered a previous injury or received compensation therefor shall not preclude compensation for a later injury or for death; but in determining the compensation for such later injury or death, his "average weekly wages" shall be such sum as will reasonably represent his weekly earning capacity at the time of such later injury in the employment in which he was working at such time, and shall be arrived at according to and subject to the limitation of this section.

related injuries that, in combination, result in a present incapacity, section 2(2)(F) requires that the average weekly wage at the time of the second injury be used to determine the amount of compensation unless the first injury affected the employee's earning level at the time of the second injury.[4] 537 A.2d at 585-86; *see also Johnson v. S.D. Warren*, 432 A.2d 431, 434 (Me. 1981). The statutory language of section 2(2)(F) was designed to "'provide a method of arriving at an estimate of the employee's future earning capacity as fairly as possible,'" *Warren*, 537 A.2d at 585 (quoting *Fowler v. First Nat'l Stores, Inc.*, 416 A.2d 1258, 1260 (Me. 1980)). The later average weekly wage "will more accurately reflect the actual loss of the employee's future earning capacity, which the compensation based on the average weekly wage is designed to accomplish." *Warren*, 537 A.2d at 586.

Contrary to the reasoning of the Appellate Division, the use of the average weekly wage at the time of the second injury is not changed by the fact that the case involves a single insurer on the risk during both injuries, or that the average weekly wage at the time of the second injury is higher than the first injury average weekly wage. *Id.*; *see also Johnson*, 432 A.2d at 434. Therefore, the Commission erred in not applying *Warren* and should have based the compensation on McDonald's average weekly wage at the time of the second injury.

McDonald further contends that because his first injury occurred in 1986, he has a vested right to the annual inflation increases mandated by 39

[4] Contrary to the conclusion of the Appellate Division and the contention of McDonald, the Commission did not find, nor is there sufficient evidence to support a finding, that McDonald's first injury affected his earnings at the time of the second injury.

M.R.S.A. § 54-A, which was in effect at that time. *See supra* note 1. We disagree. As an employee who has suffered successive, equally contributing injuries, McDonald's rights "cannot be determined until the time of the second injury, since it is not until that time that both injuries combine to cause the incapacity." *Warren*, 537 A.2d at 586. The legislature, in an effort to curtail the costs of workers' compensation, was free to limit the inflation adjustment of the average weekly wage, and to provide that it apply to all injuries occurring after the effective date of the legislative change. McDonald's second injury occurred in 1988, subsequent to the November 20, 1987 effective date of the enactment of Section 54-B.

The entry is:

The decision of the Appellate Division is vacated. Remanded to the Appellate Division for remand to the Commission for an award of compensation based on the average weekly wage at the time of the second injury.

All concurring.

Attorney for Appellant:
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Attorney for Appellee:
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BERMAN & SIMMONS, P.A.
129 Lisbon Street
P. O. Box 961
Lewiston, Maine 04243-0961

NOTICE: Readers are requested to notify the Reporter of Decisions, Box 368, Portland, Maine 04112, of any typographical or other formal errors in this opinion.

LYNCH CHIROPRACTIC ARTS BUILDING
1200 Broadway
South Portland, Maine 04106

Dr. Robert P. Lynch, Jr.

Tel. (207) 799-2263
Fax (207) 799-7112

July 21, 1992

Richard Dalbeck
Co-Chair Blue Ribbon Commission
Blue Ribbon Workers Comp Commission
University of Maine School of Law
246 Deering Ave.
Portland, ME 04102

Dear Dick,

I have had the opportunity to review a suggested workers compensation medical system by Harvey Picker. In review of Mr. Pickers suggestion I would like to make a short comment.

1. The Michigan Workers Compensation system does not call for independent medical examiners (IME). Mr. Picker recommends placing Chiropractors on the medical advisory board but in his later presentation he does not have chiropractors as independent medical examiners. He has a selective panel of up to 25 M.D. and D.O.'s as mediators and hearing officers.

2. It is my opinion and the opinion of that the system would benefit from having like providers reviewing each other and not having M.D.'s reviewing Chiropractic cases or D.O.'s reviewing medical doctors cases, ect.

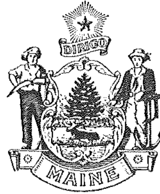
3. There are many chiropractors in the State of Maine whom have expertise as a diagnostician to be able to determine the necessity for the chiropractic care being provided and the limitations in the work capacity as a result of the alleged injuries.

Sincerely,

Robert P. Lynch, Jr., D.C.

RPL/pl

John R. McKernan, Jr.
Governor



Stephen G. Ward
Public Advocate

Executive Department
PUBLIC ADVOCATE
Telephone (207) 289-2445
FAX (207) 289-4317

July 21, 1992

Senator William Hathaway
Danton Towers
207 E. Grand Avenue, Apt. 6D
Old Orchard Beach, ME 04064

Reference: BLUE RIBBON COMMISSION ON WORKERS' COMPENSATION

Dear Senator Hathaway:

As I promised in our telephone conversation earlier this morning, I enclose the list of proposed servicing standards that were submitted in late June to the Mitchell-Kany group by the third-party administrators, Sedgwick-James and Northern General Services.

Sincerely,

Bill Black

William C. Black
General Counsel

pjm
Enclosure

State House Station 112, Augusta, Maine 04333 — *Offices Located on* 7th Floor, State Office Building

THE CHAMBER

July 22, 1992

Honorable William Hathaway, Co-Chair
Mr. Richard Dalbeck, Co-Chair
Mr. Emilian Levesque
Dr. Harvey Picker
Blue Ribbon Commission on Workers' Compensation
246 Deering Avenue
Portland, ME 04102

Dear Blue Ribbon Commission Members:

The Board of Directors of Lewiston-Auburn Area Chamber of Commerce, representing 715 businesses and organizations in our metropolitan area, has taken action to join with the Chamber of Commerce of the Greater Portland Region, to express to you our support of the labor-management Workers' Compensation Group reform proposal, based on the Michigan Workers' Compensation System.

Like other Chambers of Commerce, business and trade organizations, our membership has been active in past reform efforts to achieve a more cost-effective and equitable workers' compensation system for Maine employers and employees. Those efforts have fallen short of our goals and the crisis has grown deeper. The Lewiston-Auburn area economy has lost upwards of a thousand jobs as a result. While we continue to pursue an aggressive economic development program, the failure to address the workers' compensation problems remain a serious deterrent to new business development and job creation, particularly in our manufacturing sector. Your role in developing a meaningful reform program makes the Blue Ribbon Commission an important stakeholder in our economic future.

We believe past reform efforts have failed as a result of the fragmentation caused by special interest groups and the lack of consensus on the fundamental needs of employers and employees. The coalition represented by the Worker's Compensation Group, through their detailed analysis, selection criteria and decisionmaking process, provides an alternative which we believe deserves your support.

LEWISTON-AUBURN AREA

CHAMBER OF COMMERCE

179 LISBON STREET

LEWISTON, ME 04240

Achieving the full benefits of any comprehensive reform effort will take time as well as changed behaviors and attitudes on the part of employers and employees. The labor-management coalition represented in the Workers' Compensation Group gives us confidence that the latter outcome is achievable.

At it's meeting July 17, the Board of Directors of the Lewiston-Auburn Area Chamber of Commerce voted to:

> **"Endorse the criteria established by the Workers' Compensation Group and the concepts contained in The Michigan system. The Chamber commits to working with the Workers' Compensation Group and the Blue Ribbon Commission toward implementation of the Michigan System concepts, with appropriate changes that may be necessary for transition and which are suitable for the employers and employees in the State of Maine, if such changes are unanimously endorsed by the Workers' Compensation Group".**

We believe it is in Maine's best interest to encourage continued labor and management participation in refining final recommendations. We applaud your work and commitment to achieving a solution to Maine's Workers' Compensation crisis and look forward to your final report.

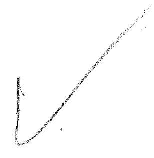
Sincerely

Dennis Barriault
Chairman

DB/pv

Windham Chamber of Commerce

Serving the Entire Business Community



P.O. Box 1015, Windham, Maine 04062

Tel. 207-892-8265

July 22, 1992

Honorable William Hathaway, Co-Chair
% Blue Ribbon Commission on Workers Compensation
246 Deering Avenue
Portland, Me. 04102

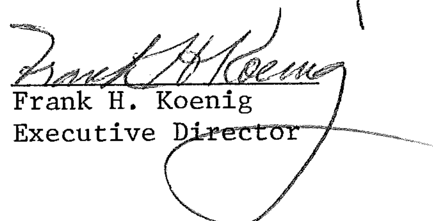
Dear Mr. Hathaway,

The Windham Chamber of Commerce, an independant Chamber representing over 300 members,are urging revision of the Workers Compensation Program, for obvious reasons.

We endorse the criteria established by the Workers Compensation Group and the concepts contained in the "Michigan System", with revisions to fit the needs of Maine employers and employees.

Your understanding and cooperation will be appreciated.

Sincerely,



Frank H. Koenig
Executive Director

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Vice President .... Timothy W. Seavey
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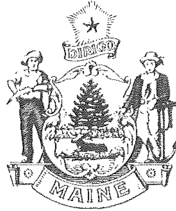
President of the Senate



Tel: (207) 289-1500

State of Maine
Senate Chamber
Augusta, Maine 04333

July 22, 1992

Senator William Hathaway
Danton Tower, Apt 6D
Old Orchard, ME 04064

Mr. Richard Dalbeck
17 Spoondrift Lane
Cape Elizabeth, ME 04107

Dear Gentlemen:

I have received a copy of the letter from Governor McKernan recently sent to you dated July 6, 1992, and wish to share my views on the scope of the Blue Ribbon Commission's work.

As you know, and as the Governor acknowledges in his letter to you, Resolve 59 does not include in its scope a study of the residual pool problems. It was the Legislature's intent that the energies of your panel needed to be focused principally upon the redesign of the workers' compensation system in Maine for the future.

I am writing to you today to urge that the commission first and foremost carry out the charge of the legislation. If, after you have finalized the report, completed the assignments put forth in Resolve 59 and after you have sent us the proposed legislation, you still have the time and energy, then we would certainly welcome any views that you may have to share with us concerning the residual pool deficit.

I think it is important that the priority continue to be the task put before you in Resolve 59 because that task is broad in scope and one which we hope will have benefits well into the future. Furthermore, the definition of the scope of your functions was a result of careful craftsmanship on the part of the Legislature, taking into account the concerns of both political parties in both the legislative and executive branches of government. For any one of those parties to now attempt to expand or redefine the mission of the commission does some violence to the spirit that created Resolve 59 and could be perceived as threatening the independence which is so important for the Blue Ribbon Commission to maintain.

As you know, I have refrained from attempting to influence the commission as it has carried out its duties. I am, however, encouraged by the reports that I receive of your progress. All of us in the Senate look forward to your report and accompanying legislation. After that, to the extent that you are able, any advice you have to offer on the residual pool deficit will receive our most careful attention and consideration.

Sincerely,

Charles P. Pray
President of the Senate

CPP/meb

cc. Governor McKernan
Speaker Martin
Dr. Harvey Picker
Emilien Levesque

1 an anniversary review by the court at which, unless waived by the employer, the court shall make findings as to whether maximum medical improvement has been reached, as to the degree of functional impairment and/or disabilility of the employee, and as to whether the employee should be classified as partially disabled or totally disabled. Temporary total disability shall not last beyond the anniversary review. Unless waived by the employer, an anniversary review shall be conducted annually thereafter. The court shall perform this anniversary review of cases where injury occurs after the effective date of this statute.

11 SECTION 11. CHAPTER 28-33 OF THE GENERAL LAWS ENTITLED "WORKERS' COMPENSATION -- BENEFITS" IS HEREBY AMENDED BY ADDING THERETO THE FOLLOWING SECTION:

14 28-33-47. Reinstatement of injured worker. -- (a) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position, with reasonable accommodation made by the employer in the manner in which the work is to be performed. A workers' former position is "available" even if that position has been filled by a replacement while the injured worker was absent as a result of the worker's compensable injury. If the former position is not available, the worker shall be reinstated in any other existing position which is vacant and suitable. A certificate by the attending physician that the physician approves the worker's return to the worker's regular employment or other suitable employment shall be prima facie evidence that the worker is able to perform such duties.

29 (b) Such right of reinstatement shall be subject to the provisions for seniority rights and other employment restrictions contained in a valid collective bargaining agreement between the employer and a representative of the employer's employees, and nothing shall exempt any employer from or excuse full compliance with any applicable provi-

1 sions of the Americans with Disabilities Act and chapter 42-87 (Dis-
2 crimination Against the Handicapped) of the general laws.
3 (c) Notwithstanding subsection (a) of this section:
4 (1) The right to reinstatement to the worker's former position
5 under this section terminates upon any of the following:
6 (A) a medical determination by the treating physician, impartial
7 medical examiner or comprehensive independent health care review team
8 that the worker cannot, at maximum medical improvement, return to the
9 former position of employment or any other existing position with the
10 same employer that is vacant and suitable;
11 (B) the approval by the director of labor of a vocational reha-
12 bilitation program for the worker to train the worker for alternative
13 employment with another employer;
14 (C) the worker's acceptance of suitable employment with another
15 employer after reaching maximum medical improvement;
16 (D) the worker's refusal of a bona fide offer from the employer
17 of light duty or modified employment which is suitable prior to reach-
18 ing maximum medical improvement;
19 (E) the expiration of ten (10) days from the date that the worker
20 is notified by the insurer or self-insured employer by mail at the ad-
21 dress to which the weekly compensation benefits are mailed that the
22 worker's treating physician has released the worker for employment
23 unless the worker requests reinstatement within that time period;
24 (F) the expiration of (i) thirty (30) days after the employee
25 reaches maximum medical improvement or concludes or ceases to partici-
26 pate in an approved program of rehabilitation, or (ii) one (1) year
27 from the date of injury, whichever is sooner. Notwithstanding the
28 foregoing, where the employee is participating in an approved program
29 of rehabilitation specifically designed to provide the employee with
30 the ability to perform a job for which he or she would be eligible
31 under subsection (a) the right of reinstatement shall terminate when
32 the employee concludes or ceases to participate in such program or
33 eighteen (18) months from the date of injury, whichever is sooner;

1 (G) except where otherwise provided under a collective bargaining
2 agreement, the approval by the court of a settlement pursuant to this
3 act.
4 (2) The right to reinstatement under this section does not apply
5 to:
6 (A) a worker hired on a temporary basis;
7 (B) a worker employed in a seasonal occupation;
8 (C) a worker who works out of a hiring hall operating pursuant to
9 a collective bargaining agreement;
10 (D) a worker whose employer employs nine (9) or fewer workers at
11 the time of the worker's injury;
12 (E) a worker who is on a probationary period of less than
13 ninety-one (91) days.
14 (d) Any violation of this section is hereby deemed an unlawful
15 employment practice. If the employee applies for reinstatement under
16 this section and the employer in violation of this section refuses to
17 reinstate the employee, the department of labor is authorized to order
18 reinstatement and award back pay and the cost of fringe benefits lost
19 during the period as appropriate, and may require the employer to
20 reimburse the carrier for indemnity benefits, which the carrier shall
21 continue to pay during the period of violation.
22 (e) When an employee is entitled to reinstatement under section
23 28-33-47, but the position to which reinstatement is sought does not
24 exist or is not available, the employee may file for unemployment ben-
25 efits as if then laid off from that employment, and unemployment bene-
26 fits shall be calculated pursuant to section 28-42-3(10) of the
27 Employment Security Act. Provided, however, that an employee cannot
28 collect both workers' compensation indemnity benefits and unemployment
29 benefits under this section.
30 (f) The education division of the department of labor shall pro-
31 vide information to employees who receive benefits under this title of
32 the provisions of this section.
33 SECTION 12. Sections 28-34-4 and 28-34-6 of the General Laws in

1 ~~provisions-of-this-chapter~~ assign the matter for a mandatory pre-trial
2 conference on the date set forth in the notice pursuant to section
3 28-35-20. ~~If--the--commission--is-not-satisfied-that-the-employee-has~~
4 ~~returned-to-work-at-an-average-weekly-wage-equal-to-or--in--excess--of~~
5 ~~that--which--he-was-earning-at-the-time-of-his-injury;-it-shall-notify~~
6 ~~the-employer-or-insurer-to-continue-or--resume--compensation--payments~~
7 ~~even-after-they-have-been-suspended.~~
8 28-35-57. Limitation of claims for compensation. -- (a) An
9 employee's claim for compensation under chapters 29 to 38, inclusive,
10 of this title shall be barred unless payment of weekly compensation
11 shall have commenced , or a petition as provided for in this chapter,
12 shall have been filed within ~~three-(3)~~ two (2) years after the occur-
13 rence or manifestation of the injury or incapacity, or in case of the
14 death of the employee, or in the event of his or her physical or
15 mental incapacity, within ~~three-(3)~~ two (2) years after the death of
16 the employee or the removal of such physical or mental incapacity.
17 (b) The time for filing shall not begin to run in cases of latent
18 or undiscovered physical or mental impairment due to injury including
19 disease until:
20 (1) the person claiming the benefits knew, or by exercise of
21 reasonable diligence should have known, of the existence of such
22 impairment and its causal relationship to his or her employment or
23 (2) after disablement, whichever is later .
24 (c) In any case in which weekly compensation benefits have been
25 paid, pursuant to section 28-35-8, in which the employer or insurer
26 has failed to file the required notices, the claimants right to file a
27 petition for compensation benefits shall be preserved without time
28 limitation.
29 28-35-57.1. Bar of claims. -- An employee's claim for compensa-
30 tion from an employer under chapters 29 to 38, inclusive of this
31 title, shall be barred from the date the employee commences employment
32 for a period of two (2) years in the event the employee wilfully pro-
33 vided false information ~~of-or-intentionally-fail-to--disclose--his--or~~

1 ~~her--worker's--compensation--history--to-the-employer-on-an-employment~~
2 ~~application-requesting-that-information,-which-information-is-directly~~
3 ~~related-to-the-personal-injury-which-injury-is-the-basis--of--the--new~~
4 ~~claim--for--compensation.---This--section--shall--not-apply-unless-the~~
5 ~~employment-application-advises-the-employee-of-the-substance--of--this~~
6 ~~section~~, as to his or her ability to perform the essential functions
7 of the job, without reasonable accommodations, to the employer on an
8 employment application requesting that information, which information
9 is directly related to the personal injury which injury is the basis
10 of the new claim for compensation. This section shall not apply
11 unless the employment application advises the employee of the sub-
12 stance of this section, and nothing herein shall exempt any employer
13 from or excuse full compliance with any applicable provisions of the
14 Americans with Disabilities Act and chapter 42-87 (Discrimination
15 Against the Handicapped) of the general laws..
16 ~~28-35-61.--Decrees---procured---by---fraud---or---otherwise.-----~~
17 28-35-61. Decrees procured by fraud. -- (a) The workers' compensation
18 ~~commission~~ court may, upon petition of an employee, the dependents of
19 a deceased employee, an employer, an insurance carrier, or any party
20 in interest, vacate, modify, or amend any final decree entered within
21 a period of six (6) months prior to the filing of the petition, either
22 by a single ~~commissioner~~ judge or by the full ~~commission~~ court, if it
23 shall appear that the decree;
24 (1) Has been procured by fraud or
25 (2) Does not accurately and completely set forth and describe the
26 nature and location of all injuries sustained by the employee.
27 (b) The petition shall be served in the same manner as is pro-
28 vided for in chapters 29 -- 38 inclusive, of this title, for all other
29 petitions.
30 (c) The workers' compensation ~~commission~~ court shall hear any and
31 all such petitions and make its decision in accordance with the provi-
32 sions of those chapters.
33 SECTION 14. Section 28-37-31 of the General Laws in Chapter

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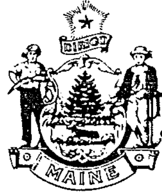

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MEMORANDUM

To: Members
Blue Ribbon Commission on Workers' Compensation
and John H. Lewis

From: Jane Orbeton

Date: July 23, 1992

Subj: Workers' compensation insurance rate regulation portions of Title 24-A and NAIC Model Workers' Compensation Competitive Rating Act

I am enclosing the portions of Title 24-A MRSA that relate to regulation of workers' compensation insurance rates.

Also enclosed is the NAIC model Workers' Compensation Competitive Rating Act.

I enclose both documents for you, not in response to a particular request, but in case they prove helpful to you in your deliberations.

Title 24-A MRSA sections pertaining to workers' compensation insurance rate making

24A § 2361. Title

This subchapter shall be known and may be cited as the "Workers' Compensation Rating Act." .

24A § 2362. Workers' compensation rates

Workers' compensation rates and classifications shall be approved, modified, or disapproved by the superintendent subject to this chapter. Rates determined by the superintendent are maximum rates. Premium rates less than those approved may be used if filed with the superintendent within 5 days after commencing use. If the superintendent has reason to believe that the filing produces rates which are inadequate or unfairly discriminatory, he may disapprove them under chapter 23 and chapter 25, subchapter I.

24A § 2362-A. Disclosure of premium information

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

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

24A § 2362-B. Workplace health and safety consultations

Workplace health and safety consultation services provided by workers' compensation insurance carriers to employers with an experience rating factor of one or

more are subject to the following.

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

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

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

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

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

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

6. Reports to employers. In any workplace health and safety consultation that includes an on-site visit,

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

7. Safe workplace responsibility. Workplace health and safety consultations provided by an insurer do not diminish or replace an employer's responsibility to provide a safe workplace. An insurance carrier or its agents or employees do not incur any liability for illness or injuries that result from any consultation or recommendation.

24A § 2363. Approval of insurance policies and rates

The following provisions apply to workers' compensation insurance policies and rates.

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

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

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

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

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

3. Notice of filing. At least 20 days prior to any filing for rates under this section, a person filing shall notify the superintendent in writing of the intention to file and shall disclose the approximate amount of a requested increase or decrease and a description of major rating rule changes to be proposed. Within 10 days of receipt, the superintendent shall notify the public by publication in a newspaper of general circulation and notify the Public Advocate that a rate filing is to be made. Restrictions on ex parte communications, as provided for in Title 5, section 9055, shall be applicable on the date the superintendent receives the notice of intention to file.

4. Contents of filing. A rate filing shall include:

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

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

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

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

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

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

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

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

(a) A list of all deviating carriers;

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

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

(d) The total amount of deviations in dollars;

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

(f) The average percentage deviation for all carriers;

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

(a) A list of all carriers issuing dividends;

(b) The total amount of dividends in dollars;

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

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

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

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

B. Credibility factor development and application. All information relating to the selection of the credibility factors contained in the filing shall be provided, which shall include:

(1) A complete description of the methodology used to derive the factors;

(2) A description of the criteria used to select the methodology for inclusion in the filing;

(3) Details on the application of the methodology to this filing; and

(4) A listing of alternative methodologies used in other states in filings made during the last 2 years;

C. Loss development factor development and application.

(1) The following loss data at successive evaluation dates shall be provided:

(a) At least the latest available 12 years of data for matching companies for all pairs of successive evaluation dates, except that for a rate filing made in 1989 and 1990 the data periods shall be 10 and 11 years, respectively;

(b) Data on both a policy year and an accident year basis;

(c) Data separated into indemnity and medical losses as well as combined data;

(d) Data separated into paid, case-incurred, including incurred but not reported losses and case-incurred excluding incurred but not reported portions as well as total losses;

(e) Reported indemnity, medical, and total claims for all years and evaluation dates for which loss information is provided;

(f) The latest available 5-unit statistical policy years of loss data for matching companies for all pairs of successive evaluation dates;

(g) Case-incurred losses, number of claims, standard earned premium and earned exposures;

(h) Losses separated into indemnity and medical losses;

(i) Compensable claim experience separated into deaths, permanent totals, major permanent partials, minor permanent partials and temporary totals;

(j) Current on-level benefit factors for each injury type split between indemnity and medical; and

(k) For each policy year, the actual average wage and the average wage after the application of any payroll limitation.

(2) All information relating to the selection of the loss development factors contained in the filing shall be provided. This information shall consist of:

(a) A complete description of the methodology used to arrive at the selected factors;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states during the last 2 years; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology for this filing;

D. Trending factor development and application, which shall include:

(1) The following trend information:

(a) Indemnity and medical trend factor calculations based upon both policy year data and accident year data from this State;

(b) Indemnity and medical trend factor calculations based upon countrywide policy year data;

(c) For the medical trend, separate compilations for fee schedule and nonfee schedule states on both a policy year and an accident year basis; and

(d) Any econometric projections done of claim severity, claim frequency and average weekly wages based on models used by or in the possession of the rating bureau; and

(2) All information relating to the selection of the trend factors contained in the filings. This information shall include:

(a) A complete description of the methodology used to derive the selected factors;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology of this filing;

E. Changes in premium base and exposures. The following information shall be provided with any filing proposing a change in premium discounts, expense constants or minimum premiums:

(1) Information on the distribution by size of policy shall be provided so that the effects of premium discount, the expense constant and the minimum premium rule can be calculated. This information shall include the number of policies and the dollar amount of premium in this State for the latest available 3 years separately for stock and nonstock companies, and combined using the following premium size distribution: $0-$199; $200-$299; $300-$499; $500-$999; $1,000-$2,999; $3,000-$4,999; $5,000-$9,999; $10,000-$24,999; $25,000-$49,999; $50,000-$99,999; $100,000-$249,999; and over $249,999. Information shall be provided for the premium bands affected by the proposed changes; and

(2) Any countrywide distributions of number of policies or premium by layer that is used in the filing shall be described. Details shall be provided concerning how these distributions have been used in the rate filing, the sources and dates of the information used to produce the distributions and a description of any adjustments that have been made to the distributions;

F. Limiting factor development and application, which shall include the following information:

(1) Limitations on losses included in the statistical data used in the filing;

(2) Limitations on the extent of the rate level change;

(3) Limitations on the extent of classification rate changes; and

(4) Any other limitations applied;

G. Overhead expenses. The part of the filing pertaining to overhead expenses shall include the following:

(1) The expense provisions used in the filing and an explanation of the derivation of the expense provisions which shall include the following information:

(a) A complete description of the methodology used to derive the selected provisions;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology for this filing;

(2) Support for all the expense, tax and profit provisions for the proposed rates, under both the current and proposed expense provisions. An explanation shall be provided concerning why these provisions are appropriate for stock and nonstock insurance companies;

(3) Expense experience allocable to the coverage of risks in this State, including acquisition and field supervision expenses; taxes, licenses and fees; general expenses; and loss adjustment expenses. Safety engineering expense and loss control services expense shall be stated separately under general expense;

(4) A description of any adjustments of countrywide data to reflect conditions within this State and the details of the underlying calculations. If the proposed expense provisions differ from those indicated by the data, an explanation shall be provided;

(5) A description of how proposed allowances for expenses are reviewed each year by committees of the rating bureau;

(6) The dollar amount, if any, of taxes and assessments included in the collected loss data;

(7) The details of the derivations of the tax multiplier;

(8) Expense data required by this subsection, reported in the aggregate for all insurers. The expense data shall be reported separately for each of the 10 largest

insurers, based on written premium in the prior calendar year;

(9) For each of the 10 largest writers of workers' compensation insurance in this State, a statement regarding any expense reduction activities undertaken in the last 3 years; and

(10) The changes and improvements instituted in loss control and employee safety engineering for the 10 largest carriers, based on written premium in the prior calendar year.

If the superintendent finds that state expense data is not fully credible, the superintendent may consider expense data from outside this State;

H. Law amendment valuation. For any law changes becoming effective during that period in which rates will be in effect, or in effect but not evaluated in prior rate filings, the following information shall be provided:

(1) A complete description of the methodology used to evaluate the law change;

(2) Identification of assumptions made and supporting information for those assumptions, both as to information before and after the law change; and

(3) Identification of the source and timeliness of data, including identification of data from experience within this State and data from countrywide or other states;

I. A showing of the overall statewide rate change as well as the amount of the change attributable to each of the following: Loss experience; a modification of the trend factor; a change in expense provisions; law amendments; a change in the tax provision; a change in the assessment provision; and any other factors. The rate changes for each industry group and each classification shall also be shown;

J. The proposed rates for each classification;

K. Investment earnings. The following information related to anticipated investment income shall be provided:

(1) Information on the amount of investment income earned on loss, loss expense and unearned premium reserves in relation to both net and standard earned premium for workers' compensation in this State calculated for the latest 5 years, and the total amount of investment income expected to be earned on loss, loss expense and unearned premium reserves in relation to both net and standard premium reserves for workers' compensation policies sold in this State during the years in which the proposed rates will be in effect. The derivation of these calculations shall be provided in detail, including the amount of the composite reserves of each type at the beginning and end of the specified years.

(2) The estimated pay-out pattern of compensable injuries and illnesses in this State, adjusted to current law; and

(3) Composite information from the annual statement for all workers' compensation insurers in this State. The following information from the latest 2 annual statements shall be provided in the same format and detail as the exhibits in individual company statements:

(a) Page 2, Assets, line one through the line identified "Totals.";

(b) Page 3, Liabilities, Surplus and Other Funds, line one through the line identified "Totals.";

(c) Page 4, Underwriting and Investment Exhibit, line one through the line identified as "Surplus as regards policyholders, December 31 current year.";

(d) Exhibit one, Analysis of Assets, line one through the line identified "Totals."; and

(e) Schedule P sections dealing with workers' compensation;

L. An identification of all statistical plans used or consulted in preparing this filing. A description of the data compiled by each plan shall also be provided;

M. The resulting rates of return on equity capital resulting from the selected underwriting profit and contingency factor. The derivation of all factors used in producing the calculations and justification that the rate of return on equity is just and reasonable shall be provided;

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

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

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

O. The following miscellaneous information:

(1) For the following items, an explanation of the purpose for and a detailed description of the derivation shall be included:

(a) Expected loss rate;

(b) D-ratio;

(c) Excess loss factors;

(d) Excess loss adjustment amounts; and

(e) Table of weighting and ballast values;

(2) The following information relating to the derivation of the profit and contingency loading contained in the filing shall be provided:

(a) A complete description of the methodology used to arrive at the selected loading;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology for this filing; and

(3) Information shall also be provided on all filings by the rating bureau that have been submitted with an underwriting profit and contingency loading other than the provision used in this filing. The following information shall be listed for all such filings in the last 3 years: The State; the underwriting profit and contingency loading submitted; the loading approved; and the effective date of the rate.

For a filing made on or after July 1st in any year, the data and information required in paragraphs A, C, D, G, K and N shall be for the period ending with the immediately preceding calendar year. For a filing made prior to July 1st, the data and information required in paragraphs A, C, D, G, K and N shall be for the period ending with the second preceding calendar year.

5. Aggregate data.

5-A. Voluntary and residual market rates. If rates and rating factors for the voluntary market and the residual market are submitted concurrently, the following information shall be included in the filing:

A. An explanation of the derivation of the rate differential, or differentials, among the voluntary market rates, the safety pool rates and the accident prevention account rates; and

B. For a filing made on or after July 1st in any year, for the 3 calendar years immediately preceding the date of filing, the actual written premium, earned premium, incurred losses, incurred loss adjustment expenses, paid losses and paid loss adjustment expenses. For a filing made prior to July 1st, the premium loss and expense information required by this paragraph shall be for the 2nd, 3rd and 4th preceding calendar years.

6. Additional information. The superintendent may require, at any time, any additional information the superintendent deems necessary and may reasonably extend the time periods established in subsection 11 to allow time to provide that information.

A. Within 30 days of receipt of a filing, the superintendent shall determine if the filing is complete.

(1) If the filing is incomplete, the superintendent shall notify the applicant and all parties in writing of those deficiencies.

(2) An applicant shall complete or amend the filing within 30 days of that written notice. Upon motion by the applicant made within the 30-day period and upon a showing of good cause, the superintendent may extend the 30-day period as the superintendent deems appropriate.

(3) An action or inaction by the superintendent under this paragraph does not constitute a substantive finding that the information in the filing is sufficient to establish that any action or relief should be granted or that any facts have been proven or limit the superintendent's authority to request further information or data.

B. If the applicant fails to furnish the information within the time prescribed, the superintendent may issue an order dismissing the filing.

C. For all purposes, the date of completing the filing shall be deemed the date on which the last document that made the filing complete was received by the superintendent, except that the superintendent may treat the day that the incomplete filing was filed as the filing date if the incompleteness is found to be immaterial or not to have delayed, impeded or interfered with the ability of the superintendent, bureau or any party to respond to, investigate or process the filing.

7. Standard for approval. This subsection applies to determination of just and reasonable rates for a filing.

A. The superintendent shall establish rates, based on the filing and sworn testimony, which are, in addition to any other requirements:

(1) Just and reasonable and not excessive, inadequate or unfairly discriminatory; and

(2) Based only on a just and reasonable profit.

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

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

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

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

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

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

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

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

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

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

C. The justness and reasonableness of rates shall be determined for the period in which the rates are in effect. Deficits in the residual market in any preceding year may not be included in the determination of rates.

D. The filer shall have the burden of proving that the rates meet the requirements of this chapter and chapter 23.

E. The superintendent may not approve an increase or decrease in rates unless he finds that the information supplied in the filing and sworn testimony is accurate and sufficient to meet the requirements of this section.

F. For the introduction of a new rate for a new classification or the adjustment of a single rate for an existing classification, the requirements of paragraph A, subparagraph (1); subsection 2; subsection 4, paragraphs B to E; and subsections 8, 10, 13 and 14 shall apply. The superintendent shall establish the new rate at a level which is not unfairly discriminatory in relation to the currently approved rates for other classifications.

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

8. Public record. A rate filing shall be a public record and shall be available for public review and inspection.

9. Public Advocate participation. The Public Advocate shall participate as follows.

A. The Public Advocate, as appointed under Title 35-A, section 1701, shall be a party to the proceeding resulting from each rate filing made under this section. A copy of the filing shall be served on the Public Advocate at the same time as it is filed with the superintendent.

B. A party filing for a rate change under this section shall pay to the superintendent at the time of filing a filing fee of $50,000, that the superintendent shall immediately credit to the Public Advocate. The fee must be segregated and expended for the purpose of employing outside consultants and of paying other expenses to fulfill the requirements of this subsection. Any portion of the fee not so expended must be returned to the filer. In addition, the party filing for a rate change shall pay the superintendent at the time of filing an additional fee of $15,000 to cover the salaries of Public Advocate staff for the purpose and period of the staff involvement in the rate proceeding. The superintendent shall transfer this fee, and any other fees received for staff salaries, to the Public Advocate Regulatory Fund established pursuant to Title 35-A, section 116, subsection 8.

10. Information for parties and intervenors. A party or intervenor may make written application to the superintendent for an order that a filer produce information relevant to whether the filing meets the requirements of this Title, except for information relating to a particular claim or information which is unduly burdensome or repetitious. If the party filing fails to furnish the information within the time prescribed by the superintendent, the party or intervenor making the request may make written application to the superintendent for an order dismissing the filing. If, after a hearing, the superintendent determines that the failure to furnish the information was without good cause, he shall issue an order for dismissal of the filing.

11. Public hearing. The superintendent shall hold a public hearing as provided in sections 229 to 235 on each filing. The public hearing shall be conducted no sooner than 30 days and no later than 60 days of the date the rate filing is deemed complete by

the superintendent, unless the superintendent extends these limits under subsection 6. The superintendent shall establish just and reasonable rates and state his findings in a written order issued within 90 days from the date the filing is completed, unless he extends this limit under subsection 6. If the superintendent denies or dismisses a filing, any further filing shall be deemed to be a new filing, subject to this public hearing requirement.

12. Subsequent filing. A person may not file a rate filing within 180 days of receiving a rate increase or decrease. If a filing has been disapproved by the superintendent, the requirements of this subsection shall not operate to delay a new filing and the data required by subsection 4, paragraph A, shall only be required for each of the 3 most recent calendar years for which data are available.

13. Procedure; rules. Subject to the applicable requirements of the Maine Administrative Procedure Act, Title 5, chapter 375, the superintendent may adopt rules establishing procedures for the administration of this section, including, procedures governing submission of petitions for intervenor status, prefiling of testimony and exhibits, information requests, subpoenas, prehearing conferences and conduct of hearings.

14. Costs. For the purpose of determining whether a filing meets the requirements of this section, the superintendent may employ outside consultants. The organization or insurer making the filing shall be responsible for the reasonable costs related to the review of workers' compensation rate filings, including conduct of the hearing.

24A § 2364. Uniform classification system; experience and merit rating plans

1. Uniform plans. Every workers' compensation insurer, including self-insurers, shall adhere to a uniform classification system and uniform experience rating plan filed with the superintendent by an advisory organization. An insurer may develop subclassifications of the uniform classification system on which a rate may be made provided that:

A. A subclassification must be filed with the superintendent 30 days prior to its use; and

B. The superintendent may disapprove a subclassification if:

(1) The insurer fails to demonstrate that the data produced may be reported consistent with the uniform statistical plan and classification system; or

(2) The proposed subclassification:

(a) Is not reasonably related to the exposure;

(b) Is not adequately defined;

(c) Has not been shown to distinguish among insureds based on the potential for or hazard of loss; or

(d) Is likely to be unfairly discriminatory.

2. **Statistical advisory organization.** The superintendent shall designate an advisory organization to assist in gathering, compiling and reporting relevant statistical information. Every workers' compensation insurer shall record and report its workers' compensation experience to the designated advisory organization as set forth in the uniform statistical plan. The organization designated pursuant to section 2371, subsection 1, shall collect and compile data for employers who are self-insured.

3. **Manual rules.** The designated advisory organization shall develop and file manual rules, subject to the approval of the superintendent, which are reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and uniform classification system.

4. **Experience and merit rating plans.** An experience or merit rating plan shall contain reasonable eligibility standards and provide adequate incentives for loss prevention and for sufficient premium differentials to encourage safety. The experience rating plan shall provide reasonable and equitable limitations on the ability of policyholders to avoid the impact of past adverse claims experience through change of ownership, control, management or operation.

A. (TEXT EFFECTIVE UNTIL 1/1/92) The uniform experience rating plan shall be the exclusive means for providing prospective premium adjustments based upon the past claim experience of an individual insured.

A. (TEXT EFFECTIVE 1/1/92) The uniform experience rating plan must be the exclusive means for providing prospective premium adjustments based upon the past claim experience of an individual insured. The experience rating plan must provide that the claims experience for the 3 most recent years for which data is available be considered on the following basis.

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

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

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

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

B. Insurers may file rating plans that provide for retrospective premium adjustments based on an insured's past experience. Except as provided in section 2366, subsection 7, in both the voluntary market and the residual market, retrospective rating plans shall be voluntary and shall not be used without the prior consent of the insured.

C. If an insured is not eligible for an experience rating plan, a merit rating plan shall be applied using the following guidelines.

(1) A plan shall provide for the following minimum credits or maximum debits to be applied to the otherwise applicable manual premium, based on the number of lost-time claims of the insured during the most recent 3-year period for which statistics are available:

(a) No claims or a loss ratio of less than 1.0, an 8% credit;

(b) One claim resulting in a loss ratio greater than 1.0, no credit or debit; and

(c) Two or more claims resulting in a loss ratio greater than 1.0, an 8% debit.

(2) The insurer shall notify the insured of the premium adjustment and the reason for the adjustment.

C-1. (TEXT EFFECTIVE 1/1/92) An experience or merit rating plan may not permit in the calculation of experience modification factors consideration of those lost-time cases attributable to work-related injuries that are aggravations of or that combine with any prior lost-time work-related injury to produce an incapacity. The superintendent shall adopt rules to protect employers from the impact of these subsequent injury claims and to equitably compensate insurers that provide coverage to these employers.

D. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance by January 30, 1989, regarding the operation of the merit rating plan in paragraph C. The report shall include the number of insureds using the merit rating plan, the number receiving either a debit or credit, and any recommendations on ways to improve the effectiveness of the merit rating law.

24A § 2365. Optional deductibles

1. Optional deductible. Each insurer transacting or offering to transact workers' compensation insurance in this State shall offer optional deductibles to employers not subject to section 2366, subsection 6, which may be used upon election by the insured.

A. Deductibles shall be available for indemnity benefits in amounts of $1,000 and $5,000 a claim and such other reasonable amounts as may be approved by the superintendent.

B. The deductible form shall provide that the claim shall be paid by the applicable insurer, which shall then be reimbursed by the employer for any deductible amounts paid by the carrier. The employer shall be liable for reimbursement up to the limit of the deductible.

C. An insurer shall not be required to offer a deductible to an employer if, as a result of a credit investigation, the insurer determines that the employer is not sufficiently financially stable to be responsible for the payment of deductible amounts.

24A § 2365-A. Medical expense deductibles (WHOLE SECTION TEXT EFFECTIVE 1/1/92)

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

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

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

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

24A § 2366. Workers' compensation insurance residual market mechanism

1. Participation. All insurers authorized to write workers' compensation and employers' liability insurance in this State shall participate in the workers' compensation insurance residual market mechanism, which is composed of an Accident Prevention Account and a Safety Pool. The residual market mechanism is not a state fund and the State shall have

no proprietary interest in it or in any contributions made to it. This mechanism shall be exempt from any budgetary control or supervision by state agencies, except to the extent an insurance company is supervised or controlled by state agencies.

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

2. Accident Prevention Account; eligibility. Eligibility for insurance from the Accident Prevention Account shall be as follows.

A. The Accident Prevention Account shall be an insurance plan that provides for the equitable apportionment among insurers of insurance which may be afforded applicants who are entitled to, but unable to, procure that insurance through ordinary methods because of their demonstrated accident frequency problem, measurably adverse loss ratio over a period of years or demonstrated attitude of noncompliance with safety requirements.

B. (TEXT EFFECTIVE UNTIL 1/1/92) An employer is eligible for insurance from the Accident Prevention Account if:

(1) The employer has a loss ratio greater than 1.00 over the last 3 years for which data is available; and

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

B. (TEXT EFFECTIVE 1/1/92) An employer is eligible for insurance from the Accident Prevention Account if:

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

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

3. Safety Pool; eligibility. Eligibility under the Safety Pool shall be as follows.

A. (TEXT EFFECTIVE UNTIL 1/1/92) The Safety Pool is an insurance plan that provides for an alternative source of insurance for employers with good safety records and is intended to operate within the framework of the voluntary insurance market.

A. (TEXT EFFECTIVE 1/1/92) The Safety Pool is an insurance plan that provides for an alternative source of insurance for employers with good safety records.

B. (TEXT EFFECTIVE UNTIL 1/1/92) An employer shall be eligible for the Safety Pool if that employer:

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

(2) Has a loss ratio which does not exceed 1.0 over the last 3 years for which data is available; or

(3) Has been in business for less than 3 years, provided that the eligibility shall terminate if his loss ratio exceeds 1.0 at the end of any year.

B. (TEXT EFFECTIVE 1/1/92) An employer is eligible for the Safety Pool if that employer:

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

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

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

C. A member of the Safety Pool who fails to meet eligibility requirements under paragraph B shall be ordered to leave the Safety Pool after notice under Title 39, section 23, subsection 1.

4. Plan of operation. The superintendent shall adopt rules pursuant to Title 5, chapter 375, subchapter II, establishing a plan of operation for the residual market mechanism. The plan of operation shall contain those terms which the superintendent in his discretion deems necessary.

A. The plan shall include an experience rating system and merit rating plan providing that the premium of each employer in the account is modified either prospectively or retrospectively. An experience modification shall only be applied to the manual rate of the plan. The sensitivity of a rating system may vary by size of the risk involved.

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

B. The plan provides for premium surcharges for employers in the Accident Prevention Account based on their specific loss experience within a specified period or other factors which are reasonably related to their risk of loss.

(1) No premium surcharge may be applied to a risk whose threshold loss ratio is less than 1.00. The threshold loss ratio is based on the ratio of "L" to "P" where:

(a) "L" is the actual incurred losses of a risk during the previous 3-year experience period as reported, except that the largest single loss during the 3-year period is limited to the amount of premium charged for the year in which the loss occurred; and

(b) "P" is the premium charged to a risk during that 3-year period.

(2) Premium surcharges apply to a premium that is experience or merit rating modified.

(3) Premium surcharges are based on an insured's adverse deviation from expected incurred losses in this State. The surcharge is based on the ratio of "A" to "B" where:

(a) "A" is the actual incurred losses of a risk during the previous 3-year experience period as reported; and

(b) "B" is the expected incurred losses of a risk during that period as calculated under the uniform experience or merit rating plan multiplied by the risk's current experience or merit rating modification factor.

(4) The premium surcharge is as follows:

Ratio of "A" to "B"	Surcharge
Less than 1.20	None
1.20 or greater, but less than 1.30	5%
1.30 or greater, but less than 1.40	10%
1.40 or greater, but less than 1.50	15%
1.50 or greater	20%

C. Commissions under a plan shall be established at a level that is neither an incentive nor a disincentive to place an employer in the residual market.

D. In addition to factors in paragraphs A to C, any servicing contract shall be approved on the basis of acceptable price and performance.

E. If after notice and hearing the superintendent determines that insurers are unwilling to provide services which are reasonably necessary for the operation of the plan, the superintendent may award service contracts within various areas of the State on the basis of acceptable price and performance. If the superintendent chooses to award such contracts, the specifications shall give special consideration to loss control, safety engineering and any other factor that affects safety.

F. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance by January 30, 1989, regarding the servicing fee and performance of the servicing insurer. The report shall include recommendations regarding the institution of a bidding process to award servicing contracts.

5. Rates. Rate filings for rates in the Accident Prevention Account and the Safety Pool shall be made together and shall be subject to section 2363.

A. A rate filing for the residual market shall include experience and merit rating plans. The experience rating plan shall be the uniform experience rating plan. The merit plan shall provide the maximum credits possible to Safety Pool members on the basis of individual loss experience, including frequency and severity, consistent with this chapter and sound actuarial principles.

B. The superintendent shall review the rates, rating plans and rules, including rates for individual classifications and subclassifications, in the Accident Prevention Account and the Safety Pool at least once every 2 years and may review rates more frequently if necessary.

C. (TEXT EFFECTIVE 1/1/92) In a residual market rate proceeding, the superintendent may order payment of dividends to insureds in the Safety Pool to the extent that the pool's experience supports them. The superintendent may adopt rules establishing a dividend plan for the Safety Pool to provide an incentive for implementation of safety programs by insureds in the pool. The superintendent may employ outside consultants to assist in the development of these rules, the

costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

6. Mandatory deductible. A deductible applies to all workers' compensation insurance policies issued to employers in the Accident Prevention Account that meet the following qualifications:

A. A net annual premium of $20,000 or more subject to adjustment pursuant to this section in this State;

B. A premium not subject to retrospective rating; and

C. The employer's threshold loss ratio, as determined under subsection 4, paragraph B, subparagraph (1), is 1.00 or greater.

The deductible is $1,000 a claim but applies only to wage loss benefits paid on injuries occurring during the policy year. In no event may the sum of all deductibles in one policy year exceed the lesser of 15% of net annual premium or $25,000. Each loss to which a deductible applies must be paid in full by the insurer. After the policy year has expired, the employer shall reimburse the insurer the amount of the deductibles. This reimbursement must be considered as premium for purposes of cancellation or nonrenewal.

For purposes of calculations required under this section, losses must be evaluated 60 days from the close of the policy year.

Beginning July 1, 1991, the superintendent shall, by rule, annually adjust the $20,000 premium level established in this subsection to reflect any change in rates for the Accident Prevention Account and any change in wage levels in the preceding calendar year. Changes in wage levels are determined by reference to changes in the state average weekly wage, as computed by the Department of Labor, Bureau of Employment Security. Any adjustment is rounded off to the nearest $1,000 increment.

This subsection takes effect on the effective date of the first approved rate filing after the effective date of this Act.

7. Mandatory retrospective rating. The superintendent may impose retrospective rating plans under the following circumstances:

A. The superintendent shall by rule establish standards governing the application of retrospective rating plans whereby the superintendent may order, after hearing, a retrospective rating plan for an employer in the Accident Prevention Account who has sufficient size in terms of premium and number of employees to warrant such rating and:

(1) For the 3 most recent years for which data is available, an experience modification factor and a loss ratio which may indicate a serious problem of workplace safety; or

(2) A demonstrated record of repeated serious violations of workplace health and safety regulations adopted under the Maine Revised Statutes, Title 26, chapter 6, or the United States Code, Title 29, Chapter 15, whichever is applicable.

B. In no event may the maximum premium, including any applicable surcharge under this section, exceed 150% of standard premium.

7-A. (TEXT EFFECTIVE 1/1/92) Credits for qualifying safety programs. The superintendent shall adopt rules to establish dividend plans and premium credits between 5% and 15% of net annual premiums for policyholders that establish or maintain qualifying safety programs. The rules must identify the classifications by which policyholders are eligible for the credits and establish criteria for qualifying safety programs and procedures to be followed by servicing carriers in approving and auditing compliance with the safety programs. The superintendent may employ outside consultants to assist in the development of rules under this subsection, the costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

8. Contracts; consultants. The superintendent may, in the superintendent's discretion, enter into contracts for the provision of any services necessary or appropriate to the operation of the residual market mechanism and may retain consultants to provide such other technical and professional services as the

superintendent may require for the discharge of the superintendent's duties.

9. Report. Beginning in 1989, the superintendent shall annually issue a report on or before April 1st, to the Governor, the President of the Senate and the Speaker of the House of Representatives. The report shall include at least the following information relating to the Safety Pool:

A. The percentage of total insured premium in this State written in the Safety Pool;

B. The percentage of all insured employers in this State written in the Safety Pool;

C. The number of employers in the Safety Pool and the number who have entered or left;

D. The total earned premium, paid losses, reserves and incurred losses; and

E. The investment income of the Safety Pool and its method of allocation or determination.

10. Rules. The superintendent shall adopt rules to provide for an equitable distribution among insurers of any deficit or surplus in the residual market not subject to section 2367. The rules must give due consideration to efforts by individual insurers to underwrite risks in the voluntary market.

11. (TEXT EFFECTIVE 1/1/92) Producer fees. The servicing carrier in the residual market shall pay a fee to the producer designated by the employer on renewed policies upon payment of premium due. The fee must be 4% of the first $5,000 of renewal premium and 2.5% of renewal premium in excess of $5,000. The fee must be based on the state standard premium.

24A § 2367. Workers' compensation rates; annual surcharges and credits

Beginning in 1990, the superintendent shall annually determine whether premiums collected from risks in the residual market and investment income allocable to those premiums are greater or less than the incurred losses and expenses associated with that market. The superintendent shall hold a hearing before making the determination and issue the determination by the earlier of June 1st or the date of decision

concerning any request for a rate change pending before the superintendent on January 1st of that year. In establishing surcharges under this section, the superintendent may approve application of surcharges to policies issued on or after January 1st, but prior to the date of the superintendent's order, provided that the policies contain language approved by the superintendent that is sufficient to notify policyholders that they may be subject to surcharges approved after the effective date of their policies. For purposes of this section, the residual market is the Accident Prevention Account and the Safety Pool. For purposes of this section, "deficit" means the amount by which incurred losses and expenses associated with the residual market exceed premiums collected from risks in that market and investment income allocable to those premiums. The superintendent shall also determine whether insurers have in good faith made their best efforts to maximize the number of risks in the voluntary market for workers' compensation insurance in the State. The superintendent may make timely and appropriate requests for any data determined necessary by the superintendent to make these determinations.

In making the determinations required by this section, the superintendent shall apply statutory insurance accounting standards and utilize sound actuarial principles. In making these determinations, no losses for policies issued prior to January 1, 1988, shall be considered. Each review shall be on a policy-year basis and apply to the policy year prior to the year in which the review is being made and all other prior policy years beginning on or after January 1, 1988. The calculations and determinations required of the superintendent shall be made on a cumulative basis for each policy year under consideration such that each year's determination shall be based on all available data relating to a given policy year. For each year under review, the superintendent shall determine the following.

1. Premium surplus. If the superintendent determines that premiums collected from the insureds in the residual market and investment income allocable to those premiums are greater than the incurred losses and expenses attributable to the risks in that market, the superintendent shall order an appropriate credit applied to the premiums paid by policyholders in the residual market and employers who were policyholders during the policy year for which the surplus was determined but who have since become self-insured.

2. Premium deficit. Payment of any premium deficit is determined in the following manner.

A. If the superintendent determines that premiums and investment income attributable to those premiums are less than incurred losses and expenses in the residual market, the superintendent shall then determine the rate of return for the insurance industry in the entire Maine workers' compensation market. If the rate of return is found, considering all relevant factors, to be less than reasonable, the superintendent shall order a surcharge on premiums paid by insureds in both the voluntary and involuntary markets and employers who were in either market during the policy year for which the deficit was determined but who have since become self-insured.

B. Any deficit determined by the superintendent pursuant to paragraph A is not the responsibility of the insurers on an individual or collective basis but is the financial obligation of all insured employers in the State, including employers who were insured during the policy year for which the deficit has been determined but who have since become self-insured. The surcharge must be an amount at least to offset the adverse cash flows resultant from the deficiency, provided that the application of the surcharge does not produce a rate of return in excess of a just and reasonable profit in the entire Maine workers' compensation market. In any event, the amount of the surcharge in any year must be at least equal to the investment income that would be earned in the 12 months following the surcharge on any portion of the deficit that is not recovered by surcharge in that year, except that the superintendent is not required to order this minimum amount in the first policy year in which a deficit is determined with respect to a policy year.

C. Beginning in 1991, the superintendent, after hearing and only if the rates in the entire workers' compensation market are inadequate to produce a reasonable rate of return, shall determine as of March 15th of each year whether insurers have in good faith made their best efforts to maximize the number of risks in the voluntary market. If the superintendent's determination is affirmative, the surcharge in paragraph A applies.

If the determination is negative, then the superintendent shall determine the percentage of workers' compensation insurance, by premium volume, that has been written voluntarily statewide. If the premium volume in the voluntary market is greater than or equal to the amount specified in the table below, then the surcharge in paragraph A applies.

Policy Year	Premium Volume
1989	50%
1990	60%
1991 and later	70%

If the superintendent determines that the percentage of premium in the voluntary market is less than the percentage in the table above, the deficit collectible from insured employers is reduced as follows: for each reduction of 5%, or part thereof, below the required percentage, the total deficit amount is reduced by 10% subject to a maximum reduction of 50% of the deficit.

3. **Application of credit or surcharge.** Credits or surcharges ordered by the superintendent apply to policies issued or renewed during the calendar year after the order of the superintendent is issued or for such other period as the superintendent may order. In the case of an employer who was insured during the policy year for which the surplus or deficit has been determined but who is self-insured in the year in which the surcharge or credit is ordered, individually or as part of a group, the surcharge must be applied to the lowest of the:

A. Discounted standard premium applicable to the employer for the period during which the employer was insured in the policy year the deficit was created;

B. Manual premium applicable to the employer for the year prior to the year to which the surcharge is applied, multiplied by a fraction, the numerator of which is the number of days the employer was insured in the policy year the deficit was created and the denominator of which is 365; or

C. Discounted standard premium applicable to the employer for the year prior to the year to which

the surcharge is applied, multiplied by a fraction, the numerator of which is the number of days the employer was insured in the policy year the deficit was created and the denominator of which is 365.

The superintendent shall adopt rules to determine the method of collecting any surcharge or paying any credit ordered with respect to self-insured employers subject to surcharge or credit.

4. Rules regarding distribution of deficit. The superintendent shall promulgate rules which provide for the equitable distribution among insurers of the portion of any deficit not surcharged to insured employers, provided that the regulations shall give due consideration to efforts by individual insurers to underwrite risks in the voluntary market.

5. Review of market. The superintendent shall review, on an annual basis, the operation of the entire market to determine the effectiveness of section 2367. The superintendent may make such recommendations, on a prospective basis, to the joint standing committee of the Legislature having jurisdiction over insurance as he deems appropriate.

6. Report regarding self-insurers and other employers.

7. Public Advocate participation. The Public Advocate may participate as follows.

A. The Public Advocate, as appointed under Title 35-A, section 1701, may participate as a party in the hearing in which the superintendent makes the determinations required by this section. The Public Advocate may make timely and appropriate requests for data necessary to participate in those determinations.

B. At the time the superintendent begins the proceeding required by this subsection, the insurance carriers participating in the proceeding shall pay to the superintendent a fee of $20,000, which the superintendent shall immediately credit to the Public Advocate. If the insurance carriers file the data necessary for the superintendent's determination under this section at the same time as the carriers file for a rate change under section 2363, the carriers shall be required to pay a fee of only $10,000. The fee is to be

segregated and expended for the purpose of employing outside consultants and paying other expenses, including staff salaries, to fulfill the requirements of this subsection. Any portion of the fee not so expended is to be returned to the insurance carrier.

7-A. Exemption from 1990 surcharge. Notwithstanding this section, employers who were policyholders during the policy year for which the deficit was determined but who are self-insured in 1990 are not subject to any surcharge ordered in 1990. This subsection does not exempt those employers from surcharges ordered after 1990 with respect to the deficit determined for the policy year beginning January 1, 1988.

8. Limit on deficits or surpluses. Notwithstanding any provision of this section, neither a surcharge or credit may be applied with respect to deficits or surpluses arising from policies issued to employers on or after January 1st of the policy year following a determination by the superintendent that:

A. No deficit exists in the residual market regarding one or more policy years under review; or

B. The rate of return in the entire Maine workers' compensation market, as determined for the purposes of this section, is just and reasonable consistent with subsection 2, paragraphs A and B.

9. Final determination of deficit or surplus; timetable for surcharge or credit. In making the annual determination required by this section, the superintendent shall make a final determination of the deficit or surplus for any policy year with respect to which the superintendent has received 7 complete annual evaluations of residual market policy year experience. Regardless of receipt of 7 complete evaluations, the superintendent shall make a final determination regarding a policy year no later than the 8th calendar year following the close of the policy year under review. If the superintendent determines that there is a surplus for that policy year, the superintendent shall order a credit under subsection 1. If the superintendent determines that there is a deficit for that policy year, the superintendent shall establish a schedule of surcharges to recover the remainder of the deficit for that policy year over a period not to exceed 10 years, except that in each year application of the surcharge is subject to subsection 2.

24A § 2368. Safety groups

A safety group shall be an insured plan that provides for an alternative source of insurance for members of an organization or association. An insurer may issue a workers' compensation and employers' liability policy or policies insuring a safety group if the following requirements are met.

1. Filings. The organization or association shall file with the superintendent:

A. A copy of its articles of incorporation and bylaws or its agreement of association and rules governing the conduct of its business, all certified by the custodian of the originals;

B. An agreement that only members of the organization or association shall be eligible for insurance as a member of the group and that it will notify its insurers within 10 days if any member fails to remain a member in good standing in accordance with the standards and rules of the organization or association;

C. A description of the operation and makeup of a safety committee which, by means of education and otherwise, will seek to reduce the incidence and severity of accidents or claims; and

D. If a group policy, an agreement in writing duly executed guaranteeing that, if the insurer notifies the safety group of the nonpayment of a premium by an insured member within 60 days after the premium was due, the safety group will pay to the insurer the amount of any past due premium which does not exceed the amount of the dividends that are due the safety group or its members from the insurer. The safety group shall promptly notify the insurer of the known insolvency of any member of the group and shall request, upon learning of the insolvency, the removal of the member from the group. A copy of the resolution of the governing superintendent of the group authorizing the execution of the guarantee agreement shall be filed with the superintendent and with the insurer issuing the group policy.

2. Advance premium discounts. Any advance premium discount for any new or existing safety group shall be filed with the superintendent not later than 5 days after the effective date.

3. Management. The safety group shall designate a person to act as the manager or authorized representative of the group. The manager or representative may be remunerated by the members for expenses, including all ordinary operating expenses of the group, but in no instance shall the amount charged to members exceed 10% of earned premiums.

4. Dividends. Dividends or returned premiums paid or credited to a safety group shall be paid or credited to the individual members of the group, except that the indebtedness for any unpaid premium shall be first deducted from any dividend or premium returned.

5. Other requirements. Any safety group formed or operating under this section shall be subject to the requirements of sections 2931 to 2940, except that the safety group or the insurer may establish reasonable underwriting standards regarding eligibility for acceptance and continued membership of the safety group. These underwriting standards shall be filed with the superintendent and may be disapproved by the superintendent if they unreasonably limit membership in the safety group.

24A § 2369. Examinations

1. Examination. The superintendent may examine an insurer, rating organization or advisory organization as he deems necessary to ascertain compliance with this subchapter.

2. Records. Every insurer, rating organization and advisory organization shall maintain reasonable records of the type and kind reasonably adapted to its method of operation, containing its experience or the experience of its members, including the data, statistics or information collected or used by it in its activities.

A. These records shall be available at all reasonable times.

B. These records shall be maintained in an office within this State or shall be made available to the superintendent at his office on reasonable notice.

3. Cost. The reasonable cost of an examination shall be paid by the examined party on presentation of a detailed account of these costs.

4. Report. In lieu of an examination, the superintendent may accept the report of an examination by the insurance supervisory official of another state, made pursuant to the laws of that state.

24A § 2370. Report regarding report on unsafe work site

The Bureau of Insurance and the Department of Labor shall study the feasibility of instituting a program allowing an employee to report unsafe work conditions to the Department of Labor in order to improve safety. This report shall be made to the joint standing committee of the Legislature having jurisdiction over insurance by January 30, 1988.

24A § 2371. Statistical recording and reporting

1. Collection and reporting system. The statistical advisory organization designated pursuant to section 2364, subsection 2 shall develop and file with the superintendent a plan which will include a comprehensive data collection and reporting system for insurers. The superintendent shall designate an organization to collect and report, to the extent applicable, the data for self-insurers required by this section. The purpose of the system is to permit the superintendent, in a timely manner, to analyze insurance rates and claims practices of insurers and self-insurers.

2. Data collected. The data collection and reporting system shall contain, at a minimum, the following.

A. Basic information on each claim, including:

(1) Name, address and identification information of the employee, employer and insurer or self-insurer;

(2) File identification number or numbers, insurance policy number, occupation and classification codes;

(3) Date of hire, age of employee at injury and employee's prior workers' compensation claim history; and

(4) Attorney, if any, and date of involvement.

B. Claims history information on each claim, including:

(1) Date of injury or exposure to disease, date of first report, type of injury or exposure disclosure and affected body part;

(2) Preinjury wage history, date of initial payment and date of notice of controversy, if any, together with the reason for denial;

(3) Date of maximum medical improvement;

(4) Identification of cumulative or opened claims; and

(5) Duration of wage loss period or periods.

C. Information concerning Workers' Compensation Commission proceedings, including:

(1) As to each informal conference, the date, commissioner, involvement of attorney or other designated representative and the resolution; and

(2) As to each hearing, the date, commissioner, involvement of attorney or other designated representative and the commissioner's decision. If a disputed claim results in multiple hearing dates, the commissioner's decision shall be reported for the last hearing date.

D. Cost of payment information on each claim, identified as open or closed, including:

(1) Aggregate payments to date to any physician, hospital or other medical provider. The superintendent may require information on payments to date to any physician, hospital, medical rehabilitation provider or other medical provider, together with a description of the services, the name of the provider, the amount of payment and the date of service;

(2) Payments made to date for weekly compensation, impairment benefits, death benefits, funeral expenses, employee legal expenses, employer legal expenses, lump sums,

witness fees, penalties, vocational rehabilitation services with a description of the services and name of the rehabilitation provider, and any other type of payments under Title 39;

(3) With respect to open claims, an estimate of total outstanding liability and separately stated outstanding liability for medical care, indemnity, vocational rehabilitation and any other type of payments; and

(4) Identification, both on payments and outstanding liabilities, of benefit offsets for Social Security, unemployment insurance, employer provided pensions and any other source.

For medical only claims, the superintendent may establish a claim threshold for which the detailed claim reporting requirements of this subsection shall not apply.

3. Medical and health care expenses; system.

3-A. Special data calls. The superintendent may, with prior notice, require the insurer and self-insurer statistical advisory organizations to conduct special data calls to collect information usable to evaluate the costs or operations of the workers' compensation system. Any special data call imposed by the superintendent under this provision shall give due consideration to the information collected and maintained by insurers and self-insurers. Requests for information not being collected on the effective date of this subsection shall be prospective.

4. Other data collection systems. The statistical advisory organization may rely on data collected and reported by other data gathering organizations or agencies, such as the Workers' Compensation Commission or the Department of Labor. If the statistical advisory organization is to incorporate data from other sources it shall satisfy itself that the data is sufficiently complete and accurate for the purposes for which it is to be used. The Workers' Compensation Commission and the Department of Labor shall assist the statistical advisory organization in the development and maintenance of a comprehensive data base by recording and making available information within the custody and control of each, respectively, pursuant to the request of the statistical advisory organization.

5. Compliance penalties. The statistical advisory organization shall include as part of its plan a means of monitoring member or subscriber compliance with the reporting requirements and shall include a schedule of monetary penalties for failure to comply with reporting requirements.

6. Reports. The superintendent shall prescribe the frequency of and schedule for reports by the statistical advisory organization. Reports shall be required on at least an annual basis.

7. Rules. The superintendent shall have the authority to promulgate reasonable rules with respect to the recording and reporting of claim information, including the recording and reporting of expense or experience items which are not specifically applicable to this State but require an allocation of experience or expenses to this State.

8. Confidentiality. Any report of information relating to a particular claim shall be confidential and shall not be revealed by the superintendent, except that the superintendent may make compilations including this experience. Any information provided to the superintendent regarding self-insurance shall be confidential to the extent protected by Title 39, section 23, subsection 10.

9. Accuracy. The statistical advisory organization shall take all reasonable steps to insure the accuracy of the information provided to it and reported by it.

10. Claims covered. This section shall apply to all claims occurring on or after January 1, 1989; to all death, permanent total and major permanent partial claims occurring between January 1, 1987 and December 31, 1988; and to a reasonable sample, as approved by the superintendent, of all other indemnity claims occurring between January 1, 1987 and December 31, 1988. The superintendent may suspend the reporting requirements of specific items for periods when information which is to be obtained from the Workers' Compensation Commission is temporarily unavailable from that commission.

24A § 2372. Periodic profitability reports

1. Applicability. Each insurer with direct written premium of 1% or more of the total workers'

compensation market shall submit a quarterly report, as described in this section, to the superintendent. The superintendent may amend the reporting to an annual basis as the policy year experience matures.

2. Market share. For purposes of this section, market share shall be determined using the combined direct written premium of all authorized insurers under common management or control or all affiliated companies. For the quarters ending March 31st and June 30th, the market share shall be determined using direct written premium for the year prior to the immediately preceding year. For the quarters ending September 30th and December 31st, the market share shall be determined using direct written premium for the immediately preceding year.

3. Reports. Reports shall be submitted not later than 60 days following the close of a quarter. The quarterly report shall contain the following:

A. Written premium;

B. Earned premium;

C. Paid losses;

D. Paid loss adjustment expenses;

E. Incurred losses;

F. Incurred loss adjustment expenses;

G. Paid underwriting expenses;

H. Incurred underwriting expenses;

I. Investment income allocable to the State workers' compensation insurance for the quarter;

J. Losses outstanding;

K. Loss adjustment expenses outstanding; and

L. Dividend allowed or returned to policyholders.

4. Residual market report. On a quarterly basis not later than 90 days following the end of a quarter, the designated statistical advisory organization shall submit to the superintendent a report containing the following information for the Safety Pool and the Accident Prevention Account:

A. The number of policies issued;

B. The number of policies renewed;

C. The number of policies terminated;

D. Written premium;

E. Earned premium;

F. Paid losses;

G. Incurred losses; and

H. Assessments to members and subscribers to cover pool operating gains or losses.

24A § 2373. Penalty for violations

1. Civil penalties. A person or organization in violation of this chapter shall be assessed by the superintendent a civil penalty not more than $1,000 for each violation, except that where a violation is willful, a civil penalty of not more than $10,000 shall be assessed for each violation. These penalties may be in addition to any other penalty provided by law.

2. Separate violation. For purposes of this section, an insurer using a rate for which that insurer has failed to file the rate, supplementary rate information or supporting information as required by this subchapter, shall have committed a separate violation for each day that failure continues.

3. License. The license of an advisory organization, rating organization or insurer which fails to comply with an order of the superintendent may be suspended or revoked by the Administrative Court.

24A § 2374. Public Advocate

1. Participation and duties. The Public Advocate shall represent the interests of insureds and policyholders in matters under this subchapter within the jurisdiction of the superintendent, including, but not limited to:

A. Rate filings, whether under section 2363 or section 2366;

B. Rulemakings;

C. Petitions by insurers to terminate license authority, or withdrawal plans submitted pursuant to section 415-A;

D. Proceedings by the superintendent concerning the reasonableness and adequacy of the service provided by any insurer;

E. Proceedings by the superintendent concerning the reasonableness and adequacy of the rates charged by any insurer; and

F. Proceedings instituted by the superintendent concerning an insurer's license authority.

The Public Advocate shall have the same right to request data as any other party before the superintendent and may petition the superintendent, for good cause shown, to be allowed such other information as may be necessary to carry out the purposes of this section.

2. Petition. The Public Advocate shall have the right to request that the superintendent investigate the reasonableness of the service provided by, or the rates charged by, insurers.

3. Expert witnesses. The Public Advocate may employ witnesses and pay appropriate compensation and expenses to employ such witnesses. The funds therefor shall be supplied as indicated in sections 2363 and 2366.

4. Appeal from superintendent's orders. The Public Advocate has the same rights of appeal from the superintendent's orders or decisions to which he has been a party as other parties.

ALTERNATIVE MODEL WORKERS' COMPENSATION COMPETITIVE RATING ACT

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Section 1. Purposes

The purposes of this Act are:

A. To prohibit price fixing agreements and other anticompetitive behavior by insurers;

B. To protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

C. To promote price competition among insurers so as to provide rates that are responsive to competitive market conditions;

D. To provide regulatory procedures for the maintenance of appropriate data reporting systems;

E. To improve availability, fairness and reliability of insurance;

F. To authorize essential cooperative action among insurers in the ratemaking process and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly; and

G. To encourage the most efficient and economical marketing practices.

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Section 2. Definitions

A. "Advisory organization" means any entity which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers and which assists insurers in rate-making related activities. Two or more insurers having a common ownership or operating in this state under common management or control constitute a single insurer for the purpose of this definition. Advisory organization does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management or their employees or manager.

B. "Classification system" or "classification" means the plan, system or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.

C. "Competitive market" means a market which has not been found to be noncompetitive pursuant to Section 4.

D. "Expenses" means that portion of any rate attributable to acquisition and field supervision; collection expenses and general expenses; and taxes, licenses and fees.

E. "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

F. "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

G. "Market" means the interaction between buyers and sellers of workers' compensation insurance within this state pursuant to the provisions of this Act.

H. "Noncompetitive market" means a market for which there is a ruling in effect pursuant to Section 4 that a reasonable degree of competition does not exist.

I. "Pure premium rate" means that portion of the rate which represents the loss cost per unit of exposure including loss adjustment expense.

J. "Rate" means the cost of insurance per exposure base unit, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

K. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

L. "Statistical plan" means the plan, system or arrangement used in collecting data.

M. "Supplementary rate information" means any manual or plan of rates, classification system, rating schedule, minimum premium, policy fee, rating rule, rating plan, and any other similar information needed to determine the applicable premium for an insured.

N. "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required to be filed by the commissioner.

Section 3. Scope of Application

This Act applies to workers' compensation insurance and employers' liability insurance written in connection therewith.

Section 4. Competitive Market

A competitive market is presumed to exist unless the commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the commissioner issues an order to that effect. Such an order shall expire no later than one year after issue. In determining whether a reasonable degree of competition exists, the commissioner may consider relevant tests of workable competition pertaining to market structure, market performance and market conduct.

Section 5. Rate Standards

A. General. Rates shall not be excessive, inadequate or unfairly discriminatory.

B. Excessiveness.

(1) Competitive market. Rates in a competitive market are not excessive.

(2) Noncompetitive market. Rates in a noncompetitive market are excessive if it is likely to produce a long-run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered.

C. Inadequacy. Rates are not inadequate unless clearly insufficient to sustain projected losses and expenses and the use of such rates, if continued, will tend to create a monopoly in the market.

D. Unfair Discrimination. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

Section 6. Payment of Dividends

A. Nothing herein prohibits or regulates the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, but in the payment of such dividends there shall be no unfair discrimination between policyholders.

B. A plan for the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers is not considered a rating plan or system.

C. It is an unfair trade practice to make the payment of a dividend or any portion thereof conditioned upon renewal of the policy or contract.

Section 7. Rating Criteria

In determining whether rates comply with the excessiveness standard in a noncompetitive market, the inadequacy standard and the unfair discrimination standard, the following criteria shall apply:

A. Basic factors in rates. Due consideration may be given to past and prospective loss and expense experience within and outside of this state, to catastrophe hazards and contingencies, to events or trends within and outside of this state, to loadings for leveling premium rates over time, for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers, and to all other relevant factors, including judgment.

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B. Expenses. The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and, so far as it is credible, its own actual and anticipated expense experience.

C. Profits. The rates may contain provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of profit, consideration should be given to all investment income attributable to premiums and the reserves associated with those premiums.

Section 8. Uniform Administration of Classifications; Reporting of Rates and Other Information

A. Every workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating plan filed with the commissioner by an advisory organization designated by the commissioner and subject to his disapproval. An insurer may develop subclassifications of the uniform classification system upon which a rate may be made; provided, however, that such subclassifications must be filed with the commissioner thirty days prior to their use. The commissioner shall disapprove subclassifications if the insurer fails to demonstrate that the data thereby produced can be reported consistent with the uniform statistical plan and classification system.

B. The commissioner shall designate an advisory organization to assist him in gathering, compiling and reporting relevant statistical information. Every workers' compensation insurer shall record and report its workers' compensation experience to the designated advisory organization as set forth in the uniform statistical plan approved by the commissioner.

C. The designated advisory organization shall develop and file manual rules, subject to the approval of the commissioner, reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and the uniform classification system. Every workers' compensation insurer shall adhere to the approved manual rules and experience rating plan in writing and reporting its business. No insurer shall agree with any other insurer or with an advisory organization to adhere to manual rules which are not reasonably related to the recording and reporting of data pursuant to the uniform classification system or the uniform statistical plan.

Section 9. Filing of Rates and Other Rating Information

A. Filings as to Competitive Markets. In a competitive market, every insurer shall file with the commissioner all rates and supplementary rate information which are to be used in this state, except as provided in Section 8. Such rates and supplementary rate information shall be filed not later than thirty days after the effective date. An insurer may adopt by reference, with or without deviation, the rates and supplementary rate information filed by another insurer. If the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least thirty days before the effective date, all such rates and such supplementary rate information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

B. Prefiling in a Noncompetitve Market. In a noncompetitive market every insurer shall file with the commissioner all rates and supplementary rate information which are to be used in this state, except as provided in Section 8. Such rates and supplementary rate information and supporting information required by the commissioner shall be filed at least thirty days before the effective date. Upon application by the filer, the commissioner may authorize an earlier effective date.

C. Rates filed pursuant to this section shall be filed in such form and manner as prescribed by the commissioner. In a noncompetitve market, whenever a filing is not accompanied by such

information as the commissioner has required under this section, the commissioner shall so inform the insurer as soon as possible and the filing shall not be deemed to be made until the information is furnished.

D. **Filings Open to Inspection. All rates, supplementary rate information and any supporting information for risks filed under this Act shall, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge.**

Section 10. Uniform Experience Rating Plan

The experience rating plan shall contain reasonable eligibility standards, provide adequate incentives for loss prevention, and shall provide for sufficient premium differentials so as to encourage safety.

Section 11. Disapproval of Rates

A. Timing of Disapproval.

(1) A rate may be disapproved at any time subsequent to the effective date.

(2) A rate subject to prefiling under Section 9 may also be disapproved before the effective date.

(3) A rate for a residual market in which insurers are mandated by law to participate shall not become effective until approved by the commissioner, as provided in Section 18.

B. Bases of Disapproval.

(1) The commissioner may disapprove a rate if the insurer fails to comply with the filing requirements under Section 9.

(2) The commissioner shall disapprove a rate for use in a competitive market if he finds that the rate is inadequate or unfairly discriminatory under Section 5.

(3) The commissioner shall disapprove a rate for use in a noncompetitive market if he finds that the rate is excessive, inadequate or unfairly discriminatory under Section 5.

C. Disapproval Procedure, Order, Interim Rates.

(1) Disapproval procedure.

(a) If the commissioner finds that a reasonable degree of competition does not exist in a market in accordance with Section 4 he may require that the insurers in that market file supporting information in support of existing rates. If the commissioner believes that such rates may violate any of the requirements of this Act, he shall call a hearing prior to any disapproval.

(b) If the commissioner believes that rates in a competitive market violate the inadequacy or unfair discrimination standard in Section 5 or any other applicable requirement of this Act, he may require that the insurers in that market file supporting information in support of existing rates. If after reviewing the supporting rate information, the commissioner continues to believe that the rates may violate these requirements he shall call a hearing prior to any disapproval.

(c) The commissioner may disapprove, without hearing, rates prefiled pursuant to Section 9 that have not become effective. However, the insurer whose rates have been disapproved shall be given a hearing upon a written request made within thirty days after the disapproval order.

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(d) Every insurer or advisory organization shall provide within this state reasonable means whereby any person aggrieved by the application of its filings may be heard on written request to review the manner in which such rating system has been applied in connection with the insurance afforded or offered. If the insurer or advisory organization fails to grant or reject such request within thirty days, applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of such insurer or advisory organization on such request, may within thirty days after written notice of such action, appeal to the commissioner who, after a hearing held upon not less than ten days' written notice to the appellant and to such insurer or advisory organization, may affirm, modify or reverse such action.

(2) If the commissioner disapproves a rate, the commissioner shall issue an order specifying in what respects it fails to meet the requirements of this Act and stating when, within a reasonable period thereafter, such rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within thirty days after the close of the hearing or within such reasonable time extension as the commissioner may fix. Such order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on such date.

(3) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds of less than ten dollars ($10) per policyholder shall not be required.

Section 12. Monitoring Competition

In determining whether or not a competitive market exists pursuant to Section 4, the commissioner shall monitor the degree of competition in this state. In doing so, he shall utilize existing relevant information, analytical systems and other sources; cause or participate in the development of new relevant information, analytical systems and other sources; or rely on some combination thereof. Such activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner.

Section 13. Licensing Advisory Organizations

A. License Required. No advisory organization shall provide any service relating to the rates of any insurance subject to this Act, and no insurer shall utilize the services of such organization for such purposes unless the organization has obtained a license under Subsection C.

B. Availability of Services. No advisory organization shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

C. Licensing.

(1) Application. An advisory organization applying for a license shall include with its application:

(a) A copy of its constitution; charter; articles of organization, agreement, association or incorporation; and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of one or more residents of this state upon whom notices, process affecting it, or orders of the commissioner may be served;

(d) A statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

(e) Any other relevant information and documents that the commissioner may require.

(2) Change of Circumstances. Every advisory organization which has applied for a license shall notify the commissioner of every material change in the facts or in the documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty days before it becomes effective.

(3) Granting of License. If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of law are met, he shall issue a license specifying the authorized activity of the applicant. He shall not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen competition in the market.

(4) Duration. Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the state or until the license is suspended or revoked. The commissioner may at any time, after hearing, revoke or suspend the license of an advisory organization which does not comply with the requirements and standards of this Act.

Section 14. Insurers and Advisory Organizations: Prohibited Activity

A. No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization or other person which has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

B. No insurer shall agree with any other insurer or with an advisory organization to adhere to or use any rate, rating plan, other than the uniform experience rating plan, or rating rule except as needed to comply with the requirements of Section 8.

C. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently, the same rates, rating plans, rating schedules, rating rules, policy forms, rate classifications, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

D. Two or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this Act as if they constituted a single insurer.

Section 15. Advisory Organizations: Prohibited Activity

In addition to other prohibitions contained in this Act, except as specifically permitted under Section 16, no advisory organization shall:

A. Compile or distribute recommendations relating to rates that include expenses (other than loss adjustment expenses) or profit.

B. File rates, supplementary rate information or supporting information on behalf of an insurer.

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Section 16. Advisory Organizations: Permitted Activity

Any advisory organization in addition to other activities not prohibited, is authorized to:

A. Develop statistical plans, including class definitions.

B. Collect statistical data from members, subscribers or any other source.

C. Prepare and distribute pure premium rate data, adjusted for loss development and loss trending, in accordance with its statistical plans. Such data and adjustments should be in sufficient detail so as to permit insurers to modify such pure premiums based on their own rating methods or interpretations of underlying data.

D. Prepare and distribute manuals of rating rules and rating schedules that do not contain any rules or schedules including final rates or permitting calculation of final rates without information outside the manuals.

E. Distribute information that is filed with commissioner and open to public inspection.

F. Conduct research and collect statistics in order to discover, identify and classify information relating to causes or prevention of losses.

G. Prepare and file policy forms and endorsements and consult with members, subscribers and others relative to their use and application.

H. Collect, compile and distribute past and current prices of individual insurers if such information is made available to the general public.

I. Conduct research and collect information to determine the impact of benefit level changes on pure premium rates.

J. Prepare and distribute rules and rating values for the uniform experience rating plan. Calculate and disseminate individual risk premium modification.

K. Assist an individual insurer to develop rates, supplementary rate information or supporting information when so authorized by the individual insurer.

Section 17. Advisory Organizations: Filing Requirements

Every advisory organization shall file with the commissioner every pure premium rate, every manual of rating rules, every rating schedule and every change or amendment or modification of any of the foregoing proposed for use in this state no more than thirty days after it is distributed to members, subscribers or others.

Section 18. Residual Market Mechanism

All insurers authorized to write workers' compensation and employers' liability insurance shall participate in a plan providing for the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. A plan shall be submitted for the commissioner's approval within sixty days of the effective date of this Act. The rates, supplementary rate information and policy forms to be used in such a plan and any future modification thereof must be submitted to the commissioner for approval at least thirty days prior to their effective date. Such rates shall reflect residual market experience to the extent it is actuarially appropriate.

The commissioner shall disapprove any filing that does not meet the requirements of Section 5. A filing shall be deemed to meet such requirements unless disapproved by the commissioner within thirty days after the filing is made. In disapproving a filing made pursuant to this section, the commissioner shall have the same authority and follow the same procedure as in disapproving a

filing pursuant to Section 11. The designated advisory organization may make and file the plan of operation, rates, rating plans, rules and policy forms under this section.

Section 19. Examinations

A. The commissioner may examine any insurer, advisory organization or residual market mechanism as he deems necessary to ascertain compliance with this Act.

B. Every insurer, advisory organization and residual market mechanism shall maintain reasonable records of the type and kind reasonably adapted to its method of operation containing its experiences or the experience of its members including the data, statistics or information collected or used by it in its activities. These records shall be available at all reasonable times to enable the commissioner to determine whether the activities of any advisory organization, insurer or association comply with the provisions of this Article. Such records shall be maintained in an office within this state or shall be made available to the commissioner for examination or inspection at any time upon reasonable notice.

C. The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation of a detailed account of such costs.

D. In lieu of any such examination the commissioner may accept the report of an examination by the insurance supervisory official of another state, made pursuant to the laws of such state.

Section 20. Penalties

A. The commissioner may, if he finds that any person or organization has violated any provision of this Act, impose a penalty of not more than one thousand dollars ($1,000) for each such violation but if he finds such violation to be willful he may impose a penalty of not more than ten thousand dollars ($10,000) for each such violation. Such penalties may be in addition to any other penalty provided by law.

B. For purposes of this section, any insurer using a rate for which the insurer has failed to file the rate, supplementary rate information or supporting information, as required by this Act, shall have committed a separate violation for each day such failure continues.

C. The commissioner may suspend or revoke the license of any advisory organization or insurer which fails to comply with an order of the commissioner within the time limit specified by such order, or any extension thereof which the commissioner may grant.

The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him, unless he modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed.

No penalty shall be imposed and no license shall be suspended or revoked except on a written order of the commissioner, stating his findings, made after hearing.

Section 21. Judicial Review

A. Any order, regulation or decision of the commissioner, made after a hearing, shall be subject to judicial review in accordance with [cite applicable provision of state civil practice act].

B. Upon request of any insurer or organization to which the commissioner has directed an order made without a hearing, the commissioner shall grant a hearing within twenty days of such request. Within fifteen days after such hearing the commissioner shall affirm, reverse or modify the previous action, specifying the reasons therefor.

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Section 22. Severability

If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Section 23. Effective Date

The provision of the Act shall become effective one year after enactment.

Legislative History (all references are to the Proceedings of the NAIC).

1983 Proc. I 6, 35-36, 790, 807, 812-820 (adopted).

Model Regulation Service - January 1992

ALTERNATIVE MODEL WORKERS' COMPENSATION COMPETITIVE RATING ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	NO ACTION TO DATE	
Alaska	NO ACTION TO DATE	
Arizona	NO ACTION TO DATE	
Arkansas	NO ACTION TO DATE	
California		CAL. INS. CODE §§ 11730 to 11744 (1935/1988) (Prior approval).
Colorado	NO ACTION TO DATE	
Connecticut	NO ACTION TO DATE	
Delaware	NO ACTION TO DATE	
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 627.091 to 627.215 (1959/1987) (Prior approval).
Georgia	NO ACTION TO DATE	
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO CODE §§ 41-1601 to 41-1625 (1961) (File and use).
Illinois	ILL. REV. STAT. ch. I.C. §§ 454 to 471 (1981/1984) (Use and file).	
Indiana		IND. CODE §§ 27-7-2-1 to 27-7-2-39 (1935/1989) (Prior approval).

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Iowa	NO ACTION TO DATE	
Kansas		KAN. STAT. ANN. §§ 40-2109 to 40-2110 (1961/1969) (Prior approval).
Kentucky	NO ACTION TO DATE	
Louisiana	NO ACTION TO DATE	
Maine		ME. REV. STAT. ANN. tit. 24-A §§ 2361 to 2374 (1987/1990) (Prior approval, includes loss cost provisions).
Maryland		MD. ANN. CODE art. 48A § 244Y (1988) (File and use).
Massachusetts	NO ACTION TO DATE	
Michigan	MICH. COMP. LAWS §§ 500.2400 to 500.2430 (1982) (File and use).	
Minnesota	MINN. STAT. §§ 79.50 to 79.62 (1982/1983) (File and use).	
Mississippi	NO ACTION TO DATE	
Missouri	NO ACTION TO DATE	
Montana	NO ACTION TO DATE	
Nebraska	NO ACTION TO DATE	
Nevada	NO ACTION TO DATE	
New Hampshire		N.H. REV. STAT. ANN. §§ 412:8 to 412:13 (1921) (Prior approval).
New Jersey	NO ACTION TO DATE	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
New Mexico		N.M. STAT. ANN. §§ 59A-17-8, 59A-17-10, 59A-17-14 (1984/1987) (Prior approval).
New York	NO ACTION TO DATE	
North Carolina	NO ACTION TO DATE	
North Dakota	NO ACTION TO DATE	
Ohio	NO ACTION TO DATE	
Oklahoma	NO ACTION TO DATE	
Oregon	NO ACTION TO DATE	
Pennsylvania	NO ACTION TO DATE	
Puerto Rico	NO ACTION TO DATE	
Rhode Island	NO ACTION TO DATE	
South Carolina	NO ACTION TO DATE	
South Dakota	NO ACTION TO DATE	
Tennessee	NO ACTION TO DATE	
Texas		TEX. INS. CODE ANN. art. 5.55 to 5.68-1 (1953/1991) (Includes loss cost filing).
Utah		UTAH CODE ANN. § 31A-19-401 to 31A-19-415 (1985) (File and use).
Vermont	NO ACTION TO DATE	
Virgin Islands	NO ACTION TO DATE	
Virginia	NO ACTION TO DATE	
Washington	NO ACTION TO DATE	

Model Regulation Service - January 1992

ALTERNATIVE MODEL WORKERS' COMPENSATION COMPETITIVE RATING ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
West Virginia	NO ACTION TO DATE	
Wisconsin		WIS. STAT. §§ 626.02 to 626.51 (1976) (Prior approval).
Wyoming	NO ACTION TO DATE	

NAIC Copyright 1992

STATE OF MAINE
WORKERS' COMPENSATION COMMISSION
STATE HOUSE STATION 27
AUGUSTA, MAINE 04333
207-289-3751

July 24, 1992

Mr. Harvey Picker
P.O. Box 677
Camden, ME 04843

Dear Mr. Picker:

At our meeting on July 20th, you asked Ralph Tucker and me for ideas about strengthening informal dispute resolution. This letter is to put those ideas in written form and to expand on other topics we discussed.

Under the statute, Commissioners preside at informal conferences. We think using hearing officers at this level would be preferable. Hearing officers would not decide the case later, if the dispute progressed to litigation. They would not be concerned about prejudicing themselves; so, they could take an active approach. Additionally, they could hold conferences more quickly and spend more time on individual cases. Hearing officers might be vested with the ability to make a binding, interlocutory order on small cases, similar to small claims court. This also would make the process more meaningful.

I don't think changing the formal hearings or the appeals process would reduce system costs or increase efficiency. Our Commissioners are already faster than the courts or most similar agencies in other states. In the past, the sheer volume of litigation has been the primary source of delay. However, we are now seeing fewer and fewer petitions. This reduction is, perhaps, the only beneficial effect of the recession.

We would like to be doing more in the area of monitoring individual cases. Developing electronic data exchange between the Commission, self insured employers, and adjustment companies would be an important part of this. Budget has been the restraining factor.

Structurally, I like the idea of a labor management board of directors. I think it is important that the board consist of genuine employers and labor officials. If lobbyists or political insiders are appointed, I doubt it will work. The effectiveness of the board also depends on the source of funds. Without dedicated revenue, I suspect its authority would be undermined by the appropriations process.

The Blue Ribbon Commission is discussing many ideas about duties, structure, and procedures of the Workers' Compensation Commission. However, I think any specific changes to the agency's structure or procedures should be developed by this board of directors. They would be in a better position to oversee the practical complexities.

Although our operations can be improved, I think it is extremely speculative to expect to lower system cost by expanding the state agency. A state agency can not make basic decisions about things such as reemployment or job modification. I think its status as a non-payer raises serious questions about its potential efficiency as medical cost controller. Much of the clout in medical cost containment comes from simply having the power to decide whether to write a check.

Possibly, expanding our duties might have a small effect. However, I don't see how it could significantly change either the total costs or the unfair assessment of these costs against small employers.

I think the Blue Ribbon Commission is spending too much time redesigning the Workers' Compensation Commission. This approach has been common during previous failed reforms. It is, and please forgive the colorful language, like rearranging the deck chairs on the Titanic. I think the Blue Ribbon Commission should be spending more time examining alternatives to the current financing mechanism for small employers.

The fundamental problems lay in private claims adjustment and benefit financing. Private insurance seems to provide an insufficient linkage between safety programs, return to work efforts, and premiums. I will assert that claims management and return to work efforts are the most critical element of cost.

The success of self insurance is an example. Self insurers do have other advantages. They tend to be larger companies and, therefore, have more flexibility in terms of light duty jobs or reemployment. Self insurance is not practical for most small employers. However, their need for another financing system is very strong.

This is why I see the fundamental solution as developing an alternative funding mechanism for small employers. This needs to include a way to involve employers in long term claim management. This would give small employers some positive, financial incentives that self insurers now experience.

If history had been different, private insurance might be able to play a larger role in solving this problem. However, considering their experiences, I think they will exit the market and cut their losses.

It is true that carriers played a role in the history of this crisis. However, it is unfair to scapegoat. Carriers have a reasonable argument that poor claims service relates to the large residual market. I think the primary cause of the crisis is that state government has made serious mistakes, particularly in the early 1980s.

Some of my comments may seem a little blunt. However, I don't mean them critically. Considering the nature of its task, I think the Blue Ribbon Commission is doing better than most observers expected.

Sincerely,

Frank R. Richards
Assistant to the Chairman

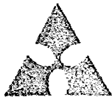
FRR:km

cc: William Hathaway
Richard Dalbeck
Emilien Levesque

MAINE VERSUS MICHIGAN

ESTIMATED EFFECT OF REPLACING MAINE LAW WITH MICHIGAN LAW

TYPE OF INJURY	PERCENT OF LOSSES	VARIATION OF EFFECT	
Fatal	1.6%	-70.0%	-80.0%
Permanent Total	2.7%	-50.0%	-60.0%
Permanent Partial	44.8%	50.0%	40.0%
Temporary Total	10.9%	-20.0%	-30.0%
Medical	40.0%	-5.0%	-10.0%
Total	100.0%	15.8%	7.8%



AMERICAN INSURANCE ASSOCIATION
LAW DEPARTMENT

1130 Connecticut Avenue N.W.
Suite 1000
Washington, D.C. 20036
(202) 828-7100
(202) 293-1219 FAX

July 26, 1992

JUL 1992
Received
Office Of
The Governor

Abby Harkins
Law Clerk
State House, Station One
Augusta, Maine 04333

Dear Ms. Harkins:

As you requested, enclosed is a copy of the Rhode Island workers' compensation reform act and a memorandum on the issue of compensability.

With regard to the Texas Workers' Compensation Commission (Commission), the concept of an equal number of members representing labor and management is not an effective method for administering the act. As a result of balanced representation, the Commission has stalemated on a number of issues. For example, the Commission could not agree upon an executive director to manage the Commission. After two years, the Commission settled on the acting executive director. The Commission also experienced deadlock in the area of extra-hazardous employers. The labor representatives sought punitive measures against extra-hazardous employers, but would not agree to punitive measures against employees who violated safety provisions. After two years, the extra-hazardous employer program is not fully implemented and the Commission recently suspended all operation of the program. Unless the workers' compensation act outlines the rights and responsibilities of employers and employees, the Commission may become fertile ground for endless debate on labor/management issues.

If you need further information, please give me a call at (202) 828-7175.

Sincerely,

Christopher Roe

Christopher Roe
Assistant Counsel

cc: Joe DiGiovanni
Eric Oxfeld

CPR:m.abby

WILLIAM E. BUCKLEY, CHAIRMAN — ROBERT B. SANBORN, CHAIRMAN ELECT — JOHN P. MASCOTTE, VICE CHAIRMAN — DOUGLAS W. LEATHERDALE, VICE CHAIRMAN — ROBERT E. VAGLEY, PRESIDENT

MEMORANDUM

TO: Eric Oxfeld

FROM: Christopher P. Roe CR

DATE: July 27, 1992

SUBJECT: Compensability under Workers' Compensation

The standard for compensability for an injury under workers' compensation law typically is "arising out of and in the course of employment." By interpretation, this standard has been extended in some states to encompass injuries whose work-causation is tenuous.

Controversy over compensability can roughly be divided into two categories - (1) "in the course of employment" = whether the claimant was at work when the injury happened (e.g. going and coming cases, recreational injury), and (2) "arising out of employment" = whether the injury had a nonoccupational medical causation (e.g., stress claims, heart attack, aggravation). The more prevalent problem in terms of cost relates to compensation for injury or a medical condition that is essentially nonoccupational, such as the following:

- Aggravation of a non-work-related injury
- Nonoccupational aggravation of a work-related injury
- Heart attacks and cardiovascular disease
- Back injuries
- Hernia
- Hearing loss

Presently, to satisfy the two requirements that an injury arise out of and in the course of employment, case law has held that the employee need only show that employment is a contributory cause. The trend seems to be to compensate for an injury which has any connection with work activity. Herlick, California Workers' Compensation Handbook, 159 (10th ed., 1990). As a result, the workers' compensation system provides fertile ground for the compensability of heart attacks, back injuries, and mental stress claims.

California is one of a few states with a statutory proximate cause test for workers' compensation. Labor Code §3600 requires not only that an injury arise out of and occur in the course of the employment, it also requires that the injury be "proximately caused by the employment, either with or without negligence." When the Workers' Compensation Act was first adopted in California, the courts construed proximate cause very narrowly. However, recent court decisions have ignored the proximate cause requirement. Today, the connection between the injury and the employment need only be causal. Warren L. Hanna observes: "Thus our courts, in the name of liberal interpretation and the modern trend, have evinced a willingness, in fact, a determination to accept almost any incidental, indirect, or merely contributing relationship or connection as a substitute for the "proximate cause" required by the compensation law." 2 Hanna, California Law of Employee Injuries and Workmen's Compensation (2d Ed. 1969 §8.03).

To address the issue of compensability, several states tightened their compensability standard for specific injuries. For example, several states passed laws which do not recognize the compensability of mental injuries caused by workplace stress. When states have tightened compensability, insurers have not experienced an adverse reaction with tort claims.

The AIA advocates that work be the predominant cause of a medical condition before it can be considered compensable. If work is the predominant cause, it should be fully compensable, even if there are contributing nonoccupational factors. Where a state has a predominant cause requirement, AIA opposes apportionment between work and nonoccupational causation because of the litigation over fine degrees of relatively subjective distinction.

The 1990 Oregon reform law addressed aggravation consistent with AIA's policy, principally by providing compensation only when the combined injury was predominantly work-related. A provision modeled on Oregon §§656.005(7) and 656.273(1), is as follows:

> (A) No injury or disease is compensable as a consequence of a compensable injury unless the consequential injury is the predominant cause of the consequential condition.
> (B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the predominant cause of the disability or need for treatment.
> (C) If the predominant cause of a worsened condition is an injury not occurring within the course and scope

> of employment, the worsening is not compensable. If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for a worsened condition must be made within 5 years after the date of injury.

The Oregon law provides a model for addressing the Maine Supreme Court's decision in Brackett. In this case, the employee sustained a work-related back injury and returned to work. Subsequently, the employee sustained a non-work-related back injury in a motor vehicle accident resulting in total incapacity. The court held that the employee sustained a compensable injury even though the subsequent non-work-related injury was the major cause of the disability. The court reasoned that as long as the work-related injury remained a cause in the disability, then the total disability is fully compensable.

Texas, Oklahoma, Louisiana, and Kansas recently addressed the compensability of heart attacks. Kansas furnishes a good model for dealing with heart attacks, in §44-501(c):

> Compensation shall not be paid in cases of coronary or coronary artery disease or cerebrovascular injury unless it is shown that the exertion of the work necessary to precipitate the disability was more than the employee's usual work in the course of the employee's regular employment.

Louisiana requires that employment should be the predominant cause of a compensable heart attack.

> §1021(7)(e) Heart-related or perivascular injuries. A heart-related or perivascular injury, illness or death shall not be considered a personal injury by accident arising out of and in the course of employment and is not compensable pursuant to this Chapter unless it is demonstrated by clear and convincing evidence that:
>
> (i) The physical work stress was extraordinary and unusual in comparison to the stress or exertion experienced by the average employee in that occupation, and
>
> (ii) The physical work stress or exertion, and not some other source of stress of preexisting condition, was the predominant and major cause of the heart-related or perivascular injury, illness, or death.

Alabama, California, Louisiana, Massachusetts, Missouri, and Oklahoma amended their workers' compensation acts to alter the compensability of mental injuries. Alabama and Oklahoma do not compensate mental injuries without some physical injury to the body. Louisiana and Missouri provide that a mental injury caused

by mental stress is not compensable unless the mental injury was extraordinary and unusual. Specifically, Louisiana Title 23, Section 1021(7) (b) and (c) states:

> (b) Mental injury caused by mental stress. Mental injury or illness resulting from work-related stress shall not be considered a personal injury by accident arising out of and in the course of employment and is not compensable pursuant to this Chapter, unless the mental injury was the result of a sudden, unexpected, and extraordinary stress related to the employment and is demonstrated by clear and convincing evidence.
>
> (c) Mental injury caused by physical injury. A mental injury or illness caused by a physical injury to the employee's body shall not be considered a personal injury by accident arising out of and in the course of employment and is not compensable pursuant to this Chapter unless it is demonstrated by clear and convincing evidence.
>
> (d) No mental injury or illness shall be compensable either under Subparagraph (b) or (c) unless the mental injury or illness is diagnosed by a licensed psychiatrist or psychologist and the diagnosis of the condition meets the criteria as established in the most current issue of the Diagnostic and Statistical Manual of Mental Disorders presented by the American Psychiatric Association.

Chapter 152, Section 1(7A), of the General Laws of Massachusetts provides a predominant cause test for compensable mental injuries:

> Personal injuries shall include mental or emotional disabilities only where the predominant contributing cause of such disability is an event or series of events occurring within the employment. No mental or emotional disability arising principally out of a bona fide personnel action including a transfer, promotion, demotion, or termination except such action which is the intentional infliction of emotional harm shall be deemed to be a personal injury within the meaning of this chapter.

In response to the growth in mental stress claims, the California legislature enacted reform amendments in 1989 and 1991. The 1989 amendments to the workers' compensation act established the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders as the standard for evaluating permanent psychiatric disability. The legislature also altered the compensability threshold for psychiatric injuries to a new and higher threshold of compensability of at least 10 percent of the total causation from all sources contributing to the psychiatric injury. To cure the decision in

Albertson's, Inc. v. W.C.A.B., 131 Cal. App. 3d 308, 188 Cal. Rptr. 304 (1982), the legislature required that "actual events of employment" should give rise to a claim. In Albertson's, the court held that a mental disability resulting from asserted job stress was compensable even if the events causing the stress existed only in the employee's mind. In 1991, the California legislature again tightened the standards for receiving workers' compensation for a psychiatric injury. Under the new law, mental stress claims are not compensable in the first six months of employment unless caused by "sudden and extraordinary" work conditions other than good-faith employment actions. Although mental stress claims have been declining somewhat since the law changes in California, these measures have not significantly improved the situation.

These recent reforms have prompted legal challenges. In Montana, the Workers' Compensation Court held that the workers' compensation act's exclusion of mental injuries caused by emotional or mental stress violated the equal protection clause of the Montana Constitution. The exclusion of mental injuries caused by mental stress was part of the reform of workers' compensation laws passed by the Montana Legislature in 1987. The court noted that cost savings may have been the reason for excluding workers' compensation claims as a result of mental stress, but there does not seem to be a rational basis for the classification. To inoculate legislative reform from these types of constitutional challenges, the legislature should present a clear legislative history that the workers' compensation act is not intended to compensate injuries with doubtful work causation.

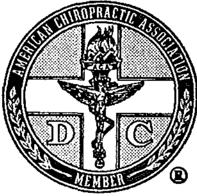
In the past year, Alabama altered the burden of proof for compensable cumulative traumas. Cumulative trauma disorders include injuries caused by exposure, stress, and repetitive trauma. Cumulative injuries are mentally or physically traumatic activities extending over a period of time, whose combined effect causes any disabilities or need for medical treatment. Ordinarily, the incidents could not be sufficiently severe to cause injury, but their cumulative effect over a long period causes a condition and symptoms requiring medical attention. While Alabama has not changed the compensability standard for cumulative traumas, the change in the burden of proof may have some beneficial effect. Section 25-5-81(c) of the Code of Alabama provides:

> The decision of the court shall be based on a preponderance of the evidence as contained in the record of the hearing, except in cases involving injuries which have resulted from gradual deterioration or cumulative physical stress disorders, which shall be deemed compensable only upon a finding of clear and convincing proof that those injuries arose out of and in the course of the employee's employment.

For the purpose of this amendatory act, 'clear and convincing' shall mean evidence that, when weighted against evidence in opposition, will produce in the mind of the trier a fact of firm conviction as to each essential element of the claim and a high probability as to the correctness of the conclusion. Proof by clear and convincing evidence requires a level of proof greater than a preponderance of the evidence or the substantial weight of the evidence, but less than beyond a reasonable doubt.

Back injury and hernia can be addressed by a specific duration limit on a schedule, but care must be taken to establish a duration that is no greater than the typical benefit duration under present law. No particular model can be suggested without more information about the extent of the problem.

cc: Joe DiGiovanni



LYNCH CHIROPRACTIC ARTS BUILDING

1200 Broadway
South Portland, Maine 04106

Dr. Robert P. Lynch, Jr.

Tel. (207) 799-2263
Fax (207) 799-7112

July 27, 1992

William Hathaway
c/o Michelle Bushey
University of Maine-Law School
246 Deering Ave.
Portland, ME 04102

Dear Bill,

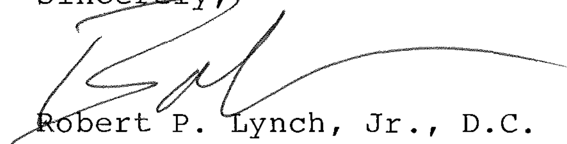
I have had the opportunity to review a suggested workers compensation medical system by Harvey Picker. In review of Mr. Pickers suggestion I would like to make a short comment.

1. The Michigan Workers Compensation system does not call for independent medical examiners (IME). Mr. Picker recommends placing Chiropractors on the medical advisory board but in his later presentation he does not have chiropractors as independent medical examiners. He has a selective panel of up to 25 M.D. and D.O.'s as mediators and hearing officers.

2. It is my opinion and the opinion of that the system would benefit from having like providers reviewing each other and not having M.D.'s reviewing Chiropractic cases or D.O.'s reviewing medical doctors cases, ect.

3. There are many chiropractors in the State of Maine whom have expertise as a diagnostician to be able to determine the necessity for the chiropractic care being provided an the limitations in the work capacity as a result of the alleged injuries.

Sincerely,



Robert P. Lynch, Jr., D.C.

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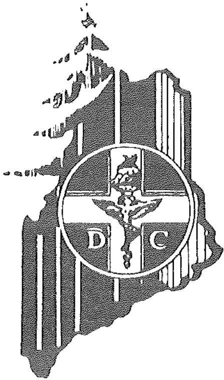

MAINE CHIROPRACTIC ASSOCIATION, INC.

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John W. Royce, II

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David R. Odiorne, D.C.

July 27, 1992

Senator Richard Hathaway
Blue Ribbon Commission
University of Maine
246 Deering Avenue
Portland, Maine 04102

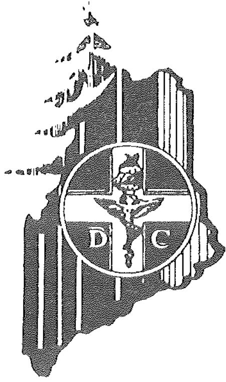
Dear Senator Hathaway,

In June I welcomed the opportunity to provide the Blue Ribbon Commission with an outline of successful cost containment programs being used by self insured and progressive independent businesses in the State of Maine. Since my presentation, I have continued to monitor the hard work of The Blue Ribbon Commission and most recently reviewed a draft of a medical systems proposal by Dr. Harvey Picker.

In this model medical system, Dr. Picker appropriately included Chiropractors on the Workers' Compensation Advisory Board. Since Chiropractors are trained specialists in the diagnosis and treatment of musculoskeletal injuries, and because they treat approximately 30-35% of work related injuries in Maine, their inclusion on the Advisory Board as well as on the IME panel is necessary and valuable.

Surprisingly, in what may have been a clerical error or simple oversight in the medical system draft that I reviewed, Chiropractic Doctors were not included in the IME panel. Excluding Chiropractors from the IME panel will set up an adversarial and disruptive relationship between the injured, the insurance industry, and the insured. Past testimony by representatives of the injured, the health care providers as well as by the outside consultants, all describe how compensation costs are escalated as a result of the adversarial nature of the present system.

Additionally, the materials I provided during my presentation to the Blue Ribbon Commission documents enormous savings by progressive Maine companies who did everything possible to improve communication and avoid medical/legal confrontation.



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Including Chiropractors on the IME panel will discourage the adversarial relationship between Chiropractors and Medical Doctors which has proven costly for all third party reimbursement systems, and additionally, saving time and money. It will also avoid future tinkering and modification to the Workers' Compensations system in future legislative sessions.

Finally, as President of the Maine Chiropractic Association and as a Diplomate of the American Board of Chiropractic Occupational Health Care, I feel that the credentialing process of the IME panel doctors is key to the success of utilization management of workers injuries. All doctors on the IME panel should:

1. Have board certification in occupational health care, diagnostics, or IME protocols;
2. Have actual experience treating work related injuries;
3. Provide evidence of a minimum of 12 hours of continuing education credits in occupational medicine each year.

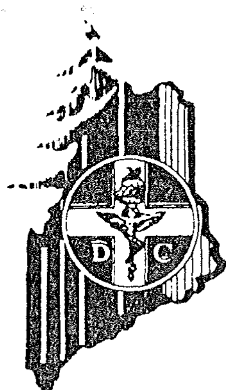
Thank you for taking the time to review these comments. If you would like additional information regarding "credentialing protocol", I would be happy to provide your commission with this information.

Good luck with this enormous task.

Respectfully submitted,

Dr L G Saulter

Leonard G. Saulter, D.C., DABCOH
President, Maine Chiropractic Association
LGS/vmp



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July 27, 1992

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Blue Ribbon Commission
University of Maine
246 Deering Avenue
Portland, Maine 04102

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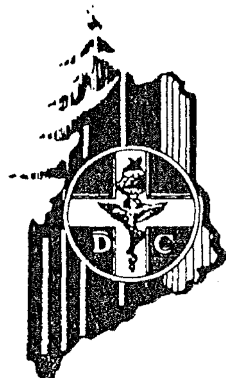

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2. Have actual experience treating work related injuries;
3. Provide evidence of a minimum of 12 hours of continuing education credits in occupational medicine each year.

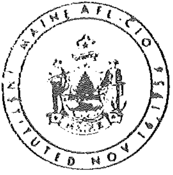
Thank you for taking the time to review these comments. If you would like additional information regarding "credentialing protocol", I would be happy to provide your commission with this information.

Good luck with this enormous task.

Respectfully submitted,

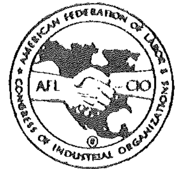
Dr. Leonard G. Saulter

Leonard G. Saulter, D.C., DABCOH
President, Maine Chiropractic Association
LGS/vmp



maine afl-cio

157 Park Street
P.O. Box 2669
Bangor, Maine 04402-2669
Tel. 207-947-0006



President
Charles J. O'Leary

Secretary-Treasurer
Edward Gorham

July 28, 1992

Hon. William Hathaway
Richard Dalbeck, Co-Chairs
Maine Blue Ribbon Commission on
Workers' Compensation
246 Deering Avenue
Portland, ME 04102

Dear Chairmen Hathaway and Dalbeck:

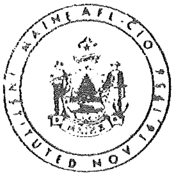
Labor's willingness to cooperate with the management members of the Workers' Compensation Group has been shown by the joint labor-management testimony from the Group before your committee and in the intense consideration your committee is giving to the unanimous labor management recommendation of the Michigan plan.

Certain trade associations wrote a letter to various Maine newspapers on July 8, 12 and 14, and that letter contained substantial financial and conceptual inaccuracies which I have sought to correct by the enclosed letter.

Sincerely,

Charles J. O'Leary
President

Enclosure
cc: The Hon. Emilien Levesque
Dr. Harvey Picker



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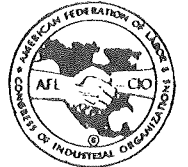


President
Charles J. O'Leary

Secretary-Treasurer
Edward Gorham

7/27/92

MISREPRESENTING FACTS, IGNORING HISTORY

Some trade associations who have been active participants in the long political struggles on workers' compensation have criticized the Labor Management Group's recommendation for adoption of the Michigan plan in order to control Maine's continuing workers' compensation program difficulties.

These trade associations have a perfect right to express their views but they should feel under an obligation not to ignore or misrepresent fundamental facts. THE LETTER FROM THE TRADE ASSOCIATIONS MISREPRESENTS THE FUNDAMENTAL FACT THAT MOST INSURED BUSINESSES IN MICHIGAN PAY SUBSTANTIALLY LESS FOR WORKERS' COMPENSATION INSURANCE THAN SIMILAR INSURED BUSINESSES DO IN MAINE.

Self insured businesses also pay substantially less in Michigan than in Maine. A worldwide paper company with plants in both Michigan and Maine pays 2/3rds less in Michigan. Likewise a large nationwide transportation company pays about 60% less in Michigan than Maine.

The trade associations misrepresented the costs facts by comparing the highest insurance rates charged in the Michigan market (about 3% of the market) with the lowest rates charged in the Maine market (about 80% of the Maine market) and thus falsely concluded that Michigan's rates are higher than Maine's.

The truth is just the opposite.

Using the same occupations as selected by the trade associations, the facts about the highest rates in both systems (Michigan's assigned risk system and Maine's accident prevention account) are listed below.

	Maine (Accident Prevention Account minimum)		Maine (A.P.A. maximum)	Michigan (Assigned Risk)
Logging/Lumbering	$44.36	--	$53.23	50.43
Boiler Installation	32.98	--	39.58	31.08
Excavation	16.39	--	19.67	15.75
Boatbuilding/repair	9.06	--	10.87	10.73
Trucking	20.15	--	24.18	19.50
Clothing Store	1.88	--	2.26	1.82
Hardware Store	2.70	--	3.24	2.62
Retail Store	2.40	--	2.88	2.36
Meat/Grocery Store	4.82	--	5.78	4.73
Gas/Oil Dealers	9.89	--	11.87	12.91
Auto Repair	6.28	--	7.54	6.75
Convalescent Nursing Home	7.84	--	9.41	8.43
Hospital Professional	2.33	--	2.80	2.15

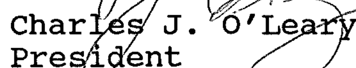
But in Michigan only 3% of employers pay insurance rates are at the high level whereas Maine high rates are paid by 20% of insureds.

Another misrepresentation by the trade associations is the claim that Maine's workers' compensation law covers non-work related disabilities. That is untrue. Maine follows the same basic formula for eligibility requiring disabilities to be work related for compensation eligibility as 45 other states, including Michigan. The Blue Ribbon Commission has investigated the trade associations' misleading claim and will, based on the facts, find it to be inaccurate.

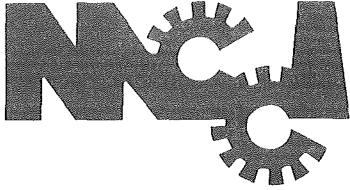
In addition to misrepresenting the cost in the high risk pools in Maine and Michigan, the requirement of work-relatedness for compensation in both systems and indeed, almost all workers' compensation systems, the trade associations ignore the fundamental fact that Maine has listened to them and their insurance allies and done what they have wanted in the past 6 years resulting in utter failure. During the last 6 years, doing what the insurance companies and trade associations wanted, Maine's injury rate and lost time rate have stayed very high, Maine's insurance costs have increased an average of 90% while benefits, particularly long-term benefits for Maine injured workers, have been cut by over 50%.

The demonstrated failure of the trade associations' position is the reason the Labor Management Group came together and coalesced on the Michigan plan and the reason the Maine Blue Ribbon Commission is giving thoughtful consideration to the Michigan plan. Even more importantly, reestablishing a consensus within the State of Maine so that Mainers can work together rather than continue futile and costly political squabbling is our best hope of fundamental change for the better.

Sincerely,



Charles J. O'Leary
President



Maine Chamber of Commerce & Industry

126 Sewall Street ▪ Augusta, Maine 04330 ▪ (207) 623-4568

July 30, 1992

Honorable William D. Hathaway, Co-Chair
Blue Ribbon Commission on Workers' Compensation
246 Deering Avenue
Portland, Maine 04102

Dear Mr. Hathaway:

We have learned from your staff that the Blue Ribbon Commission intends to submit its report and recommendations directly to the Governor and legislature without exposing them to the interested parties and/or conducting public hearings. I would like to urge you to consider another course.

I think it is likely that elements of your report will cause concern for business or labor. It may be possible to work through these rough spots if the ball is kept in your court. If, however, your report goes first to the Governor and legislators, I believe we will quickly re-politicize the issue. That is exactly what the Blue Ribbon Commission was supposed to avoid.

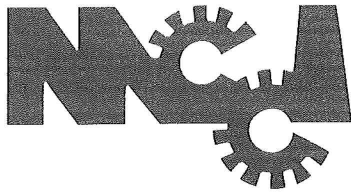
Please consider seriously our concern for the method you have chosen.

Sincerely,

Jack

John S. Dexter, Jr.
President

cc: Harvey Picker
Emilien Levesque



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July 30, 1992

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6707 Wemberly Way
McLean, Virginia 22101

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Sincerely,

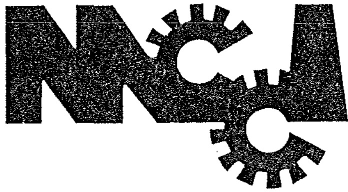
Jack

John S. Dexter, Jr.
President

cc: Harvey Picker
Emilien Levesque

The Voice of Maine Business

Called 8/7 - per Hathaway - draft probably won't be done until near due date



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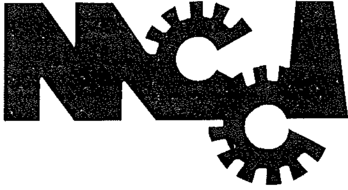
The Voice of Maine Business



Maine Chamber of Commerce & Industry

126 Sewall Street ■ Augusta, Maine 04330 ■ (207) 623-4568

July 30, 1992

Mr. Richard B. Dalbeck, Co-Chair
Blue Ribbon Commission on Workers' Compensation
246 Deering Avenue
Portland, Maine 04102

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