OREGON
WORKERS'
COMPENSATION

Monitoring the Key Components of Legislative Reform

Sixth Edition

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Oregon Workers' Compensation: Monitoring the Key Components of Legislative Reform

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Introduction

This report is the sixth in a series that describes Oregon's workers' compensation system and shows the effect legislative reform has had. The last edition was published in January 2001 and covered the period 1987 - 1999. This report adds statutory changes made by the 2001 legislature and provides new data through 2001. The report contains nine sections and two appendices. Each section includes descriptions of legislative changes, major findings, and numerical data. The appendices contain a summary of the changes in legislation and a summary of selected court cases.

During the period covered by this report, the Oregon workers' compensation system has undergone major changes. In 1986, Oregon ranked 6th highest in the nation in the average workers' compensation premium rates paid by employers. It also had one of the nation's highest occupational injury and illness claims rates. To improve the system, the 1987 legislature enacted House Bill 2900. This bill expanded the requirements for safety and health loss prevention programs, increased penalties against employers who violate the state safety and health act, created the Preferred Worker Program and limited other vocational assistance, increased benefits, limited the authority of the Workers' Compensation Board, and created the Ombudsman for Injured Workers. A companion bill, HB 2271, limited mental stress claims and placed on the worker the burden of proving that a claim is compensable.

Three years later, Oregon's premium rate ranking had improved only slightly, to 8th highest in the nation. Workers' compensation costs remained high, and SAIF Corporation had canceled many small employer policies. These conditions provided the impetus for further reforms. During a May 1990 special session, the legislature passed Senate Bill 1197 and other legislation. SB 1197 expanded the requirement for safety and health committees, required that the department's disability standards be used at claim closure and for all subsequent litigation, required that the department create a workers' compensation claims examiner program, limited attending physicians and palliative care, allowed the use of managed care organizations, modified the Preferred Worker Program so that its costs were excluded from ratemaking, increased benefits, created Claims Disposition Agreements, expanded the department's administrative dispute resolution processes, and created the Ombudsman for Small Business and the Management-Labor Advisory Committee. It also redefined compensable claims, stating that the injury must be the major contributing cause for the need for treatment and that the claim was compensable only as long as the compensable condition remained the major contributing cause for the need for treatment. To allow insurers more time to investigate claims, the bill increased the period for claim acceptance or denial from 60 to 90 days. Also, OR-OSHA staffing was increased. Following the passage of SB 1197, workers' compensation premium rates began falling rapidly; in 1994, Oregon had the 32nd highest premium rate ranking in the country.

By the end of 1994, several court decisions had interpreted the intent of some of the legislative provisions. Then, in February 1995, the Oregon Supreme Court ruled in *Errand v. Cascade Steel Rolling Mills* that the exclusive remedy provision of workers' compensation law applied only to compensable claims, not to denied claims. In response to these decisions, the 1995 legislature passed SB 369. This bill restated the legislative intent of SB 1197 by revising the definitions of compensability, disabling claims, and objective findings. It also stated that the exclusive remedy provisions applied to all claims. The bill also created the Worksite Redesign Program and expanded the Employer-at-Injury Program.

The 1997 and 1999 legislatures made few major changes to the workers' compensation system. Changes tended to limit the department's functions and expand insurers' responsibilities. The 1997 legislature eliminated the State Advisory Council on Occupational Safety and Health. The 1999 legislature eliminated the department's claim examiner program and the department's responsibility to establish medical utilization and treatment standards; both responsibilities had been added by SB 1197. The 1999 legislature also transferred all claim closure responsibility from the department to insurers and self-insured employers.

The 1999 legislature allocated funds for a study of the effects of some of the changes to the workers' compensation law. A group of nationally known researchers measured the effects on costs and benefits of the major contributing cause language and discussed related issues. The findings are summarized in the compensability section of this report. The full report can be found at www.cbs.state.or.us/wcd/docs/finalmcc.pdf.

For budgetary reasons, the 2001 legislature further limited the department's oversight. The numbers of health and safety inspectors and consultants and reemployment assistance consultants were reduced, and funding for the Workplace Redesign Program was eliminated. The functions were not needed because of the decline in disabling claims and the availability of private-sector programs.

The 2001 legislature passed one major bill: SB 485. In part, this was a response to another court decision. In May 2001, the Oregon Supreme Court ruled in *Smothers v. Gresham Transfer, Inc.*, that some of the exclusive remedy provisions in SB 369 were unconstitutional. Workers whose claims were denied because their injuries were not the major contributing cause of the need for treatment were permitted to pursue civil action against their employers. SB 485 created a process for these suits. It also revised the definitions of preexisting conditions and stated that the employer has the burden of proof in showing that the compensable condition is not the major contributing cause of the need for treatment. The legislature also mandated that a legislative proposal for a revised system be created in time for the 2003 session.

SB 485 and companion bills included other important changes. To address worker concerns, it expanded the calculation of temporary disability benefits to include the time lost from multiple jobs, added the right of workers to submit depositions during the reconsideration process, and added the ability of some workers to have medical exams during the claim denial hearing process. To lessen the uncertainty of the claims process, the bill clarified time limits in the claim process, reduced the time an insurer has to accept or deny a claim from 90 to 60 days, and added the responsibility for workers' compensation insurers to pay for some medical services prior to a claim denial.

In addition to these reforms, the 1987 legislature created the Department of Insurance and Finance. In 1993 the department was restructured, and its name was changed to the Department of Consumer and Business Services. This agency contains nearly all of the administrative and adjudicative functions of the workers' compensation system. These functions include providing safety and health enforcement and consultative services; regulating the workers' compensation system; setting workers' compensation insurance rates; and resolving disputes administratively through a dispute resolution process.

Under the leadership of three governors and the legislature, and with much assistance from business and labor leaders, Oregon has become a national model for workers' compensation and workplace safety and health. When considering reform, other states look at Oregon's compensibility standards, safety committees, return-to-work programs, advisory committees, and ombudsman offices.

Highlights

- Between 1987 and 2001, the number of accepted disabling claims dropped 40 percent, and the number of compensable fatalities dropped 56 percent. Over the same period, employment grew 46 percent.

- Permanent partial disability claims decreased 46 percent from 1987 to 2001, and the PPD rate per employee dropped 63 percent during the same period.

- Injury and illness frequencies, as measured by the U.S. Bureau of Labor Statistics, have dropped substantially. The lost workday cases incidence rate and the total cases incidence rate decreased 43 percent from 1987 to 2001.

- In 2000, the Oregon Population Survey included questions about work-related injuries. About 7 percent of employed Oregonians reported that they had suffered at least one workplace injury in the past year. Forty percent of these injured workers did not file a workers' compensation claim. Of those who did not file a claim, 56 percent reported that they missed at least one day from work; their average was 15 days.

- There were 5,380 OR-OSHA inspections in FFY 2001, 6 percent fewer than in 1988. Approximately 198,000 employees were covered by these inspections, the highest number since FFY 1995.

- Workers' compensation premium rates have decreased by 57.4 percent since 1990, saving Oregon employers $7.5 billion in direct costs. Based on 2002 premium rates, Oregon's average workers' compensation premium rate ranked 35th highest in the nation, a significant improvement from sixth highest in 1986.

- The denial rate of disabling claims has remained relatively stable since FY 1993; the current denial rate of 17 percent is three percentage points higher than in FY 1989.

- The median number of days insurers took to accept a disabling claim increased 68 percent from 1990 to 1998; it declined 23 percent between 1998 and the first half of 2002.

- Insurer performance on timeliness of acceptance or denial of claims improved from 85 percent in 1990 to 96 percent in 1994. It was 92 percent in 2001.

- The Oregon workers' compensation system was one of the first in the nation to identify and investigate allegations of inappropriate actions by employers, insurers, workers, and others. In FY 2002, 122 investigations of fraud or abuse complaints were opened.

- Approximately 1.1 million employees, 69 percent of Oregon's workers, are now covered for medical services by managed care organizations.

- Vocational assistance cases decreased by over 90 percent from 1987 to 2001; costs as a percentage of premium have been cut in half.

- The Preferred Worker Program, which provides incentives for employers to hire injured workers, grew 75 percent from fiscal year 1988 to 1996. Since then, the number of workers assisted has dropped faster than the number of PPD cases.

- The Employer-at-Injury Program, which provides benefits to employers who return their injured employees to work quickly, grew from 447 programs in 1993 to 10,069 programs in 1998 before declining; there were 8,596 programs in 2001. Approximately 4,400 of the programs approved in 2001 were for nondisabling claims; as a result, thousands of claims were closed before being classified as disabling.

- Injured workers who use their Preferred Worker benefits or whose employers use the EAIP are nearly twice as likely to be working 13 quarters after their injury than are injured workers who resolve their claims with a CDA.

- Maximum scheduled and unscheduled PPD benefits for injured workers received a tremendous boost in 1995. With subsequent increases, the maximum scheduled PPD benefits were 347 percent higher at the end of fiscal year 2002 than in fiscal year 1987; unscheduled PPD benefits were 407 percent higher. Maximum PPD benefits are now almost at the national median.

- A national study has shown that for PPD claims, Oregon's indemnity payments replace 42 percent of pre-tax wages. This is below the researchers' standards for adequate PPD benefits, which they set at 67 percent of pre-tax wages.

- Requests for hearing have dropped 60 percent since 1989; requests for board review have declined 59 percent between 1991 and 2001.

- Hearing request rates on disabling claim closures decreased from 21 percent in 1989 to five percent in 2001. Permanent disability, which was at issue in 46 percent of hearing orders in 1987, was at issue in only six percent of the 2001 orders.

- Claimant attorney fees dropped from a peak of $21.4 million in 1991 to $16.0 million in 2001. Insurer attorney fees totaled $24.7 million.

- The number of contacts with the office of the Ombudsman for Injured Workers increased 54 percent between 1997 and 2001. The issues that prompted the most inquiries were benefits, medical issues, claim processing issues, and settlements.

The best way to reduce the costs and suffering associated with workers' compensation claims is to reduce workplace injuries, illnesses, and fatalities. The department's Occupational Safety and Health Division provides leadership and support to business and labor through both enforcement programs and voluntary services.

Between 1987 and 1991, the Oregon legislature increased the emphasis on safety and health in the workplace. This was done in a number of ways: by increasing the safety and health enforcement, training, and consultative staff; by increasing penalties against employers who violate state safety and health regulations; by requiring insurer loss prevention consultative services; by providing employer and employee training opportunities through a grant program; by requiring joint labor-management safety committees; and, by targeting safety and health inspections more effectively.

Most of the more recent legislative changes have affected agriculture. In 1995, small agricultural employers who had not had serious accidents and who followed specified training and consultation schedules were exempted from scheduled inspections. Small agriculture employers without high injury rates were exempted from OR-OSHA's safety committee requirements. In 1997, the legislature transferred from the Bureau of Labor and Industries to the department the authority for enforcement of the law that requires farmworker camp operators to provide seven days of housing in the event of camp closure by a government agency. The 1999 legislature exempted corporate farms for which the farm's only employees are family members from occupational safety and health requirements. In 2001, HB 3573 created the Farmworker Housing Development Account and directed that the money collected from civil penalties imposed for the non-registration of farmworker camps be put into the account.

In 1999, the legislature also passed HB 2830. It directed OR-OSHA to notify certain employers of the increased likelihood of an inspection and to focus OR-OSHA enforcement activities on the most unsafe workplaces.

Partnerships

OR-OSHA is monitored by federal OSHA by means of its strategic plan. OR-OSHA developed its strategic plan over 18 months with input from Oregon employers and labor groups. OR-OSHA's five-year strategic plan was the first to be approved by federal OSHA and became a model for other states.

In federal fiscal year 1999, OR-OSHA developed programs and tools to lead employers toward self sufficiency in safety and health programs. One tool is a web-based assessment that provides employers and employees with a confidential means of evaluating their safety and health programs. Once the assessment is completed, employers may contact OR-OSHA for a consultation. OR-OSHA, in conjunction with the Oregon construction industry, also developed the Joint Emphasis Program to reduce construction injuries and fatalities. The program is a cooperative effort to design joint training sessions and to provide communication about safety problems and solutions.

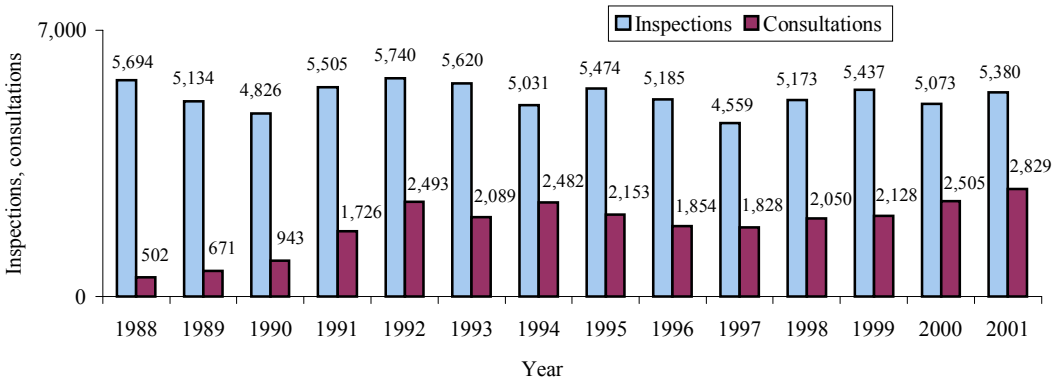
One factor in the success of OR-OSHA's consultation and enforcement activities is the performance of its consultants and compliance officers. The department's Information Management Division routinely surveys employers that have been inspected by OR-OSHA. The survey allows employers to rate the performance of compliance officers. On average, about 90 percent of completed questionnaires show good to excellent ratings for compliance officers in the areas of general knowledge of the job, professional and personal attributes, and clarity in the ability to explain the reason for the inspection and the rights and responsibilities of the firm inspected.

Consultative services

Between 1988 and 1992, OR-OSHA consultations increased 397 percent. After a period of decline, the number of consultations has increased again, rising 55 percent between 1997 and 2001. There is evidence that consultations have a large effect in reducing hazards. A 1995 department study found that OR-OSHA consultants noted 1,528 serious hazards at 107 establishments. Subsequent inspections of the same establishments resulted in citations for 173 alleged serious violations. This indicates that these employers had reduced serious hazards by 89 percent. A companion study found that the same establishments had an 18 percent decrease in accepted disabling injury claims in the two years following the consultation.

OR-OSHA also provides training of both employers and employees. Attendance at public education and conference training sessions has totaled almost 80,000 between 1998 and 2001.

Figure 1. OR-OSHA inspections and consultations, 1988-2001



Note: Inspections are by FFY; consultations are by calendar year.

From 1989 to 1999, workers' compensation insurance carriers provided mandatory loss prevention consultative services to employers. Employers with at least three accepted disabling claims and a claims rate above the statewide average or with at least 20 claims were required to receive these services. In an OR-OSHA administrative rule, effective July 15, 1999, insurers assumed the responsibility for identifying employers needing loss prevention services. As a result, the insurer must offer assistance in developing a loss prevention plan to each employer with a claims frequency or severity greater than the average for its industry. OR-OSHA continues to monitor and enforce the requirements of insurers to provide these services, but it no longer identifies the employers that receive services.

OR-OSHA inspections

Although the number of OR-OSHA inspections has varied from year to year, there has been no long-term increase in the number of inspections. The number of inspections totaled 5,380 in federal fiscal year 2001, fewer than the 5,694 inspections in 1988. Over the same period, the number of Oregon employers grew by 39 percent. OR-OSHA penalties assessed for employer violations of state safety and health standards was $2.4 million in federal fiscal year 2001. This amount was slightly higher than the 2000 amount of $2.3 million, which was the lowest amount since 1989.

OR-OSHA grants

Since 1990, OR-OSHA has awarded over $1.8 million in grants to nonprofit organizations and associations to develop innovative occupational safety and health training programs.

In 1995, with SB 369, the legislature created the Worksite Redesign Program. Between 1995 and 2001, OR-OSHA awarded Worksite Redesign Program project and product grants to develop new solutions to workplace ergonomic, health, and safety problems. They approved 50 Worksite Redesign project grants, totaling slightly over $4.0 million; they also approved 387 product grants, totaling almost $1.4 million. In 2001, SB 5507 eliminated funding for the program.

Figure 2. Accepted disabling claims and employment, 1987-2001

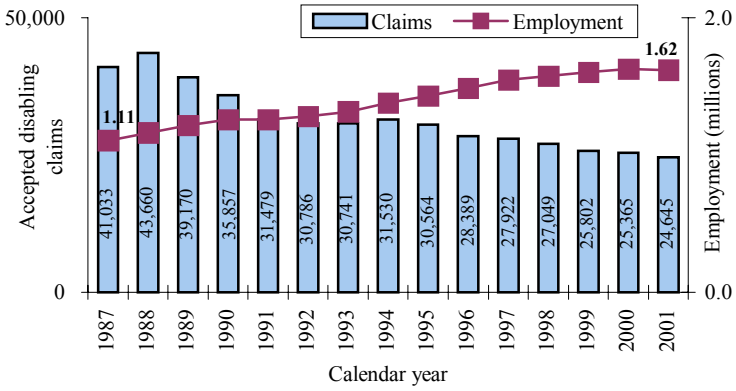


Figure 3. Compensable fatality rates per 100,000 workers, 1987-2001

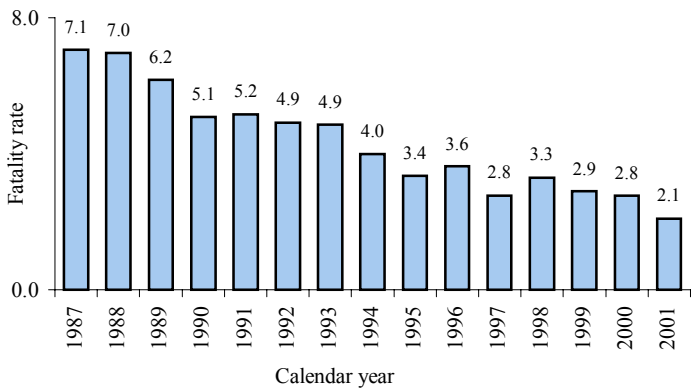
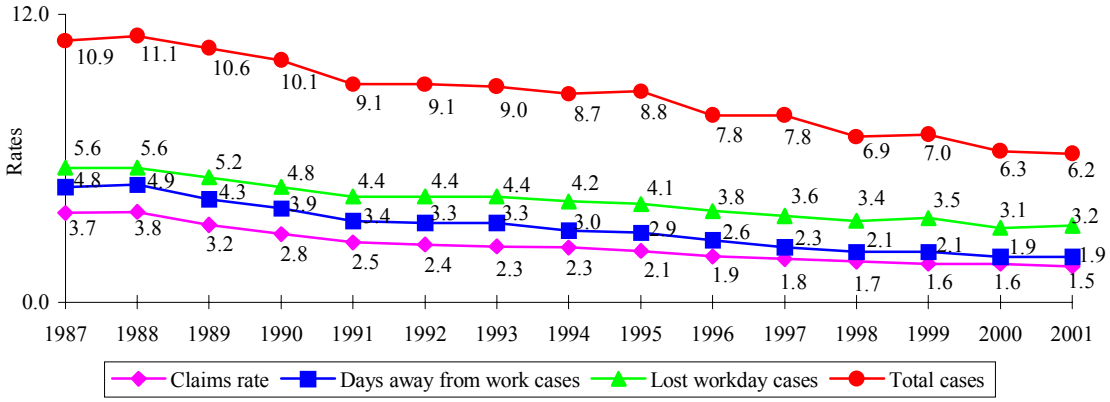


Figure 4. Accepted disabling claims rates and private sector occupational injuries and illnesses incidence rates, 1987-2001



Notes: The claims rate is the number of accepted disabling claims per 100 workers. The days away from work rate is the number of injuries and illnesses per 100 private sector workers that resulted in days away from work. The lost workday cases rate is the number of injuries and illnesses per 100 private sector workers that resulted in days away from work or restricted duty or both. The total cases incidence rate is the total number of injuries and illnesses per 100 private sector workers.

Injury rates

The numbers and rates of injuries and fatalities have dropped substantially over the past 15 years. From 1987 to 2001, employment grew 46 percent. In contrast, the number of accepted disabling claims decreased 40 percent. Compensable fatalities declined 56 percent between 1987 and 2001, to 34 in 2001. This is the fewest recorded in Oregon. As a result, the accepted disabling claims rate and the compensable fatality rate declined by 59 percent and 70 percent respectively. Also, as determined by the U. S. Bureau of Labor Statistics survey of employers, the lost workday cases incidence rate decreased by 43 percent from 1987 to 2001; the total cases rate dropped the same amount.

It is difficult to determine how much the increased emphasis on the safety and health has affected work-related claims and frequencies. Changes in the definition of compensability, insurer claims management practices, and alterations in the economy and industrial mix affect changes in both claims volume and rates. National data shows that claims and incidence rates have fallen at rates similar to Oregon's rates. There is also a question of data reporting. In 2000, for the first time, the Oregon Population Survey included questions about work-related injuries. About 7.4 percent of employed Oregonians reported that they had suffered at least one workplace injury in the past year. Forty percent of these injured workers did not file a workers' compensation claim. Of those who did not file a claim, 56 percent reported that they missed at least one day of work; the average was 15 days. The costs of these unreported injuries are presumably paid through employer health insurance and other benefits, rather than through workers' compensation insurance.

Despite these qualifications, the increased emphasis on safety and health has played a major role in the reduction of workers' compensation costs in Oregon.

Statistics

Accepted disabling claims, employment, and claims rates, 1987-2001

Year	Accepted disabling claims	Employ-ment (1000s)	Claims rate (per 100)
1987	41,033	1,105.2	3.7
1988	43,660	1,161.1	3.8
1989	39,170	1,214.9	3.2
1990	35,857	1,258.6	2.8
1991	31,479	1,258.6	2.5
1992	30,786	1,280.5	2.4
1993	30,741	1,317.1	2.3
1994	31,530	1,378.8	2.3
1995	30,564	1,431.6	2.1
1996	28,389	1,487.3	1.9
1997	27,922	1,547.8	1.8
1998	27,049	1,576.1	1.7
1999	25,802	1,602.7	1.6
2000	25,365	1,627.6	1.6
2001	24,645	1,619.0	1.5

The number of accepted disabling claims decreased by 40 percent between 1987 and 2001; employment grew 46 percent over the same period. The claims rate declined by 59 percent over the period.

Permanent partial disability claims, 1987-2001

Year	PPD claims	PPD rate (per 100,000)
1987	12,877	1,165
1988	12,336	1,062
1989	13,800	1,136
1990	13,731	1,091
1991	9,980	793
1992	9,562	747
1993	9,349	710
1994	9,529	691
1995	9,491	663
1996	9,060	609
1997	8,064	521
1998	7,764	493
1999	7,445	465
2000	7,058	434
2001	6,986	432

The number of PPD claims decreased 46 percent between 1987 and 2001, and the PPD rate decreased 63 percent. Much of this reduction can be attributed to increased emphasis upon workplace safety and health.

Compensable fatalities, 1987-2001

Year	Number of fatalities	Fatality rate (per 100,000)
1987	78	7.1
1988	81	7.0
1989	75	6.2
1990	64	5.1
1991	65	5.2
1992	63	4.9
1993	64	4.9
1994	55	4.0
1995	48	3.4
1996	54	3.6
1997	43	2.8
1998	52	3.3
1999	47	2.9
2000	45	2.8
2001	34	2.1

The number of compensable fatalities decreased 56 percent from 1987 to 2001. The 34 deaths in 2001 were the lowest recorded in Oregon. The fatality rate in 2001 was 70 percent lower than the 1987 rate.

Statistics

Occupational injuries and illnesses incidence rates, private sector, 1987-2001

Year	Total cases IR (per 100)	Lost workday cases IR (per 100)
1987	10.9	5.6
1988	11.1	5.6
1989	10.6	5.2
1990	10.1	4.8
1991	9.1	4.4
1992	9.1	4.4
1993	9.0	4.4
1994	8.7	4.2
1995	8.8	4.1
1996	7.8	3.8
1997	7.8	3.6
1998	6.9	3.4
1999	7.0	3.5
2000	6.3	3.1
2001	6.2	3.2

The lost workday cases incidence rate and total cases incidence rate declined 43 percent between 1987 and 2001. The 2001 incidence rate of 6.2 is a record low.

Industry total cases incidence rates, 1987-2001

Year	Agriculture, forestry, fishing	Con-struction	Manufac-turing	Transportation, public utilities
1987	14.2	15.6	16.9	11.3
1988	12.7	15.6	17.5	10.1
1989	13.1	16.1	16.8	10.6
1990	11.7	15.4	15.6	10.7
1991	10.3	14.1	14.2	10.0
1992	10.3	13.3	12.9	10.3
1993	9.8	12.7	12.8	10.7
1994	9.3	11.8	12.3	9.9
1995	9.1	11.8	12.3	9.1
1996	9.1	11.8	10.5	9.1
1997	8.7	10.2	10.4	11.5
1998	7.3	8.6	10.3	7.7
1999	7.2	9.3	10.5	9.8
2000	7.2	9.0	9.2	6.1
2001	8.4	8.9	8.1	7.5

The industry divisions that have the highest rates of occupational injuries and illnesses had declines in total cases incidence rates ranging from 34 percent to 52 percent between 1987 and 2001. The manufacturing sector had the largest percentage decrease in total cases incidence rate.

OR-OSHA inspections, FFY 1988-2001

Federal fiscal year	Number	Covered workers	Percent in compliance
1988	5,694	147,400	19.4%
1989	5,134	167,619	21.8%
1990	4,826	158,312	18.9%
1991	5,505	164,272	16.5%
1992	5,740	201,861	15.3%
1993	5,620	248,270	18.1%
1994	5,031	265,613	19.2%
1995	5,474	227,427	23.4%
1996	5,185	195,630	24.6%
1997	4,559	182,097	26.9%
1998	5,173	152,355	26.6%
1999	5,437	168,264	27.0%
2000	5,073	165,029	25.9%
2001	5,380	197,808	25.1%

OR-OSHA inspections decreased by 6 percent between 1988 and 2001. The percentage of employers inspected who were in compliance with all safety and health regulations has generally risen since 1992. The number of workers covered by inspections increased in 2001 to its highest level since 1995.

Statistics

OR-OSHA citations, violations, and proposed penalties, FFY 1988-2001

Federal fiscal year	Citations	Violations	Penalties ($ millions)
1988	4,336	15,740	$1.9
1989	3,874	12,353	1.5
1990	3,750	14,006	2.8
1991	4,452	17,139	2.8
1992	4,683	19,411	3.2
1993	4,462	17,620	4.7
1994	3,960	15,294	4.6
1995	4,070	15,303	5.8
1996	3,812	12,434	2.9
1997	3,251	10,357	3.9
1998	3,716	11,366	2.4
1999	3,755	11,155	3.0
2000	3,623	10,785	2.3
2001	3,864	12,382	2.4

OR-OSHA penalties for employer violations of safety and health standards in FFY 2001 were 59 percent lower than the 1995 high of $5.8 million. The numbers of citations and violations have generally been increasing since the 1997 lows. The average penalty per violation has been following a trend of decreases since 1997, with the 2001 figure reaching the lowest since 1992.

OR-OSHA consultations, 1988-2001

Year	Number of requests	Number of consultations	Employees reached
1988	N/A	502	N/A
1989	N/A	671	N/A
1990	N/A	943	N/A
1991	N/A	1,726	N/A
1992	2,800	2,493	343,116
1993	2,104	2,089	249,387
1994	2,134	2,482	256,604
1995	2,157	2,153	231,113
1996	1,931	1,854	233,732
1997	1,900	1,828	153,922
1998	1,876	2,050	219,565
1999	2,179	2,128	233,675
2000	2,534	2,505	241,965
2001	2,992	2,829	260,719

OR-OSHA consultations increased 464 percent between 1988 and 2001 as a result of additional staff and increased emphasis on the consultative services program. The number of employees reached in 2001 was 24 percent lower than the 1992 figure, indicating more focus on smaller employers.

Note: Consultations do not include mandatory loss prevention services.

Safety and health training programs, 1998-2001

Year	Attendance at training sessions
1998	15,494
1999	27,104
2000	19,069
2001	17,522

Attendance at public education and conference training has totaled almost 80,000 from 1998-2001. Safety and health training was accomplished with the use of ED-NET, conferences, public workshops and on-site special training sessions. Attendance fluctuates from year to year due to attendance at the Governor's Occupational Safety and Health Conference, which is held every other year.

Statistics

OR-OSHA safety and health grant programs, 1989-2001

Period	Grants	Total $ awarded
1989-1991	11	$309,658
1991-1993	9	271,100
1993-1995	12	342,780
1995-1997	12	370,595
1997-1999	9	285,923
1999-2001	7	254,974

Since the start of the grant program, just over $1.8 million has been awarded for 60 approved grants for organizations to develop innovative safety and health training programs.

Worksite Redesign Program approved project and product grants, 1995-2001

Period	Approved project grants	Total $ awarded	Approved product grants	Total $ awarded
1995-1997	6	$364,673	0	$0
1997-1999	17	1,442,385	66	753,312
1999-2001	27	2,239,304	321	598,059

From 1995-2001, the grant program awarded slightly over $4.0 million for 50 approved project grants and almost $1.4 million for 387 approved product grants.

In 2001, Senate Bill 5507 eliminated funding for the Worksite Redesign Program.

Note: The number of grants are the numbers of employers receiving grants.

Insurer loss prevention consultative programs, 1989-1999

Year	Number	Percent of employers
1989	2,239	3.3%
1990	1,888	2.9%
1991	1,582	2.3%
1992	1,450	2.1%
1993	1,490	2.1%
1994	1,500	2.0%
1995	1,560	2.1%
1996	1,519	2.0%
1997	1,392	1.8%
1998	1,324	1.7%
1999	1,290	1.6%

The percentage of employers requiring insurer loss prevention services (three or more accepted disabling claims and a claims rate above the statewide average, or at least 20 claims) remained about the same from 1992 to 1996. It then declined slightly to a low of 1.6 percent in 1999.

Effective July 15, 1999, the responsibility for identifying employers needing loss prevention services was transferred from OR-OSHA to insurers. While OR-OSHA audits insurers to assure they provide these services, the numbers of employers receiving them are no longer tracked.

Employers' safety committee citations, violations, and penalties, FY 1990-2002

Fiscal year	Citations	Violations	Proposed penalties
1990	128	131	$13,040
1991	223	236	24,730
1992	891	1,023	61,530
1993	781	963	49,410
1994	754	927	60,930
1995	820	980	146,070
1996	703	858	102,835
1997	718	878	74,635
1998	848	953	139,855
1999	797	933	129,390
2000	667	724	149,305
2001	799	943	171,565
2002	867	1,011	166,345

In FY 1992, there was a large increase in citations, violations, and penalties as a result of new rules that became effective in March 1991. These figures have fluctuated since FY 1992, with a substantial increase in penalties assessed in 1995, reaching a record high in 2001. FY 2002 citations and violations reached their highest levels since 1992.

Although reform began in 1987, the cost of the Oregon workers' compensation system did not decrease significantly until after the 1990 special legislative session. Workers' compensation premium rates have decreased by 57.4 percent since 1990. Oregon is the only state with rate decreases for 12 consecutive years (1991-2002). Reform legislation and the accompanying rate reductions have saved Oregon employers approximately $7.5 billion in direct costs. Oregon's average premium rate ranking dropped from 6th highest in the nation in 1986 to 38th highest in 1998 and then rose slightly to 35th in 2002.

Oregon's reforms include provisions giving incentives to employers to minimize claim durations and frequencies, to facilitate continuous coverage availability for employers, and to ensure the financial integrity of workers' compensation insurers. Employers are allowed to pay medical claim costs of up to $500 for nondisabling claims and to exclude the costs from their rating experience. The eligibility for board's own motion relief (aggravation more than 5 years after first claim closure) is restricted; the disabling claims costs are paid from the Workers' Benefit Fund and excluded from loss experience. In addition, employers are encouraged to hire injured workers who have failed to return to work after injury (Preferred Worker Program). Employers do not pay premiums for those workers for three years, and claim costs arising from a new injury during the first three years of hire are paid from the Workers' Benefit Fund and excluded from ratemaking. Employers are also encouraged to return their injured workers to work quickly through the Employer-at-Injury Program. In addition to lowering claim costs through quicker return to work, this program provides employers with wage subsidies, worksite modifications, and obtained employment purchases.

Figure 5. Premium rate changes, 1987-2003

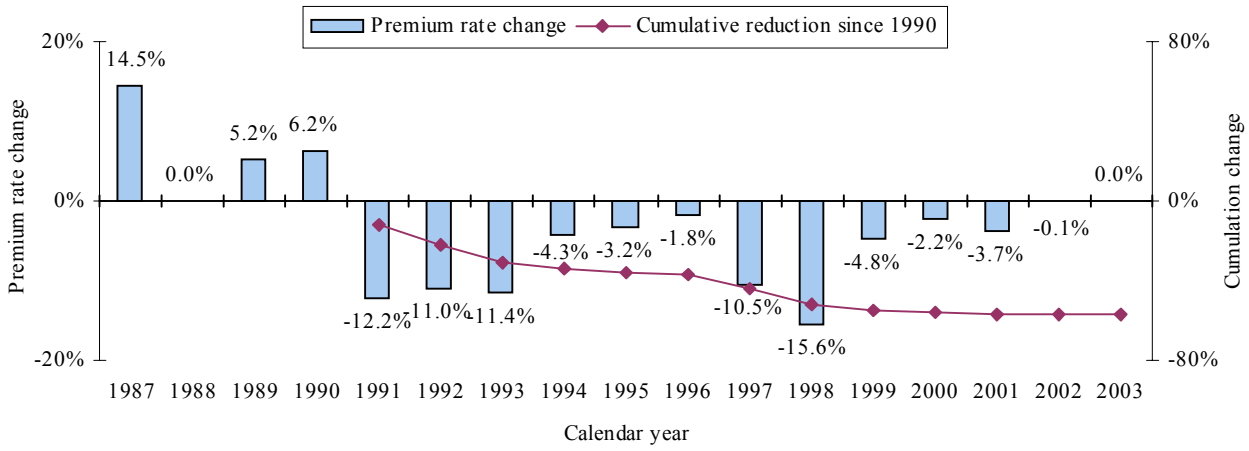
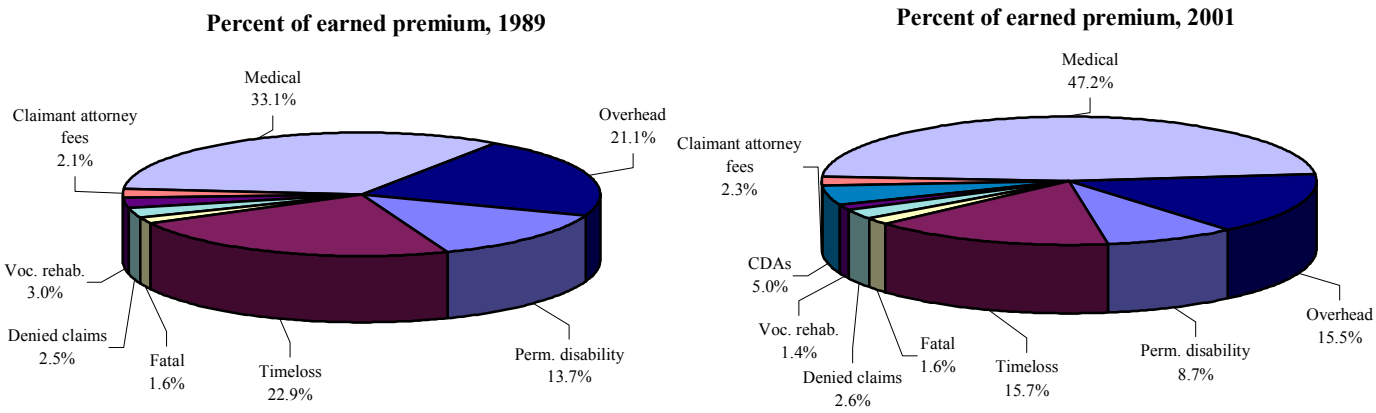


Figure 6. Workers' compensation premium breakdown, calendar years 1989 and 2001



Tiered rating plan

A tiered rating plan was first mandated in 1991 for assigned risk plan (Oregon Workers' Compensation Insurance Plan) employers too small to qualify for experience rating plans. As a result of the rating plan, over 85 percent of the employers in the assigned risk plan in 1998 received the non-experience-rated credit of 11 percent, resulting in an estimated saving of $802,000 in premium for policy year 1998. Since the inception of the 11 percent credit program, employers have saved over $10.3 million. In addition, in 1994, a second tier credit was added to the assigned risk plan for new small businesses. The additional credit is for 15 percent and has resulted in an extra savings of $1.0 million since 1994.

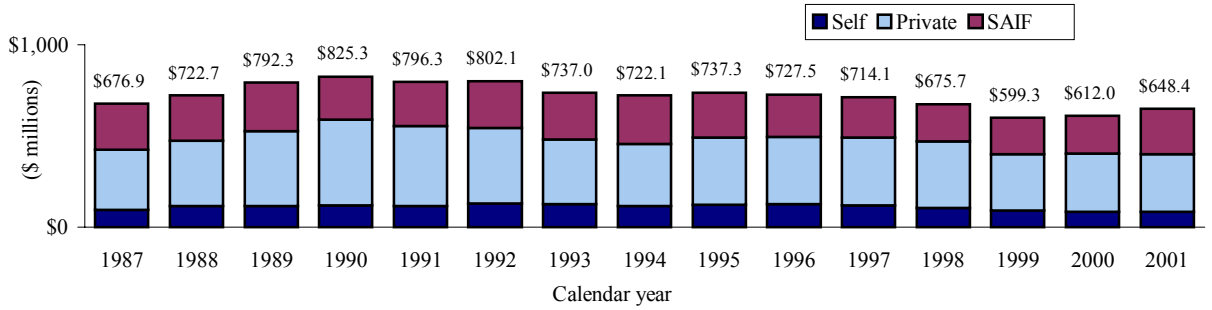
Due primarily to SAIF Corporation's cancellation of thousands of small employer policies, Oregon's Pool premium, as a percentage of voluntary market premium, increased from 3.3 percent in 1987 to 11.4 percent in 1991. It has since decreased to 4.5 percent in 2001. Nationally, the percentage of total premium written by assigned risk plans averages 4.8 percent.

Prior to reform, the Oregon workers' compensation insurance market was exhibiting signs of financial strain. Many small employers covered by the voluntary market were being canceled, and the loss ratio (losses divided by premiums) for SAIF and private insurers combined was over 100 percent. Since the reforms, some dramatic improvements in the Oregon market are evident. During the period 1987 to 1999, private insurers' loss ratio improved from 84.6 percent to 67.3 percent, subsequently rising to 87.4 in 2001. SAIF's loss ratio improved from 114.4 percent to 40.6 in 1998, rising to 140.4 in 1999, and declining to 94.5 in 2001. The volatility of SAIF's loss ratio has resulted in part from substantial reserve adjustments over time. The 2001 combined loss ratio for SAIF and private insurers amounted to 90.5 percent. From 1990 through 2001, SAIF and private insurers combined have paid $942.5 million in dividends.

In 1986, SAIF and the Liberty group combined to hold 60 percent of the workers' compensation market. In the early 1990's, increased profitability in the market resulted in more competition. By 1999, the market share of SAIF and the Liberty group had dropped to 52 percent. However, with negative returns on net worth in 1999 and 2000, the market share of SAIF and the Liberty group increased to 55 percent in 2001.

Reform also allowed the department to establish a contracting classifications premium adjustment program to provide employers subject to contractor class premium rates the economic incentive to enhance safety and health in the workplace. Over 2,200 employers participated during the first five years of the program.

Figure 7. Direct premiums earned and market share, by insurer type, 1987-2001



Large deductible premium credits

In 1996, large deductible premium credits were added as an option to workers' compensation in Oregon. LDPCs allow employers to partially self-insure in return for a credit on their workers' compensation premium. The insurer administers all workers' compensation claims and bills the employer for costs up to a specified deductible. Just as self-insured employers are assessed on simulated premiums, insurers and employers are assessed on premium prior to deductible credits. Few credits were applied in 1996, but an estimated $24.4 million in LDPCs were applied in 1999 and an estimated $37.7 million were applied in 2001. This was 12.0 percent of private insurers' assessable premium and 5.8 percent of total workers' compensation assessable premiums.

Premiums were $648.4 million in 2001, down $176.9 million from 1990, despite substantial growth in the workforce during the period. There has been some change in the percentage distribution among the premium cost components. The percent of earned premium to pay for indemnity benefits decreased from 45.8 percent in 1989 to 37.2 percent in 2001; conversely, the percent of premium to pay for medical benefits increased from 33.1 percent in 1989 to 47.2 percent in 2001. Insurer overhead expenses constituted 15.5 percent of premiums in 2001, down from 21.1 percent in 1989 but an increase from 1999.

Statistics

Workers' compensation premiums and rate changes, 1987-2003

Year	Premiums ($ millions)	Annual premium rate changes
1987	$676.9	14.5%
1988	722.7	0.0%
1989	792.3	5.2%
1990	825.3	6.2%
1991	796.3	-12.2%
1992	802.1	-11.0%
1993	737.0	-11.4%
1994	722.1	-4.3%
1995	737.3	-3.2%
1996	727.5	-1.8%
1997	714.1	-10.5%
1998	675.7	-15.6%
1999	599.3	-4.8%
2000	612.0	-2.2%
2001	648.4	-3.7%
2002	652.8 (est.)	-0.1%
2003	690.0 (est.)	0.0%

Workers' compensation premium rates decreased 57.4 percent between 1991 and 2003. Annual premiums decreased by $226.0 million between 1990 and 1999 and have increased $49.1 million from 1999 to 2001.

Workers' compensation average premium rate ranking, 1986-2002

Year	Rate ranking
1986	6th
1988	8th
1990	8th
1992	22nd
1994	32nd
1996	34th
1998	38th
2000	34th
2002	35th

Oregon's average premium rate ranking improved from 6th highest in the nation in 1986 to the 38th highest in 1998. In 2002, the ranking dropped slightly, to 35th highest.

Note: This premium rate ranking is based on the manual rates of the 50 states applied to Oregon's mix of occupations.

Workers' compensation premium market share, by insurer type, 1987-2001

Year	SAIF	Private	Self-insured
1987	37.5%	48.1%	14.4%
1988	34.7%	49.1%	16.2%
1989	33.6%	51.6%	14.8%
1990	28.4%	57.0%	14.6%
1991	30.4%	54.8%	14.8%
1992	32.4%	51.2%	16.4%
1993	34.7%	48.0%	17.3%
1994	37.1%	46.8%	16.1%
1995	33.2%	50.2%	16.6%
1996	32.1%	50.6%	17.3%
1997	31.3%	51.6%	17.1%
1998	30.2%	54.3%	15.5%
1999	33.0%	51.8%	15.1%
2000	34.1%	51.8%	14.1%
2001	38.4%	48.3%	13.3%

Private insurers' share of the workers' compensation market in Oregon was 48 percent of the premium volume in 2001. The Liberty group had 34.5 percent of the private market in 2001.

Statistics

WC insurance plan (Assigned Risk Pool) characteristics, 1987-2001

Year	Covered employers	Pool premium ($ millions)	Percent of total premium
1987	1,935	$19.4	3.3%
1988	1,872	20.1	3.2%
1989	3,658	28.8	4.2%
1990	12,765	71.9	9.8%
1991	11,970	71.7	11.4%
1992	12,140	50.2	7.7%
1993	16,056	48.6	8.0%
1994	17,821	53.1	8.7%
1995	17,982	49.1	7.9%
1996	13,627	34.5	5.6%
1997	12,663	26.8	4.5%
1998	11,369	21.3	3.9%
1999	9,840	17.3	3.4%
2000	7,237	16.5	3.2%
2001	8,316	25.2	4.5%

Annual Pool premium written increased over 270 percent from 1987-1990; it has since dropped 77.1 percent to the lowest level recorded in 2000 before increasing to $25.2 million in 2001. Annual Pool premium as a percent of the voluntary market premium more than tripled between 1987 and 1991, before shrinking to 3.2 percent in 2000, and rising to 4.5 percent in 2001. The national average was 4.8 percent in 2001.

Assigned Risk Pool tiered rating plan credit, 1991-1998

Policy year	Percent of pool	Credit savings
1991	83.3%	$1,614,000
1992	80.7%	1,268,000
1993	80.9%	1,275,000
1994	81.1%	1,511,000
1995	84.3%	1,707,000
1996	86.9%	1,198,000
1997	86.1%	936,000
1998	85.2%	802,000

The tiered rating plan credit of 11 percent has saved employers over $10.3 million between policy years 1991 and 1998 for an average of almost $1.3 million per year.

Note: More current data are not available from the National Council on Compensation Insurance.

SAIF Corporation financial characteristics, 1987-2001

Year	Loss ratio	Dividends paid ($ millions)
1987	114.4	$0.5
1988	134.8	0.6
1989	104.8	0.0
1990	69.3	20.4
1991	72.6	17.7
1992	79.0 (est)	22.6
1993	100.4 (est)	32.6
1994	69.2	29.7
1995	82.4	80.2
1996	125.6	50.1
1997	66.6	69.8
1998	40.6	121.1
1999	140.4	211.5
2000	166.2	159.4
2001	94.5	0.1

From 1988 to 1998, SAIF's loss ratio fell 94.2 percentage points. However, by 2000 it showed a considerable increase to 31.4 percentage points over the 1988 figure. SAIF has paid substantial dividends to policyholders since 1990, reaching $211.5 million in 1999 before declining in 2000 and 2001.

Note: The 1992 and 1993 loss ratios were estimated by the department because the figures published by SAIF were affected to a large extent by reserve adjustment.

Statistics

Private insurers' financial characteristics, 1987-2001

Year	Loss ratio	Dividends paid ($ millions)
1987	84.6	$3.6
1988	80.0	7.1
1989	83.3	8.4
1990	69.0	7.6
1991	61.9	10.0
1992	65.6	14.3
1993	66.1	10.1
1994	72.8	12.5
1995	68.2	12.5
1996	65.9	10.3
1997	61.9	9.4
1998	70.8	10.3
1999	67.3	11.6
2000	76.2	10.3
2001	87.4	8.4

Private insurers' loss ratio fell 22.7 percentage points from 1987 through 1991. It has risen 20.1 percentage points in the past two years, to 87.4 percent in 2001. Dividends rose from $3.6 million in 1987 to $14.3 million in 1992; they were $8.4 million in 2001.

Employers and employees, by insurer type, 2001

Insurer type	Employers	Employees (est)
SAIF	40,287	482,000
Private	42,484	865,000
Self	1,600	272,000
Total	84,371	1,619,000

At the end of 2001, private insurers covered 50 percent of the employers and 53 percent of the workers in Oregon's workers' compensation system.

Premium adjustment program for contracting employers, 1991-1995

Year	Employers participating	Average credit
1991	584	11.2%
1992	460	11.2%
1993	564	11.8%
1994	292	7.4%
1995	362	5.7%

Some 2,262 employers participated during the first five years of this program. The average credit declined from 11.2 percent in 1991 to 5.7 percent in 1995.

Note: More current data are not available from the National Council on Compensation Insurance.

One purpose of a no-fault workers' compensation system is to compensate injured workers for work-related claims. Limiting claims to those that are work-related reduces the costs to the workers' compensation system. Oregon's reforms tightened the requirements for establishing that an injury, disease, or aggravation claim is work-related.

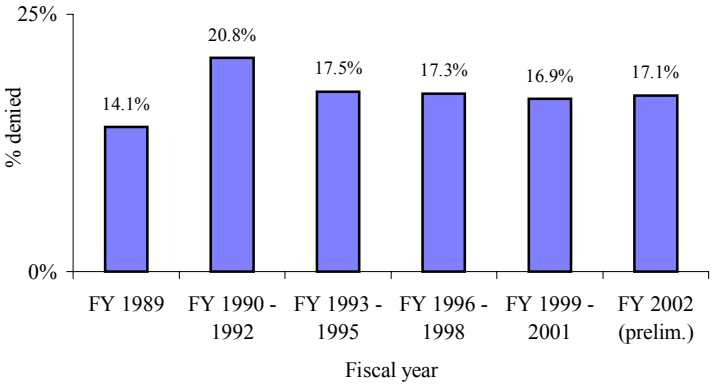
Mental stress

By HB 2271 in 1987, mental stress claims were restricted to those arising out of real and objective employment conditions not generally inherent in every working situation. There must be "clear and convincing evidence" that the mental disorder arose out of and in the course of employment. As a result, the number of accepted disabling stress claims dropped 56 percent between 1987 and 1989.

Claim denial rates

Largely as a result of a major change in SAIF Corporation's claims management practices, the denial rates of disabling claims jumped in fiscal year 1990. The denial rate for disabling claims was 21 percent, and the denial rate for disabling occupational disease claims was 44 percent. Concerned about the increased denial rates, the department conducted a denied disabling claims study in late 1991 and early 1992. As a result of the study, SAIF again changed its claims handling procedures. The denial rate of disabling claims declined to 17 percent in fiscal year 1993 and has remained relatively stable since.

Figure 8. Percentage of disabling claims denied, FY 1989-2002



Definition of compensability

In 1990, through SB 1197, the definitions of compensability for both injuries and diseases were changed. The reforms required that a compensable injury be established by medical evidence supported by objective findings. In addition, the compensable injury must be the major contributing cause of a consequential condition for that condition to be compensable. If the compensable injury combines with a preexisting condition, the resultant condition is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment. Injuries from recreational and social activities were excluded. Injuries arising from the use of alcohol or drugs were excluded if it is proved by clear and convincing evidence that the drug or alcohol use was the major contributing cause. (The standard was reduced to "preponderance of evidence" by the 1995 legislature.) Likewise, the definition of a compensable occupational disease was changed. To be compensable, the disease must be caused by substances or activities to which an employee is not ordinarily subjected; the employment must be the major contributing cause; and, the existence of the disease must be established by medical evidence supported by objective findings. These changed definitions of compensability are in part responsible for the decrease in claims.

The reforms also allowed insurers to deny a previously accepted claim during the two-year period following the date of original claim acceptance. (The 1995 legislature removed this two-year limitation when the acceptance was due to fraud, misrepresentation, or other illegal activity by the worker.) They also required that claims for aggravation be established by medical evidence supported by objective findings that show that the worsened condition resulted from the original injury. In addition, when a worker sustains a compensable injury, the responsible employer remains responsible for future aggravations, unless the worker sustains a new compensable injury involving the same condition. Also, by SB 369 in 1995, a doctor's report must be accompanied by a claim for aggravation to be recognized as such rather than a doctor's report by itself. The number of aggravation claims dropped 61 percent between 1991 and 2001.

Major contributing cause

The 1999 legislature allocated funds for a study of the effects of changes in the compensability language. The primary focus was the major contributing cause language that was added to the statute through SB 1197 in 1990 and revised through SB 369 in 1995. Legislators were interested in learning the extent to which these changes affected the costs of the workers' compensation system and the benefits paid to injured workers. Since

the statute requires physicians to determine the extent to which a medical condition is due to the compensable injury, the legislature also wanted to know if physicians could accurately make such decisions. A final goal of the study was to look at the major contributing cause language in combination with the exclusive remedy language for denied claims. In part, the legislature commissioned the study because of a case before the Oregon Supreme Court, *Smothers v. Gresham Transfer, Inc.* In this case, it was asserted that the combination of the major contributing cause language and the exclusive remedy language unconstitutionally denied injured workers with pre-existing medical conditions a legal remedy for their injuries.

The department contracted with the Workers' Compensation Center at Michigan State University to complete the study. They enlisted the services of several of the country's leading workers' compensation researchers. They issued their report in October 2000. Copies are available from the department or at www.cbs.state.or.us/wcd/docs/finalmcc.pdf.

The study had a number of facets. The researchers looked at over 1,500 denials in the claim files of five insurers and self-insured employers to determine how often major contributing cause language was used to deny claims. The researchers found that after the passage of SB 369, about 42 percent of the denials included major contributing cause language as the basis for denial. Prior to 1990, the denial rate of disabling claims was under 14 percent; after 1995 it was nearly 17 percent. The researchers concluded that many of the claims denied due to major contributing cause language would have been denied for other reasons under the pre-SB 1197 language. Because of this, it was very difficult to know the financial effects of the statutory changes.

The researchers also conducted econometric analyses to estimate the size of the benefit changes caused by the legislation. They used Oregon and national data to compare Oregon trends with national trends. One of the complicating factors was the decline in workers' compensation costs throughout the nation during the 1990s. Therefore, the researchers had to determine how much of the decline in Oregon's costs was due to legislative changes and how much would have occurred as a result of the national trends. They concluded that SB 1197 (the entire bill, not just the major contributing cause language) resulted in a reduction in benefits of at least 6.4 percent and that SB 369 resulted in a reduction of at least another 6.7 percent. This savings was due to a drop in the number of claims; the average cost per claim remained about the same.

The researchers also conducted a survey of physicians to learn their perspectives. Physicians reported that the major contributing cause standard was practical. Yet, they emphasized that it requires medical expertise to apply the standard accurately.

Finally, the researchers conducted a law review of comparable statutes and legal decisions in other states. The review showed that the major contributing cause standard was also used in three other states. It was the highest standard used broadly by any state. Courts in other states have generally ruled that when workers' compensation benefits are denied to a certain group of claims, the claimants are not restricted by exclusive remedy clauses. Therefore, these workers are allowed to file civil actions against their employers. This suggested that if the Oregon Supreme Court ruled in the same manner as other courts, they would find portions of Oregon's workers' compensation law unconstitutional.

Figure 9. Major contributing cause study: percentage of disabling claims initially denied

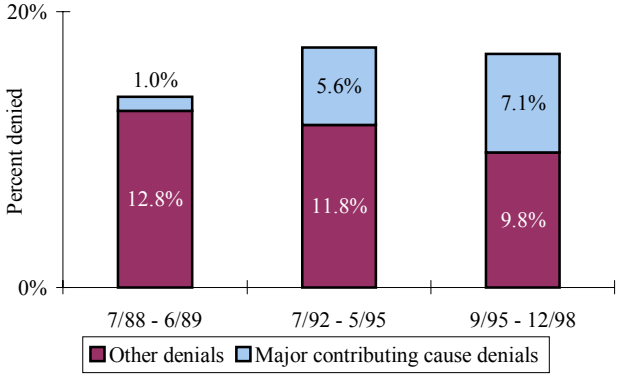
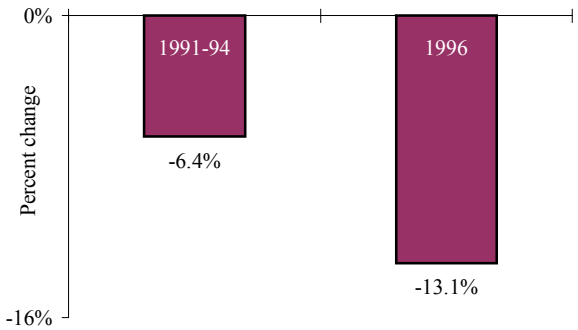


Figure 10. Major contributing cause study: benefit changes due to statute amendments



Smothers v. Gresham Transfer, Inc.

In May 2001, during the legislative session, the Oregon Supreme Court issued its decision in the *Smothers v. Gresham Transfer, Inc*. case. The court ruled that when a workers' compensation claim is denied for failure to prove that the work-related incident was the major contributing cause of the injury or condition, then the exclusive remedy provisions implemented by SB 369 are unconstitutional. The statute violated Article 1, section 10 of the Oregon constitution. This section guarantees every Oregonian "remedy by due course of law for injury done him in his person, property, or reputation." Under these circumstances, the employee whose claim has been denied may take civil action against his employer.

The 2001 legislature passed SB 485 in part to address this court decision. SB 485 created a process for civil suits against employers. It also revised the definitions of preexisting conditions and established that while a worker continues to have the burden of proving that the claim is compensable, the employer has the burden of proof in showing that the compensable condition is not the major contributing cause of the need for treatment.

Statistics

Total reported claims, FY 1989-2002

Fiscal year	Accepted disabling	Denied disabling	Percent denied disabling	Denied nondisabling
1989	40,515	6,640	14.1%	8,022
1990	35,918	9,534	21.0%	10,551
1991	31,156	8,024	20.5%	12,426
1992	28,577	7,522	20.8%	12,930
1993	29,125	6,013	17.1%	13,414
1994	29,731	6,235	17.3%	13,251
1995	29,740	6,535	18.0%	13,377
1996	27,373	5,958	17.9%	14,118
1997	26,918	5,515	17.0%	14,759
1998	26,032	5,354	17.1%	14,962
1999	24,857	5,244	17.4%	14,683
2000	24,405	4,899	16.7%	13,742
2001	23,908	4,687	16.4%	13,932
2002	22,072	4,559	17.1%	13,139

The number of denied nondisabling claims has increased 64 percent since FY 1989. In FY 1989, 45 percent of the denials were disabling claim denials; in FY 2002, 26 percent of the denials were disabling claim denials.

Note: With few exceptions, insurers do not report accepted nondisabling claims to the department.

Disabling occupational disease claims, FY 1989-2002

Fiscal year	Accepted	Denied	Percent denied
1989	3,980	2,041	33.9%
1990	3,496	2,761	44.1%
1991	3,068	2,115	40.8%
1992	3,101	2,293	42.5%
1993	3,212	1,941	37.7%
1994	3,289	2,039	38.3%
1995	3,384	2,083	38.1%
1996	3,247	1,926	37.2%
1997	3,349	1,905	36.3%
1998	3,180	1,685	34.6%
1999	2,766	1,597	36.6%
2000	2,890	1,479	33.9%
2001	3,017	1,480	32.9%
2002	2,802	1,634	36.8%

In fiscal years 1990-1992, the denial rate for disabling occupational disease claims was 43 percent. The denial rate has continued to decline slowly, averaging 35% in fiscal years 2000-2002.

Accepted disabling stress claims, 1987-2001

Year	Accepted stress claims	Stress claims per 1,000 ADC
1987	196	4.78
1988	176	4.03
1989	87	2.22
1990	71	1.98
1991	75	2.38
1992	66	2.14
1993	71	2.31
1994	76	2.41
1995	75	2.45
1996	79	2.78
1997	66	2.36
1998	48	1.77
1999	60	2.33
2000	64	2.52
2001	53	2.15

The number of accepted disabling stress claims dropped 56 percent between 1987 and 1989. Since 1989, the number of stress claims per 1,000 accepted disabling claims has remained fairly constant.

Statistics

Disabling aggravation claims, 1991-2001

Year	Accepted	Denied	Percent denied
1991	2,042	1,675	45.1%
1992	2,201	1,514	40.8%
1993	2,099	1,337	38.9%
1994	1,915	1,171	37.9%
1995	1,593	907	36.3%
1996	1,565	950	37.8%
1997	1,351	993	42.4%
1998	1,172	763	39.4%
1999	1,038	730	41.3%
2000	883	616	41.1%
2001	892	565	38.8%

The number of aggravation claims dropped 61 percent between 1991 and 2001. Over the same period, the number of accepted disabling claims dropped 22 percent.

Note: The counts are aggravation claims reported to the department by insurers.

Claims Processing

Prior to legislative reform, there were concerns about claims processing: the evaluation of the extent of disability was inconsistent, the acceptance or denial of claims and the payment of timeloss benefits were too slow, and delays in claim closure resulted in unrecoverable overpayments by insurers to claimants. These factors contributed to a controversial claims processing environment that fostered litigation.

Claims examiners

In 1990, SB 1197 required that the department establish a workers' compensation claims examiner program. This was expected to ensure that claims examiners fully understood claims processing requirements, thereby enabling them to process claims timely and accurately.

In 1999, SB 221 shifted the responsibility for certification to insurers, self-insured employers, and third party administrators. The bill charged them with administering certification standards that the department was required to specify by rule. The department may impose civil penalties against the insurers if they employ uncertified examiners. The department's certification program was terminated in November 1999. At that time, there were 1,342 certified examiners.

Claim acceptance or denial

SB 1197 increased the allowed number of days for acceptance or denial of a claim from 60 to 90 days. This was done so that insurers could make better decisions. It was hoped that this would lessen the number of appealed denials. The median number of days to accept a claim increased, reaching 52 days in 1998 compared to 31 days in 1990. The median number of days to deny a claim increased even more.

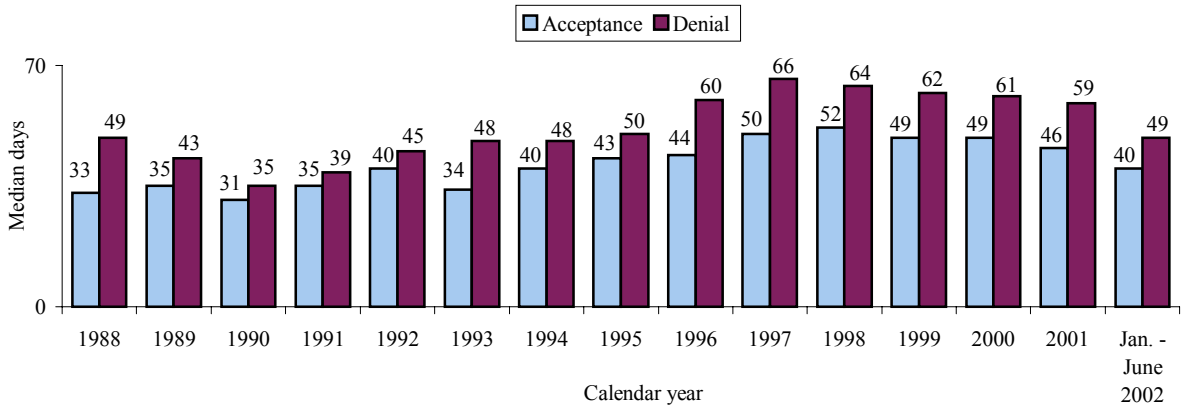
The increased length of time until a compensability decision resulted in longer periods of uncertainty for workers and for the medical providers who had provided medical services to the injured workers. In 2001, as part of SB 485, the legislature reduced the allowable time for acceptance or denial from 90 back to 60 days. This has had some effect on the average time for compensability decisions.

Modified acceptances

The 1997 legislature passed one bill that affected the claims process. HB 2971 required insurers and self-insured employers to modify notices of acceptance when medical or other information changes a previously issued notice of acceptance. At the time of claim closure, they are also required to issue an updated notice of acceptance that specifies the compensable conditions. Also, if a condition is later found compensable, the insurer or self-insured employer must reopen the claim for processing that condition. HB 2971 also states that an insurer's or self-insured employer's failure to appeal or seek review of a determination order, notice of closure, reconsideration order, or litigation order does not preclude them from subsequently contesting the rated condition in the order, unless they have formally accepted that condition.

In 1999, in the *Johansen v. SAIF Corporation* decision, the Court of Appeals ruled that there are no time limits for liability on a new condition, a condition other than the ones previously accepted. In SB 485, the legislature refined the procedure for these conditions. A worker must request formal written acceptance of a new or omitted medical condition. The insurer then has 60 days to accept or deny the condition. For disabling claims,

Figure 11. Median calendar days from employer knowledge to claim acceptance or denial, 1988-June 2002



the period of aggravation rights extends five years after the first closure. If compensable new conditions arise during this period, the insurer pays the claim costs. If the new condition arises after the aggravation period and the insurer doesn't voluntarily accept the claim, the worker must pursue the claim through the Workers' Compensation Board's own motion process. If the condition is found compensable, benefits are paid from the Workers' Benefit Fund.

Temporary disability benefits

In 2001, SB 485 included several changes to temporary disability benefits. For the first time, workers can be paid timeloss benefits for wages lost from multiple jobs. A worker is responsible for providing the insurer with documentation of the multiple jobs. The disabling status of the claims is determined by the status in the job at injury. Therefore, if a worker can return immediately to the job at injury but not to a second job, the claim is nondisabling, and no timeloss benefits are paid.

To protect employers and insurers from the cost of these added benefits, SB 485 does a couple of things. For employers, the supplementary benefits paid cannot be used for ratemaking, for an individual employer's rating, or for dividend calculations. Insurers may pay the supplemental benefits; if they do, the department reimburses the insurer for the benefits and its administrative costs from the Workers' Benefit Fund. If the insurer chooses not to pay the benefits, the department pays them directly. As of the end of November 2002, the department had paid about $100,000 in reimbursements and direct payments.

SB 485 raised the ceiling on temporary total disability benefits to 133% of the state-wide average weekly wage. The bill also changed the definition of "worker," stating that claimants are not eligible for timeloss or permanent total disability benefits for periods during which they have withdrawn from the workforce.

Claims closure

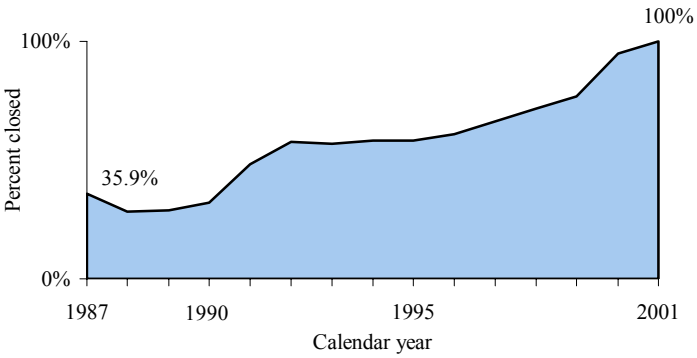
Prior to 1987, only the department could close a claim and rate permanent disability. In 1987, insurers completed 36 percent of the claim closures. The 1987 reforms allowed insurers to close permanent disability claims, as long as the worker had returned to work. At the same time, the department was allowed to promulgate standards for the evaluation of disability; the insurer had to use these standards.

Insurers' authority was expanded in 1990. With SB 1197, the legislature allowed insurers to close a claim when the worker's attending physician released the employee to return to work. This let insurers terminate timeloss payments earlier in the life of a claim. At the same time, the department was required to promulgate standards for the evaluation of disability. The standards are used for the initial rating and for all subsequent litigation. In 1992, insurers completed 58 percent of the claim closures.

The percentage of claims closed by insurers increased gradually, reaching 77 percent in 1999. In SB 220, the 1999 legislature shifted responsibility for all claim closures from the department to insurers and self-insured employers. The bill stated that the transition had to be completed by July 1, 2001. The transition was completed January 1, 2001.

After peaking in 1990, the median number of days from injury to first closure declined quickly, from 184 days in 1990 to 152 days in 1992. The median changed little between 1992 and 2000. In 2001, it increased to 162 days.

Figure 12. Percentage of claims closed by insurers, 1987-2001

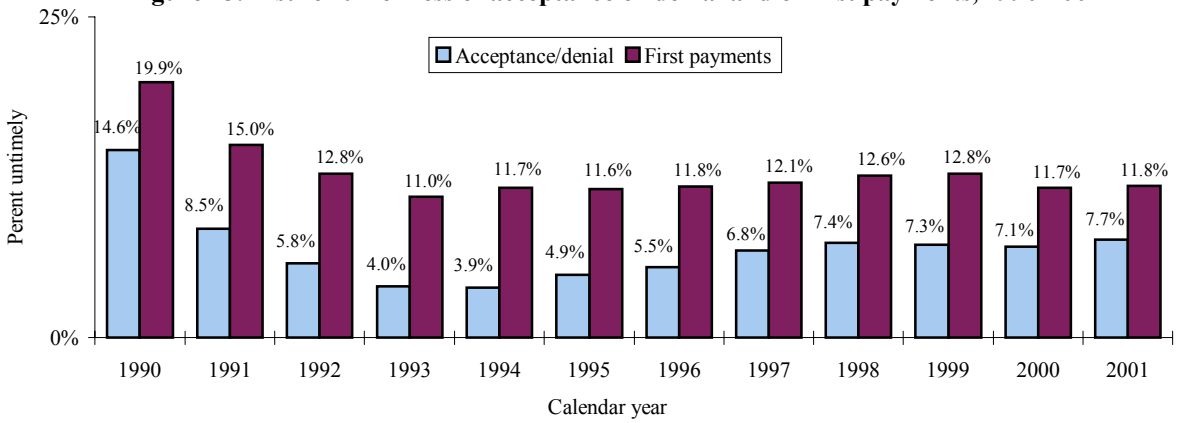


Insurer performance

Insurer performance, measured by the timeliness of making first payments, acceptance or denial of a claim, filing the first report of injury, and requesting claim determination, improved between 1990 and 1993. Insurer performance has declined slightly since 1993.

In 1990, the legislature changed the forum for penalties against insurers for unreasonable claims denial or delay in benefits. Before then, a worker seeking a penalty against an insurer had to request a hearing at the board. This was changed by SB 1197. If the sole issue is

Figure 13. Insurer timeliness of acceptance or denial and of first payments, 1990-2001



whether the insurer has unreasonably delayed benefits, the worker files a request for penalty with WCD, and the issue is resolved through an administrative process.

The department also heightened its monitoring of claims processing activities in several areas. Performance audits of insurers are now conducted on a triennial cycle. Also, computerized claims processing statistics are now monitored quarterly to ensure compliance with timeliness requirements for payment of compensation, claim acceptance or denial, and claim closure. The department issues civil penalties to those insurers and self-insured employers who do not meet acceptable standards in these areas. The number of citations issued peaked in 2000 with more than double the number issued in 1990. In 2001, the penalty amounts for these citations totaled about $204,000.

System abuse

Through the reforms, the department expanded its efforts to eliminate abuse from the workers' compensation system. It was one of the first in the nation to implement a program to identify and investigate allegations of inappropriate actions by employers, providers, insurers, workers, and other parties. A toll-free hotline allows the public to report abuses. In fiscal year 2002, 122 investigations of fraud or abuse complaints were opened. The most frequent complaints received were failure to report/improper reporting of claims-related documents by employers, insurers, and medical providers; improper claims processing by insurers or medical providers; and employer pressure to not file a claim or harassment of workers for filing a claim.

Workers' compensation information line

The department has a workers' compensation information line where department staff answer workers' questions about their claims, describes workers' rights and responsibilities, and helps them understand the workers' compensation system. In 2001, the number of calls to the information line exceeded 11,600. In addition, there were almost 7,000 calls from insurers, medical providers, attorneys, employers, legislators, and others.

Statistics

WC claims examiners certified, FY 1991-1999

Fiscal year	Examiners certified	Number of certified examiners at year-end
1991	519	502
1992	422	928
1993	530	976
1994	570	1,114
1995	633	1,211
1996	616	1,253
1997	707	1,370
1998	606	1,354
1999	728	1,346

During the first two years of the program, 941 examiners were certified. Many of the later certificates were issued for examiners being re-certified for another two-year period. At the end of the program, November 22, 1999, there were 1,342 certified examiners.

Insurer closures, 1987-2001

Year	Insurer closures	Total closures	% of total closures
1987	18,153	50,587	35.9%
1988	14,194	50,223	28.3%
1989	14,053	48,732	28.8%
1990	14,884	46,488	32.0%
1991	18,483	38,351	48.2%
1992	19,876	34,506	57.6%
1993	19,256	33,823	56.9%
1994	20,192	34,631	58.3%
1995	20,742	34,657	59.8%
1996	20,583	33,784	60.9%
1997	20,924	31,649	66.1%
1998	22,051	30,789	71.6%
1999	22,185	28,898	76.8%
2000	26,240	27,637	94.9%
2001	26,961	26,961	100.0%

The percentage of claims closed by insurers grew steadily through the 1990's. SB 220, passed in 1999, phased out the department's role in closing claims. By January 1, 2001, insurers, self-insured employers and third part administrators handled all claims closures.

Note: Insurers' disabling status reclassifications are included in the total closures.

Time lag from injury date to first closure, 1987-2001

Year	Average days	Median days
1987	255	169
1988	260	170
1989	271	181
1990	277	184
1991	271	176
1992	241	152
1993	231	148
1994	229	151
1995	232	155
1996	228	153
1997	224	150
1998	222	156
1999	225	156
2000	233	156
2001	247	162

The average and median days from injury to first closure peaked in 1990. The average dropped 20 percent from 1990 to 1998; it rose 11 percent between 1998 and 2001. The median number of days is the highest since 1991.

Statistics

Timeloss days paid, 1987-2001

Closure year	Average days	Median days
1987	90	21
1988	95	21
1989	95	23
1990	98	22
1991	89	21
1992	80	20
1993	74	20
1994	68	19
1995	64	19
1996	60	17
1997	56	16
1998	57	18
1999	57	18
2000	54	17
2001	58	19

The average number of timeloss days paid peaked in 1990. The average declined 45 percent between 1990 and 2000; it increased by seven percent in 2001.

Insurer claim acceptance and denial, median time lag days, 1988-June 2002

Year	Accepted	Denied
1988	33	49
1989	35	43
1990	31	35
1991	35	39
1992	40	45
1993	34	48
1994	40	48
1995	43	50
1996	44	60
1997	50	66
1998	52	64
1999	49	62
2000	49	61
2001	46	59
2002	40	49

By SB 1197 in 1990, the time allowed for insurers to make an acceptance or denial was extended from 60 days to 90 days. The median numbers of days to acceptance increased 68 percent from 1990 to 1998 but declined 23 percent by the first half of 2002. For denied claims, the median increased 89 percent by 1997 and declined 26 percent by 2002. By SB 485 in 2001, the time allowed was reduced to 60 days.

Note: The 2002 data is for January-June claims.

Insurer timeliness of first payments, 1990-2001

Year	Percent timely
1990	80.1%
1991	85.0%
1992	87.2%
1993	89.0%
1994	88.3%
1995	88.4%
1996	88.2%
1997	87.9%
1998	87.4%
1999	87.2%
2000	88.3%
2001	88.2%

Insurer performance on timeliness of first payments to claimants improved between 1990 and 1993; it has declined since.

Note: These data are self-reported by the insurers and audited by WCD.

Statistics

Insurer timeliness of acceptance or denial, 1990-2001

Year	Percent timely
1990	85.4%
1991	91.5%
1992	94.2%
1993	96.0%
1994	96.1%
1995	95.1%
1996	94.5%
1997	93.2%
1998	92.6%
1999	92.8%
2000	92.9%
2001	92.3%

Insurer performance on timeliness of acceptance or denial of claims improved from 1990 to 1994; it has declined since.

Note: These data are self-reported by the insurers and audited by WCD.

Insurer timeliness of filing forms 801 and 1503, 1990-2001

Year	Form 801 percent timely	Form 1503 percent timely
1990	59.2%	53.7%
1991	78.9%	64.8%
1992	93.3%	84.7%
1993	92.2%	88.2%
1994	92.8%	87.0%
1995	89.4%	83.7%
1996	91.9%	88.3%
1997	91.3%	86.8%
1998	89.9%	84.6%
1999	90.4%	85.1%
2000	89.5%	79.2%
2001	91.5%	80.2%

Insurer performance on timeliness of filing reports of occupational injury or disease (Form 801) and notices of closure (Form 1503) improved greatly between 1990 and 1994. Since then, performance has declined.

Workers' compensation information line calls for assistance, 1990-2001

Year	Workers calls	Other calls
1990	23,263	N/A
1991	21,475	N/A
1992	15,181	N/A
1993	18,243	N/A
1994	19,678	7,575
1995	17,503	6,699
1996	16,938	7,701
1997	15,737	8,425
1998	14,960	8,098
1999	13,711	7,930
2000	12,155	6,490
2001	11,662	6,936

In 2001, there were 11,662 calls from workers to the workers' compensation information line with questions about their claims, the claims process, or the workers' compensation system. The hotline also received 6,936 calls from insurers, medical providers, attorneys, employers, legislators, and others.

Statistics

Civil penalties issued, 1990-2001

Year	Citations	Penalty amount
1990	407	$158,325
1991	420	156,775
1992	506	163,101
1993	621	166,650
1994	679	197,025
1995	525	139,325
1996	491	140,850
1997	629	244,175
1998	813	254,925
1999	789	243,375
2000	844	248,875
2001	738	204,400

In 2001, the department issued 738 citations. The amount of these penalties exceeded $200,000.

Abuse complaint investigations, FY 1991-2002

Fiscal year	Opened	Closed
1991	243	223
1992	237	259
1993	342	398
1994	255	243
1995	250	253
1996	244	215
1997	211	194
1998	244	287
1999	231	222
2000	252	237
2001	220	259
2002	122	110

The number of complaints received of inappropriate actions by employers, providers, insurers, workers, and other parties peaked in fiscal year 1993. The number of investigations closed in FY 2002 was 28 percent of the FY 1993 figure.

Medical

During the 1980s, the rapidly increasing cost of medical care was one of the major cost drivers of the workers' compensation system throughout the nation. This trend was also prevalent in the general health care market, but the evidence suggested that the problem was worse in the workers' compensation system because there were fewer cost controls. While medical providers have long been required to charge workers' compensation insurers the same fees for the same service provided to other patients, there were few mechanisms prior to 1990 to control unnecessary utilization of diagnostic tests and treatments. In 1990, the legislature implemented numerous changes.

Palliative care

In 1990, SB 1197 eliminated most palliative care after the worker becomes medically stationary. Palliative care is treatment aimed at relieving symptoms rather than improving the worker's underlying condition. Workers can receive palliative care only if they are determined to have permanent total disability, when it is necessary to monitor prescription medication or a prosthetic device, or when the attending physician feels the palliative care is necessary for the worker to continue current employment. The restrictions on palliative care affected both new and existing claims and had an immediate impact on workers who had been receiving ongoing palliative treatments. SAIF's medical payments for palliative care in the first six months after the medically stationary date dropped more than 30 percent following the 1990 reforms.

Attending physicians

The 1990 legislation also placed limits on who can be an attending physician. The attending physician acts as the gatekeeper for most treatment and indemnity benefits. All other care must be provided upon referral from the attending physician. Outside of managed care organizations, a chiropractor cannot be the worker's attending physician after 12 visits or 30 days, whichever comes first. These limitations, restrictions on palliative care, and the use of MCOs have had an impact on the distribution of medical payments by provider type. SAIF's payment data suggests that the most dramatic change affected chiropractors. The proportion of total payments received by chiropractors dropped from 16 percent prior to 1990 to 3 percent after 1990.

Utilization and treatment standards

SB 1197 also required the department to establish utilization and treatment standards for all medical services. This requirement was beyond the department's resources; only draft standards for carpal tunnel syndrome were completed. In time, the consensus emerged that the medical community was better able to set its own standards. In 1999, this requirement was revoked through SB 223.

Twenty-four-hour coverage

Legislation to implement a 24-Hour Coverage Pilot Program was proposed by the department and passed by the legislature in August 1993. The legislation authorized the director to approve pilot plans by July 1994 and to operate the program until July 1998. The department obtained a $336,000 grant from the Robert Wood Johnson Foundation to develop and launch the program. The approved pilot plans linked the medical benefits of workers' compensation and group health insurance. They provided a broad network of participating doctors and hospitals. Enrolled employees used the network for all medical services. Doctors and hospitals submitted the insurance claims to the 24-hour plan and received a uniform payment for both work-related and other services. The goal of these plans was to enhance the delivery and improve the cost effectiveness of medical services for workers and employers.

By the end of 1995, only five of the approved plans had enrollments, with just 14 participating employers. A 1996 program evaluation found that the low enrollment was due largely to Oregon's success in curtailing workers' compensation costs. While employers remained curious about the 24-hour coverage, the declines in both workers' compensation costs and the rate of growth in group health costs had reduced their interest in participating. Program enrollments were not sufficient for an evaluation of the pilot plans, and the department phased out the program.

Fee schedules

The department has had medical services fee schedules since 1982. These schedules have been subsequently expanded through administrative rules. Medical fee schedules now include anesthesiology, surgery, radiology, laboratory and pathology, medicine, physical medicine and rehabilitation, evaluation and management, multi-disciplinary services and other Oregon-specific codes, durable medical equipment and medical supplies, and pharmacy. The medical fee schedules establish the maximum allowable reimbursement (ceiling) for services. From 1986 to 1995, the ceiling was set at the 75th percentile of usual and customary fees. However, by SB 369 of 1995, new fee schedules were to represent the reimbursement generally received for services provided in the general health care industry. The transition to this new methodology is still in progress. In 1997, the department also adopted the Federal Resource Based Relative Value

Schedule. The RBRVS is used to determine the maximum level of reimbursement for medical services covered by the fee schedule.

The department implemented a hospital fee schedule using adjusted cost-to-charge ratios on January 1, 1991. In July 1992, the department began publishing revised CCRs on a semi-annual basis for all general, acute-care hospitals in the state. The department uses the term "hospital" as defined by the Office for Oregon Health Policy and Research to decide what facilities are legally considered hospitals in the state; specialty hospitals, such as rehabilitation centers, psychiatric hospitals, and juvenile hospitals, are excluded from these regulations.

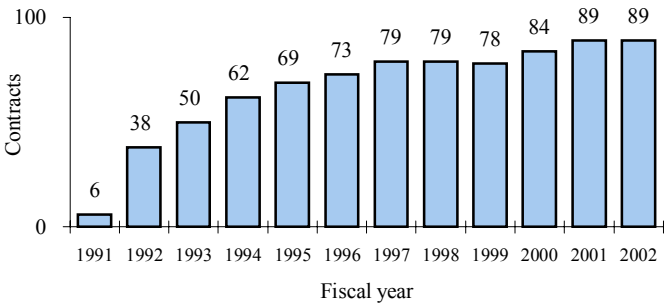
The CCR is the percent of the hospital bill that insurers reimburse Oregon hospitals for treating injured workers covered by workers' compensation insurance. The process for computing the CCR includes information from each hospital's audited financial statement and Medicare cost report (CMS-2552). The ratio allows all hospitals to recover the cost of providing facility-related services to injured workers, a reasonable rate of return on their capital asset base, and an allowance for bad debt and charity losses. The CCR is revised annually at a time based on the hospital's fiscal year and is published twice yearly under WCD Bulletin 290. Each March, a new growth factor (used in the rate-of-return analysis) is computed and used for one year. Rural hospitals may be excluded from imposition of the CCR based upon a determination of economic necessity. Economic necessity is determined using the financial flexibility index, a composite measure of seven financial ratios that measure different dimensions of funds flow. Exemption from the CCR is reevaluated each September for those Oregon hospitals designated by the Office of Rural Health as rural hospitals.

Managed care organizations

The 1990 reforms introduced managed care into Oregon's workers' compensation system. SB 1197 allowed workers' compensation insurers to contract with department-certified managed care organizations, and required workers covered by such contracts to obtain treatment within the MCO (except under certain conditions).

MCOs in Oregon contract with medical providers who agree to terms and conditions established by the MCOs. In return, these providers have the opportunity to treat the workers covered by the MCOs. The terms and conditions differ by MCO, but they must include treatment and utilization standards and peer review. Each panel of providers must include eight types of medical service providers: chiropractors, naturopaths, acupuncturists, osteopaths, dentists, optometrists, podiatrists, and physicians. As of June 30, 2002, there were seven certified MCOs in Oregon that had contracts with workers' compensation insurers and self-insurers. There were 89 insurer and self-insurer MCO contracts in effect. Contracts in effect October 1, 2001, covered 58,884 Oregon employers and 69 percent of the state's covered work force.

Figure 14. MCO insurer contracts in effect at the end of the fiscal year, FY 1991-2002



By SB 369 in 1995, the legislature allowed insurers to require an injured worker to receive treatment in an MCO prior to the acceptance of the claim. If, however, the insurer eventually denies the claim, the insurer must cover the services until the worker receives notice of the denial or until three days after the denial notice is mailed.

Figure 15. Percentage reduction in accepted disabling claims costs due to managed care coverage, 1998

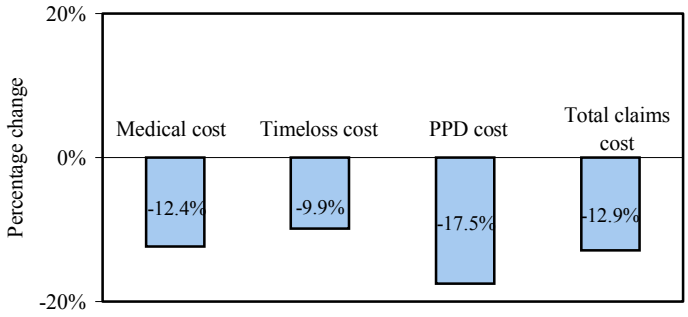


Figure 16. Percentage of workers satisfied with their overall medical treatment, 1998

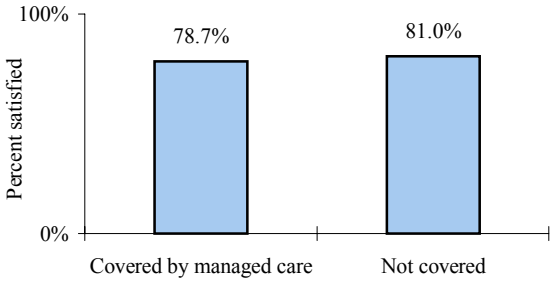
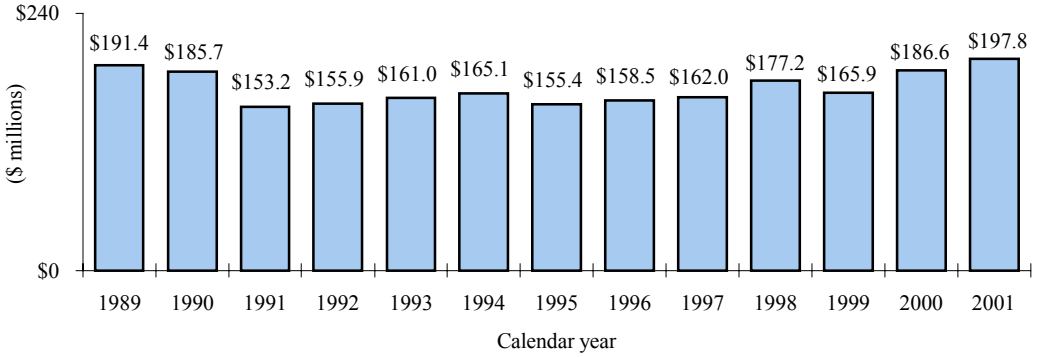


Figure 17. Medical losses paid by SAIF and private insurers, 1989-2001



Consequently, most enrollment dates continue to coincide with the claim acceptance dates.

During 1998, the department conducted a study of the effectiveness of managed care in Oregon's workers' compensation system. The study group consisted of workers injured between July 1995 and December 1997 whose disabling claims closed during the last four months of 1997. The study included a comparison of medical, timeloss, and permanent disability costs for workers covered and not covered by MCO contracts. The findings indicate that, after controlling for severity and other differences, disabling claims covered by MCO contracts had lower medical, timeloss, and PPD costs than claims not covered. Medical costs were reduced 12 percent, timeloss costs by 10 percent, and PPD costs by 18 percent. These reductions resulted in a 13 percent savings in total cost for MCO-covered disabling claims.

The study also included a medical treatment satisfaction survey of the same workers. The findings showed few differences in satisfaction between the workers covered by MCO contracts and the workers not covered.

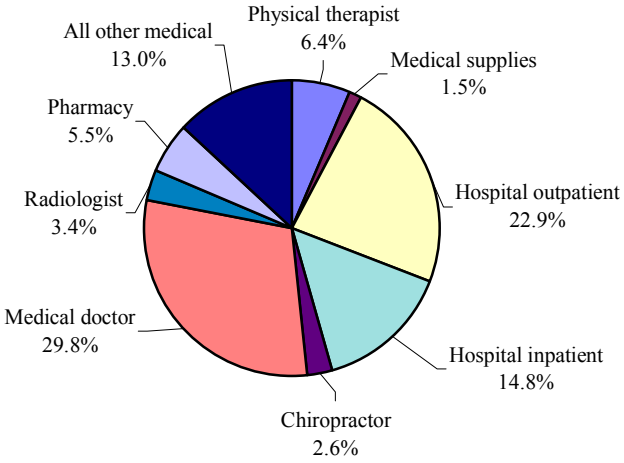
Medical costs

The medical payments made by SAIF and private insurers dropped by 20 percent between 1989 and 1991. After that, medical payments increased by one percent per year until 1999. The total payments made by these insurers continued to fall, so medical payments grew as a percentage of total payments from 40 percent in 1991 to 48 percent in 1999. After this period of relative stability, medical payments jumped 19 percent between 1999 and 2001.

Medical payments

In 1991, the department began requiring that insurers with 100 or more accepted disabling claims report their medical payment data to the department. WCD Bulletin 220 describes the reporting requirements. In 2001, approximately 80 percent of total medical payments were reported to the department; nearly 90 percent of these payments were for services subject to fee schedules. On average, reimbursements for services subject to the fee schedule were reduced 20 percent from the charged amounts. The majority of the reductions resulted from applying the fee schedule maximums. On average, hospital charges subject to the cost-to-charge fee schedule were reduced by 35 percent.

Figure 18. Medical payments by provider type, 2000



In 2001, medical payment data and data from the National Council on Compensation Insurance were used to create a model for estimating the total workers' compensation medical payments during the first quarter of 2000. The estimated total medical payments were $58.3 million. The estimate was developed by inflating the first quarter of 2000 medical payment data with NCCI market data to reflect the quarter's total medical payments. (Bulletin 220 medical payment data reflected about 82 percent of the NCCI market data in 1999). This estimate was then used to create a model that estimates medical payments across provider and service types. For the first quarter of 2000, payments to medical doctors and for hospital inpatient and outpatient care

Table 1. Top 20 workers' compensation medical services, in descending order of total payments, first quarter 2000

Service code	Description of Services	Total payments	Percent of total*
97110	Therapeutic exercises	$3,000,000	5.1%
99213	Office/outpatient visit for established patient with problem(s) of low to moderate severity	$2,272,000	3.9%
NA	Insurer medical exam	$1,834,000	3.1%
NA	Anesthesia services	$1,584,000	2.7%
80.51	Laminectomy, excision interverterbral disc	$1,159,000	2.0%
97140	Manual therapy	$1,146,000	2.0%
99199	Special service, procedure, report; adjunct to basic services performed	$1,044,000	1.8%
72148	Magnetic image, spinal canal, lumbar	$907,000	1.6%
99214	Office/outpatient visit for established patient w/ problem(s) of moderate to high severity	$824,000	1.4%
99283	Emergency dept visit	$809,000	1.4%
99203	Office/outpatient visit for new patient with problem(s) of moderate severity	$790,000	1.3%
73721	Magnetic image, any joint of lower extremity	$689,000	1.2%
97530	Therapeutic activities	$675,000	1.2%
99212	Office/outpatient visit for established patient w/ problem(s) of minimal severity	$662,000	1.1%
97001	Physical therapy evaluation	$638,000	1.1%
97035	Ultrasound therapy	$612,000	1.0%
29881	Knee arthroscopy/surgery	$515,000	0.9%
98940	Chiropractic manipulation	$511,000	0.9%
NA	Surgical facility charges	$500,000	0.9%
73221	Magnetic image, any joint of upper extremity	$442,000	0.8%
	Remaining services	$37,692,000	64.1%
	Totals	**$58,305,000**	**100.0%**

*Percents may not add to total because of rounding.

accounted for 68 percent of total medical payments. Physical therapists and pharmacies each received about six percent, and radiologists and chiropractors each received about three percent.

The model provided information about the services with the largest payment amounts. Therapeutic exercises comprised over five percent of all payments to medical providers. Therapeutic services involve applying physical therapy to improve an injured worker's strength, stamina, and flexibility. The presence of similar therapeutic services among the top 20 services illustrates the importance of physical therapy in workers' compensation medical treatment. Office and outpatient visits also make up a large percentage of medical services. Four office visit services rank among the top 20 services. Next in importance are insurer medical exams. IME services, grouped together to include basic exams, reports, and specialized IME services, comprised three percent of total medical payments.

The model also showed the top pharmacy payments by drug name, type, and total payments. Narcotic analgesics ranked as the top category of drugs given to injured workers, followed by anti-inflammatory agents and anti-convulsants. The individual drug with the highest payments was Oxycontin, a narcotic analgesic (pain reliever). Payments for Oxycontin totaled $339,000, 11 percent of the total pharmacy payments. There is a higher use of generic drugs in workers' compensation than in the overall pharmacy market. During first quarter of 2000, generic drugs made up 61 percent of the prescriptions written for injured workers.

Table 2. Top 20 pharmacy payments by drug name, first quarter 2000

Description	Type of drug	Total payments	Percent of total*
OxyContin	Narcotic analgesic	$339,000	10.6%
Neurontin	Anticonvulsant	$233,000	7.3%
Celebrex	Cox-2 inhibitor	$155,000	4.8%
Ultram	Miscellaneous analgesic	$117,000	3.6%
Acetaminophen-Hydrocodone Bitartrate	narcotic analgesic combination	$110,000	3.4%
Prozac	SSRI antidepressant	$106,000	3.3%
Prilosec	Proton pump inhibitor	$96,000	3.0%
Relafen	Nonsteroidal anti-inflammatory agent	$81,000	2.5%
Duragesic	Narcotic analgesic	$70,000	2.2%
Carisoprodol	Skeletal muscle relaxant	$67,000	2.1%
Paxil	SSRI antidepressant	$63,000	2.0%
Vioxx	Cox-2 inhibitor	$59,000	1.8%
Zoloft	SSRI antidepressant	$54,000	1.7%
MS Contin	Narcotic analgesic	$51,000	1.6%
Acetaminophen-Propoxyphene Napsylate	Narcotic analgesic combination	$42,000	1.3%
Cyclobenzaprine Hydrochloride	Skeletal muscle relaxant	$38,000	1.2%
Ambien	Anxiolytics, sedatives and hypnotic	$35,000	1.1%
Daypro	Nonsteroidal anti-inflammatory agent	$32,000	1.0%
Lovenox	Heparin	$30,000	0.9%
BuSpar	Anxiolytic, sedative and hypnotic	$29,000	0.9%
Remaining pharmacy		$1,400,000	43.7%
Totals		$3,207,000	100.0%

*Percents may not add to total because of rounding.

Interim medical benefits

Workers' compensation insurers have been responsible for the medical costs of only the claims they accept. Before claim acceptance, therefore, there is uncertainty about who will be responsible for medical bills. Some medical providers may be reluctant to treat injured workers, or they may delay some types of treatment, until an insurer's compensability decision. As a result, injured workers' recovery may be delayed. In 2001, SB 485 attempted to lessen this concern in two ways. First, the bill reduced the time allowed for insurers to accept or deny a claim from 90 to 60 days. Second, the bill amended the law regarding the payment of some medical services prior to the initial acceptance or denial of a claim.

This amendment applies to claims with dates of injury since January 1, 2002. It covers certain services: pain medicine, diagnostic services required to identify appropriate treatment or to prevent disability, and services required to stabilize the worker's claimed condition and to prevent further disability. It excludes, however, any services provided to workers enrolled in MCOs. If the insurer denies the claim, costs are paid as follows:

1. If the insurer denies the claim more than 14 days after the employer knowledge date and the worker has health insurance, the health insurer pays for the services, subject to the limitations in its policy; the workers' compensation insurer pays any balance.
2. If the insurer denies the claim within 14 days of the employer knowledge date and the worker has health insurance, the health insurer pays for the services, subject to the limitations in its policy; the worker pays the balance.
3. If the insurer denies the claim and the worker has no health insurance, the worker pays the entire bill.

The first case may reduce providers' worries about reimbursement. At this time, there is insufficient data to measure its effect on workers' compensation insurers' costs. In 2002, approximately 80 percent of denials were made more than 14 days after the employer knowledge date. According to the 2000 Oregon Population Survey, 84 percent of working age Oregonians have health insurance. However, insurance rates are lower for lower-income workers and for men, both characteristics of the injured worker population. This implies that 50 - 60 percent of the denials will fall into the first case.

Statistics

Managed care organizations, employers and employees covered, 1993-2001

Date	Employers		Employees	
01/1993	26,211	(38.3%)	393,900	(30.7%)
11/1993	28,320	(40.0%)	462,500	(35.1%)
12/1994	33,083	(44.8%)	484,000	(35.1%)
10/1996	40,128	(51.8%)	648,500	(43.6%)
10/1997	47,200	(59.3%)	901,900	(58.3%)
10/1998	52,608	(64.7%)	969,200	(61.5%)
10/1999	52,048	(63.7%)	993,600	(62.0%)
10/2000	57,532	(68.3%)	1,121,000	(68.9%)
10/2001	58,884	(69.3%)	1,118,000	(69.1%)

As of October 2001, 69 percent of Oregon workers and employers were covered by MCOs.

MCO contracts with insurers and self-insured employers, FY 1991-2002

Fiscal year	Insurers	Self-insured employers	Total
1991	3	3	6
1992	16	22	38
1993	20	30	50
1994	25	37	62
1995	28	41	69
1996	32	41	73
1997	35	44	79
1998	36	43	79
1999	33	45	78
2000	35	49	84
2001	37	52	89
2002	34	55	89

At the end of FY 2002, there were 89 MCO contracts in effect with insurers and self-insured employers. Seven certified MCOs had contracts with insurers and self-insured employers.

Note: These figures are based on reports submitted by MCOs and may change as new data are reported.

SAIF and private insurers' total paid and medical paid, 1989-2001

Year paid	Total paid ($ millions)	Medical paid ($ millions)	Medical percent
1989	$427.8	$191.4	44.7%
1990	418.0	185.7	44.4%
1991	379.9	153.2	40.3%
1992	380.2	155.9	41.0%
1993	376.1	161.0	42.8%
1994	383.0	165.1	43.1%
1995	360.9	155.4	43.1%
1996	358.1	158.5	44.3%
1997	352.7	162.0	46.0%
1998	367.1	177.2	48.0%
1999	347.5	165.9	47.7%
2000	380.8	186.6	49.0%
2001	415.8	197.8	47.6%

Between 1989 and 1991, medical payments by SAIF and private insurers fell by 20 percent. Between 1991 and 1999, medical payments grew an average of one percent per year. Medical payments jumped 12 percent in 2000 and 6 percent in 2001. Nearly half of the total payments are medical payments.

Return-to-Work Assistance

A fundamental goal of Oregon's workers' compensation law is to return the injured or ill worker to work as quickly as possible, to a wage as close as possible to the pre-injury wage. This is also an effective strategy to reduce workers' compensation claims costs. One way Oregon has chosen to do this is by legislating against unlawful employment discrimination while providing reemployment and reinstatement rights to injured workers. The Oregon Bureau of Labor and Industries enforces those laws (now in ORS 659A), with some funding coming out of the Workers' Benefit Fund as a result of the legislature's second special session of 2002. A second method is through incentives within the benefit structure: for the employer at injury through unscheduled permanent partial disability benefits, and for both the employer and worker through temporary partial disability benefits. The third way is formal programs for returning injured workers to employment.

Since the 1970s, the Oregon workers' compensation system has gone through numerous changes in return-to-work programs as the legislature has attempted to find better and more cost-effective ways of getting injured workers back to work. Although the specifics have changed over the years, ORS 656 describes two primary programs. First, insurers provide vocational assistance to help workers overcome barriers to successful return to work; employers pay the costs from premiums. Second, the department administers the Reemployment Assistance Program (including Preferred Worker and Employer-at-Injury Programs), which provides incentives to employers who hire injured workers. Costs are borne by the Workers' Benefit Fund, from equal taxes on hours worked paid by both workers and their employers. Effective July 1, 2001, the WBF also funds a portion of the department's operating costs associated with the administration of WBF programs.

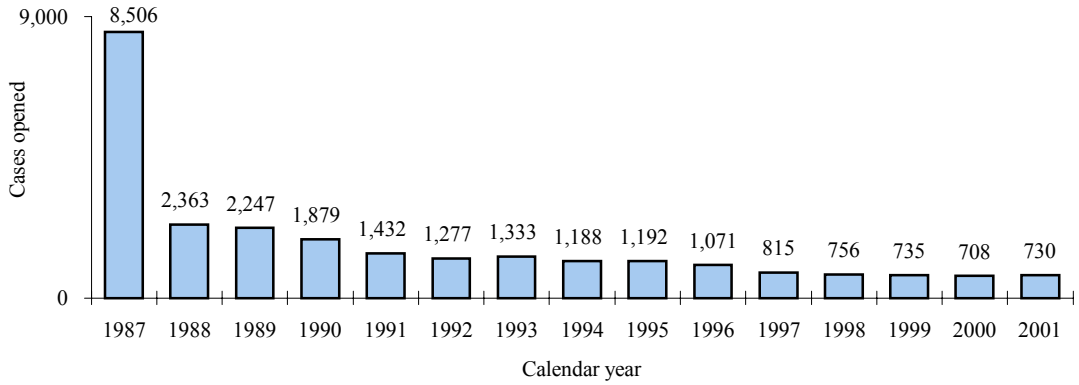
Vocational assistance

In 1987, the legislature significantly restricted eligibility for vocational assistance: workers who can return to their employer at injury or to any other job that pays at least 80 percent of their job at injury do not receive vocational assistance. During the 1990 special session, the assembly phased out the Handicapped Workers Reserve, which provided reimbursement of some claims costs as an incentive to employers to hire disabled workers. It also enhanced incentives available for Preferred Workers under the Reemployment Assistance Program.

In 1993, administrative rule amendments expanded reemployment benefits for Preferred Workers and created the Employer-at-Injury Program, which offers incentives to employers to return injured employees to light duty before claim closure. A legislative enactment from 1993 also directed that the Workers' Benefit Fund pay for a portion of benefits provided to injured workers by the Oregon Vocational Rehabilitation Division; those payments continued into Fiscal Year 2000. In 1995, the legislature further restricted eligibility for vocational assistance under ORS 656, for claims reopened due to aggravation of the injury, but extended eligibility for the Employer-at-Injury Program to accepted nondisabling claims.

Overall, the effect of legislation has been to de-emphasize mandatory vocational assistance for injured

Figure 19. Vocational assistance cases opened, 1987-2001



workers and to expand and refine optional employer incentives to return injured workers to work. The number of new vocational assistance cases has declined greatly. Costs as a percent of premium have been halved. Workers most in need of vocational assistance, those who qualify for more costly retraining, continue to be eligible for that benefit, though at about half the rate as in 1987. Successful vocational assistance cases were 158 in 2001 compared to 3,680 in 1987, but return-to-work rates for completed cases have been at historically high levels. Completion rates have hovered around 35 percent, however, largely because nearly half of eligible workers opt to release rights to vocational assistance through a claim disposition agreement. Settlement by CDA, legalized in 1990, has been the most frequent reason for ending eligibility since 1993.

Preferred Workers

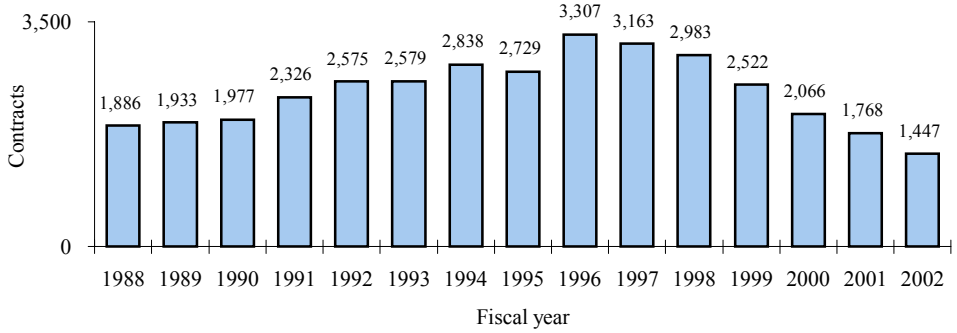
Since 1990, a worker automatically receives a Preferred Worker ID Card when the insurer reports at claim closure, on an accepted claim, that the worker has a permanent partial disability, has not refused suitable employment with the employer at injury, and cannot return to regular work. An employer choosing to hire a Preferred Worker is eligible for exemption from workers' compensation premiums on the worker for a period of three years. Other available benefits, arranged by the department, include 50-percent, six-month wage subsidy; worksite modification; and obtained employment purchases. In addition, if the worker sustains a new injury, the department reimburses the insurer for all claims costs, including administrative expenses.

In recent years, about 25 percent of workers (500 to 600 annually) who receive Preferred Worker ID Cards use the card to find a job. Assistance to Preferred Workers, measured by the number of "contracts," increased 75 percent from 1988 to 1996. Since then, activity has dropped at a rate considerably steeper than the drop in permanent disability claims. Total dollars spent on assistance annually has also declined, but is still about triple the pre-1990 level.

The Employer-at-Injury Program

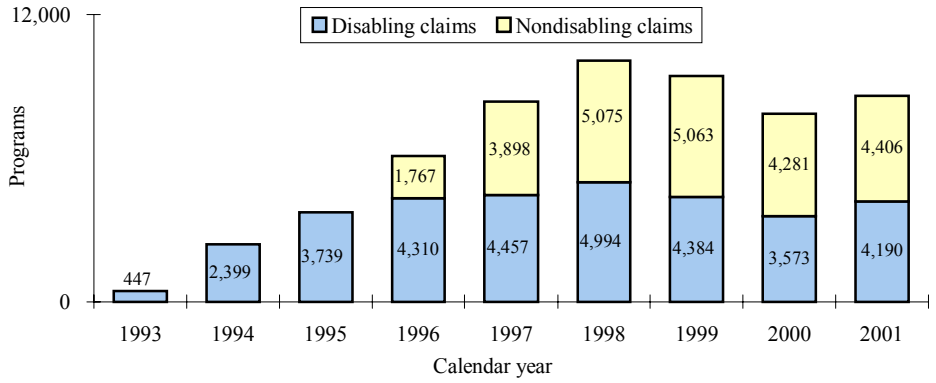
The EAIP is available to employers with injured workers who have accepted open claims and have not been released to regular work but can return to light-duty, transitional jobs. Insurers arrange placements, for which they receive a flat fee. Assistance to employers generally consists of a 50-percent wage subsidy for a period up to three months, though worksite modification and early-return-to-work purchases are also available. Statute provides that the insurer may be able to reduce or discontinue timeloss benefits if the worker refuses modified work, including an EAIP placement. Effective mid-2001, Senate Bill 485 conferred upon injured workers new rights to refuse modified work. A worker may refuse modified work if the job requires a commute that is beyond the worker's physical ability, is more than 50 miles away, is not with the employer at injury or not at that employer's worksite, or is inconsistent with the employer's practices or a collective bargaining agreement.

Figure 20. Preferred Worker contracts started, FY 1988-2002



One result of the expansion of the EAIP in 1995 has been to preclude many nondisabling claims from becoming disabling, by getting the worker back to a job soon after the injury or illness. Following six years of steady growth in use of the program, 1999 brought a leveling off in worker placements and expenditures. In 2001, there were 4,190 placements for disabling injuries and 4,406 for nondisabling injuries. Total costs reimbursed from the Worker Benefit Fund for these placements came to $11.2 million.

Figure 21. Employer-at-Injury Program, placements approved, 1993-2001

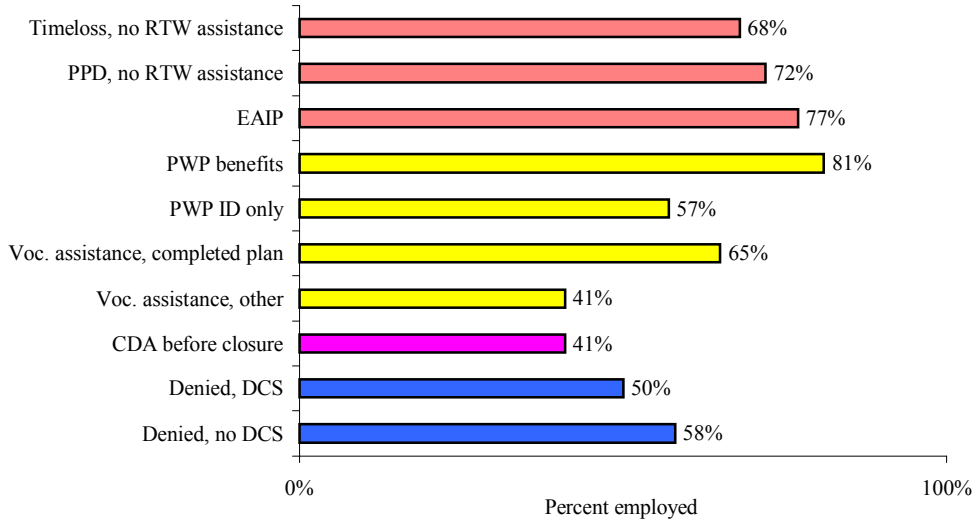


Studies

With increasing frequency, the department has conducted studies of the labor market experience of injured workers, using wage records reported to the Oregon Employment Department. The results of the 1995 study, for workers whose claims first closed in 1991, confirmed that workers who are able to return to their job at injury are more likely to suffer fewer breaks in employment and increase their wages, compared to workers who cannot. Similarly positive results were found for Preferred Workers who use their benefits and severely disabled workers who completed a vocational training plan, usually to return to work with a new employer, compared to workers who do not use their benefits. These findings have been replicated three times, in performance measures constructed from the results of studies on workers with injuries in 1992-1993, 1995, and 1997. Results for 1998 are due in early 2003.

Also, workers who settle their claims by a claim disposition agreement, rather than going through the process of claim closure, have substantially lower return-to-work rates. Statistics suggest that this group of injured workers has injuries as complex, on average, as those suffered by Preferred Workers. However, the workers making up the CDA group were not identified as Preferred Workers, and thus were ineligible to receive reemployment assistance. Workers with denied disabling claims also have shown relatively low rates of employment after injury.

Figure 22. Wage employment 13 quarters after injury, disabling claims from accident year 1997



Statistics

Handicapped Workers Program claims and costs, FY 1987-2002

Fiscal year	New claims	Total costs ($ millions)
1987	380	$ 9.8
1988	312	12.1
1989	222	11.8
1990	200	10.7
1991	0	9.0
1992	0	6.4
1993	0	4.5
1994	0	3.8
1995	0	2.6
1996	0	1.8
1997	0	2.1
1998	0	2.0
1999	0	2.2
2000	0	1.7
2001	0	1.3
2002	0	1.2

Beginning in May 1990, no new applications were accepted. Costs for approved claims will steadily decline.

Vocational assistance, 1987-2001

Year	Cases opened	Cases closed	Total cost ($ millions)
1987	8,506	8,959	$38.4
1988	2,363	5,977	30.9
1989	2,247	2,951	22.5
1990	1,879	2,333	21.4
1991	1,432	2,300	26.2
1992	1,277	1,758	20.4
1993	1,333	1,493	18.0
1994	1,188	1,291	15.1
1995	1,192	1,297	14.5
1996	1,071	1,128	13.8
1997	815	844	11.1
1998	756	732	10.2
1999	735	648	8.8
2000	708	587	9.0
2001	730	588	9.2

The number of new cases opened has dropped by over 90 percent since 1987, while the total cost of closed cases as a percentage of the premium dollar has been cut by more than half. Costs excludes eligibility determinations and CDA amounts. Currently, most cases either end by CDA soon after eligibility or go on to receive training services.

Note: Data for cases closed and total cost will change whenever redeterminations result in reopened eligibility.

Vocational assistance plans and return-to-work rates, 1987-2001

Year	DEP plans	Training plans	RTW rates
1987	3,334	1,041	74%
1988	2,050	852	74%
1989	786	717	68%
1990	362	731	70%
1991	213	908	78%
1992	111	703	80%
1993	61	595	78%
1994	58	467	79%
1995	51	468	85%
1996	36	449	91%
1997	20	378	84%
1998	6	339	85%
1999	4	292	85%
2000	4	282	81%
2001	4	280	79%

The number of vocational assistance cases in Direct Employment Plans declined to just 4 cases by 1999. The return-to-work rate for workers who completed their program has been at historically high levels, peaking in 1996.

Note: Data will change whenever redeterminations result in reopened eligibility.

Statistics

Preferred Worker contracts started, FY 1988-2002

Fiscal year	Contracts	Total cost ($ millions)
1988	1,886	$3.0
1989	1,933	2.7
1990	1,977	3.2
1991	2,326	4.2
1992	2,575	5.8
1993	2,579	6.3
1994	2,838	8.5
1995	2,729	9.0
1996	3,307	10.8
1997	3,163	11.2
1998	2,983	11.6
1999	2,522	10.8
2000	2,066	9.3
2001	1,768	8.0
2002	1,447	7.9

The number of Preferred Worker contracts started increased 75 percent from 1988 to 1996, dropping in recent years at a rate steeper than for PPD cases. Total dollars spent on assistance annually has also declined, but it is still about triple the pre-1990 level.

Note: Data for the most recent years are revised as reimbursement requests are received and paid.

Preferred Worker contract costs, FY 1988-2002

Fiscal year	Worksite mods ($ millions)	Premium exempt ($ millions)	Wage subsidies ($ millions)
1988	$0.4	-	$2.6
1989	0.2	-	2.4
1990	0.2	-	2.6
1991	0.8	$ 0.0	3.0
1992	2.2	0.3	3.0
1993	2.3	0.7	3.1
1994	3.1	1.7	3.5
1995	2.2	3.0	3.6
1996	3.0	2.8	4.5
1997	3.0	3.0	4.6
1998	3.4	2.9	4.7
1999	2.6	3.5	4.1
2000	2.1	3.1	3.6
2001	1.8	2.9	3.0
2002	1.8	3.0	2.8

Despite a continuing decline, expenditures for worksite modifications and wage subsidies remain above pre-1990 levels. Obtained employment purchases totaled $4.3 million from 1988 to 2002. The cost of premium relief, the predecessor of premium exemption, reached nearly $1 million in total costs for the life of the program.

Preferred Worker premium exemption program, FY 1991-2002

Fiscal year	Cards issued	Workers hired
1991	4,181	1,521
1992	3,529	1,110
1993	3,079	990
1994	3,293	966
1995	3,584	1,110
1996	4,187	1,099
1997	3,498	951
1998	2,916	754
1999	2,797	602
2000	2,422	557
2001	2,292	475
2002	2,467	322

For workers who receive a Preferred Worker card, roughly one-quarter are expected to use the card for employment. ID Cards issued have declined along with PPD claims.

Note: This table uses a running count of hires by the year of ID Card issue. The counts of cards issued have been adjusted for rescinds since the last report.

Statistics

Employer-at-Injury placements approved, 1993-2001

Year	Workers	Employers	Total cost ($ millions)
1993	447	141	$0.4
1994	2,399	726	3.0
1995	3,739	1,189	5.0
1996	6,077	1,346	7.5
1997	8,355	1,508	9.9
1998	10,069	1,782	11.8
1999	9,447	1,837	10.6
2000	7,854	1,577	9.5
2001	8,596	1,663	11.2

Following six years of steady growth in use of the program, 1999 brought a leveling off in worker placements and expenditures for light duty.

Prior to legislative reform, Oregon was continually singled out as a state with one of the nation's most costly workers' compensation systems, and yet, with woefully inadequate permanent disability benefits for injured workers. The Oregon reforms not only intended to reduce system costs, but also included provisions to increase the permanent partial disability benefits to injured workers, to provide a benefit structure that compensates those more severely injured with higher awards, and to ensure that injured workers receive their benefits faster.

National rankings

Of seven categories of maximum indemnity (statutory cash) benefits for disability that are capable of national ranking, five of Oregon's maximums were at or above the national median as of January 2002. As a result of 2001 legislation that increased the ceiling on temporary total disability benefits — giving a raise to roughly 10 percent of workers disabled by the job — Oregon's ranking for those benefits is now at the 88th percentile. Benefits below the national median include unscheduled PPD, which has been close to the median value, and survivors' benefits for spouses without children.

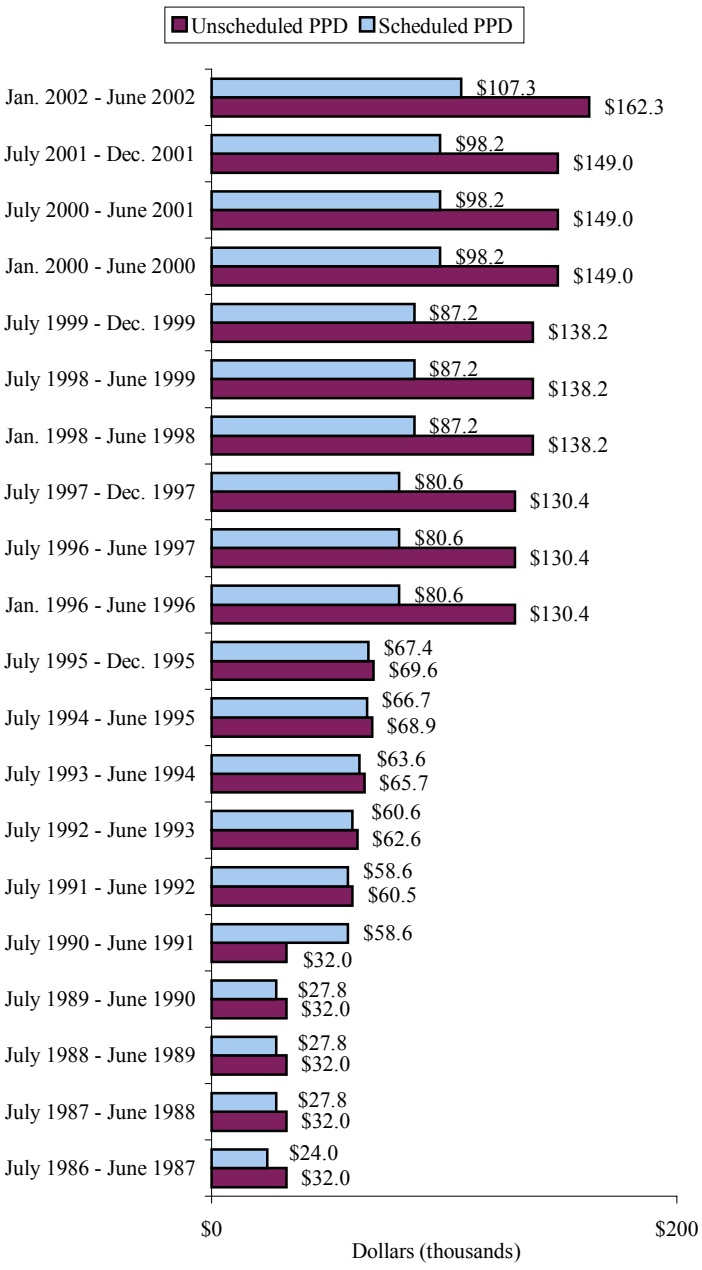
Since 1987, the legislature has enacted several changes to the value of a degree of permanent partial disability, both for scheduled and unscheduled injuries (one percent of disability is generally 3.2 degrees). The value of a scheduled degree — for limbs, vision, and hearing — has increased by 347 percent, from $125 in 1987 to the current value of $559 per degree. As a result, Oregon's national ranking for maximum scheduled PPD rose from the tenth percentile in 1988 to the 50th as of January 2002.

Maximum benefits for unscheduled disabilities — to the back and other body parts and systems not named in statute — have also risen, by 407 percent from 1987 to 2002. Oregon's maximum unscheduled PPD, which was far below the national average at the eighth percentile in 1994, shot up to the 47th percentile by the beginning of 1998; the ranking in 2002 is the 38th percentile.

Although the national median for maximum benefits has been a useful tool for comparing PPD benefits among states, this single measure is insufficient to evaluate generosity of benefits. Oregon is one of few states that compute PPD benefits as fixed amounts, regardless of the individual worker's weekly wage. Other states provide larger maximum benefits only for high-wage workers. For this reason, when the worker's wage is taken into account, maximum benefits for Oregon's low-wage workers appear relatively generous compared to most other states.

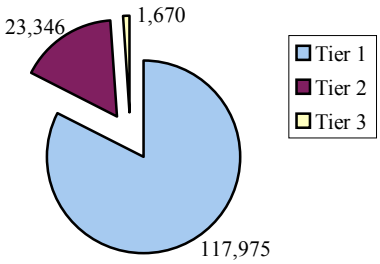
For unscheduled benefits, moreover, the maximum has other deficiencies as an indicator of benefit generosity. Since 1991, Oregon has been one of few states with a tiered structure of benefits for unscheduled disability. The intent has been to compensate the more severely injured at higher degree values. The 1995 legislature refined the tiers to make higher benefits available to

Figure 23. Maximum PPD benefits (thousands of dollars), FY 1987-2002



more workers. However, few workers receive the highest level of benefits. About three-quarters of Oregon unscheduled claims receive only the bottom-tier benefits, which have been among the lowest in the country. Unlike maximums, benefit levels for claims in the current lowest tier had failed to keep pace with inflation for about two decades, despite annual adjustments for PPD benefits from 1992 until 1995 and increases at two-year intervals by each successive legislature. To address this, the 1999 and 2001 legislatures increased bottom and middle-tier unscheduled benefits at higher rates than top-tier benefits.

Figure 24. Distribution of unscheduled PPD degrees by tier, 2001



Average permanent partial disability awards

While statutory benefits have increased, the average degrees actually awarded for both scheduled and unscheduled PPD claims have decreased since 1987: scheduled by more than half to about 17 degrees currently, and unscheduled by about one third to 47 degrees. However, average dollars awarded for scheduled PPD claims have more than doubled since 1989's low point. Conversely, the average dollars for unscheduled PPD continued to decline until benefit increases began to take effect from the 1991 legislation. Since 1992, average unscheduled benefits per claim have increased by 41 percent.

Determining whether injured workers are actually receiving higher and more equitable benefits subsequent to reform is not straightforward. Several factors complicate the use of the change in average degrees and dollars awarded to draw conclusions about average benefits to injured workers. Claims settled by claim disposition agreements most certainly involve cases for which permanent partial disability is compensated, but are not included in the above PPD data. Moreover, standardization of procedures for disability rating and changes in injury severity and return-to-work patterns probably contribute to the decline in average degrees awarded.

The Management-Labor Advisory Committee has been studying the adequacy of permanent partial disability benefits. Recommendations for policy objectives include the following:

- ✓ Retain predictable and objective factors
- ✓ Explore wage-based benefits in order to match compensation better to lost earnings
- ✓ Simplify the tiered-benefit structure
- ✓ Achieve and maintain, or exceed, parity with the benefit generosity of other states
- ✓ Encourage return to work

Faster benefits

Reform legislation has been built on the premise that a predictable and objective structure for PPD benefits yields faster benefits to injured workers, where frictional costs and delays — for adversarial medical opinions, investigations, attorney fees, and adjudication — are minimized. The goal has been a system where only a small minority of injured workers feel the need to litigate their level of entitlement to benefits.

Following the mandates in 1990 for administrative reconsideration and standardized rating of disability, the number of cases continuing on to formal appeal has decreased dramatically. For example, 42 percent of unscheduled degrees were awarded on appeal in 1987, compared to 10 to 15 percent at reconsideration or appeal in recent years. One implication is that injured workers, on average, are receiving their benefits faster.

Cash benefits

Historically, permanent total disability claims, although small in number, have accounted for a significant portion of indemnity dollars. However, the net number of new PTD claims has declined from 195 in 1988 to negative 1 in 2001. Law amendments affecting PTD benefits include the mandate for standardized rating of permanent disability, the legalization of claim disposition agreements, and the redefining of gainful employment. Changes in claims-management practices, shifts in Oregon's industrial mix, and increased emphasis on workplace safety and health are other contributing factors.

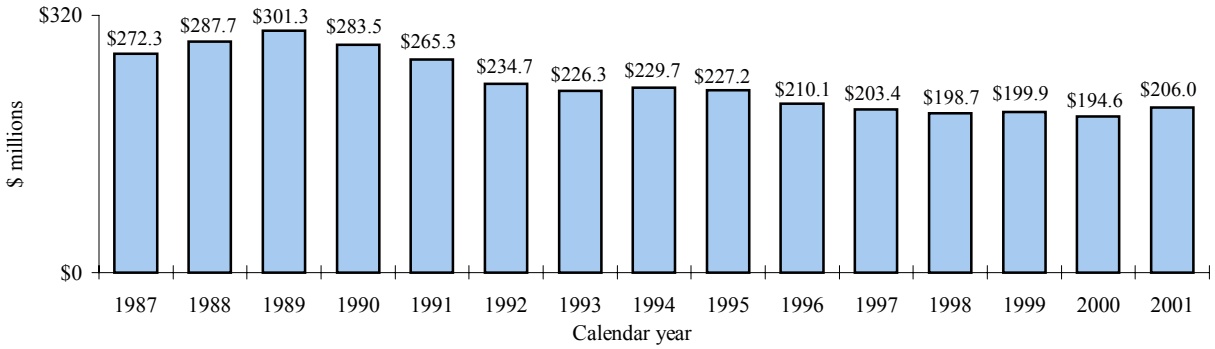
Combined cash benefits per accepted disabling claim — for temporary disability, permanent disability and

fatality awards, and claim disposition agreements — is one measure of benefits available to injured workers. Average cash benefits paid to injured workers have been up and down since 1987. The $8,122 for 2001 claims is 20 percent higher than 1987's figure, compared to an 82 percent increase in average wages, which are used to set most benefits. Decreases in average days of temporary disability paid, average degrees of PPD awarded, and the number of PTD awards contribute to the relatively flat trend line in average cash benefits paid, despite legislated increases in PPD benefits and automatic inflation adjustments for other benefits.

A major 2001 study, conducted for the state of New Mexico by the RAND Institute for Civil Justice, provided a multi-state evaluation of the adequacy and equity of cash benefits, especially PPD. Oregon was among the group of four comparison states. The study matched injured workers with similar but uninjured workers to derive an estimate of post-injury wage loss, and the proportion of lost wages replaced by indemnity benefits.

None of the states studied met the researchers' standards (two-thirds replacement) for adequate PPD benefits, either before-tax or after-tax, for replacement of estimated wage losses for the ten years following injury. Workers with PPD "experienced significant and sustained earnings losses" from their injuries. No state's indemnity benefits replaced as much as half of the estimated ten-year earnings losses. Oregon's overall rate of pre-tax wage replacement was 42.4 percent, second to New Mexico's rate and above Washington's rate. The study did note that workers' post-injury earnings losses were proportionately lower in Oregon, compared to all states except Washington. The researchers concluded that this is largely a product of Oregon's emphasis upon return-to-work incentives as a means of reducing occupational disability.

Figure 25. Cash benefits paid to workers for accepted disabling claims, 1987-2001



Statistics

Oregon percentile ranking for maximum benefits, 1988-2002

Benefit	1988	1994	1996	1998	2000	2002
TTD	68	73	71	74	74	88
Sch. PPD	10	33	48	46	49	50
Unsch. PPD	6	8	46	47	46	38
PTD	70	73	75	74	74	66
Death-no child	28	25	27	22	26	24
Death-child	86	88	88	91	91	87
Burial	78	43	67	81	85	75

In 2002, Oregon's maximum indemnity benefits were at or above the national median in five of the seven benefit categories. Those below the median included compensation for unscheduled PPD and death with no children.

Maximum PPD benefits, FY 1987-2002

Fiscal year	Maximum scheduled PPD	Maximum unscheduled PPD
1987	$24,000	$32,000
1988	27,840	32,000
1989	27,840	32,000
1990	27,840	32,000
1991	58,560	32,000
1992	58,577	60,503
1993	60,601	62,592
1994	63,631	65,723
1995	66,722	68,915
1996 (1st half)	67,402	69,617
1996 (2nd half)	80,640	130,400
1997	80,640	130,400
1998 (1st half)	80,640	130,400
1998 (2nd half)	87,168	138,224
1999	87,168	138,224
2000 (1st half)	87,168	138,224
2000 (2nd half)	98,168	149,033
2001	98,168	149,033
2002 (1st half)	98,168	149,033
2002 (2nd half)	107,328	162,272

Between fiscal years 1987 and 2002, maximum scheduled PPD benefits increased 347 percent and unscheduled benefits increased 407 percent.

Average degrees for permanent partial disability cases, 1987-2001

Year	Scheduled PPD	Unscheduled PPD
1987	36.1	69.4
1988	33.6	68.0
1989	28.4	65.2
1990	27.6	63.6
1991	23.5	57.3
1992	20.8	55.5
1993	20.0	57.9
1994	18.8	55.9
1995	19.0	53.0
1996	17.6	52.0
1997	17.3	49.9
1998	16.2	49.7
1999	15.9	47.7
2000	16.5	49.1
2001	17.2	47.3

Both average scheduled and unscheduled PPD degrees have decreased since HB 2900; CDAs, standardization of disability rating, claim severity, and changes in return-to-work patterns are factors in this decline.

Statistics

Average dollars for permanent partial disability cases, 1987-2001

Year	Scheduled PPD	Unscheduled PPD
1987	$3,939	$6,783
1988	3,898	6,711
1989	3,623	6,492
1990	3,760	6,336
1991	4,280	5,710
1992	4,969	5,547
1993	5,313	5,944
1994	5,513	5,967
1995	6,055	5,939
1996	6,146	6,131
1997	6,635	6,417
1998	6,582	6,992
1999	6,792	6,962
2000	7,349	7,623
2001	8,219	7,810

Average scheduled PPD dollars awarded have more than doubled since 1989. Average unscheduled PPD declined after the passage of HB 2900, but benefit increases beginning in 1992 have resulted in an upward trend, taking recent years' averages beyond the peak of 1987. Average degrees and dollars are calculated by tallying each claim's awards; averages may change as claims receive more PPD through claim reopening or litigation.

Permanent total disability, 1987-2001

Year	Grant	Rescind	Net number
1987	204	27	177
1988	209	14	195
1989	139	15	124
1990	81	36	45
1991	68	22	46
1992	47	5	42
1993	26	13	13
1994	36	9	27
1995	32	17	15
1996	17	6	11
1997	20	5	15
1998	16	6	10
1999	24	11	13
2000	12	6	6
2001	13	14	-1

The net number of PTDs decreased dramatically between 1988 and 2001. CDAs, legalized in 1990, have played a prominent role in sustaining the historically low counts of PTDs.

Cash benefits paid to injured workers for accepted disabling claims, 1987-2001

Year	Benefits paid ($ millions)	Average benefits per claim
1987	$272.3	$6,781
1988	287.7	7,010
1989	301.3	6,900
1990	283.5	7,238
1991	265.3	7,400
1992	234.7	7,456
1993	226.3	7,351
1994	229.7	7,471
1995	227.2	7,206
1996	210.1	6,874
1997	203.4	7,165
1998	198.7	7,117
1999	199.9	7,390
2000	194.6	7,543
2001	206.0	8,122

Average cash benefits paid (current dollars) have been up and down since 1987. The $8,122 for 2001 claims is 20 percent higher than 1987's figure, compared to an 82 percent increase in average wages used to set most benefits. Cash benefits include timeloss, PPD, CDA, PTD and fatality indemnity benefits, but exclude non-cash benefits such as medical, vocational rehabilitation, and attorney fees.

During the 1980s, the number of claims with litigation grew. Two goals of the early reform were to ensure that injured workers received their benefits with as little litigation as possible and to resolve litigated disputes quickly. A number of provisions were enacted to reduce litigation. For example, the department was required to establish standards for the evaluation of permanent disability. These standards are to be consistently applied at the claim closure and though all levels of litigation.

WCD administrative dispute resolution

Oregon has expanded its use of administrative dispute resolution processes. This reduces the number of claims that are litigated in a formal hearing or court setting. The department's Reemployment and Dispute Resolution Services Section provides assistance through informal and formal mediation. When these processes do not resolve the dispute, the department issues an administrative order that can be appealed as a contested case hearing to the Hearings Division.

Before the 1990 reforms, the department had some voluntary alternative dispute resolution processes. There was a reconsideration process available for parties who disagreed with the disability benefit amount awarded at closure and a review process to resolve medical treatment and fee disputes. These processes were rarely used until they became mandatory in 1990.

Reconsideration of claim closures

By SB 1197 in 1990, the legislature required that a party disputing a claim closure seek departmental reconsideration of the closure before proceeding to a hearing. If there is no dispute over impairment findings, the reconsideration process can take no more than 18 working days. When there is a dispute about permanent disability, the department appoints an independent medical arbiter to examine the worker. Even in the absence of such a dispute, the department may appoint a medical arbiter if the available medical information is insufficient to determine the extent of the disability. In 2001, 66 percent of the reconsideration orders included medical arbiter exams. An additional 60 calendar days is allowed for the medical arbiter process. When a medical arbiter is involved, no medical evidence subsequent to the arbiter's report may be used in litigation before the Hearings Division, the board, or courts.

The reforms also allow the assessment of an insurer penalty when, on reconsideration, an insurer's rating of permanent disability is increased by at least 25 percent. In 2001, there were 22 of these penalties.

By SB 369 of 1995, the legislature made four changes to the reconsideration process. It required the request for reconsideration be made within 60 days of the closure; it required the hearing request be made within 30 days of the reconsideration; at hearing, it prohibited contesting an issue that was not raised at reconsideration or that did not arise out of the reconsideration; and, it prohibited admission of evidence at hearing that was not submitted at reconsideration. In 2000, the Oregon Supreme Court ruled in *Koskela v. Willamette Industries, Inc.,* that in a small number of cases this prohibition of additional evidence at hearing was an unconstitutional deprivation of workers' rights to due process. Specifically, in PTD cases at hearing, oral testimony about workers' willingness to work and their job-seeking progress had to be permitted.

The number of reconsideration requests jumped in 1995 because of the reduction in the appeal period. Since 1995, the number of reconsideration requests has fallen 37 percent. This decline is due both to a decline in the number of claim closures and to a decline in the percentage of closures for which reconsiderations are requested.

In 1995, the decision in *Guardado v. J.R. Simplot Company* raised the possibility that a single closure could have two reconsiderations. To eliminate this possibility, the 1997 legislature, in SB 118, limited the reconsideration process to one reconsideration per closure. The bill also included modified time frames for conducting the reconsideration. Additional procedural changes were made in SB 119.

In 2001, as a part of SB 485, the legislature addressed some concerns by allowing for a deposition in the reconsideration process. The deposition is limited to the testimony and cross-examination of the worker about his condition at the time of claim closure. The deposition's cost is paid by the insurer.

Reconsideration orders have usually dealt with PPD. In 1997, the principal outcome of 57 percent of the orders was the affirmation or modification of PPD awards. The percentage fell to 49 percent in 2001, the first year it was under 50 percent. In recent years, increasing percentages of the orders have modified timeloss benefits and rescinded closures.

Reconsideration orders may be appealed to the Hearings Division; about a third are appealed.

Medical disputes

Prior to 1990, there were voluntary administrative review processes to resolve medical treatment and fee disputes. These processes were used infrequently. The 1990 reforms made the review processes mandatory. The legislature's intent was to resolve the majority of these matters with medical experts so that only the most adversarial cases go on to hearing.

The number of medical dispute resolution requests peaked in 1992 at 1,518. Following the Court of Appeal's decision in *Meyers v. Darigold* in October 1993, the department lost jurisdiction over disputes involving proposed medical treatment. As a result, the number of requests fell to 466 in 1994. SB 369 restored this jurisdiction, and the number of requests rose again.

SB 369 subjected dissatisfaction with the action of a managed care organization regarding the provision of medical services, peer review, or utilization review to the medical dispute resolution process. In 2001, eight percent of the requests concerned MCO issues.

By SB 728, the 1999 legislature transferred to the Hearings Division the disputes for which the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service is at issue. These compensability issues are resolved before other medical issues such as medical services or the appropriateness of treatment are resolved. Those cases in which compensability or causality are found are then returned to the Medical Review Unit for resolution of the medical service dispute. There were 101 compensability cases in 1999 and 220 in 2000, causing new growth in the total number of medical disputes. These cases were 14 percent of all 2001 medical dispute resolution requests.

The medical dispute process differs from many of the other processes in that the injured worker may not be directly involved in the dispute. In 2001, 43 percent of the medical dispute requests were from medical providers. Half of these requests concerned fee disputes, disagreements about reduced reimbursement. Many of the other provider requests concerned medical services disputes, disagreements between the provider and insurer about the services to which the injured worker was entitled.

Medical dispute orders, other than orders involving insurer medical exams or compensability issues, can be appealed through the contested case hearings process. (IME and compensability disputes are appealed to the Hearings Division.) In 2001, nine percent of the orders were appealed.

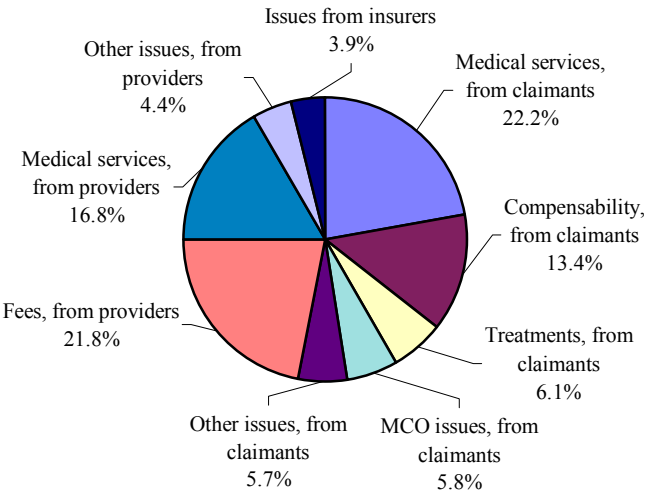
Vocational assistance disputes

In contrast to medical disputes, parties with vocational assistance disputes frequently used mediation and arbitration processes prior to the reforms. These processes were not notably changed by the 1990 reforms. The number of requests for vocational dispute resolution fell 75 percent between 1991 and 2001. Most of the decline is the result of the decline in the number of vocational assistance eligibility determinations. Approximately 20 percent of vocational assistance cases have at least one dispute. Most disputes follow an insurer's denial of eligibility for vocational assistance; the other disputes concern vocational training programs, the quality of professional services, or worker purchases.

The Rehabilitation Review Unit strives to resolve disputes through agreements. In 2001, 69 percent of the vocational disputes filed with the department were dismissed or resolved through agreements; 31 percent required a formal administrative order. The insurer prevailed in 57 percent of these orders, and the worker prevailed in 35 percent; the remainder involved mixed decisions.

RRU's orders can be appealed to contested case hearings. Thirty-one percent of the 2001 orders were appealed.

Figure 26. CY 2001 medical disputes, by issue and requester



Contested case hearings

The process for appealing administrative orders is the contested case hearing. By SB 369, the legislature took jurisdiction for appeals of vocational service dispute orders and most medical service dispute orders from the Hearings Division and made them contested cases. With this change, the number of requests for contested case hearing jumped from 90 in 1994 to 274 in 1995.

Prior to 1998, Appellate Review Unit orders concerning timeliness of reconsideration requests and jurisdictional questions were appealed as contested cases. However, a 1998 Court of Appeals decision, *James Jordan v. Brazier Forest Products*, determined that all ARU decisions were reconsideration orders and, therefore, appealable to the board. This eliminated the flow of appeals from ARU to contested case hearings. Now, most requests for contested case hearings are appeals of medical dispute or vocational dispute orders.

In 1999, HB 2525 revised the contested case hearings process. It created a centralized hearings officer panel within the Employment Department. The panel consists of the administrative law judges from several agencies. Effective January 2000, all contested cases are heard by this panel.

Contested case orders may be appealed to the Court of Appeals. Seven percent of the 2001 orders were appealed.

Workers' Compensation Board

The reforms included a number of provisions to speed the formal litigation process. The 1987 legislature reduced the time allowed to request a hearing following claim closure from one year to 180 days. The appeal period was further reduced by SB 369. The board was required to schedule a hearing or board review for a date no later than 90 days after the receipt of a request. The hearing or board review shall not be postponed except in extraordinary circumstances beyond the control of the requesting party. An order must be issued within 30 days of the hearing or board review. Also, legislation limited the submission of additional medical reports and findings to the board in appeals of reconsideration orders, reducing time delays for the development of additional medical evidence.

In addition, the number of board members was expanded from three to nine with the appointment of six temporary board members in September 1989. The 1991 legislature phased out the six temporary board members and added two limited duration members and two pro-tem members. In 1993, the two pro-tem positions were abolished, and the two limited duration board members were made permanent for a total of five permanent board members.

In 1987, the Hearings Division was required to establish an expedited claim service to resolve informally those claims where compensability is not an issue and the amount in controversy is $1,000 or less, or where the only matters unresolved are attorney fees or penalties.

Mediation

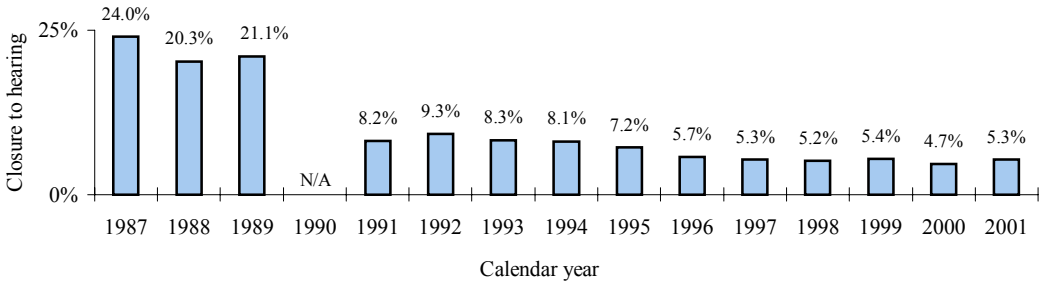
The 1995 legislature provided for mediation by a private party when the only issue to be resolved is insurer responsibility. This service has not been used. However, for several years the board has had a voluntary program to help parties settle disputes — on an ad hoc basis as well as through mass settlement conferences. The board offers the parties the help of trained administrative law judge mediators, at no cost to the parties. Almost 90 percent of the cases that are mediated are settled. The majority of the cases being mediated are complex cases: mental stress claims, occupational disease claims, cases with a claim for permanent total disability benefits, and cases that include claims under ORS Chapter 659 (civil rights and unlawful employment practices), the Americans with Disabilities Act, or other employment-related issues. Historically a third of mediations were about psychological disease, and 45 percent of mediations included issues in addition to workers' compensation issues. The board also has entered into an agreement with the Court of Appeals to provide mediation services in workers' compensation cases pending before the court.

Hearing requests and appeal rates

Prior to reform, the number of hearing requests increased for more than 20 years, reaching a peak in 1989. After the first reforms, the number dropped quickly; the number of requests in 1997 was 41 percent of the 1989 figure. Since then, requests have leveled off at about 11,000. One of the reasons for the decline has been the reconsideration process, which cut the hearing request rate on initial disabling claim closures. The appeal rate on claim closures has fallen from 21 percent in 1989 to 5 percent.

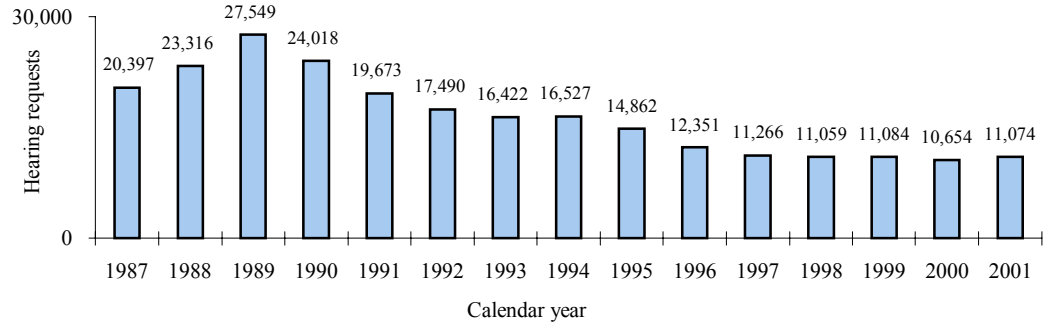
The number of pending cases at hearing peaked in June 1987 at 15,664. By the end of June 2000, pending cases had dropped to about 5,400 (a drop of 65 percent), but

Figure 27. Hearing request rates on disabling claims closures, 1987-2001



Notes: Prior to the implementation of the reconsideration process, closures were appealed directly to hearings.

Figure 28. Requests for hearing, 1987-2001



it has risen slowly since. The median time lag from hearing request to order dropped almost 50 percent from 1987 to 1988; since 1991 it has been about 125 days. The board review median time lag from request to board order in 2001 declined to 110 days, an 80 percent reduction since the peak in 1989. The Court of Appeals request-to-order time lag has risen steadily from a low in 1994 to a record-high 426 days (14 months) in 2001.

The goal of reducing litigation includes reducing the appeal rates from each level of review. The percentage of reconsiderations that have been appealed has dropped from 53 percent in 1992 to 34 percent in 2001. The hearing appeal rate has been between 9 percent and 11 percent each year from 1991 through 2001, but has declined slowly since 1997. The appeal rate of board orders has been between 17 and 23 percent since 1993, well below the 28 percent appeal rate of 1992. (Note: The 1987 reform legislation changed the review standard for the courts. The *de novo* review was replaced by a review of the record for substantial evidence supporting the board's decision and for errors of law.) Many of the appeals of board orders deal with precedent-setting reform issues. The number of these issues has decreased.

The composition of the issues litigated at hearing has changed significantly subsequent to reform legislation. In 1987, permanent disability was at issue in 46 percent of the hearing cases; by 2001, the percentage had dropped to 6 percent. Claim denial was at issue in 25 percent of the orders in 1987. After peaking at 49 percent in 1993, it dropped to 40 percent in 2001. In 1987, insurer penalties were at issue in 15 percent of the orders; in 2001 the percentage was 8 percent. Disability evaluation standards, administrative penalty provisions, and the mandatory reconsideration process have played a role in altering the composition of the issues resolved.

Claims disposition agreements

The reforms allowed for an alternative method of settling accepted claims. The 1990 special session authorized compromise and release settlements (claims disposition agreements) of claims benefits, except for medical services. The agreements are entered into by claimants and insurers; they are reviewed and approved by the Workers' Compensation Board. In 2001, 3,145 CDA approving orders were issued. The settlements for these orders amounted to $39.2 million, an average of about $12,500 per agreement.

Attorney fees

One reason for reducing litigation is that claimants retain a higher proportion of their overall awards when they pay less in attorney fees. In 1990, the law limited penalty-related attorney fees to half of the penalty

amount. In 1995, by SB 369 the legislature made three changes that reduced claimant attorney fees: it limited fees in responsibility disputes, it prohibited the Hearings Division from awarding penalties and fees for matters arising under the review jurisdiction of the director, and it limited fees for the reversal of a denial prior to a hearings decision to those cases in which the denial is based on compensability of the underlying condition. The legislature also froze the maximum fees until February 1999, when for the first time in nearly 10 years, the board raised the maximum out-of-compensation fees for a claimants' counsel, payable from increased awards.

In the reconsideration process, attorney fees are limited to 10 percent of the increased award. Attorney fees paid in 2001 resulting from reconsiderations totaled $777,000. Fees for proceedings before the Hearings Division and on board review totaled nearly $9.2 million. Claimant attorney fees from all sources (reconsiderations, hearings, board review, and CDAs) increased from $16.6 million in 1989 to $21.4 million in 1991; since then fees have gradually decreased and have leveled off to around $16 million in the last five years. Attorney fees connected with lump-sum settlements (CDAs and disputed claim settlements) have accounted for a growing share of claimant attorney fees, rising from roughly one-fourth of fees in 1989 to 56-61 percent of all fees since 1991.

Other changes

Two additional provisions in 1995 by SB 369 were intended to reduce litigation. One allowed Hearings Division ALJs and the board to impose attorney sanctions for appeals that are frivolous, made in bad faith, or for harassment. The other required workers who believe that a condition has been omitted from a notice of acceptance to notify the insurer and not merely allege a de facto denial in a hearing request.

In 2001, SB 485 added the opportunity for a medical exam as part of some compensability denial hearings. The cases have the following restrictions: the injury occurs since January 1, 2002; the request for a hearing is timely; and the denial is based on insurer medical exams with which the worker's attending physician disagreed. In these cases, the worker can ask the department to provide the name of a physician who will conduct a new, independent exam. The worker has the burden of proving that he is eligible for the exam. The insurer pays the costs of the exam and the physician's report. The physician's report then becomes a part of the hearing record.

As of the end of November 2002, there had been 49 requests for these worker-requested exams. Of these, 26 requests had been approved.

Statistics

Reconsideration requests and orders, 1991-2001

Year	Requests received	Orders issued	Time lag days (mean)
1991	6,137	5,996	65
1992	6,678	6,518	45
1993	6,098	6,028	58
1994	6,014	6,026	61
1995	6,917	6,564	62
1996	5,901	6,299	66
1997	4,721	4,790	68
1998	4,650	4,582	70
1999	4,439	4,544	71
2000	4,210	4,244	72
2001	4,350	4,253	72

The mandatory reconsideration process began in mid-1990. The number of requests jumped in 1995 as SB 369 shortened the timelines during which a reconsideration request could be made. Requests have since dropped as the number of closures has fallen. The lag time has increased as the percentage of disputed closures going to a medical arbiter has increased.

Note: The figures include the reconsideration of disabling status reclassification orders.

Types of reconsideration orders issued, 1997-2001

Year	Affirm time-loss	Modify time-loss	Affirm PPD	Grant/ Modify PPD	Rescind closure	CDA dis-missal	Dis-abling status	Other
1997	17.3%	4.7%	9.5%	47.4%	6.7%	2.9%	2.0%	9.5%
1998	15.4%	6.4%	8.1%	47.4%	8.1%	3.5%	2.6%	8.6%
1999	12.9%	11.5%	7.6%	44.4%	8.3%	3.5%	2.8%	9.0%
2000	11.0%	11.9%	7.1%	44.5%	9.6%	3.9%	3.0%	9.0%
2001	13.0%	12.6%	7.1%	41.9%	9.5%	3.7%	3.5%	8.6%

In 2001, for the first time, fewer than 50 percent of the reconsideration orders affirmed or modified PPD awards.

Most of the "other" orders are withdrawn requests and amending orders.

Medical dispute requests and orders, 1990-2001

Year	Requests	Orders	Request to order lag days (median)
1990	1,172	310	28
1991	1,386	969	112
1992	1,518	1,412	63
1993	876	987	44
1994	466	467	33
1995	741	469	39
1996	716	856	120
1997	878	816	61
1998	801	816	89
1999	904	819	84
2000	994	939	115
2001	1,184	1,204	68

Medical dispute resolution requests and orders peaked in 1992 and then declined sharply after a court decision limited the department's jurisdiction. SB 369 reversed this decision and the numbers increased. In 1999, by SB 728, authority for determining the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service was transferred to the Hearings Division. These, included in the counts of medical disputes, were the reason for the increase in disputes in 1999. Fee disputes are the reason for the recent increase in disputes.

Medical dispute issues, by year of request, 1997-2001

Year	Fees	Medical services	Treat-ments	Pallia-tive care	MCO issues	Attending physi-cians	Added IMEs	Com-pens-ability
1997	34.7%	31.2%	24.1%	4.9%	-	3.6%	1.4%	-
1998	4.1%	59.6%	26.5%	3.7%	0.1%	5.0%	1.0%	-
1999	5.4%	52.1%	17.1%	6.3%	1.5%	3.7%	2.7%	11.2%
2000	9.5%	43.6%	9.7%	5.7%	5.9%	2.1%	1.4%	22.1%
2001	22.7%	39.8%	8.8%	3.1%	8.1%	2.4%	1.1%	14.0%

The compensability issues category was added as a result of SB 728 in 1999. There was a jump in fee disputes in 2001.

Statistics

Vocational dispute requests and orders, 1991-2001

Year	Requests	Orders	Request to order lag days (median)
1991	2,067	2,137	41
1992	1,643	1,725	29
1993	1,493	1,519	25
1994	1,389	1,373	24
1995	1,347	1,304	28
1996	996	1,037	35
1997	877	881	32
1998	716	715	26
1999	630	681	28
2000	548	562	35
2001	512	477	35

The number of requests for the resolution of vocational disputes has fallen 75 percent from 1991 to 2001. The decline resulted chiefly from the decrease in the number of vocational assistance cases. The percentage of vocational assistance cases (eligible and ineligible) that have had at least one vocational dispute has remained at about 20 percent each year.

Vocational dispute resolutions, by outcome, 1997-2001

Year	Agree-ments	Insurer prevail orders	Worker prevail orders	Other orders	CDA dis-missals	Other dis-missals
1997	26.3%	34.5%	8.3%	0.6%	12.8%	17.5%
1998	29.8%	27.7%	6.9%	2.4%	13.4%	19.9%
1999	26.7%	30.5%	7.0%	1.2%	14.0%	20.6%
2000	25.6%	27.6%	6.4%	1.8%	16.7%	21.9%
2001	32.9%	17.4%	10.7%	2.5%	15.1%	21.4%

About a third of vocational disputes are resolved with agreements; more than a third are dismissed.

Contested case hearings, requests and orders, 1994-2001

Year	Requests	Orders	Request to order lag days (mean)
1994	90	107	172
1995	274	169	125
1996	311	373	117
1997	273	279	89
1998	209	191	124
1999	182	183	152
2000	130	133	195
2001	153	163	207

After the passage of SB 369, the number of requests for contested case hearings jumped. SB 369 precluded appeals to the Hearings Division in vocational service and medical service disputes. The number of requests declined 51 percent between 1996 and 2001.

Contested case hearings issues, by request date, 1997-2001

Year	Appellate Review	Comp-liance	Medical	Voc. assist-ance	Other
1997	19.0%	7.0%	35.5%	28.2%	10.3%
1998	1.0%	4.8%	51.7%	33.5%	9.1%
1999	-	7.1%	61.0%	31.3%	0.5%
2000	-	6.9%	53.1%	36.2%	3.8%
2001	-	6.5%	60.1%	31.4%	2.0%

Over 90 percent of contested case hearings concern the appeal of medical dispute or vocational dispute orders.

Statistics

Hearing request rates on claim closures, 1987-2001

Appeal year	Rate, closure to reconsideration	Rate, recon to hearings	Rate, closure to hearings
1987	-	-	24.0%
1988	-	-	20.3%
1989	-	-	21.1%
1990	-	-	N/A
1991	16.8%	49.0%	8.2%
1992	17.3%	53.4%	9.3%
1993	17.2%	48.1%	8.3%
1994	16.9%	47.8%	8.1%
1995	16.6%	43.1%	7.2%
1996	15.8%	36.4%	5.7%
1997	14.6%	36.4%	5.3%
1998	14.5%	35.6%	5.2%
1999	14.8%	36.3%	5.4%
2000	14.5%	32.0%	4.7%
2001	15.6%	33.7%	5.3%

Prior to the mandatory reconsideration process, over 20 percent of closures were appealed to hearings. Since the introduction of the reconsideration process, the percentage of closures appealed to reconsideration has declined slightly, and the percentage of reconsideration orders appealed to hearings has dropped from over 50 percent to 34 percent in 2001. As a result, the percentage of closures that are appealed to hearing has dropped to five percent.

Hearing requests, orders, and appeal rates, 1987-2001

Year	Requests	Orders	Appeal rate
1987	20,397	23,680	7.3%
1988	23,316	26,386	8.2%
1989	27,549	24,890	7.8%
1990	24,018	25,073	6.6%
1991	19,673	21,368	11.0%
1992	17,490	19,580	11.4%
1993	16,422	16,888	10.2%
1994	16,527	15,751	10.2%
1995	14,862	16,798	9.2%
1996	12,351	13,341	10.4%
1997	11,266	11,596	11.2%
1998	11,059	11,271	10.5%
1999	11,084	10,846	10.5%
2000	10,654	10,935	9.8%
2001	11,074	10,269	9.4%

Requests for hearings peaked in 1989. The number of requests in 2001 were just 40 percent of the 1989 figure. The appeal rate for board review of hearing orders has changed very little since 1991.

Note: The requests and orders include stipulations received without a prior hearing request.

Percentage of hearing orders involving selected issues, 1987-2001

Year	Permanent disability	Claim denial	Insurer penalty
1987	46.1%	24.5%	14.6%
1988	39.7%	24.5%	16.4%
1989	31.9%	32.3%	16.6%
1990	33.3%	34.8%	14.6%
1991	18.2%	43.7%	10.0%
1992	15.7%	40.9%	7.5%
1993	12.6%	48.7%	10.3%
1994	11.6%	44.7%	12.5%
1995	10.4%	39.4%	12.1%
1996	11.5%	38.2%	8.4%
1997	10.1%	46.6%	5.9%
1998	7.6%	42.9%	7.2%
1999	7.8%	42.5%	7.8%
2000	7.5%	40.7%	7.4%
2001	6.1%	39.7%	8.1%

In large part due to the introduction of the mandatory reconsideration process for disputed claim closures, the percentage of hearings in which permanent disability was an issue fell sharply from 1990 to 1991. By 2001, six percent of the hearing orders involved permanent disability. Claim compensability has been the most frequent issue since 1989.

Statistics

Disputed claim settlements at hearing, 1987-2001

Year	DCS cases	Amount ($ millions)
1987	3,778	$18.2
1988	4,139	21.6
1989	4,365	22.5
1990	5,374	29.1
1991	6,021	32.6
1992	4,942	25.7
1993	4,700	24.8
1994	4,100	20.8
1995	4,455	22.2
1996	4,001	19.1
1997	3,846	19.0
1998	3,921	20.3
1999	3,721	19.6
2000	4,019	22.8
2001	3,899	21.2

The number of disputed claim settlements has decreased gradually, but at a pace slower than that of the corresponding hearings orders.

Board review requests, orders, and appeal rates, 1987-2001

Year	Requests	Orders	Appeal rates
1987	1,719	1,222	29.6%
1988	2,151	991	12.8%
1989	1,944	1,576	13.6%
1990	1,653	3,067	17.2%
1991	2,346	2,064	23.8%
1992	2,230	2,487	27.9%
1993	1,726	1,931	19.5%
1994	1,599	1,814	20.1%
1995	1,553	1,655	17.4%
1996	1,381	1,676	17.9%
1997	1,307	1,229	18.2%
1998	1,187	1,358	18.5%
1999	1,141	1,147	19.1%
2000	1,076	1,166	21.2%
2001	966	860	22.9%

The number of requests for board review peaked in 1991; the 2001 number of requests was 41 percent of the 1991 figure. The percentage of board orders appealed peaked at 30 percent in 1987. In 2001, 23 percent of board orders were appealed.

Note: The figures exclude crime victim and third party cases.

Court of Appeals requests and decisions, 1987-2001

Year	Requests	Decisions
1987	362	287
1988	127	283
1989	214	108
1990	528	178
1991	491	332
1992	695	247
1993	377	285
1994	365	239
1995	288	172
1996	300	175
1997	224	160
1998	251	130
1999	219	126
2000	247	98
2001	197	102

Court requests peaked in 1992. In 2001, the number of requests was 28 percent of the 1992 figure.

Note: Decisions exclude remands where the court did not rule on the primary issue, or direct a specific resolution by the board, including remands to approve a settlement.

Statistics

Median time lag days from request to order, 1987-2001

Year	Hearings	Board	Court
1987	224	259	335
1988	114	306	323
1989	116	548	281
1990	147	458	298
1991	133	264	293
1992	125	255	321
1993	119	256	295
1994	121	238	286
1995	124	204	299
1996	120	163	288
1997	122	160	318
1998	121	134	330
1999	124	125	343
2000	128	118	376
2001	126	110	426

The median time lag for hearing orders in 2001 was 56 percent of that in 1987, and the board review lag was 42 percent. On the other hand, time lags for court decisions have climbed for five years to the highest on record.

Note: The time lags are for all order types.

Median time lag days from injury to order, 1987-2001

Year	Hearings	Board	Court
1987	758	1,067	1,496
1988	677	1,098	1,606
1989	602	1,320	1,512
1990	617	1,169	1,770
1991	659	978	1,512
1992	655	1,047	1,549
1993	598	966	1,443
1994	561	870	1,402
1995	574	817	1,490
1996	532	763	1,247
1997	502	723	1,484
1998	488	716	1,330
1999	485	685	1,446
2000	506	721	1,238
2001	496	714	1,281

The time lags from injury to order have declined substantially since 1987, primarily due to a changing mix of issues (whole-claim denials are litigated sooner, as hearings is the first level of appeal).

Board own motion orders and reopened claims program costs, 1987-2001

Year	B.O.M. orders	Program costs ($ millions)
1987	612	$0.0
1988	724	0.2
1989	703	2.2
1990	962	2.7
1991	1,135	4.8
1992	1,003	3.9
1993	927	3.5
1994	845	3.7
1995	751	3.9
1996	659	2.7
1997	616	3.6
1998	639	3.8
1999	593	3.9
2000	555	3.7
2001	431	3.7

The number of board own motion orders peaked in 1991; orders have declined steadily since, except for a slight increase in 1998. The Reopened Claims Reserve was effective January 1, 1988. Reimbursements to insurers for own motion claims costs peaked in 1991 at $4.8 million. Other than in 1996, reimbursements have been between $3.5 and $3.9 million a year since 1992.

Statistics

Claims disposition agreements, 1990-2001

Year	CDA requests	CDA approval orders	Amount ($ millions)
1990	559	359	$6.9
1991	2,869	2,822	45.6
1992	3,229	3,202	47.0
1993	3,301	3,283	42.5
1994	3,230	3,243	41.7
1995	3,767	3,924	48.6
1996	3,526	3,561	45.0
1997	3,293	3,265	44.3
1998	3,037	3,073	37.7
1999	3,092	3,073	39.7
2000	3,154	3,150	39.9
2001	3,097	3,145	39.2

SB 1197 authorized claims disposition agreements in 1990. In 2001, 3,145 CDAs were approved; the amount paid was $39.2 million.

Claimant attorney fees and defense legal costs, 1987-2001

Year	Claimant attorney fees ($ millions)	Defense legal costs ($ millions)
1987	$14.4	N/A
1988	16.3	N/A
1989	16.6	$23.4
1990	17.8	26.1
1991	21.4	26.9
1992	21.4	28.2
1993	19.8	27.2
1994	18.8	25.7
1995	20.0	27.4
1996	17.5	25.3
1997	16.0	24.3
1998	16.2	24.1
1999	15.9	24.0
2000	16.8	23.3
2001	16.0	24.7

The $15.9 million in claimant attorney fees in 1999 is the lowest since 1987, despite the fact that effective February 1999, the Board raised the maximum out-of-compensation fees to the claimant's counsel from increased awards by ALJs and the Board. Defense legal costs reached a record low in 2000.

Claimant attorney fees (thousands of dollars), 1987-2001

Year	Hearings	Board	CDA	Recon
1987	$14,187	$226	-	-
1988	15,967	335	-	-
1989	15,953	656	-	-
1990	15,902	1,007	$900	$1
1991	13,796	905	6,419	276
1992	12,505	1,067	7,054	727
1993	11,145	1,165	6,634	858
1994	10,400	1,140	6,465	835
1995	10,859	826	7,346	962
1996	9,100	857	6,675	903
1997	8,518	753	5,996	738
1998	8,863	802	5,664	821
1999	8,537	612	5,908	843
2000	9,128	693	6,118	866
2001	8,540	612	6,111	777

In 2001, 53 percent of the claimant attorney fees came from hearings and 38 percent from CDAs.

Statistics

Maximum out-of-compensation attorney fees

Hearings	Prior to 2/1999	2/1999 - present
PTD	$4,600	$12,500
PPD	$2,800	$4,600
Timeloss	$1,050	$1,500
DCSs	25% of the first $12,500, 10% of the remainder	25% of the first $17,500, 10% of the remainder
Board	**Prior to 2/1999**	**2/1999 - present**
PTD	$6,000	$16,300
PPD	$3,800	$6,000
Timeloss	$3,800	$5,000
CDAs	25% of the first $12,500, 10% of the remainder	25% of the first $17,500, 10% of the remainder

The maximum attorney fees were raised effective February 1999.

Advocates and Advisory Groups

Injured workers and employers often find the workers' compensation system confusing or inaccessible. Oregon is one of the few states that has recognized that the comprehensibility of and access to the system are essential elements in workers' compensation reform. Therefore, a number of advocates and advisory groups are at work in Oregon.

Ombudsman for Injured Workers

The 1987 legislature created the Workers' Compensation Ombudsman (now called Ombudsman for Injured Workers) as an independent advocate for injured workers who are struggling to resolve the disposition of their claims. Recognizing the importance of the ombudsman, the 1990 special session added two positions to the office, increasing the staff to five. Since the inception of the office, the number of annual contacts with the office increased over five-fold through 1996. The accounting procedure of the number of contacts changed from 1997, and comparison of the pre-1997 numbers with the numbers for 1997 and after is not possible. The current procedure involves counting all incoming and outgoing telephone calls, mail contacts and walk-ins; each case may have several contacts, especially telephone calls. However, even on this basis, there has been a 54 percent increase of contacts between 1997 and 2001. In the last three years, the issues that prompted the most inquiries were benefits, medical issues, claim processing, and settlements.

Figure 29. Ombudsman for Injured Workers contacts, 1988-2001

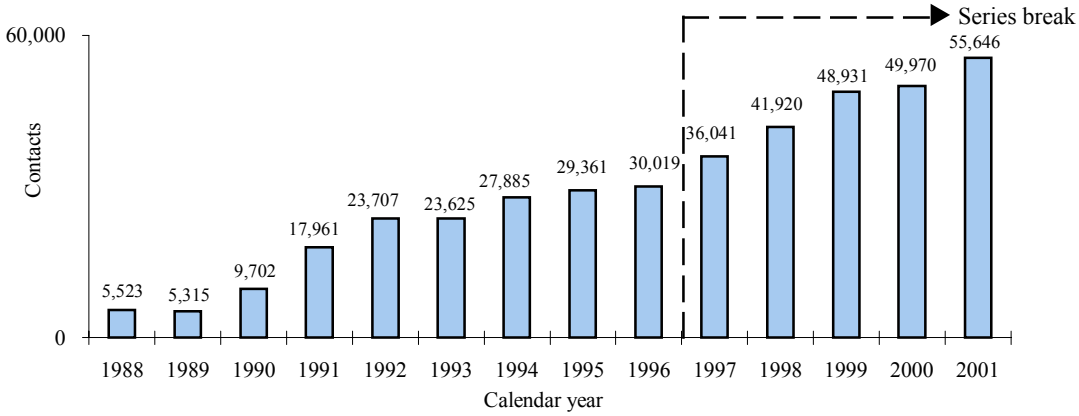
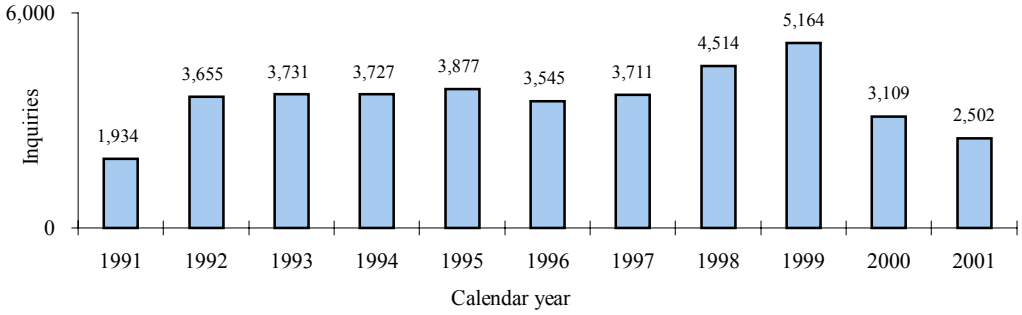


Figure 30. Small Business Ombudsman inquiries, 1991-2001



Small Business Ombudsman

The office of Small Business Ombudsman for Workers' Compensation was created during the 1990 special session to advocate for and to educate small businesses. The office had 2,500 inquiries in 2001, less than half of the number in 1999.

Innovations in Workers' Compensation

The 1990 special reform session also established the Joint Legislative Task Force on Innovations in Workers' Compensation. The task force was directed to reexamine the role of the workers' compensation system and to develop recommendations for a more fair and cost-

effective system. The task force recommended a number of bills that would allow for the development of alternatives to the current workers' compensation insurance system. The principal alternative was to allow for employers to provide combined 24-hour health insurance and indemnity benefits rather than the traditional workers' compensation coverage.

Medical Advisory Committee

Legislation passed in 1999 revised the composition and duties of this statutory committee. The new statute allows the director to appoint medical providers that most represent the health-care services provided to injured workers, and "one representative of insurers, one representative of employers, one representative of workers, one representative of managed care organizations …. " The members provide advice to the director on matters relating to medical care to workers.

Management-Labor Advisory Committee

In recognition of the success of the governor's labor-management committee in crafting the 1990 reforms, the legislature created the Management-Labor Advisory Committee. This committee reaffirms that labor and management are the principal parties in the workers' compensation system. The committee periodically reviews disability rating standards and advises the department on workers' compensation matters such as administrative rules and legislation. The 1995 legislature reduced the membership of MLAC from 14 to 10 members and included specific issues for mandatory reporting to the legislature.

During the interim between the 2001 and 2003 legislative sessions, an MLAC subcommittee was appointed to examine policy issues relating to permanent partial disability benefits. The subcommittee has recommended that several proposals be drafted as proposed legislation.

Medical Privacy Advisory Committee

The 2001 legislature created the Advisory Committee on Privacy of Medical Information and Records. The committee reviews state and federal laws concerning the privacy of medical information. The purpose is to see if state law conflicts with federal law, especially the Health Insurance Portability and Accountability Act of 1996. The members are scheduled to report to the 2003 legislature.

Statistics

Ombudsman for Injured Workers activities, 1988-2001

Year	Contacts	Outreach programs	Outreach program contacts
1988	5,523	76	
1989	5,315	106	
1990	9,702	18	
1991	17,961	75	
1992	23,707	71	
1993	23,625	0	
1994	27,885	30	
1995	29,361	1	
1996	30,019	54	
			Series break
1997	36,041	N/A	140
1998	41,920	N/A	311
1999	48,931	N/A	420
2000	49,970	N/A	939
2001	55,646	N/A	320

The number of contacts with the injured worker ombudsman office increased six percent a year between 1992 and 1996. The count procedure for contacts changed from 1997, to count all telephone calls, mail contacts and walk-ins. Therefore, pre-1997 counts are not comparable to the more recent counts. However, it is seen that contacts have increased rapidly since 1997.

Ombudsman for Injured Workers, percent of inquiries by major issue group, 2000 & 2001

Major issue group	2000	2001
Attorney	1.5%	1.6%
Benefit	21.9%	22.3%
Claim processing	16.5%	15.7%
Denials	7.4%	6.8%
Medical	14.6%	14.9%
Orders & appeals	7.9%	8.0%
Settlements	13.0%	9.5%
Unable to contact	1.8%	3.7%
Work release	7.0%	7.0%
Other issues	8.5%	10.6%
Total	100.0%	100.0%

Benefit issues were the most frequent type of inquiries in both 2000 and 2001. Medical, claim processing, and settlements were the next most important issues.

Small Business Ombudsman activities, 1991-2001

Year	Inquiries	Outreach programs	Outreach program contacts
1991	1,934	33	495
1992	3,655	40	600
1993	3,731	27	405
1994	3,727	31	465
1995	3,877	15	225
1996	3,545	16	240
1997	3,711	28	420
1998	4,514	N/A	540
1999	5,164	N/A	855
2000	3,109	N/A	1,952
2001	2,502	N/A	1,824

This program was implemented in the fall of 1990. The number of inquiries peaked in 1999. It has since declined 52 percent. Outreach program contacts have increased rapidly over the last three years, more than tripling between 1998 and 2001.

Appendix 1 - Workers' Compensation Reform Legislation

Recent major legislative reform of the Oregon workers' compensation system began during the 1987 legislative session. Two major reform bills, House Bill 2271 and HB 2900, were passed. Continuing financial strain on the workers' compensation insurance market provided the impetus for further major reform. In May 1990 the legislature passed Senate Bill 1197 and SB 1198 during a special session. The reforms were refined during the 1991 and 1993 legislative sessions.

In February 1995, the Oregon Supreme Court ruled in *Errand v. Cascade Steel Rolling Mills* that the exclusive remedy provision of workers' compensation law applied only to compensable claims, not to all claims. In response to this and several other court decisions, the legislature passed SB 369. Small reforms were implemented in 1997. In 1999, SB 460 ratified most portions of SB369. The legislature also gave more responsibility to the private sector. In SB 220, it transferred the responsibility for all claim closures to insurers and their claims administrators. In SB 221, the legislature closed the department's claims examiner certification program. This program had been created in 1990 by SB 1197.

During late 2000 and early 2001, the Oregon Supreme Court issued several rulings covering portions of the workers' compensation statute. In *Smothers v. Gresham Transfer, Inc.*, the court limited the exclusive remedy provisions in SB 369. The legislature passed SB 485 to address this and to make other changes.

A chronology of Oregon's reform legislation is provided below.

Safety and Health

1987

654.086 Increased penalties against employers who violate the state safety and health act. (HB 2900)

654.090 (4) Expanded the purposes of ORS Chapter 654 to promote more effective safety and health educational (consultative) efforts. (HB 2900)

654.097 Required insurers and self-insured employers to provide safety and health loss prevention consultative programs that conform to department standards. (HB 2900)

1989

654.191 and **705.145** Established the Occupational Safety and Health Grant program to fund organizations and associations to develop innovative education and training programs for employees in safe employment practices, with funding not to exceed $400,000 per biennium; funded from civil penalties assessed by OR-OSHA. (HB 2982)

1990

654.176 (1) Required that all employers with more than ten employees establish a safety and health committee. Also required that employers with ten or fewer employees establish safety committees if the employer has had a lost workday cases incidence rate in the top 10 percent of all rates for employers in the same industry or is subject to a premium classification in the highest 25 percent of premium rates. (SB 1197)

1991

654.086 Mandated increases in penalties to federal maximums against employers who violate occupational safety and health standards. (HB 3017)

1995

654.154 (1) Exempted small agricultural employers (10 or fewer employees) from scheduled inspections by OR-OSHA, providing that the employer has not had a complaint filed in the prior two years or a serious accident, receives a consultation once every four years and corrects any identified hazards within 90 days, and has a minimum of four hours training annually on agricultural safety rules and procedures at a course conducted or approved by the department. (HB 3019)

654.176 (1) Exempted small agricultural employers (10 or fewer employees) from OR-OSHA safety committee requirements unless the employer has a lost workday cases incidence rate in the top 10 percent of all rates for employers in the same industry. (HB 2541)

656.622 Established a Worksite Redesign Program, including engineering design work and occupational health consulting services, to prevent the recurrence of on-the-job injures. (SB 369) (Funding for this program was eliminated by the 2001 legislature by removing funding from the department's budget in SB 5507.)

1997

656.796 Repealed this section. Abolished the State Advisory Council on Occupational Safety and Health. SACOSH was established to assist the director in the development of occupational safety and health policies and programs. OR-OSHA's extensive use of external and internal committees in establishing policies and programs eliminated the need for this advisory council. (SB 135)

658.790 Transferred enforcement authority of the law that requires farmworker camp operators to provide seven days of housing in the event of camp closure by a government agency from the Bureau of Labor and Industries to the department. (SB 38)

1999

654.005 Exempted corporate farms from safety and health requirements when the farm's only employees are family members. (HB 2402)

654.003, 654.035, 654.067, and **654.071** Provided that OR-OSHA schedule inspections by predominantly focusing resources on the most unsafe places of employment. OR-OSHA will notify employers with the most unsafe places of employment that they have an increased likelihood of inspection. Employers may designate attorneys to act as representatives during inspections. (HB 2830)

2001

654.086 (4) & (5) and **658.815 (1)** Established a Farmworker Housing Development Account and directed that money collected from civil penalties imposed for the non-registration of farmworker camps be put in the account. The account is within the Oregon Housing Fund. The Oregon Department of Housing and Community Services administers the fund. The purpose of the account is to expand the state's supply of housing for low-income farmworkers. (HB 3573)

654.335 and **654.336** Amended employer liability law by removing the contributory negligence language in 654.335 and adding comparative negligence language through 654.336. (SB 485)

656.622 Eliminated funding for the Workplace Redesign Program. (SB 5507)

Amended tax law to transfer the administration of the Farmworker Housing Tax Credit from OR-OSHA to the Oregon Department of Housing and Community Services. Also amended housing law to declare that it is the policy of the state to ensure adequate housing for farmworkers. (HB 3172)

Amended tax law to remove the December 31, 2001, sunset of the Farmworker Housing Construction tax program and made the program permanent. Also increased the amount of the credit to 50 percent of the eligible costs, extended the period for claiming the credits to 10 years, increased the annual cap on certified project costs to $7.5 million, and allowed the owner or operator to transfer up to 80 percent of the credit amount to project contributors. (HB 3173)

Insurance

1987

656.262 (5) Allowed employers to pay for medical services up to $500 for nondisabling claims. Excluded these medical costs from modifying the employers' experience rating. (HB 2900)

656.622 (8) Excluded claim costs incurred as a result of an injury sustained by a Preferred Worker during the first two years of hire from data used for ratemaking or individual employer rating. (HB 2900)

656.625 Established the Reopened Claims Reserve for reimbursing to insurers the additional amounts of compensation payable to injured workers for board own motion cases; excluded own motion claims costs from loss experience. (HB 2900)

1990

656.052 (4) Increased the liability of corporations, and their officers and directors, as noncomplying employers. (SB 1197)

656.427 Enacted amendments to insurance coverage termination procedures to better assure continuous coverage availability for employers to minimize the magnitude of noncomplying employers. (SB 1198)

656.622 (8) Extended from two to three years from hire the exclusion from ratemaking for the Preferred Worker claim costs arising from injury or occupational disease; changed the program to a premium exemption program. (SB 1197)

656.730 (1)(a) Mandated a tiered rating scheme for insureds too small to qualify for experience rating plans in the assigned risk pool. (SB 1198)

656.752 (2)(b) Amended the statutory purpose of SAIF Corporation to make insurance available to as many Oregon employers as inexpensively as possible consistent with sound insurance principles. (SB 1198)

Allowed for the director to establish a contracting classification premium adjustment program. This provided employers subject to contractor class premium rates the economic incentive to enhance safety in the workplace. (SB 1197)

1991

746.230 and **746.240** Subjected the SAIF Corporation to that portion of the Insurance Code governing unfair claims settlement practices and undefined trade practices. (SB 24)

1993

656.018, 656.403, 656.850, 656.855, and **737.270** Established director's authority to regulate employee leasing companies. Specified fees and methods of licensure by the director; specified the responsibility for workers' compensation coverage and the basis for experience rating; required leasing companies to assure leased workers are properly trained in safety matters required under ORS Chapter 654; and required reporting of client employers to the director and other statistical information to the appropriate rating bureau. (HB 2282)

1997

656.018 (5) and **656.850 (1)** Clarified the definition of employees of temporary employment companies and their exclusive remedy provisions. (SB 699)

656.307 (1)(b) Required that insurers submit claim closures of pro rata and paying agent claims to WCD for redetermination. All parties have the right to request reconsideration. (SB 116)

656.593 (6) & (7) Allowed workers to release insurer liability in a third-party action that exceeds $1 million. (SB 484)

656.790 Increased the Workers' Benefit Fund reserves to 12 months of anticipated expenditures. (SB 484)

1999

656.170, 656.172, and **656.174** Allowed for the director to establish a process for up to two construction trades unions to receive authorization to collectively bargain agreements for workers' compensation benefits. This bill was established as a pilot project where eligibility for such agreements will end January 1, 2002. The bill also required a status report to the 2001 legislature. (HB 2450)

656.430 (7) Removed the "same industry" requirement to be included in a self-insured employer group. (SB 591)

656.506 Made permanent the policy that the Workers' Benefit Fund will maintain a target balance of 12 months of anticipated expenditures. (SB 213)

656.530 Eliminated the 75 percent reimbursement of workers' compensation premium for rehabilitation facilities from the Workers' Benefit Fund. (SB 288)

656.612 (5) Required the director to use rulemaking process to establish workers' compensation premium assessments. (SB 592)

737.318 Required insurers to give notice to employers of the right to appeal the results of a premium audit. (HB 3055)

737.017, 737.225, 737.265, 737.270, 737.355, and **737.560** Authorized the director to license one or more rating organizations for workers' compensation insurance under the Insurance Code. The bill specified the services to be provided by the workers' compensation rating organization. (SB 280)

746.147 Prohibited an insurer or agent from quoting projected net insurance premiums that are not guaranteed in the policy. (HB 2021)

2001

656.210 (2)(c) Stated that the supplemental temporary disability benefits paid for multiple jobs are not to be used for ratemaking or for individual employer rating or dividend calculations. (SB 485)

656.445, 656.506 (4), 656.605 (2)(a), 734.360, 734.510, 734.570, 734.630, 734.635, and **734.695** Established the director's authority to advance payments from the

Workers' Benefit Fund to injured workers when an insurer has defaulted on its obligations to pay claims but has not yet been placed in liquidation by the court. After liquidation proceedings are completed and the insurer placed in receivership, the Oregon Insurance Guaranty Association will refund the Workers' Benefit Fund any moneys advanced. (SB 977)

656.506 (6) Allowed Workers' Benefit Fund assessments to be reported annually. (SB 354)

656.772, 657.774, and **656.776** Required the Secretary of State to conduct an annual audit of the SAIF Corporation. The bill specifies the subjects of the audit. SAIF must pay for the audit. (HB 3980)

Compensability

1987

656.266 Placed on the worker the burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability. The worker cannot prove compensability simply by disproving other explanations. (HB 2271)

656.802 (3) Restricted mental stress claims to those arising out of real and objective employment conditions not generally inherent in every working situation, and required "clear and convincing evidence" that the mental disorder arose out of and in the course of employment. (HB 2271)

1990

656.005 (7) Redefined a compensable injury to require that it be established by medical evidence supported by objective findings. In addition, the compensable injury must be the major contributing cause of a consequential condition. If the compensable injury combines with a preexisting condition, the resultant condition is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment. Excluded injuries from recreational and social activities. Excluded injuries that arose from the use of alcohol or drugs if it is proven by clear and convincing evidence that the drug or alcohol use was the major contributing cause. (SB 1197)

656.262 (6) Allowed insurers to deny a previously accepted claim at any time up to two years from the date of claim acceptance if the claim is accepted in good faith, but it is later determined not to be compensable or that the insurer is not responsible for the claim. (SB 1197)

656.273 Required that claims for aggravation be established by medical evidence supported by objective medical findings that the worsened condition resulted from the original injury. (SB 1197)

656.308 Specified that when a worker sustains a compensable injury the responsible employer shall remain responsible for future aggravations unless the worker sustains a new compensable injury involving the same condition. (SB 1197)

656.802 (1) & (2) Changed the definition of occupational disease, and provided that compensable diseases must be caused by substances or activities to which an employee is not ordinarily subjected or exposed, and that the employment be the major contributing cause. The existence of the disease must be established by medical evidence supported by objective findings. (SB 1197)

1995

656.005 (2)(b) Excluded from definition of "beneficiary" a person who intentionally caused the compensable injury or death of the injured worker. (SB 369)

656.005 (7)(a)(B) Decreed that a combined condition was compensable only as long as and to the extent the otherwise compensable injury was the major contributing cause of the combined condition or the need for treatment. (SB 369)

656.005 (7)(b)(C) Reduced the standard of proof required to show that the major contributing cause was consumption of alcoholic beverages or a controlled substance, to "preponderance of evidence" from the previous "clear and convincing evidence." (SB 369)

656.005 (7)(c) Changed the previous definition of "disabling injury" to specifically exclude those injuries where no temporary benefits were due and payable, unless there was a reasonable expectation that permanent disability would result from the injury. (SB 369)

656.005 (19) Expanded the definition of "objective findings" to be verifiable indications of injury or disease, and excluded physical findings or subjective responses to physical examinations that were not reproducible, measurable, or observable. (SB 369)

656.262 (6)(a) Authorized the denial of an accepted claim to be issued at any time when the denial was for fraud, misrepresentation, or other illegal activity, to be proved by a preponderance of evidence. Changed the standard of proof for a back-up denial based on evidence uncovered after acceptance that the claim was not compensable or the insurer was not responsible, to "preponderance of evidence" from "clear and convincing evidence." (SB 369)

656.262 (6)(d) Required that an injured worker who believed that a condition had been incorrectly omitted from the acceptance notice, or that the notice was otherwise deficient, to first communicate in writing to the insurer or self-insured employer the worker's objections. Precluded a worker who failed to comply with this requirement from taking the matter up at a hearing. (SB 369)

1997

656.027 Exempted certain landscape contractors (sole proprietorships, partnerships, corporations and limited liability companies) from coverage requirements. (HB 2038)

656.126 (2) & (7) Exempted extraterritorial coverage requirements for workers employed in another state but temporarily working in Oregon. (SB 544)

1999

656.012 and **656.018** Repealed most of the sunset provisions from SB 369, except for the exclusive remedy provisions. These provisions were extended until December 31, 2004. (SB 460)

656.630 (Note) Directed the Center for Research on Occupational and Environmental Toxicology (CROET) to provide a report for the legislature's assessment of the need for modifying the compensability criteria for hepatitis B and C. (HB 3629)

(Budget note) Directed the department to undertake a study of the impact of the major contributing cause and combined conditions on the workers compensation system and provided $250,000 in limitation for contract costs. (HB 5012)

2001

656.005 (24) and **656.804** Revised the definition of preexisting conditions. It provided separate definitions for injury claims and for occupational disease claims. (SB 485)

656.012 (2)(e) Removed the December 31, 2004, sunset on the declaration that one of the policy objectives of the workers' compensation system is to be the exclusive remedy for injuries or diseases arising from employment. (SB 485)

656.017 and **656.126** Amended public contracts and purchasing law to state that each public contract must include a clause that all subject workers temporarily in the state are either covered by Oregon's workers' compensation law or are covered by the laws of another state. (SB 507)

656.027 (6) Clarified the exemption from workers' compensation law for firefighters and police employees for cities with a population of more than 200,000 that provide a disability and retirement system. (HB 3100)

656.027 (26) Exempted from workers' compensation law persons who serve as referees or assistant referees in recreational soccer matches whose services are retained on a match-by-match basis. (HB 3094)

656.266 (2) For combined condition injury claims, stated that once the worker has established that the injury is compensable, the employer has the burden of proof to show that the compensable condition is not, or is no longer, the major contributing cause of the disability or the need for treatment. (SB 485)

410.614 Amended senior and disability services law and made 14,000 home care workers subject employees. For the purposes of workers' compensation, these workers are public employees under the Home Care Commission. This was a part of the implementation of Ballot Measure 99 of 2000. (HB 3816)

1987

656.268 (4)(a) Allowed insurers to close permanent disability claims as long as department evaluation standards were applied and the worker had returned to work. (HB 2900)

656.268 (14) Allowed for insurer offsets against awards for overpayments. (HB 2900)

656.726 (3)(f) Allowed the director to provide standards for the evaluation of disabilities and altered the criteria for the evaluation of unscheduled disabilities. (HB 2900)

1990

656.160 Declared that injured workers are not eligible for timeloss benefits for periods during which they are incarcerated. (SB 1197)

656.214 (5) and **656.726 (3)(f)** Required the department's disability evaluation standards to be used for the initial rating and for all subsequent litigation; altered the definition of earning capacity to be used in calculating disability. (SB 1197)

656.262 (4) Specified various situations for which timeloss payments are not due or may be suspended by insurers. (SB 1197)

656.262 (6) Increased the time for insurer acceptance or denial of a claim from 60 to 90 days. (SB 1197) (This was reversed in 2001 by SB 485.)

656.268 (4)(a) Expanded insurers' authority to close claims when the worker has become medically stationary and the worker has returned to work or the attending physician has released the worker to regular or modified employment. (SB 1197)

656.726 (3)(f)(B) Mandated that impairment be established by a preponderance of medical evidence based on objective findings. (SB 1197)

656.726 (3)(f)(C) Required the director to adopt temporary rules amending the standards for the evaluation of disabilities when the director determines that the standards do not adequately address the worker's disability. (SB 1197)

656.780 Required the director to establish a workers' compensation claims examiner certification program. (SB 1197) (Repealed by SB 221 in 1999.)

1991

656.622 (3) Clarified that a worker may not waive eligibility for preferred worker status by entering into a claims disposition agreement. (HB 3040)

1993

192.502 Amended public records law exemptions to end access to claims histories by employers, information services, commercial interests, and others using that information to discriminate against injured workers in hiring. Information is still released for claims processing purposes, other government agency enforcement needs, research projects, to workers and their representatives, and when necessary for the director to carry out responsibilities under the law. (HB 3069)

1995

656.012 (3) Declared that provisions of workers' compensation law be interpreted in an impartial and balanced manner. (SB 369)

656.018 (6) Clarified that the exclusive remedy provisions and the liability limitations of this chapter apply whether or not the injuries or diseases were compensable. (SB 369) (This was struck down in part in 2001 by the Oregon Supreme Court in the *Smothers* decision.)

656.126 Authorized the offset of out-of-state compensation paid for the same injury or illness as in Oregon from the Oregon compensation paid. (SB 369)

656.206 (1)(a) Defined "gainful occupation" as one that pays wages equal to or greater than the state mandated hourly minimum wage. (SB 369)

656.212 (2) Authorized basing of temporary partial disability rate on the wages used to calculate temporary total disability. (SB 369)

656.262 (4)(b) Decreed that payment of wages by a self-insured employer be deemed timely payment of temporary disability benefits. (SB 369)

656.262 (4)(f) Decreed that temporary disability compensation is not due and payable unless authorized by the attending physician; limited retroactive authorization to 14 days. (SB 369)

656.262 (14) Required that injured workers cooperate with the insurer or self-insured employer in the investigation of claims for compensation. (SB 369)

656.262 (15) Required that if a worker does not cooperate, the director is to suspend the compensation due; authorized the insurer or self-insured employer to deny the claim if the non-cooperation continues for another 30 days. (SB 369)

656.265 (1) Tripled the time for filing of a claim to 90 days. (SB 369)

656.268 (1) Authorized claim closure before the worker's condition becomes medically stationary if the accepted injury ceases to be the major contributing cause of the worker's combined or consequential condition or, if without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or fails to attend a closing examination. (SB 369)

656.273 (3) Required that a claim for aggravation be in writing in a manner prescribed by the director. (SB 369)

656.726 (3)(f)(D) Required that impairment be the only factor to be considered in evaluating a worker's disability if the worker has returned to, or the attending physician has released the worker to, regular work at the job held at the time of injury. (SB 369)

1997

656.262 (b)(F) Required that the notice of acceptance be modified by the insurer or self-insured employer when medical or other information changed a previously issued notice of acceptance. The amendment was fully retroactive, regardless of the date of injury. (HB 2971)

656.262 (4)(c) Prevented public officials from receiving temporary disability benefits in addition to wages. (SB 484)

656.262 (7)(c) Required that when an insurer or self-insured employer determines that a claim qualifies for closure, the insurer or self-insured employer must issue an updated notice of acceptance that specifies the compensable conditions. If a condition is later found compensable, the insurer or self-insured employer must reopen the claim for processing that condition. The amendment was fully retroactive, regardless of the date of injury. (HB 2971)

1999

656.212 (2) Eliminated the two-year aggregate maximum for receipt of temporary partial disability payments. (SB 729)

656.268 (1) and **656.268 (Note)** Made insurers and self-insured employers responsible for closing all claims and for determining the extent of permanent disability. The department was to phase out the its own claim closure activities; insurers and self-insured employers were to assume responsibility for closing all claims no later than June 30, 2001. (SB 220)

656.268 (10) Repealed this section, removing the requirement that at the time of an injury, SAIF set aside money sufficient to pay an award. Also removed the language stating that if an insurer or self-insured employer was insolvent or threatened insolvency, the director could require the employer to deposit money adequate to pay the award. (SB 220)

656.277 (1) Required that a request by a worker for reclassification of an accepted nondisabling injury that the worker believes has become disabling must be submitted to the insurer or self-insured employer. Prior to this, these submissions were made to the department. (SB 220)

656.740 Streamlined the hearing and appeal process where subjectivity is an issue. (SB 289)

656.780 Eliminated the department's responsibility for the certification of workers' compensation claims examiners, claims examiner training programs, and continuing education courses. The department established standards for certification of claims examiners; insurers, self-insured employers, and third party administrators administer the standards. (SB 221)

2001

656.005 (30) For the purposes of determining the entitlement to temporary disability or permanent total disability benefits, excluded from the definition of "worker" anyone who has withdrawn from the workforce during the time period for which the benefits are sought. (SB 485)

656.210 (2) Defined how the weekly wage should be calculated and the disability status be defined for injured workers with multiple jobs. (SB 485)

656.210 (5) Created rules for the payment of supplemental temporary disability benefits to workers employed in more than one job at the time of injury. (SB 485)

656.262 (6)(a) & (7)(a) and **656.308 (2)(a)** Reduced the time an insurer has to accept or deny a claim from 90 days to 60 days after the employer knows

of the claim. The bill also reduced the time the insurer has to accept or deny a claim for aggravation or new or omitted condition to 60 days after the insurer receives written notice of these claims. (SB 485)

656.267 Directed that for a worker to initiate an omitted medical condition claim, the worker must clearly request formal written acceptance of a new or omitted medical condition from the insurer. The worker may initiate a new or omitted condition claim at any time. After aggravation rights have expired, a worker must pursue a claim for new or omitted conditions through the Workers' Compensation Board's own motion process. (SB 485)

656.268 (5)(b) Allowed the worker to request a claim closure when the worker is not medically stationary. (SB 269)

656.273 (4), 656.277 (1), and **656.277 (2)** Clarified the time frames for claims. The time frame for challenging a nondisabling classification is one year from the date of the claim acceptance. Aggravation rights for disabling claims extend five years from the date of the first claim closure. For claims that are originally classified as nondisabling and that are not reclassified during the year following acceptance, aggravation rights extend five years from the date of injury. (SB 316)

Medical

1987

656.245 (3)(a) Reduced the number of attending physicians an injured worker could select during the life of a claim from five to three, unless otherwise authorized by the director. (HB 2900)

656.245 (4) Allowed the director to exclude from compensability any medical treatment deemed to be unscientific or unproven. (HB 2900)

656.248 (9) Allowed the director to establish a fee schedule for specific inpatient hospital services based on diagnostic related groups. (HB 2900)

656.252 (1) Expanded the scope of medical rules to require insurer audits of billings for medical services, including hospital services. (HB 2900)

656.254 (3) Expanded sanctions against health care practitioners who failed to comply with rules adopted under the statute. (HB 2900)

656.325 (1) Limited insurer medical examinations to three per each opening of the claim unless otherwise authorized by the director. (HB 2900)

656.327 (3) - (5) Allowed the director to establish a medical review panel to review medical treatment of an injured worker upon request by any of the parties. (HB 2900)

1990

656.005 (12)(b) Limited who could be an attending physician to a medical doctor, doctor of osteopathy, or a board-certified oral surgeon. Chiropractors qualify as attending physicians for the first 30 days or 12 visits, whichever comes first. (SB 1197)

656.245 (1)(b) Eliminated palliative care after the worker became medically stationary, except when provided to a worker determined to have permanent total disability, when necessary to monitor administration of prescription medication required to keep the worker in a medically stationary condition, or to monitor the status of a prosthetic device. In addition, if the worker's attending physician believes that palliative care is appropriate to enable the worker to continue current employment, the attending physician may seek approval from the insurer for such treatment. If the insurer refuses to authorize the treatment, the attending physician can ask the department to resolve the dispute. (SB 1197)

656.248 (11) Required the director to establish utilization and treatment standards for all medical services. (SB 1197) (Repealed by SB 223 in 1999.)

656.260 Allowed groups of medical service providers or health care providers to be certified by the department as managed care organizations. Insurers can contract with MCOs to provide medical services to injured workers. (SB 1197)

656.262 (4)(d) Excluded medical services from insurer reimbursement until the attending physician provides verification of the worker's inability to work. (SB 1197)

1991

656.248 (Note) Created economic incentives for hospitals to participate with certified managed care organizations by providing scheduled, percentage exemptions from the hospital cost-to-charge ratio fee schedule. (SB 551)

1993

656.016 (Note) Authorized pilot programs to combine the medical component of workers' compensation with health insurance for non-work-related illnesses or injuries. Exempted insurers who provide combined coverage in pilot programs from certain requirements for transacting health or workers' compensation insurance. (HB 2285)

656.313 Modified the procedure for payment of medical services in disputed workers' compensation settlement proceedings. Required insurers to pay providers at one-half the rate established by ORS 656.248 in amounts not to exceed twenty percent of the total present value of the settlement amount. Where less than one-half payment can be made, all affected providers are to be paid proportionally. (HB 3111)

1995

656.005 (20) Defined "palliative care" as medical service rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition. Excluded those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition. (SB 369)

656.245 (4) Described conditions under which workers are subject to a managed care organization contract. An insurer may require an injured worker to receive medical treatment in the MCO prior to claim acceptance. However, if the claim is eventually denied, the insurer must cover those services until the worker receives notice of the denial or until three days after the denial notice is mailed. (SB 369)

656.248 (1) Changed the medical services fee schedule from representing the 75th percentile of usual and customary fees to representing reimbursements generally received for the services provided. Identified specific criteria upon which it should be based. (SB 369)

1997

656.260 (4)(h) Required an explanation to licensed medical providers denied admission to an MCO panel. (SB 484)

1999

656.245 (1)(d) Required that medical providers receive payment for medical services until they are notified by insurers that workers with disabling claims are medically stationary. (HB 2021)

656.245 (4)(a) Allowed workers to continue to treat with their attending physician when a managed care organization contract with an insurer terminates. (SB 460)

656.248 Repealed the requirement that the director establish utilization and treatment standards for all medical service categories. (SB 223)

2001

656.247 Created a procedure under which insurers are responsible for some medical costs for some services prior to claim denial. (SB 485)

656.252 (2)(a) Directed attending physicians to cooperate with insurers to expedite diagnostic and treatments procedures and with efforts to return injured workers to appropriate work. (SB 485)

656.268 (3), 656.360, and **656.362** Restricted the distribution of copies of medical reports and vocational rehabilitation reports to workers, rather than to workers and employers, unless the worker provides consent. (SB 269)

Return-To-Work Assistance

1987

656.340 (6) Restricted eligibility for vocational assistance. (HB 2900)

656.622 (3) Established the Preferred Worker Program within the Workers' Reemployment Reserve. (HB 2900)

1990

656.622 (3) Enhanced the Preferred Worker Program by exempting an employer who hires a Preferred Worker from premiums or premium assessments for the Preferred Worker for a period of three years and reimbursing the insurer for any claim costs should the Preferred Worker sustain a new injury during the three year premium exemption period. (SB 1197)

656.628 (Note) Eliminated new claims for Handicapped Workers' Reserve relief. (SB 1197)

659.415 Established injured worker employment reinstatement rights, subject to certain conditions and restrictions, with employers with more than 20 employees. (SB 1197)

1995

656.335 Repealed this section. Insurers are no longer required to provide Disability Prevention Services. (SB 369)

656.340 Clarified when vocational eligibility must be determined following aggravation and clarified the eligibility criteria. Changed the requirement for insurers to request reinstatement or reemployment on behalf of workers to require that insurers inform workers of their opportunity to seek reinstatement or reemployment. Provided that workers are not entitled to vocational assistance after the expiration of their aggravation rights. Expanded the definition of the suitable wage that is the target for vocational assistance and revised the definition of regular employment to include employment at the time of aggravation. (SB 369)

656.622 Provided for reimbursement of reasonable program administrative costs of insurers participating in the Employer-at-Injury Program and codified the existing practice of reimbursement of claim administrative costs for Preferred Workers. Expanded expenditures from the Reemployment Assistance Program to include workers with nondisabling claims as eligible for the Employer-at-Injury Program, to preclude or reduce nondisabling claims from becoming disabling. Clarified that the Preferred Worker Program may be available to workers with any disability, not just permanent, which may be a substantial obstacle to employment. (SB 369)

659.415 and **659.420** Added restrictions on when a worker may be reinstated to regular employment or re-employed in suitable and available work. (SB 369)

2001

656.268 (4)(c) and **656.325 (5)** Provided that a worker could refuse an offer of modified employment without losing benefits if the job requires a commute that is beyond the physical capacity of the worker, is more than 50 miles away, is not with the employer at injury or not at that employer's work site, or is inconsistent with the common practices of the employer or an applicable collective bargaining agreement. (SB 485)

Disability Benefits

1987

656.214 (2) Increased the value of a degree of disability for scheduled injuries from $125 to $145. (HB 2900)

1990

656.214 (2) Increased the value of a degree of disability for scheduled injuries from $145 to $305. (SB 1197)

1991

656.214 (Note) Established the value for a degree of scheduled disability as seventy-one percent of the statewide average weekly wage, thus providing annual adjustments to the value of a degree beyond the formerly authorized amount of $305. (SB 732)

656.214 (Note) Established a tiered structure for calculating the value of a degree of unscheduled disability as a function of the statewide average weekly wage, thus providing annual adjustments to the value of a degree and providing a structure that compensates the more severely injured at higher tiered rates per degree of disability. (SB 732)

1995

656.204 Reduced the classes of beneficiary children under 18 years of age to two: where there is a surviving spouse of a deceased worker, and where there is no surviving spouse. (SB 369)

656. 214 (2) & (6) Increased the value of a degree of scheduled permanent partial disability to $347.51; for unscheduled permanent partial disability, changed the structure of the tiers and increased the value of a degree in each tier. This eliminated the computation of the dollar value of a degree of disability as a percentage of the statewide average weekly wage, effective January 1, 1996. (SB 369)

656.214 (Note) Temporarily increased the value of a degree of disability over the 656.214 (2) & (6) values, effective January 1, 1996, through December 31, 2000. (SB 369)

1997

656.214 (Note) Increased PPD benefits for injuries occurring during January, 1, 1998, through December 31, 2000. Benefits for scheduled disabilities increased eight percent per degree, and benefits for unscheduled disabilities increased six percent per degree. These increases maintained the national median benefit levels established by SB 369. (HB 2549)

1999

656.202, 656.204, and **656.206** Changed workers' compensation benefits for spouse and some children of fatally injured workers: increased remarriage allowance to 36 times the monthly benefit; eliminated reduction in benefits for children of deceased workers who had remarried; equalized benefits for PTD and fatal claims for beneficiaries in full-time education; and eliminated $5 weekly beneficiary payment for PTD claims. (HB2022)

656.214 Raised maximum permanent partial disability benefit levels to a level close to the national median for injuries occurring since January 1, 2000. (SB 460)

2001

656.210 (1) Raised the maximum temporary total disability benefit to 133 percent of the Average Weekly Wage. (SB 485)

656.214 Increased the permanent partial disability benefits for injuries occurring between January 1, 2002, and December 31, 2004. (SB 485)

656.214 (Note) Provided that workers who lost PPD benefits because of a 1999 transcription error be paid the lost money. The department will pay the benefits from the Workers' Benefit Fund. (SB 485)

Litigation and Administrative Dispute Resolution

1987

656.268 (4)(f) Provided for penalties if insurer claim closure actions were unreasonable. (HB 2900)

656.268 (6)(b) Reduced the time allowed to request a hearing from one year to 180 days following claim closure. (HB 2900)

656.278 Restricted the power and jurisdiction of the Workers' Compensation Board (board) to use its own motion authority; altered eligibility criteria and excluded own motion claims costs from loss experience, providing funding for these costs from the Reopened Claims Reserve. (HB 2900)

656.283 (4) and **656.295 (4)** Required the board to schedule a hearing or board review no later than 90 days after receipt of request. The hearing or review shall not be postponed except for extraordinary circumstances beyond the control of the requesting party. (HB 2900)

656.283 (10) Mandated an informal dispute resolution process by the board. (HB 2900) (Repealed by SB 1197 in 1990.)

656.291 Required the board to establish an Expedited Claim Service to resolve those claims where compensability is not the issue and other attendant conditions are met. (HB 2900)

656.298 (6) Changed de novo review by the Court of Appeals to substantial evidence review. The Court is limited to reviewing matters of law. (HB 2900)

656.388 Required the board to approve payment for legal service by an attorney representing the insurer or the claimant. (HB 2900) (The approval requirement for insurers' attorney fees was repealed by SB 1197.)

656.388 (3) Required the board to establish a schedule of fees for attorneys representing an insurer, self-insured employer, or a worker. (HB 2900)

1990

656.236 Allowed for compromise and release settlements (Claims Disposition Agreements) of claims benefits except for medical services. (SB 1197)

656.248 (13) Allowed the director to resolve medical fee disputes using an administrative review process. (SB 1197)

656.262 (10) Gave the director exclusive jurisdiction over proceedings regarding solely the assessment and payment of penalties by insurers for unreasonable delay or refusal to pay compensation or unreasonable delays in acceptance or denial of a claim. Eliminated the assessed attorney fee for such penalties. (SB 1197)

656.268 (4)(e) & (6)(a) Required mandatory reconsideration of a disputed insurer notice of closure, or department determination order, and required reconsideration to be completed within 15 days from the date of request. An additional 60 days is allowed if a medical arbiter is appointed. (The 15 days was changed to 18 working days in the 1991 session). (SB 1197)

656.268 (4)(g) Provided for an insurer penalty if the department's determination of permanent disability on reconsideration of an insurer notice of closure is greater than the insurer's award by 25 percent or more. (SB 1197)

656.268 (7) Required claim referral to medical arbiter if impairment findings are disputed. (SB 1197)

656.268 (7) No medical evidence subsequent to the medical arbiter report is admissible before the department, the board, or the courts. (SB 1197)

656.283 (7) and **656.295 (5)** Provided that the evaluation of the worker's disability by hearings referees or the board shall be as of the date of the reconsideration order. Required the hearings referee and the board to apply the same standards for evaluation of disability as used by the department and insurers, but allowed for the worker or insurer to challenge whether the standards for evaluation of disability were incorrectly applied in the reconsideration order. (SB 1197)

656.313 (1) When the employer or insurer appeal, payment of compensation appealed is stayed except for temporary total disability and permanent total disability benefits that accrue from the date of the order appealed. Allowed for interest to accrue on the benefits stayed. (SB 1197)

656.327 (1)(a) Established additional provisions for the director's review of bona fide medical services disputes, and allowed for the delegation of the review to a panel of medical experts. (SB 1197)

656.724 (3)(b) Required the board to conduct an annual, anonymous survey of attorneys to rate hearings referees. (SB 1197)

1991

656.386 Provided for a reasonable attorney fee when an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held. Applied to all claims for which an order relating to the issue on which attorney fees are sought had not become final on or before June 19, 1991, regardless of the date of injury. (SB 540)

1995

656.236 (1)(b) Authorized waiving of the 30-day waiting period for approval of a claim disposition agreement, if the worker was represented by an attorney at the time he or she signed the agreement. (SB 369)

656.245 (1)(c)(J) Allowed the worker to request approval for palliative care if the insurer or self-insured employer denies the care. Subjected the decision of the director to a contested case review. (SB 369)

656.245 (2)(a) Subjected the director's decision regarding additional changes of attending physician to a contested case review. (SB 369)

656.245 (3) Subjected the director's decision to exclude from compensability any medical treatment that is unscientific, unproven, outmoded, or experimental to a contested cases review. (SB 369)

656.260 (6) Subjected any issue concerning the provision of medical services within a managed care organization to review by the director. (SB 369)

656.260 (14) - (16) Subjected any dissatisfaction with an action of a managed care organization regarding the provision of medical services, peer review, or utilization review to administrative review by the director. The director's order is then subjected to a contested case hearing if a written request for hearing is filed with the director. (SB 369)

656.260 (17)-(19) Subjected issues other than dissatisfaction with the provision of medical services, peer review, or utilization review within managed care organizations to a contested case hearing. (SB 369)

656.268 (4) Changed the appealable period of a notice of closure or determination order to 60 days for departmental reconsideration and another 30 days from the reconsideration order for a hearing request. (SB 369)

656.278 (2) Removed vocational assistance benefits from the board's own motion authority. (SB 369)

656.283 (1) Removed vocational assistance disputes from jurisdiction of hearings. (SB 369)

656.283 (2) Provided for dispute resolution on vocational assistance through nonadversarial procedures to the greatest extent possible consistent with constitutional procedures. Mediated agreements are subject to reconsideration by the director, but not reviewed by any other forum. Appeals of director's orders go to contested case hearing before the director and then to Court of Appeals. (SB 369)

656.283 (7) Prohibited the submission at hearing of evidence not submitted on departmental reconsideration. (SB 369)

656.307 (6) Established criteria for resolution of responsibility disputes by a private mediator. (SB 369)

656.308 (2)(d) Authorized claimant attorney fees in responsibility disputes in cases where the attorney actively and meaningfully participated in finally prevailing. (SB 369)

656.313 (1)(a) Authorized stay of payment of compensation appealed, on employer or insurer appeal of a director's order on vocational assistance. (SB 369)

656.319 (6) Authorized hearing for failure to process a claim or incorrect processing of one provided the request for hearing was made within two years. (SB 369)

656.327 (1)(a) Gave exclusive jurisdiction over all medical treatment disputes to the director. This includes treatment that the injured worker has received, is receiving, or will receive. (SB 369)

656.327 (2) Increased the amount of time allowed to issue a medical treatment order from 30 days to 60 days. Subjected the director's medical treatment administrative order to a contested case review. (SB 369)

656.385 Mandated payment of claimant attorney fees by insurer in contested case hearings held by the director (or an appeal from such a hearing) where the claimant prevails. Precluded administrative law judges from awarding penalties or attorney fees for matters arising out of contested case hearings by the director. (SB 369)

656.390 (1) Authorized administrative law judges and the Workers' Compensation Board to impose attorney sanctions for requests for hearing or board review that are frivolous, in bad faith, or for harassment. (SB 369)

656.724 Changed the title of a Hearings Division referee to "administrative law judge." (SB 369)

1997

656.262 (10) Stated that an insurer's or self-insured employer's failure to appeal or seek review of a determination order, notice of closure, reconsideration order, or litigation order does not preclude them from subsequently contesting the rated condition in the order, unless the condition has been formally accepted. The amendment was fully retroactive, regardless of the date of injury. (HB 2971)

656.268 (6) Reversed the *Guardado v. J.R. Simplot Company* decision and allowed only one reconsideration per claim closure. Time frames for conducting the reconsideration now begin when all parties request or waive reconsideration rights. (SB 118)

656.268 (7)(d) Provided additional time to allow workers to attend rescheduled medical arbiter exams and provided for suspension of benefits so that appeals are held concurrently. (SB 119)

1999

656.268 (7)(b) Provided that if neither party to a reconsideration requests a medical arbiter and the director determines that there is insufficient medical information to determine disability, the department may refer the claims to a medical arbiter. (SB 220)

656.268 (7)(e) Provided for the postponement of the reconsideration process for 60 days and the suspension of benefits if a worker fails to attend a medical arbiter examination without good cause or fails to cooperate with the medical arbiter. (SB 220)

656.702 (2) Created a centralized Hearing Officer Panel using the administrative law judges of several agencies. Appeals of the department's administrative orders (contested case hearings) are sent to this panel. Board orders and nonsubjectivity determinations are excluded from this change. (HB 2525)

656.704 (3) Moved jurisdiction to the Workers' Compensation Board when there is a dispute over the need for a proposed medical service caused by an accepted condition. The board hears the disputes that require the determination of the compensability of the medical condition for which the medical services are proposed or that require the determination that a causal relationship exists between medical services and an accepted claim. (SB 728)

656.718 The Governor will appoint the chairperson of the Workers' Compensation Board to manage and supervise Board and Hearings Division. (SB 654)

2001

656.019 and **Chapter 865, 2001 laws** Established a procedure for a civil negligence action for a work-related injury that has been determined to be not compensable because it failed to meet the major contributing cause standard. Directed that the department report to the 2003 legislature on the numbers and outcomes of these cases; directed insurers to cooperate with this data collection. (SB 485)

656.268 (6)(a) Allowed for a deposition arranged for by the worker to be included as a part of the record for the reconsideration process. The deposition is limited to the testimony and cross-examination of the worker about the worker's condition at the time of the claim closure. The cost is paid by the insurer. (SB 485)

656.268 (7)(i)(A) Allowed the director to appoint a medical arbiter during the reconsideration process when the worker is not medically stationary. (SB 297)

656.278 Provided the rules for the Board own motion process for claims of new or omitted medical conditions after aggravation rights have expired. (SB 485)

656.325 (1)(b) Created a process for a worker-requested medical exam that is made part of a hearing on a denial of compensability. When the worker has made a timely request for a hearing of a compensability denial, the worker may request an exam by a physician selected by the department. The worker must show that the denial was based on the results of an insurer medical exam with which the attending physician disagreed. The costs of the exam are paid by the insurer. (SB 485)

Advocates and Advisory Groups

1987

656.709 (1) Created the Office of Ombudsman for injured workers. (HB 2900)

1990

656.709 (2) Established the Office of Ombudsman for small business employers. (SB 1197)

656.790 Created the Workers' Compensation Management-Labor Advisory Committee to, among other things, periodically review disability evaluation standards and generally advise the department on workers' compensation matters. (SB 1197)

Established a Joint Legislative Task Force on Innovations in Workers' Compensation to reexamine the role of the workers' compensation system and to develop recommendations to develop a more fair, just, and cost-effective system. (SB 1198)

1995

656.790 (1) Reduced the membership of the workers' compensation Management-Labor Advisory Committee (MLAC) from 14 to 10 members (five representing subject workers, five representing subject employers). (SB 369)

656.790 (2) Mandated reporting to the legislature by the MLAC such findings and recommendations as the committee finds appropriate, including reports on: (a) court decisions having significant impact on the workers' compensations system; (b) adequacy of workers' compensation benefits; (c) medical and system costs; and (d) adequacy of assessments for reserve programs and administrative costs. (SB 369)

1997

656.790 (Note) Required MLAC to study income and expenditures of the Workers' Benefit Fund. (SB 484)

1999

656.794 Permitted the director broader latitude in the appointment of members of the workers' compensation Advisory Committee on Medical Care. (SB222)

2001

192.530 (Note) Created the Advisory Committee on Privacy of Medical Information and Records. The committee has 17 members. The committee's purpose is to review state and federal laws concerning the privacy of medical information and to see if state laws conflict with federal laws, such as the Health Insurance Portability and Accountability Act of 1996. The members are to report to the 2003 legislature. The department is directed to provide a representative and staff support to the committee. (SB 104)

Chapter 865, 2001 Laws Directed that MLAC recommend to the 2003 legislature an alternative remedy to civil litigation that would allow the legislature to create a constitutionally adequate system of exclusive remedies for workplace injuries. (SB 485)

Appendix 2 - Worker's Compensation Court Cases

A number of appellate decisions have modified the legislative reform of the workers' compensation system. Some of the major decisions are listed below.

1991

Robertson, 43 Van Natta 1505 (1991) The Court of Appeals ruled that the term "objective findings" does not mean solely physically verifiable impairments. Such a finding may also be based on the physician's evaluation of the worker's subjective complaints, in this case a description of the pain she was experiencing. (The effect of the decision was reversed by SB 369 in 1995 by requiring that such findings be reproducible, measurable, or observable.)

1992

SAIF v. Herron, 114 Or App 64 (1992) The Court of Appeals ruled that 1990 amendments raising the dollar value of a degree of PPD were subject to ORS 656.202 and thus were to be applied based on the date of injury rather than the date of award.

1993

Colclasure v. Washington County School District, 317 Or 526 (1993) The Supreme Court ruled that when reviewing a director's decision on a vocational dispute, the hearings referee may make independent findings of fact. (The effect of the decision was reversed by SB 369 in 1995 by placing jurisdiction in WCD.)

England v. Thunderbird, 315 Or 633 (1993) The Supreme Court ruled that disability rating rules, adopted by the department pursuant to 1987 law changes, were invalid because they failed to consider all factors used to determine loss of earning capacity. (The effect of the decision was reversed by SB 369 in 1995.)

Jefferson v. Sam's Cafe, 123 Or App 464 (1993) The Court of Appeals ruled that the director's authority in medical treatment disputes is limited by statue to treatment the claimant is receiving; therefore, disputes over proposed treatments must be decided at the Hearings Division. (The effect of the decision was reversed by SB 369 in 1995 by placing jurisdiction in WCD.)

Meyers v. Darigold, 123 Or App 217 (1993) The Court of Appeals ruled that the director has jurisdiction in medical treatment disputes only if a party requests it; otherwise, the dispute may go to hearings. (The effect of the decision was reversed by SB 369 in 1995.)

Safeway Stores v. Smith, 122 Or App 160 (1993) The Court of Appeals ruled that while there is a limitation on evidence the director may consider in a reconsideration, there is no comparable limitation on evidence an administrative law judge may consider at a hearing on the same issue. (The effect of the decision was reversed by SB 369 in 1995.)

Stone v. Whittier Wood Products, 124 Or App 117 (1993) The Court of Appeals ruled that long-standing department rules basing the computation of temporary partial disability benefits on the actual modified work wage were invalid since they failed to consider the worker's "earning power at any kind of work" as specified in statute. (The effect of the decision was reversed by SB 369 in 1995.)

U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) The Court of Appeals ruled that medical treatment for a pre-existing degenerative condition was compensable if a compensable injury caused the pre-existing condition to need treatment, as long as the injury was the major contributing cause of the need for treatment.

1994

Allen v. SAIF, 320 Or 192 (1994) The Supreme Court ruled that a medical bill paid untimely constituted a "de facto denial" for which attorney fees could be assessed under ORS 656.386(1), rather than the provisions of ORS 656.262(10). Under ORS 656.262(10), attorney fees had been limited to half the penalty amount on issues of delay or refusal to pay compensation. One intent of this provision had been to assure that attorney fees did not exceed the value of the interest involved in an issue. The effect of this decision may have been to convert many instances of untimely payment to de facto denials, thus increasing the potential for large attorney fees. (The effect of the decision was reversed by SB 369 in 1995.)

Leslie v. U.S. Bancorp, 129 Or App 1 (1994) The Court of Appeals ruled that the law does not preclude a party from raising an issue at hearing that was not raised in or did not arise out of the preceding reconsideration. (The effect of the decision was reversed by SB 369 in 1995.)

Messmer v. Delux Cabinet Works, 130 Or App 254 (1994) The Court of Appeals ruled that the failure to appeal a determination order bars the later denial of conditions rated in that order. (SB 369 contained language stating that the payment of permanent disability did not preclude insurers from contesting compensability. This language was intended to reverse the effects of this decision. In 1996, another decision was issued (see below), and the 1997 legislature passed new language in HB 2971.)

1995

Altamirano v. Woodburn Nursery, 133 Or App 16 (1995) The Court of Appeals held that the department had impermissibly interpreted the 30-day limitation on attending physician status for chiropractors as applying only to the initial claim. The court reasoned that the meaning of "claim" includes requests to reopen a previously closed claim; thus, there may be multiple 30-day periods for a single injury.

Errand v. Cascade Steel Rolling Mills, 320 Or 509 (1995) The Supreme Court ruled that the exclusive remedy provisions of Oregon workers' compensation law are operative only for claims that are found to be compensable under workers' compensation law. Employers' immunity from civil suits only extends to injuries that are compensated through the workers' compensation system. Thus, workers whose claims are work-related but not compensable are not precluded from pursuing civil actions. (The effect of the decision was reversed by SB 369 in 1995. In 2001, the decision in *Smothers v. Gresham Transfer, Inc*. modified the effects of SB 369.)

Welliver Welding Works v. Farmen, 133 Or App 203 (1995) The Court of Appeals held that the legislature had intended that vocational assistance eligibility decisions be based on the claimant's wage at the time of the original injury. The decision invalidated a department rule that used the wage at the time of aggravation in reopened claims.

1996

Delux Cabinet Works v. Messmer, 140 Or App 548 (1996) The Court of Appeals stated that SB 369, despite the legislature's intent, did not reverse the earlier court decision that the failure to appeal did preclude later denials. (The effect of the decision was reversed by the 1997 legislature by HB 2971.)

SAIF Corporation v. Walker, 145 Or App 294 (1996) The Court of Appeals considered the meaning of the change in the definition of an aggravation in SB 369. The court reviewed the legislative history and determined that a symptomatic worsening is not sufficient to establish an aggravation; instead, proof of pathological worsening is required. The Supreme court affirmed the decision.

1997

Fister v. South Hills Heath Care, 149 Or App 214 (1997) The Court of Appeals considered a case in which claimant testimony about a closure that was not submitted at reconsideration was presented and admitted at the hearing. The court ruled that, because there was no objection at the hearing, the evidence could be considered by the ALJ and, on review, by the board.

1998

SAIF Corporation v. Shipley, 326 Or 557 (1998) The Supreme Court vacated a board order that a claimant's claim for medical services was compensable. The hearing had initially involved the issue of aggravation and argued that the medical treatments were related to the original accepted condition. The board held that the medical services claim was compensable. The court found that the proper jurisdiction was the directors' review not the board. Because there is no statutory provision of the board to remand to the director, the only correct action for the board was to dismiss the case.

1999

Johansen v. SAIF Corporation, 158 Or App 672 (1999) The Court of Appeals ruled that a claim for a new medical condition could be brought at any time. It is not limited by the time frames for reclassifying claims or for aggravations.

O'Neil v. National Union Fire, 152 Or App 497 (1999) The Court of Appeals ruled that the department's contested case hearings procedures had been followed as written. The claimant had argued that the department was required to conduct a full-scale contested case procedure at a contested case hearing; the department had instead followed a more limited procedure. The court determined that this procedure is consistent with ORS 656. 327(2).

2000

Koskela v. Willamette Industries, Inc., 331 Or 362 (2000) The Supreme Court ruled that the SB 369 amendment of ORS 656.283(7) was an unconstitutional deprivation of a worker's due process rights. The amendment prohibited at hearing any evidence that was not a part of the reconsideration process. The court balanced three factors: the claimant's interest in the outcome; the risk of an erroneous decision and the value of additional safeguards; and, the government's interest and the administrative burdens that additional procedures would entail. Specifically in PTD cases, the court found that, at a minimum, a worker should have the opportunity to provide oral testimony about his willingness to work and his efforts at finding work. The existing process did not offer adequate safeguards against mistakes.

Robinson v. Nabisco, Inc., 331 Or 178 (2000) The Supreme Court ruled that a back injury suffered during a compelled medical exam arose out of and in the course of employment. Therefore, it was a new, compensable injury.

2001

Lumbermans Mutual v. Crawford, 332 Or 404 (2001) The Supreme Court ruled that ORS 656.262 (4)(g), which states that attending physicians cannot authorize the payment of temporary disability benefits more than 14 days retroactively, applied to all claims. This decision vacated Board orders that found that this section dealt with procedural compensation while the claim was open, not to substantive compensation after the claim was closed.

Rash v. McKinstry Company, 331 Or 665 (2001) The Supreme Court ruled that when a CDA "resolves all matters … arising out of claims," all matters are resolved, including insurers' matters. In this case, after a CDA was concluded, the insurer was not entitled to recover its claim costs after the claimant received a third-party award. The language involved was a part of SB 369 and had been an attempt to clarify the statute. Prior to this ruling, the interpretation had been that the CDA extinguished just the claimant's right to additional benefits.

Smothers v. Gresham Transfer, Inc., 332 Or 83 (2001) The Supreme Court ruled that when a workers' compensation claim is denied for failure to prove that the work-related incident was the major contributing cause of the injury or condition, then the exclusive remedy provisions of ORS 656.018 are unconstitutional. Under these circumstances, the employee may take civil action against his employer. (The process for these actions was set out by the 2001 legislature in SB 485. The bill also required that MLAC develop a proposal for a new process prior to the 2003 legislative session.)

2002

Everett v. SAIF Corporation, 179 Or App 112 (2002) The Court of Appeals ruled that a claimant could not testify about his job duties at hearings because he had not offered written testimony about these duties at reconsideration. These duties were used in determining functional capacity in the computation of the permanent partial disability award. Because the evidence was not submitted, the claimant had not exhausted his administrative remedies at reconsideration; therefore, he could not pursue the matter on appeal.

Logsdon v. SAIF Corporation, 181 Or App 317 (2002) The Court of Appeals ruled that the claimant did not have the right to cross examine doctors at hearing. He wished to cross examine them regarding his medically stationary date. This date is used in determining timeloss benefits. The court held that timeloss benefits differ from PTD benefits, so the decision in *Koskela v. Willamette Industries, Inc.,* does not apply.

Trujillo v. Pacific Safety Supply, 181 Or App 302 (2002) The Court of Appeals ruled that the claimant did not have the right to give oral testimony concerning his basic functional capacity at hearing. This functional capacity was used in part to determine his PPD award. The court held that PPD benefits differ from PTD benefits, so the decision in *Koskela v. Willamette Industries, Inc.,* does not apply.

SAIF Corporation v. Lewis, 335 Or 92 (2002) The Supreme Court reversed a Court of Appeals ruling that the requirement for "medical evidence supported by objective findings" in determining claims compensability meant that the indications of an occupational illness had to be verifiable at the time of the claimant's exam. The court stated that the meaning of the statute was that at some time, not necessarily at the time of the exam, the indications had to have been verifiable.

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