



PAUL R. LEPAGE  
GOVERNOR

STATE OF MAINE  
**WORKERS' COMPENSATION BOARD**  
OFFICE OF EXECUTIVE DIRECTOR/CHAIR  
DEERING BUILDING, AMHI COMPLEX  
27 STATE HOUSE STATION  
AUGUSTA, MAINE 04333-0027

PAUL H. SIGHINOLFI, ESQ.  
EXECUTIVE DIRECTOR/CHAIR

February 6, 2012

Christopher W. Rector, Senate Chair  
Kerri L. Prescott, House Chair  
Committee on Labor, Commerce, Research and Economic Development  
c/o Legislative Information  
100 State House Station  
Augusta, ME 04333

**RE: LD 1571, An Act To Amend the Laws Governing Workers' Compensation**

Dear Senator Rector and Representative Prescott,

By letter dated June 8, 2011, I was charged with reviewing LD 1571 with a stakeholder group and members of the Workers' Compensation Board staff. After the review, a report with recommendations was requested. Please consider this letter my report on your request.

The task force was comprised of members of the legislature, one representative and one senator, a representative of the insurance community, an executive from the AFL-CIO, several knowledgeable lobbyists, an insurance consultant, a representative of the self-insured community, and lawyers representing management and labor. It is as broad a group as one could expect. The group met on a number of occasions. On the first occasion, the undersigned informed the group he expected there would be disagreements when we discussed this legislation but expected further that no one would be disagreeable. As it turns out, that was the case. Our discussions were thoughtful, comprehensive, and fruitful.

This report addresses LD 1571 section by section. I have included with each section an appreciation for what it is intended to do. I also attempted to summarize the input I received from various members of the stakeholder group. Finally I include recommendations on each section. The recommendations are my own and not those of the group as a whole. Individual members of the group may agree or disagree with some or all of what I recommend.

LD 1571 contains 28 proposals. Sections 12, 13, 14, and 21 are no longer necessary. LD 1244, An Act Regarding Payment of Medical Fees in the Workers' Compensation System was enacted in the last legislative session and it addresses the issues presented in sections 12, 13, and 14.

LD 1268, An Act to Allow the Repayment of Improperly Awarded Workers' Compensation Benefits, was enacted last session. It addresses the issue presented in section 21.

Sections 1 and 2 amend Title 39-A M.R.S.A. §107. The proposal provides full reimbursement to an employer if there is a successful third party civil action filed by an injured employee who collected workers' compensation benefits. Some members of our stakeholder group support this proposal. Others argue it would fly in the face of a well-established principle of American jurisprudence, the "common fund doctrine." This doctrine is founded on the principle that one who preserves or protects a common fund works for others as well as for himself, and the others so benefiting should bear their just share of the expenses, including reasonable attorney's fees; and that the most equitable way to secure such contribution is to make such expenses a charge on the fund so protected or recovered. In short, if the employer/insurance carrier benefits from the work of an employee's attorney who successfully pursued a civil action, then they should pay for the fruits of that labor. I recommend not adopting what is proposed in sections 1 and 2.

Section 3 amends Title 39-A M.R.S.A. §151. This is the statutory provision that creates the mechanism for Board appointments. At present, the statute allows the AFL-CIO or other bona fide labor organizations or associations to supply names to the Governor for the appointment of labor members of the Board. Correspondingly, it allows the Chamber of Commerce or some other business organization the opportunity to provide names for management appointments. The proposed amendment would allow the Governor to appoint one labor representative from a list provided by the AFL-CIO and the remaining two members would be the Governor's designees. The appointment process for management members of the Board would not change.

On an annual basis, the Governor is obligated to appoint numerous individuals to state boards and commissions. This is particularly true when there is a change of administrations. The idea of having names provided to the Governor by special interest groups is attractive. The stakeholder group split along labor/management lines as to whether the proposed change makes sense. It appears one of the issues that would be addressed by the proposed change is a more balanced representation of the injured employee community. The proposal being offered would not achieve that goal. If the idea is to achieve balance, perhaps the better way to do this is to allow the executive board of the Maine AFL-CIO to nominate, but, in doing so, they should be charged with offering names, but ensure the names come from not only members of organized labor, but other employee groups, perhaps providing a specific number of positions for those who are not part of organized labor. Likewise, the same would hold true for the appointment of management members of the Board. I recommend a study group be established to review the nomination process to insure the representative inclusion of employer and employee groups on the Board.

Section 4 eliminates Title 39-A M.R.S.A. §153(2). Title 39-A M.R.S.A. §153(2) establishes the troubleshooter program of the Workers' Compensation Board. Troubleshooting was initiated as a reform in 1992. The Maine Workers' Compensation Act was significantly changed in 1992 to reduce litigation and ensure the prompt payment of benefits to injured workers. The troubleshooter program was an integral part of that legislative scheme. At present, the troubleshooter program works extremely well. The stakeholder group considered statistics for the last 10 years. Board records demonstrate that on average 9,998 cases are referred to troubleshooting annually. The troubleshooters are charged with contacting the parties, identifying issues, and resolving the issues if they are capable of informal resolution. If the cases are not resolved, they are forwarded to mediation. Our numbers demonstrate that over the last 10 years, on average, 3,359 cases a year were sent to mediation. This figure shows us the

troubleshooters resolved 66.4% of the claims they processed. This is a commendable success rate. Troubleshooting works and should be maintained. At present there are 4.5 troubleshooters. This group processes almost 10,000 cases per year. If the troubleshooter program is eliminated, it is believed there would be an increase in litigation and the Board would have to proportionally increase the size of its advocate staff. Advocates are attorneys. The salary structure for advocates is higher than that of troubleshooters. The net result of this proposal would be to increase litigation, slow down claims processing, and make the system more costly. I recommend rejecting this proposal.

Section 5 concerns Title 39-A M.R.S.A. §153(6). This statutory provision establishes the Board's mediation program. LD 1571 provides mediation would occur only in cases where both parties request mediation. This would be a mistake. The stakeholder group was shown numbers covering troubleshooting, mediation, and formal hearing over the last 10 years. On average, 3,359 cases are referred to mediation annually. If mediation fails, the claims are more often than not sent to formal hearings. Our 10-year statistics demonstrate that on an annual basis 2,324 cases are the subject of formal hearings. This shows that 30.1% of all cases sent to mediation do not go to a formal hearing. This does not necessarily mean they were fully resolved at mediation; but, one has to believe the mediation process plays some role in the resolution of the cases. We believe mediation is effective. The stakeholder group discussed this process and a concern is that if mediation is voluntary there will be more litigation. Mediation is an important part of the 1992 reforms. Mediation works and should be maintained. As an aside, the time period between a case being assigned to a troubleshooter and the case being fully mediated is on average less than 90 days. During that 90-day period, the numbers demonstrate that 76.8% of cases are resolved. Only 23.2% reach the formal hearing stage. These numbers demonstrate that the combination of troubleshooting and mediation works in our system. The proposal in Section 5 should be rejected.

Section 6 concerns Title 39-A M.R.S.A. §153 which concerns Title 39-A M.R.S.A. §213. This section will be discussed in conjunction with §213.

Section 7 concerns Title 39-A M.R.S.A. §153(9). Section 153(9) provides for Board auditing and enforcement and extends auditing authority over the Maine Insurance Guaranty Association. The proposed legislation would eliminate the Board's auditing and enforcement authority over the Maine Insurance Guaranty Association. The stakeholder group, other than two of the individuals, had no strong feelings on this proposal. The employee representatives were concerned that someone should be responsible for auditing the Maine Insurance Guaranty Association to ensure the association is complying with its obligations to promptly and properly pay injured employees. A sense of the group is they should be audited by someone, either the Workers' Compensation Board, who has the experts that do this work all the time, or the Bureau of Insurance. If the Bureau of Insurance is capable of doing this work, and is willing to do it, then perhaps changing the authority to them is acceptable. While I have no strong recommendation on this proposal, I would counsel against transferring this responsibility to the Bureau of Insurance unless the Bureau expresses a desire to undertake the work.

Section 8 concerns Title 39-A M.R.S.A. §153(A)(2) which defines who is eligible for the appointment of an advocate. Advocates represent employees in contested cases. Typically an

advocate is assigned to an injured employee after troubleshooting. If the legislature eliminates troubleshooting, the Board would likely allow the appointment of advocates earlier. This will increase the workload of the advocates and likely result in a need for additional advocate staff. Following the recommendation made in Section 4, I do not believe the troubleshooter program should be eliminated.

Section 9 concerns Title 39-A M.R.S.A. §201(5). At present, the Act provides “if an employee suffers a non-work related injury or disease that is not causally connected to a previous compensable injury, the subsequent non-work related injury or disease is not compensable under the Act.” LD 1571 adds the following: “If an employee otherwise receiving workers’ compensation benefits becomes totally disabled as a result of an independent cause, the employee’s rights and benefits cease for the duration of such total disability.” This proposal was discussed at length by the stakeholder group. The proposal is intended to address a decision issued by our Law Court in the matter of Roy v. Bath Iron Works 2008 ME 94, 952 A.2d 965 (Me. 2008) There is some validity to the proposed amendment. Its application, however, is problematic. It is difficult to balance the competing interests between the rights of an injured employee and an employer’s efforts to control costs. For example, if an employee is injured, is determined to be totally incapacitated, either by agreement of the parties or as a result of a Workers’ Compensation Board decree, and the employee then sustains a non-work related injury, is that employee now more than totally incapacitated? Should he be no longer entitled to benefits, or does the fact he is totally incapacitated by agreement or decree result in an entitlement to ongoing benefits? If an employee is totally or significantly incapacitated and has been out of the workforce because of that incapacity, the employee has not contributed to Social Security, likely does not have disability insurance, and is now incapacitated; how does the employee support herself or himself? Who would be responsible? It appears society at large and therefore the burden would be shifted from his work injury to society. It is recommended this issue be considered further in an effort to design a statutory scheme that allows for the continuation of benefits if the employee is totally or significantly incapacitated, but allowing a discontinuance of benefits if the level of incapacity at the time of the supervening independent event is modest.

Section 10 is an amendment to Title 39-A M.R.S.A. §205(9)(B)(2). It allows an employer, insurer, or group self-insurer to reduce or discontinue benefits pursuant to a decree while an appeal is pending. At present, if an employee receives an adverse decision, one that allows the employer to stop payment, and the employee takes an appeal, the employer cannot exercise the rights granted by the Board’s decision. Under our present law, if an employee takes an appeal the employee is entitled to ongoing benefits. In many cases this results in the overpayment of benefits. The proposed language is reasonable and should be adopted.

Section 11 concerns Title 39-A M.R.S.A. §207. The language in §207 allows an employer to have an injured employee examined by a doctor selected by the employer. This statutory provision has been around in various forms since our original Workers’ Compensation Act (1915). The first proposed change would eliminate the language that requires that an examining physician, surgeon, or a chiropractor have an “active practice” treating patients. The employee community considers the “active practice” language critical to insuring that the employer community use competent physicians to examine employees. At present, there is a shortage of

physicians willing to conduct non-treatment examinations of employees. In recent times, the Workers' Compensation Board has had cases where highly trained specialists in active practice have not been available to perform employer requested exams. Two instances recently arose in cases where there was a need for an evaluation by an urologist and an evaluation with a vascular surgeon. There were no actively practicing urologists in the state of Maine who were willing to evaluate the injured employee. There were, however, several retired urologists who were available. One has to wonder whether the mere act of retiring causes an experienced physician to suddenly forget how to perform a physical examination and forget all of the substantive knowledge the physician had concerning his or her unique area of practice. It would make sense to allow for the use of physicians who are not actively practicing when the need arises.

Section 11 further revises §207 of the Act with respect to an employee's right to have a physician, surgeon, or chiropractor of his or her own selection present at the time of the independent medical exam. Since 1915 physicians attending in this capacity have been reimbursed by the employer. This proposal changes the law so that the employee bears that cost. Recently, a cottage industry has developed where healthcare providers have made themselves available to attend employer requested medical examinations. A number of cases have addressed whether this is reasonable. It appears the spirit and purpose of the language in §207 is to allow a healthcare provider, who knows the employee and can help the process, to attend the exam. A physician who is a complete stranger would likely not be able to serve that purpose well. If the healthcare provider has been involved in the employee's care and treatment, and accompanies the employee to the independent medical exam, then the cost associated with that should be paid for by the employer. If on the other hand, the employee privately retains the services of a medical stranger for the purposes of having that stranger accompany the employee to the exam, then that cost should be born by someone other than the employer. I recommend this provision be modified so that the employee pays if the employee retains a non-treating physician to attend the exam, and the employer pays if a treating provider attends.

When this provision was initially made part of our Act, injured employees treated with physicians. Medical practice has evolved and changed significantly since the early twentieth century. Today many workers' compensation claimants are cared for by physician extenders-physician assistants, nurse practitioners, etc. If an employee's primary health care provider is not a physician, it would be difficult to impossible to have a physician accompany the employee to a §207 examination. I recommend the language of the statute catch up with modern medicine and allow the employee to be accompanied by the employee's primary health care provider, a physician, surgeon, chiropractor, physician assistant, nurse practitioner or other formally recognized and licensed medical professional.

Sections 15, 16, 17, and 18 amend Title 39-A M.R.S.A. §213. More time was spent discussing this proposal and §213 than any other part of LD 1571. There is no easy answer to the question to how to adequately compensate partially incapacitated employees and at the same time be fair to the employer community. A brief history of the payment of partial compensation is helpful.

The original Workers' Compensation Act provided for the payment of partial benefits for 300 weeks from the date of injury. Once 300 calendar weeks passed, the injured employee's entitlement to partial benefits expired. This scheme lasted for 55 years. In 1970, the 300 week

limit was expanded to 325 weeks. Once again, with the expiration of 325 calendar weeks, an employee's entitlement to partial benefits expired. In 1975, the weekly limit was eliminated. There were many major reforms in workers' compensation at this time, in large part, based on recommendations from the National Commission on Workers' Compensation Laws. In 1987, durational limits were reintroduced. The limit in 1987 was 400 weeks after the injured employee reached the stage of "maximum medical improvement."

In 1991, the Act was amended again removing the maximum medical improvement provision and providing for the payment of partial benefits for a period not to exceed 520 weeks. This remained the case until the 1992 reforms.

We now have a system that allows for a durational limit based on the injured employee's level of permanent impairment. The design is intended to allow the most seriously injured to collect partial benefits for the duration of incapacity. This could be lifetime. Those less injured presently have a cap of 520 weeks. Under current law, the intent is for 25% of employees to have no cap on partial benefits. The remaining 75% have a durational limit on their entitlement to partial benefits. These percentages are arbitrary and difficult to verify. The determinative factor is the employee's level of permanent impairment. This also is arbitrary in that there is no good data demonstrating a correlation between permanent impairment and incapacity. Our present system for paying partial indemnity benefits invites controversy and litigation. Neither the employee nor the employer community benefit from this system. It should be changed. Any change, however, should have a focus on being fair to the parties. In addition, it should bring certainty and simplicity.

In November of 2009, an actuary who worked with the Board on §213 issues was asked to review data provided by the Board and recommend a "single benefit duration." He did. At the time, his report was not shared with the workers' compensation community. It surfaced recently and was shared with the stakeholder group. Actuaries work with data and assumptions. The Board's actuary did this and arrived at two weighted averages. His review of the available data suggested two time frames. They were, at the low end, 9.5 years, or 494 weeks. On the upper end, 14.25 years or 741 weeks. The average of these rounds out to 618 weeks, or 11.8 years of benefits. I recommend the proposal in LD 1571 for changing Title 39-A M.R.S.A. §213 be rejected and, in the alternative, a system allowing for benefits for a period of 618 weeks be implemented.

There may be instances where 618 weeks of partial benefits is inadequate. In those cases where there is extreme financial hardship, the employee should be allowed to petition the Board to, in the exercise of its discretion, extend benefits beyond 618 weeks. Language much like this exists in our present Act. Since 1999 there have been eighteen "extreme financial hardship" appeals to the Board. A claim granting additional benefits should be subject to Board review no sooner than three years from a Board order or agreement extending benefits.

Additionally, I recommend the maximum benefit level provided for in Title 39-A M.R.S.A. §211 be changed so that injured workers with a high average weekly wage be adequately compensated for their loss. At present, the maximum benefit level is established at 90% of the state average weekly wage and that figure is adjusted annually. My recommendation is that the number

increase to 100% of the state average weekly wage. This figure only applies to highly compensated injured employees. An increase in the compensation rate is recommended only if a fixed period of 618 weeks is adopted.

Section 19 concerns Title 39-A M.R.S.A. §223, a retirement presumption in the Workers' Compensation Act. Section 223 comes into play when an employee terminates active employment and is receiving non-disability pension or retirement benefits. The proposal would eliminate the language "terminates active employment." This language was the subject of a lively discussion with the stakeholder group. The management community is rightfully concerned that if an employee is collecting a pension or retirement benefit the employee should not be entitled to workers' compensation benefits. There are, however, instances that undercut the validity of that argument. The first, most common, situation arises when an employee retires, but due to economic circumstances finds that he has to return to work for another employer. If the employee's injury becomes symptomatic and incapacitating, should he not be treated the same as all non-retired employees and be allowed to collect workers' compensation benefits? Surely, this situation should allow for the collection of benefits. There are also cases where the injured employee retires but, once retired, has a flare-up of a pre-existing compensable work injury, one that is incapacitating. Should the employee not be entitled to benefits? Perhaps the provision of the Act that allows for a set-off of the retirement benefits should be strengthened to ensure there is a set-off in circumstances like this, but that the employee would be allowed to collect incapacity benefits. There is no easy answer to the application of this provision, but fortunately not many cases presenting this issue arise. If the economy continues to be as sluggish as it presently is, perhaps this statutory provision will become more important. I recommend keeping the status quo by rejecting the proposed amendment.

Section 20 concerns Title 39-A M.R.S.A. §306, the statute of limitations provision of the Act. Our Law Court several years ago rendered a decision in the matter of Wilson v. BIW, 2008 ME 47, 942 A.2d 1237 (Me. 2008). This decision has caused a significant amount of unrest in the business and insurer community because it holds the statute of limitations does not begin to run until a required first report of injury is filed. In many instances, employees sustain injuries but do not pursue lost time claims. There is no obligation to file a first report unless there is lost time. Wilson has opened the door for cases where injuries happened multiple years ago (in some cases more than 20 years ago) are prosecuted. The proposed amendment would eliminate these very old cases. It creates a statute of limitations that is two years from the time a first report should be filed, or in a case where no first report is required, two years from the date of injury, whichever is later. This amendment to the statute of limitations is reasonable, makes good sense, and should be adopted.

Section 22 addresses two issues. First, it removes the right of the Board to assess the Maine Insurance Guaranty Association penalties for failure to pay in a timely fashion. As noted earlier in this report, either the Workers' Compensation Board or the insurance commissioner needs to oversee the operations of the Maine Insurance Guaranty Association. The proposed amendment removes an effective tool to ensure compliance. If the Maine Insurance Guaranty Association is assessed a penalty, that penalty is spread to their members.

The second provision appearing in Section 22 has to do with assessing penalties. In this provision, the Board may not assess a fine in excess of \$25,000 unless the Board finds clear and convincing evidence the employer or insurance carrier intentionally and fraudulently failed to pay compensation. This proposal creates an extremely high standard of proof, one which would be very difficult to prove. It seems that adding the language requiring proof by clear and convincing evidence might be sufficient to eliminate borderline cases. Or perhaps adding the language that the carrier intentionally failed to pay would be helpful. Intentionally, fraudulently, and by clear and convincing evidence creates a proof requirement that will be met in a small number of, if any, cases. The proposed standard is much too high. I recommend the standard be one where there is clear and convincing evidence the carrier intentionally failed to pay benefits.

Section 23 addresses attorney's fees allowed in workers' compensation cases. This proposal is unnecessary. The Act presently allows for the payment of fees in a case tried to completion to not exceed 30% of the benefits accrued. This is reasonable. It also provides for a sliding scale when a case is settled. There is no obvious problem with the scheme as it presently exists. Adopting what is proposed may inhibit an injured employee from hiring counsel. I recommend the status quo be maintained.

It became obvious to me during the course of the summer, and after meeting with members of the stakeholder group, employee representatives, insurance representatives, and the business community, that LD 1571 is helpful in that it initiated discussion about workers' compensation issues, discussions which have not been held in recent years. As a result of these discussions, I am of the opinion that LD 1571 should not be enacted. Rather, I recommend that certain provisions be saved, but be presented to the legislature in a different form. In addition, I believe we can improve our Act by amending certain provisions and adopting others. My recommendation is we change the Act as follows:

1. Change the compensation rate to one that is simpler and more easily understood;
2. Provide injured employees protection from Review when participating in approved vocational rehabilitation plans;
3. Create an Appellate Division within the Board so that Maine is no longer the only state in the union that does not have an automatic right of appeal;
4. Change the notice period from 90 days to 30 days to help insure a safe workplace;
5. Amend the partial provision of the Act to limit benefits to a period not to exceed 618 weeks.

In that regard, the following is my proposal:

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

**Sec. 1. 39-A MRSA §205, sub-§9, ¶B**, as amended by PL 2009, c. 280, §1 and affected by §2, is further amended to read:

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

(1) If no order or award of compensation or compensation scheme has been entered,

the employer, insurer or group self-insurer may discontinue or reduce benefits by sending a certificate by certified mail to the employee and to the board, together with any information on which the employer, insurer or group self-insurer relied to support the discontinuance or reduction. The employer may discontinue or reduce benefits no earlier than 21 days from the date the certificate was mailed to the employee, except that benefits paid pursuant to section 212, subsection 1 or section 213, subsection 1 may be discontinued or reduced based on the amount of actual documented earnings paid to the employee during the 21-day period if the employer files with the board the documentation or evidence that substantiates the earnings and the employer only reduces or discontinues benefits for any week for which it possesses evidence of such earning. The certificate must advise the employee of the date when the employee's benefits will be discontinued or reduced, as well as other information as prescribed by the board, including the employee's appeal rights.

(2) If an order or award of compensation or compensation scheme has been entered, the employer, insurer or group self-insurer shall petition the board for an order to reduce or discontinue benefits and may not reduce or discontinue benefits until the matter has been finally resolved ~~through the dispute resolution procedures of this Act, any appeal proceedings have been completed and an order of reduction or discontinuance has been entered by the board~~ by a decree issued by a hearing officer. The employer, insurer or group self-insurer may reduce or discontinue benefits pursuant to such a decree pending an appeal from that decree. Upon the filing of a petition, the employer may discontinue or reduce the weekly benefits being paid pursuant to section 212, subsection 1 or section 213, subsection 1 based on the amount of actual documented earnings paid to the employee after filing the petition. The employer shall file with the board the documentation or evidence that substantiates the earnings and the employer may discontinue or reduce weekly benefits only for weeks for which the employer possesses evidence of such earnings.

**Sec. 2. 39-A MRSA §211**, as amended by P.L. 1995, c. 560 §G20 is further amended to read:

Effective January 1, 1993, the maximum weekly benefit payable under section 212, 213 or 215 is \$441 or 90% of state average weekly wage, whichever is higher. Beginning on July 1, 1994, the maximum benefit level is the higher of \$441 or 90% of the state average weekly wage as adjusted annually utilizing the state average weekly wage as determined by the Department of Labor. Beginning on July 1, 2012, the maximum benefit level is the higher of \$441 or 100% of the state average weekly wage as adjusted annually utilizing the state average weekly wage as determined by the Department of Labor.

**Sec. 3. 39-A MRSA §212 sub-§1-A**, is enacted to read:

**1-A. Total incapacity.** For dates of injury on or after XXXXX, XX, XXXX, while the incapacity for work resulting from the injury is total, the employer shall pay the injured employee a weekly compensation equal to 2/3 of the employee's gross average weekly wages, earnings or salary, but not more than the maximum benefit under section 211. Compensation must be paid for the duration of the incapacity.

**Sec. 4. 39-A MRSA §213 sub-§1-A,** is enacted to read:

**1-A. Benefit and duration.** For dates of injury on or after XXXXX, XX, XXXX, while the incapacity for work is partial, the employer shall pay the injured employee a weekly compensation equal to 2/3 the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the weekly wages, earnings or salary which the employee is able to earn after the injury, but not more than the maximum benefit under section 211. An employee is not eligible to receive compensation under this section after the employee has received 618 weeks of compensation under section 212, subsection 1, this section or both. The board may in the exercise of its discretion extend the duration of benefit entitlement beyond 618 weeks in cases involving extreme financial hardship due to inability to return to gainful employment. This authority may be delegated by the board, on a case-by-case basis, to a hearing officer or a panel of 3 hearing officers. Decisions made under this subsection must be made expeditiously. A decision under this subsection made by a hearing officer or a panel of 3 hearing officers may not be appealed to the board under section 320, but may be appealed pursuant to section 322.

Orders extending benefits beyond 618 weeks are subject to review no sooner than three years from the Board order or request allowing an extension.

**Sec. 5. 39-A MRSA §214 sub-§B-1,** is enacted to read:

**B-1.** For dates of injury on or after XXXXX, XX, XXXX, if an employee is employed at any job and the average weekly wage of the employee is less than that which the employee received before the date of injury, the employee is entitled to receive weekly benefits under this Act equal to 2/3 the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the weekly wages, earnings or salary which the employee is able to earn after the injury, but not more than the maximum weekly rate of compensation, as determined under section 211.

**Sec. 6. 39-A MRSA §215 sub-§1-A,** is enacted to read:

**1-A. Death of employee.** For dates of injury on or after XXXXX, XX, XXXX, if death results from the injury of an employee, the employer shall pay or cause to be paid to the dependents of the employee who were wholly dependent upon the employee's earnings for support at the time of the injury, a weekly payment equal to 2/3 of the employee's gross average weekly wages, earnings or salary, but not more than the maximum benefit under section 211, for a period of 500 weeks from the date of death.

**Sec. 7. 39-A MRSA §221 sub-§2, ¶A-1**, is enacted to read:

A-1. For dates of injury on or after XXXXX, XX, XXXX, "after-tax amount" means the net weekly amount of any old age insurance benefit or benefit under an employee benefit plan, reduced by the prorated weekly amount which would have been paid, if any, in social security, federal income and state income taxes, calculated on an annual basis. The after tax amount of any benefits subject to income taxes shall be determined by using the maximum number of dependents' allowances to which the employee is entitled and the standard deduction or zero bracket amount applicable to the employee's filing status.

**Sec. 8. 39-A MRSA §217 sub-§8**, is enacted to read:

**8. Presumption.** If an employee is participating in a rehabilitation plan ordered pursuant to subsection 2, there is a presumption that work is unavailable to the employee for as long as the employee continues to participate in vocational rehabilitation.

**Sec. 9. 39-A MRSA §301, last ¶**, as enacted by PL 1991, c. 885, Pt. A, §8 and affected by §§9 to 11, is amended to read:

For dates of injury prior to XXXX, XX, XXXX, Proceedings for compensation under this Act, except as provided, may not be maintained unless a notice of the injury is given within 90 days after the date of injury. For dates of injury on or after XXXX, XX, XXXX, proceedings for compensation under this Act, except as provided, may not be maintained unless a notice of the injury is given within 30 days after the date of injury. The notice must include the time, place, cause and nature of the injury, together with the name and address of the injured employee. The notice must be given by the injured employee or by a person in the employee's behalf, or, in the event of the employee's death, by the employee's legal representatives, or by a dependent or by a person in behalf of either.

**Sec. 10. 39-A MRSA §306, sub-§1**, as enacted by PL 1999, c. 354, §6 and affected by §10, is amended to read:

**1. Statute of limitations.** Except as provided in this section, a petition brought under this Act is barred unless filed within 2 years after the date of injury or the date the employee's employer files a required first report of injury asif required in section 303, whichever is later.

**Sec. 11. 39-A MRSA §320, second ¶**, as amended by 2003, c. 608, §13, is further amended to read:

If a hearing officer asks for review, the time for appeal to the ~~Law Court~~ Appellate Division pursuant to section ~~322~~ 321-B is stayed and no further action may be taken until a decision of the board has been made. If the board reviews a decision of a hearing officer, any appeal must be

from the decision of the board. The time for appeal begins upon the board's issuance of a written decision on the merits of the case or written notice that the board denies review.

**Sec. 12. 39-A MRSA §321-A**, is enacted to read:

**§ 321-A. Appellate Division created**

**1. Composition.** There is created the Appellate Division of the Workers' Compensation Board. It shall be composed of panels consisting of not less than 3 full-time hearing officers. The members of each panel shall be appointed by the Executive Director of the Workers' Compensation Board from those currently serving as full-time hearing officers of the Workers' Compensation Board. No hearing officer may be a member of a panel which reviews that hearing officer's decision. A hearing officer may be a member of more than one panel at the discretion of the Executive Director of the Board.

**2. Rules.** The board shall establish uniform rules of procedure calculated to provide a prompt and inexpensive review of a decision by a hearing officer.

**Sec. 13. 39-A MRSA §321-B**, is enacted to read:

**§ 321-B. Appeal from hearing officer decision**

**1. Procedure.** An appeal shall be taken from a decision by a hearing officer by filing a copy of the decision, order or agreement, with the division within 20 days after receipt of notice of the filing of the decision by the hearing officer.

Any party in interest may present copies of any order, decision or agreement to the division.

The failure of an appellant who timely notifies the division of the appellant's desire to appeal to provide a copy of the decision, order or agreement appealed from shall not affect the jurisdiction of the division to determine the appeal on its merits unless the appellee shows substantial prejudice from that failure.

This section shall apply to cases now pending before the appellate division and to cases hereafter filed.

**2. Basis.** There shall be no appeal upon questions of fact found by any hearing officer.

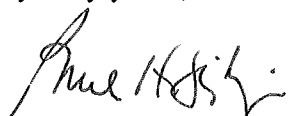
**3. Action.** The division, after due consideration, may reverse or modify any decree of the Board and shall issue a written decision. The written decision of the division shall be filed with the Board and mailed to the parties or their counsel.

4. Publication of decisions. The division shall publish its decisions and make them available to the public at such cost as is required to pay for suitable publication. Copies of all written decisions shall be distributed to the State Law Library and the county law libraries.

**Sec. 14. 39-A MRSA §322, sub-§1**, as enacted by PL 1991, c. 885, Pt. A, §8 and affected by §§9 to 11, is amended to read:

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

Very truly yours,



Paul H. Sighinolfi, Esq.  
Executive Director/Chair

Cc: Senator Thomas H. Martin, Jr.  
Senator Troy Dale Jackson  
Representative Dana L. Dow  
Representative Melvin Newendyke  
Representative Amy Fern Volk  
Representative Andre Cushing  
Representative John L. Tuttle, Jr.  
Representative Timothy E. Driscoll  
Representative Paul E. Gilbert  
Representative Robert B. Hunt  
Representative Erin D. Herbig