OREGON
WORKERS'
COMPENSATION

Monitoring the Key Components of Legislative Reform

Fifth Edition

January 2001

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

Oregon Department of Consumer & Business Services
Director, Mary Neidig

Workers' Compensation Division
Administrator, John Shilts

Oregon Occupational Safety & Health Division
Administrator, Peter DeLuca

Workers' Compensation Board
Chair, Maureen Bock

Insurance Division
Administrator, Joel Ario

Ombudsman for Injured Workers,
Maria Carraher

Ombudsman for Small Business,
John Booton

Information Management Division
Administrator, Dan Adelman

January 2001

In compliance with the Americans with Disabilities Act (ADA), this publication is available in alternative formats by calling (503) 378-4100 (V/TTY).

Visit the DCBS Web site at: http://www.cbs.state.or.us

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Research & Analysis Section
350 Winter St. NE, Room 300
Salem, Oregon 97301-3881
(503) 378-8254

Table of Contents

Figures and statistical tables

Safety and health

Insurance

Compensability

Figure:

Statistical tables:

Claims processing

Figures:

Statistical tables:

Medical

Figures:

Statistical tables:

Return-to-work assistance

Figures:

Statistical tables:

Benefits - permanent disability

Litigation and administrative dispute resolution

Advocates and advisory groups

Appendix - Oregon workers' compensation reform legislation

Introduction

In 1986, Oregon ranked sixth highest in the nation in average workers' compensation premium rates paid by employers and had one of the nation's highest occupational injury and illness claims frequencies. At the same time, medical and permanent disability costs for injured Oregonians were among the highest in the nation, while benefits were considered among the lowest.

During the 1987 legislative session, major reform legislation, HB 2900, was enacted to improve the workers' compensation system. Three years later, Oregon's premium rate ranking had improved a little to eighth position, but this left much room for improvement. Workers' compensation costs remained an urgent problem, and many small employer policies were canceled. These conditions provided the impetus for further reforms which culminated in May 1990 with the passage of SB 1197 and SB 1198 during a special session of the Oregon legislature. The 1991 and 1993 legislatures implemented several refinements to the reforms. By the end of 1994, several court decisions had lessened the impact of some reform provisions. The 1995 legislature passed SB 369 in May 1995, which contained statutory language that conveyed more clearly the legislative intent of SB 1197. It also restored the exclusive remedy doctrine for denied claims, which a 1995 court decision had brought into question. Further increases in benefits were also adopted. The 1997 legislature made few major changes.

The 1999 legislature made some relatively minor changes to the workers' compensation system. One significant change was transferring all claim closure responsibility to insurers and self-insured employers effective mid-2001.

The 1999 legislature also allocated funds for a study of the effects of some of the changes to the workers' compensation law. One purpose of the study was to measure the effects on costs and benefits of the "major contributing cause" language introduced into the law in 1990 and revised in 1995. 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.

In addition to these reforms, the legislature had the foresight to create the Department of Insurance and Finance effective July 1, 1987 (with further restructuring and a name change to the Department of Consumer and Business Services in 1993). Virtually all administrative and adjudicative functions of the workers' compensation system reside in this agency. Throughout the past decade the department has implemented administrative innovations, not explicitly provided for by legislation, that have positively influenced the workers' compensation system. No other state has the unique opportunities provided by this structure, which renders safety and health enforcement and consultative services; regulates the workers' compensation system; sets workers' compensation insurance rates; resolves disputes administratively; and provides a forum for quasi-judicial dispute resolution when litigation cannot be avoided.

Under the leadership of three governors and the legislature, and with much assistance from business and labor, Oregon has become a national model for workers' compensation reform and improved workplace safety and health. The changes introduced over the past decade have led to lower costs to employers and higher benefits for workers. Oregon has significantly reduced premiums. Moreover, Oregon's on-the-job injury, illness, and fatality rates continue to fall.

Oregon has become a national model for workers' compensation reform and improved workplace safety and health

This document is the fifth report that comprehensively describes the goals of Oregon's legislative reform, its key components, and the statistical measures that show the effect reform has had on the workers' compensation system through 1999 . The prior edition dealt with changes introduced by legislative reforms from 1987 through 1997. This report contains nine sections: safety and health, insurance, compensability, claims processing, medical, return-to-work assistance, permanent disability benefits, litigation and administrative dispute resolution, and advocates and advisory groups. Each section highlights a key component of reform and includes a description of reform goals, legislative changes, major findings, and statistical measures. The appendix includes a summary of the reform legislation.

Highlights

√ In spite of a 44 percent growth in employment from 1987 to 1999, the number of accepted disabling claims dropped 37 percent and compensable fatalities 40 percent.

√ Permanent partial disability claims decreased 42 percent from 1987 to 1999, and the PPD rate per employee dropped 60 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 decreased 38 percent from 1987 to 1999, while the total cases incidence rate dropped 36 percent.

√ OR-OSHA inspections, at 5,714 in FFY 1999, were the second highest since the 5,740 inspections in FFY 1992, and employees and employers trained per year reached a record high of over 20,000 in 1999.

√ Workers' compensation premium rates have decreased by 57.3 percent since 1990, saving Oregon employers $5.6 billion in direct costs. Based on 2000 premium rates, Oregon's average workers' compensation premium rate ranked thirty-fourth highest in the nation, a significant improvement from sixth highest in 1986.

√ After increasing in 1989 as a result of changes in SAIF Corporation's claims management practices, denial rates on disabling claims have returned to a level approximately two to three percentage points higher post-reform.

√ The number of time loss days paid declined between 1990 and 1999: the average (mean) by 44 percent and the median by 19 percent.

√ Insurer performance on timeliness of acceptance or denial of claims improved from 85 percent in 1990 to 96 percent in 1994. It fell to 93 percent in 1999.

√ 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. From FY 1991 through FY 2000, over 2500 investigations of fraud or abuse complaints were opened.

√ Almost 991,800 employees, 62 percent of Oregon's workers, are now covered for medical services by managed care organizations (MCO).

√ Vocational assistance cases decreased 91 percent from 1987 to 1999; costs declined 77 percent. The Preferred Worker program, which provides incentives for employers to hire injured workers, grew 75 percent from 1988 to 1996, before dropping along with 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 10,065 programs in 1998 before declining a little in 1999. The decline came mostly from fewer programs for disabling claims. Nearly 5,100 of the programs approved in 1999 were for nondisabling claims; as a result, thousands of claims were closed before being classified as disabling.

√ Maximum scheduled and unscheduled permanent partial disability (PPD) benefits for injured workers received a tremendous boost in 1995. With subsequent increases, the maximum scheduled PPD benefits were 309 higher at the end of fiscal year 2000 than in fiscal year 1987; unscheduled PPD benefits were 366 percent higher. Maximum PPD benefits are now almost at the national median compensation level.

√ After more than twenty consecutive years of increases, requests for hearings dropped 60 percent since 1989; requests for board review declined 51 percent between 1991 and 1999.

√ Hearing request rates on disabling claim closures decreased from 21 percent in 1989 to five percent in 1999. Permanent disability, which was at issue in 46 percent of hearings orders in 1987, was at issue in only 8 percent of the 1999 orders.

√ In 1999, on the average, it took 71 days to issue a reconsideration order. The median number of days to issue a medical dispute order was 85, and to issue a vocational dispute order was 28.

√ The median time lag for a request for WCB hearing to a hearing order dropped 45 percent from 1987 to 1999, while that for board review dropped 77 percent since its peak in 1989.

√ Attorney fees out of claimants' compensation dropped from its peak of $21.4 million in 1991 to $16.0 million in 1999. The composition also changed very much during this period: on Appellate Review Unit reconsideration from 1.4 percent to 5.6 percent, in claim disposition agreements from 29.9 percent to 36.9 percent, at WCB hearings from 64.5 percent to 53.1 percent and on board review from 4.2 percent to 3.8 percent.

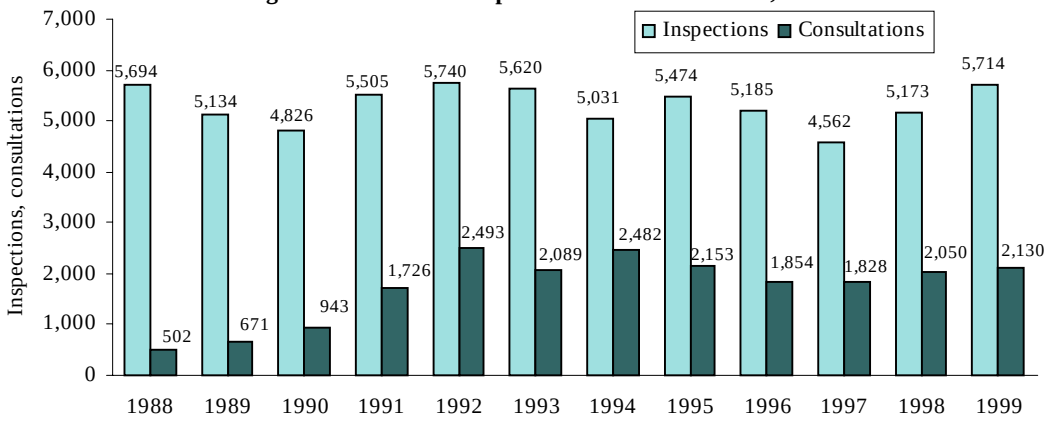
√ The number of contacts with the office of the Ombudsman for injured workers increased rapidly over the last few years. In 1999 and 2000, the issues that prompted the most inquiries were benefit issues, followed by medical issues, claim processing issues and settlement.

Safety and health

The best way to reduce the cost, human suffering, and lost productivity associated with workers' compensation claims is to reduce workplace injuries, illnesses, and fatalities. The Oregon legislature was among the first to recognize the importance of safety and health in workers' compensation reform. It significantly increased the emphasis on safety and health in the workplace. The increased emphasis was achieved in a number of ways: by increasing the safety and health enforcement, training, and consultative staff; by using 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 training grant program; by requiring joint labor-management safety committees; and by targeting safety and health inspections more effectively. The legislature recognized that improved safety and health requires the cooperation of labor, management, and government. The department's Occupational Safety and Health Division (OR-OSHA) provides leadership and support to business and labor through a balanced program of enforcement and voluntary services.

The major legislative changes occurred between 1987 and 1991. More recent legislative changes have involved 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 to the department from the Bureau of Labor and Industries 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 from occupational safety and health requirements when the farm's only employees are family members. Also in 1999, the legislature passed a bill directing 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.

Figure 1. OR-OSHA inspections and consultations, 1988-1999



Inspections are by FFY; consultations are by calendar year

OR-OSHA is monitored through federal OSHA by means of its strategic plan. OR-OSHA developed its strategic plan over 18 months with input from OR-OSHA staff, and Oregon employers, businesses, 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 assist employers toward self sufficiency in safety and health. One such 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 conjuction with the Oregon construction industry, also developed the Joint Emphasis Program (JEP) to reduce construction injuries and fatalities. The program is a cooperative effort with management, labor, and government to design focused joint training sessions and communicate safety problems and solutions through outreach efforts.

Consultative Services

For the period 1988 to 1992, OR-OSHA consultations increased nearly five-fold. The numbers have varied since then, but have remained around 2,000 per year. Also, as a result of a 43 percent increase in OR-OSHA staff subsequent to the passage of SB 1197 in 1990 (from 170 to 243), OR-OSHA training of both employers and employees increased greatly. Attendance at public education and conference training sessions has totaled close to 62,000 over the past three years.

From 1989 to 1999, workers' compensation insurance carriers provided mandatory loss prevention consultative services to 17,234 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 will continue to monitor and enforce the requirements of insurers to provide these services, but will no longer identify which employers must receive services.

OR-OSHA inspections

The number of OR-OSHA inspections increased by 19 percent between 1990 and 1992, from 4,826 to 5,740. Inspections decreased in 1997 to 4,562. Since then, 1998 and 1999 have shown an increase. At OR-OSHA's current rate of inspections, it would take about 14 years to inspect all Oregon employers. This is down 39 percent from the 1997 estimate of 23 years. OR-OSHA penalties assessed from employer violations of state safety and health standards rose from $2.4 million in 1998 to $3.0 million in 1999. The 1999 assessment was 58 percent higher than that in 1988, although down nearly three million dollars from the 1995 high of $5.8 million.

OR-OSHA grants

Since 1990, OR-OSHA has awarded over $1.6 million in grants to nonprofit organizations and associations to develop innovative occupational safety and health training programs. OR-OSHA has also awarded Worksite Redesign Program project and product grants to develop new solutions to workplace ergonomic, health, and safety problems. As of September 9, 2000, 32 Worksite Redesign project grant applications were approved with almost $2.4 million in grants; 249 product grants were approved, with $1.0 million in grants.

One factor in the success of OR-OSHA's consultation and enforcement activities in reducing injuries and illnesses is the performance of its consultants and compliance officers. In a recent study, the department's Information Management Division surveyed employers who had been inspected by OR-OSHA and asked them to rate the performance of compliance officers. In general, the ratings of compliance officers were favorable. On about 90 percent of the completed questionnaires, compliance officers were rated from good to excellent on general knowledge of their job and near the top on a five-point scale on their professional and personal attributes. Over 95 percent of the respondents rated the compliance officers as being clear in their ability to explain the reason for the inspection and the rights and responsibilities of the firm inspected.

Figure 2. Accepted disabling claims and employment, 1987-1999

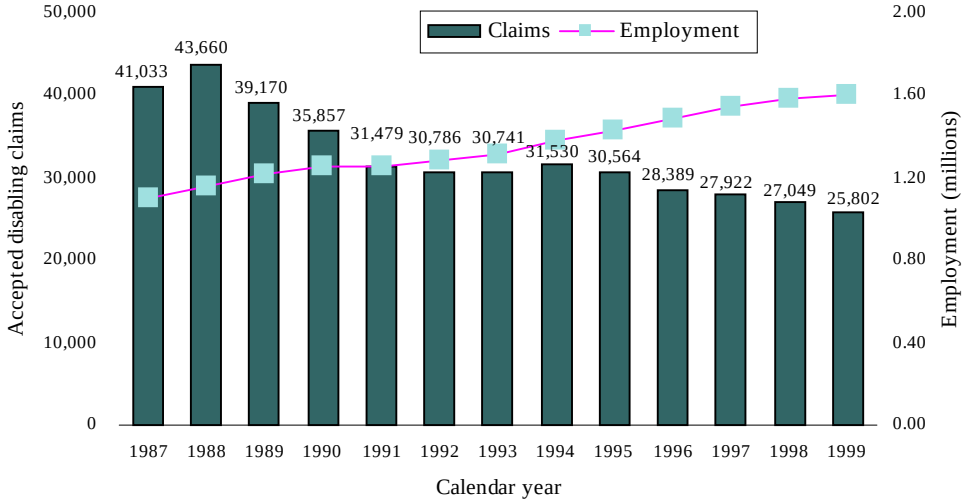
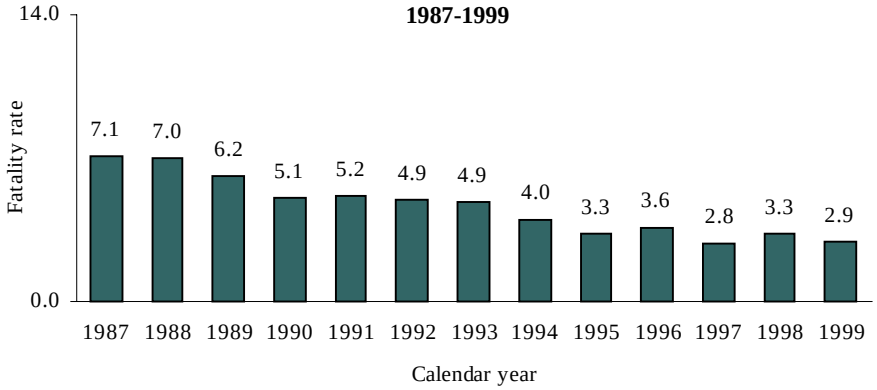


Figure 3. Compensable fatality rates per 100,000 workers, 1987-1999



Injury rates

The numbers and rates of injuries and fatalities have dropped substantially over the past several years. From 1987 to 1999, employment grew 44 percent. In contrast, the number of accepted disabling claims decreased 37 percent. Compensable fatalities declined 45 percent between 1987 and 1997, to 43 in 1997. This is the fewest recorded in Oregon. There were 47 compensable fatalities in 1999. As a result, the accepted disabling claims rate and the compensable fatality rate declined by 57 percent and 59 percent respectively. Also, as determined by the U. S. Bureau of Labor Statistics survey of employers, the lost workday cases incidence rate decreased by 38 percent from 1987 to 1999, while the total cases rate dropped by 36 percent.

There is other evidence that employers are reducing hazards, thereby reducing the number and cost of workplace injuries, illnesses, and fatalities. 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 107 establishments had an 18 percent decrease in accepted disabling injury claims in the two years following the consultation; in contrast, they had a 34 percent increase in injuries in the year prior to the assistance.

It is difficult to quantify how much the increase in the safety and health emphasis alone has decreased work-related claims and frequencies. Factors such as 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 frequencies. Nevertheless, the increased emphasis on safety and health has played a major role in the reduction of both the number and frequencies of work-related claims in Oregon. The total direct cost savings to Oregon employers due to the reduced number of claims has been approximately $5.6 billion since 1990.

Figure 4. Occupational injuries and illnesses incidence rates, private sector, 1987-1999

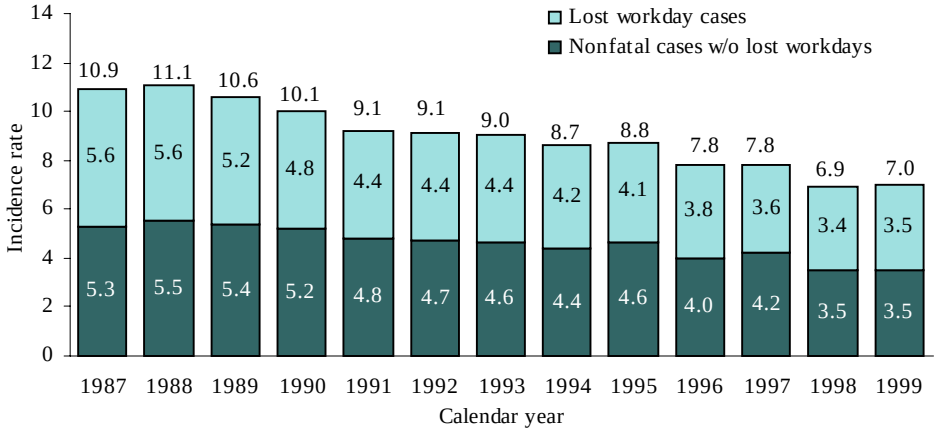
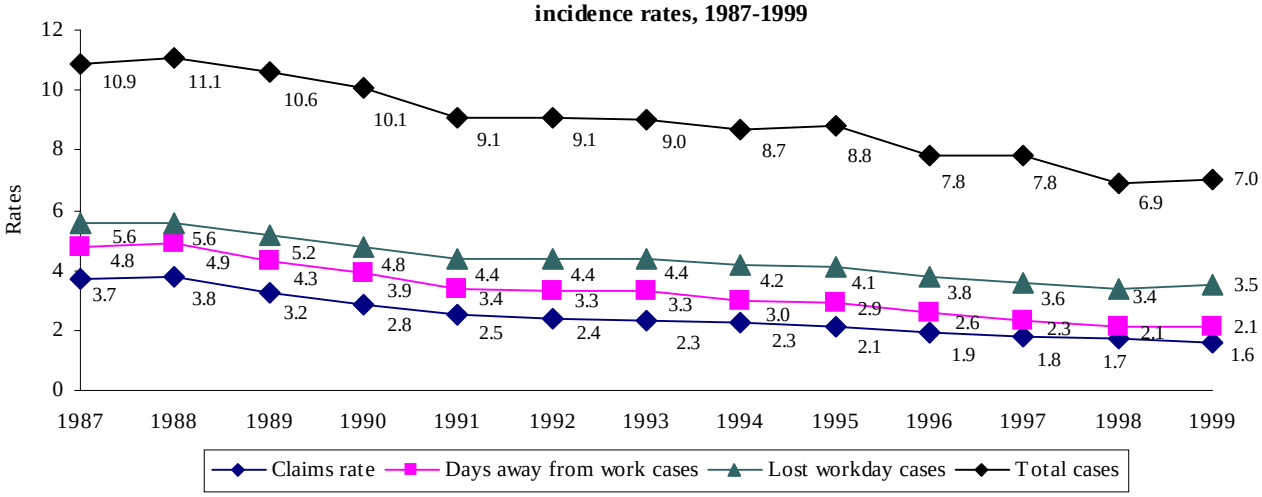


Figure 5. Accepted disabling claims rate and private sector occupational injuries and illnesses incidence rates, 1987-1999



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.

Statistics

Accepted disabling claims, employment, and claims rates, 1987-1999

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	1,575.5	1.7
1999	25,802	1,597.0	1.6

The number of accepted disabling claims decreased by 37 percent between 1987 and 1999; employment grew 44 percent over the same period. The claims rate declined by 57 percent over the period.

Note: The 1997 employment figure has been revised since the last edition of this report.

Permanent partial disability claims, 1987-1999

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	9,348	710
1994	9,531	691
1995	9,495	663
1996	9,060	609
1997	8,060	521
1998	7,765	493
1999	7,441	466

The number of PPD claims decreased 42 percent between 1987 and 1999, and the PPD rate decreased 60 percent. Much of this reduction can be attributed to increased emphasis upon workplace safety and health.

Compensable fatalities, 1987-1999

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	3.3
1996	54	3.6
1997	43	2.8
1998	52	3.3
1999	47	2.9

The number of compensable fatalities decreased 45 percent to 43 cases from 1987 to 1997 and increased slightly to 52 in 1998, dropping to 47 in 1999. The 47 deaths in 1999 were the second lowest recorded in Oregon. The fatality rate in 1999 was 59 percent lower than the 1987 rate.

Statistics

Occupational injuries and illnesses incidence rates, private sector, 1987-1999

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

The lost workday cases incidence rate (IR) declined 38 percent between 1987 and 1999; the total cases rate dropped 36 percent over the same period. The 1999 incidence rates increased slightly over the record low rates of 1998.

Industry total cases incidence rates, 1987-1999

Year	Agriculture, forestry, fishing	Construction	Manufacturing	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

The industry divisions that have the highest rates of occupational injuries and illnesses had declines in total cases incidence rates ranging from 13 percent to 49 percent between 1987 and 1999. The agriculture, forestry and fishing sector had the largest percentage decrease in total cases incidence rate.

OR-OSHA inspections, FFY 1988-1999

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	164,504	16.5%
1992	5,740	201,903	15.3%
1993	5,620	248,240	18.1%
1994	5,031	265,613	19.2%
1995	5,474	227,427	23.4%
1996	5,185	195,630	24.6%
1997	4,562	182,101	27.0%
1998	5,173	152,355	26.6%
1999	5,714	169,279	25.6%

OR-OSHA inspections increased by 10.5 percent between 1998 and 1999 after reaching their lowest levels in 1997. 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 1999 after a trend of decreases from 1995 to 1998.

Statistics

OR-OSHA citations, violations, and proposed penalties, FFY 1988-1999

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	19,412	3.2
1993	4,462	17,621	4.7
1994	3,960	15,295	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	11,365	2.4
1999	4,034	11,435	3.0

OR-OSHA penalties for employer violations of safety and health standards were 25 percent higher in 1999 than in 1998, but they were 48 percent lower than the 1995 high of $5.8 million. The numbers of citations and violations have begun to increase after a trend of decreases from 1992 to 1997. The average penalty per violation increased in 1999 after a drop in 1998.

OR-OSHA consultations, 1988-1999

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	218,565
1999	2,185	2,130	233,731

OR-OSHA consultations increased nearly five-fold between 1988 and 1994 as a result of additional staff and increased emphasis on the consultative services program. Consultations dropped 26 percent from 1994 to 1997. The number has since increased 17 percent to 2,130 in 1999. The number of employees reached in 1999 was 32 percent lower than the 1992 figure, but was 52 percent higher than the 1997 low of 153,922.

Note: Consultations do not include mandatory loss prevention services.

Safety and health training programs, 1988-2000

Year	Attendance at training sessions
1998	15,494
1999	27,104
2000	19,275

Attendance at public education and conference training sessions in calendar year 2000 was 29 percent lower than in 1999. This drop was largely due to attendance at the 1999 Governor's Occupational Safety and Health Conference, which is held every other year. Training was accomplished with the use of ED-NET, conferences, public workshops, and on-site special technical training sessions.

Statistics

OR-OSHA safety and health grant programs, 1989-1999

Period	Grants	Total $ awarded
1989-91	11	$309,658
1991-93	9	271,100
1993-95	12	342,780
1995-97	12	370,595
1997-99	10	325,923

Since the start of the grant program, just over $1.6 million has been awarded for 54 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
1995-97	6	$364,673	0	$0
1997-99	17	$1,442,385	66	$753,312
1999-01	9	$551,142	183	$287,843

Since the start of the grant program, almost $2.4 million has been awarded for 32 approved project grants and $1.0 million has been awarded for 249 approved product grants.

Note: The number of grants are the numbers of employers receiving grants. The 1999/2001 awards are the number of grants awarded as of September 9, 2000.

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 has declined slightly each year since, to a low of 1.6 percent in 1999.

Employers' safety committee citations, violations, and penalties, FY 1990-2000

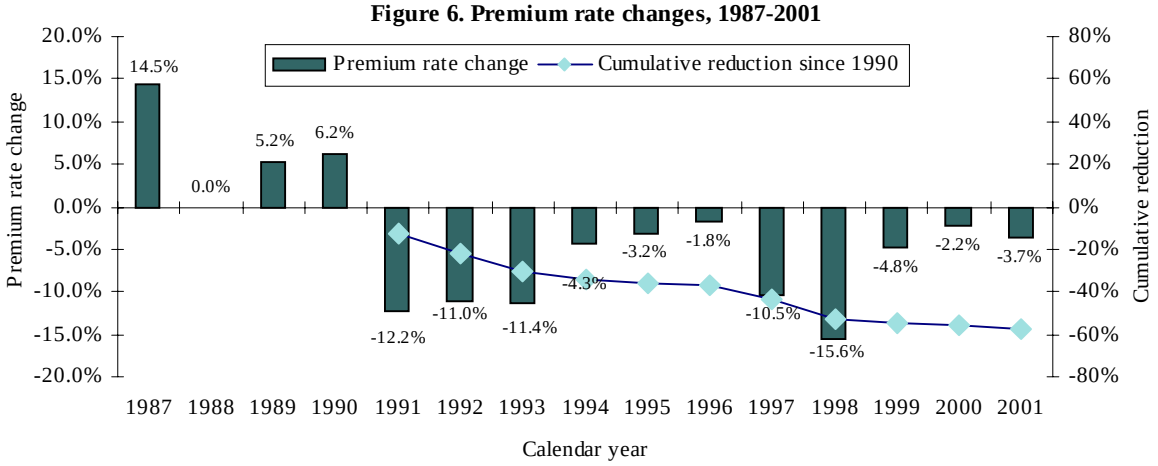
Fiscal year	Citations	Violations	Proposed penalties
1990	128	131	$13,040
1991	223	236	24,730
1992	891	1,023	61,530
1993	781	963	49,410
1994	754	927	60,930
1995	820	980	146,070
1996	703	858	102,835
1997	718	878	74,635
1998	848	953	139,855
1999	1,011	1,147	129,390
2000	920	974	139,455

In FY 1992, there was a large increase in all three categories, 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 FY 1995. All three categories which dropped in FY 1996, bounced back in the next few years.

Insurance

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 57.3 percent since 1990. Oregon is the only state with rate decreases for eleven consecutive years (1991-2001). Reform legislation and the accompanying rate reductions have saved Oregon employers approximately $5.6 billion in direct costs. Oregon's average premium rate ranking dropped from sixth highest in the nation in 1986 to thirty-eighth highest in 1998 and then rose slightly to thirty-fourth in 2000.

Figure 6. Premium rate changes, 1987-2001



Oregon's reforms include provisions to provide economic incentives to employers to minimize claims frequencies, to institute termination procedures that 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 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 Workers); 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 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.

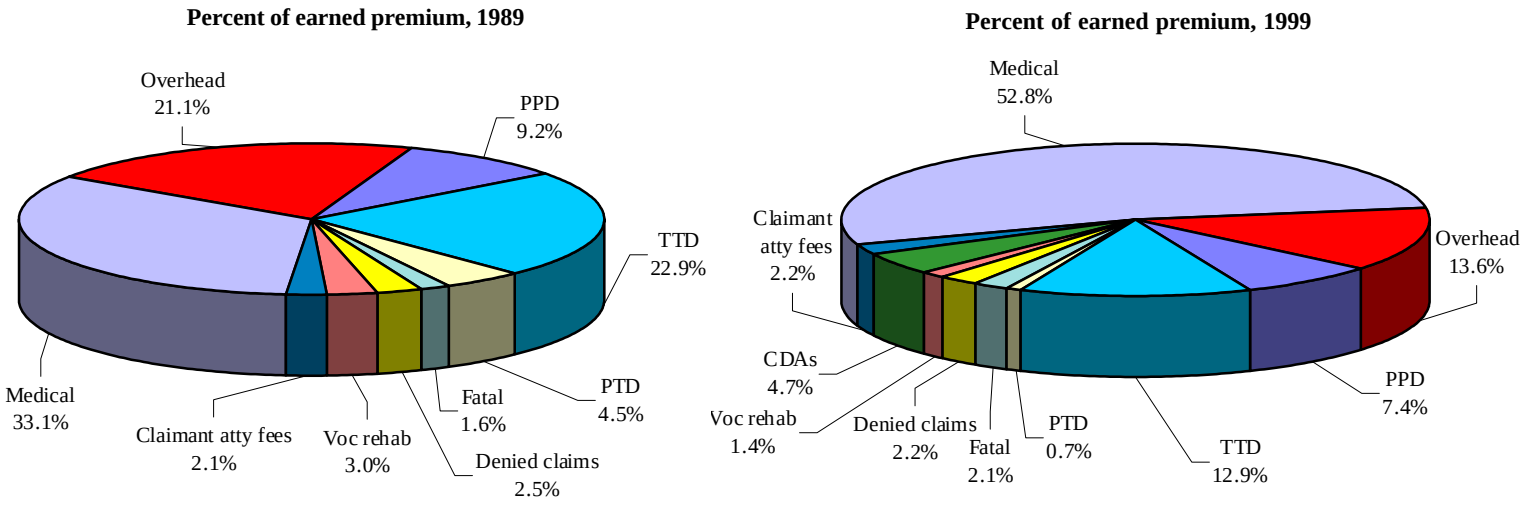
Tiered rating plan

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 3.4 percent in 1999. Nationally, the percentage of total premium written by assigned risk plans averages 2.7 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 Corporation 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, the private insurers' loss ratio improved from 84.6 percent to 67.3 percent. SAIF Corporation's loss ratio improved from 114.4 percent to 40.6 in 1998. However, it rose to 140.4 in 1999. The 1999 SAIF Corporation and private insurers combined loss ratio amounted to 95.8 percent. Moreover, from 1990 to 1999, the SAIF Corporation and private insurers combined have paid $764.3 million in dividends.

Figure 7. Workers' compensation premium breakdown, calendar years 1989 and 1999



The increased profitability of the workers' compensation insurance market has resulted in more competition. In 1986, SAIF and the Liberty group had 60 percent of the workers' compensation market. That percentage fell to 58 percent in 1994 and decreased to 53 percent in 1999.

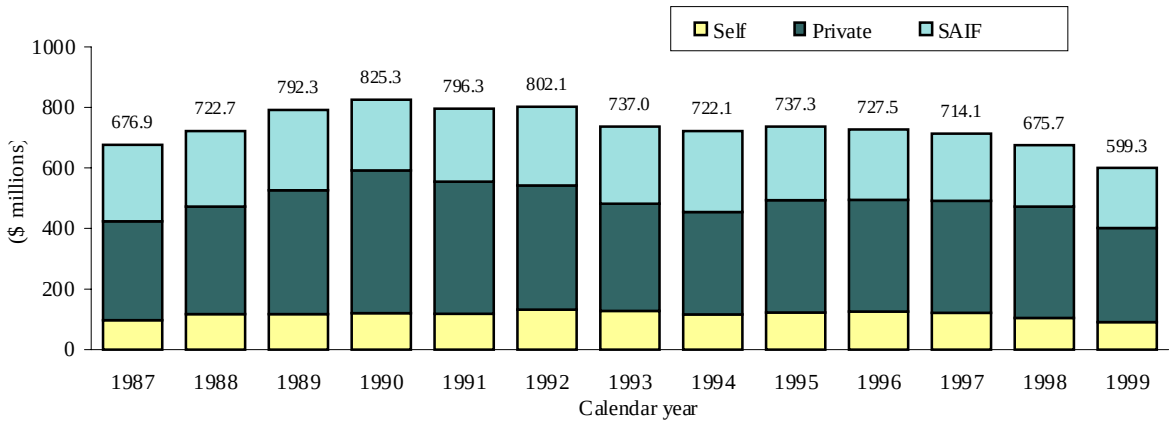
Reform also allowed the department to establish a contracting classifications premium adjustment program to provide employers subject to contractor class premium rates the economic incentive to enhance safety and health in the workplace. Over 2,200 employers participated during the first five years of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

Large deductible premium credits

In 1996, Large Deductible Premium Credits (LDPCs) were added as an option to workers' compensation in Oregon. Few credits were applied in 1996, but an estimated $24.4 million in LDPCs were applied in 1999, 7.9 percent of the private insurers' assessable premiums, and 4.1 percent of the total workers' compensation assessable premiums. Large deductible premium credits 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.

Premiums were $599.3 million in 1999, down $226.0 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 33.7 percent in 1999; conversely, the percent of premium to pay for medical benefits increased from 33.1 percent in 1989 to 52.7 percent in 1999. Insurer overhead expenses constituted 13.6 percent of premiums in 1999, down from 21.1 percent in 1989.

Figure 8. Direct premiums earned and market share, by insurance type, 1987-1999



Statistics

Workers' compensation premiums and rate changes, 1987-2001

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	597.5 (est)	-2.2%
2001	599.4 (est)	-3.7%

Workers' compensation premium rates decreased 57.3 percent between 1991 and 2001. Annual premiums decreased by $226.0 million between 1990 and 1999.

Workers' compensation average premium rate ranking, 1986-2000

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

Oregon's average premium rate ranking improved from 6th highest in the nation in 1986 to the 38th highest in 1998. In 2000, the ranking dropped slightly, to 34th 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, 1987-1999

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%

Private insurers' share of the workers' compensation market in Oregon was 51.8 percent of the premium volume in 1999. The Liberty group had 38.3 percent of the private market in 1999.

Statistics

WC insurance plan (Assigned Risk Pool) characteristics, 1987-1999

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%

Annual Pool premium written increased over 270 percent from 1987-1990; it has since dropped 75.9 percent to the lowest level recorded. Annual Pool premium as a percent of the voluntary market premium more than tripled between 1987 and 1991, before shrinking to 3.4% in 1999. The national average is 2.7 percent in 1999.

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.

SAIF Corporation financial characteristics, 1987-1999

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

From 1988 to 1998, SAIF's loss ratio fell 94.2 percentage points. However, in 1999 it showed considerable increase to a little over the 1988 figure. SAIF has paid substantial dividends to policyholders in the past ten years, reaching $211.5 million in 1999.

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, 1987-1999

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

Private insurers' loss ratio fell 22.7 percentage points from 1987 through 1991, rose slightly through 1994 and has now dropped to 67.3 percent. Dividends rose from $3.6 million in 1987 to $14.3 million in 1992; they were $11.6 million in 1999.

Employers and employees, by insurer type, 1999

Insurer type	Employers	Employees (est)
SAIF	35,392	418,800
Private	44,074	873,700
Self	1,830	304,500
Total	81,296	1,597,000

At the end of 1999, private insurers covered 54 percent of the employers and 55 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.

Compensability

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.

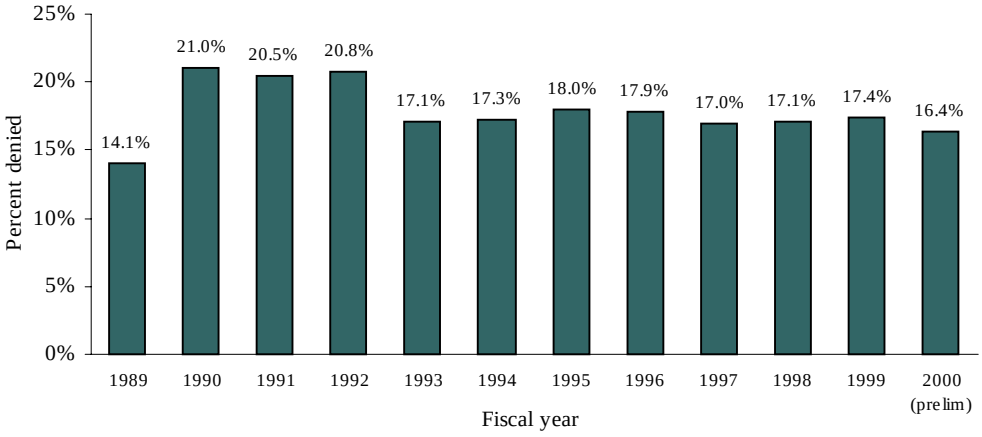
Mental stress

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.

Definition of compensability

By SB 1197 in 1990, 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 dramatic decrease in claims.

Figure 9. Percentage of disabling claims denied, FY 1989-2000



Claim denial

Largely as a result of a major change in the SAIF Corporation's claims management practices, the denial rates of disabling claims jumped in fiscal year 1990. Denial rates then remained relatively constant through fiscal year 1992: the denial rate for disabling claims was 21 percent, and the denial rate for disabling occupational disease claims was 43 percent. The denial rate of disabling claims declined to 17 percent in fiscal year 1993 and remained fairly constant through fiscal year 1999.

Changes in the definition of compensability may also be responsible for the increasing number of denied nondisabling claims. The number of denied nondisabling claims reported by insurers has increased by 73 percent since fiscal year 1989. The changes in the system can also be seen by comparing the numbers of denied disabling and denied nondisabling claims. In fiscal year 1989, 45 percent of the denials were denials of disabling claims. In fiscal year 2000, by comparison, 26 percent of the denials were of disabling 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 54 percent between 1991 and 1999.

In 1997 the department conducted a study of the reasons that insurers were citing in their claim denial letters. The reasons for the denials were taken from copies of the letters sent by insurers to workers. The denials were classified by the statute language that most closely matched the language of the denial letters. The study showed that most denials were made because the insurer felt the injury did not arise out of the employment, the employment conditions were not the major contributing cause of the injury or disease, the insurer was not responsible for the claim, or there was insufficient evidence that the claim was compensable. The study also showed that denial letters by themselves often were inadequate to determine why claims had been denied. For better results, a study of claims files was needed.

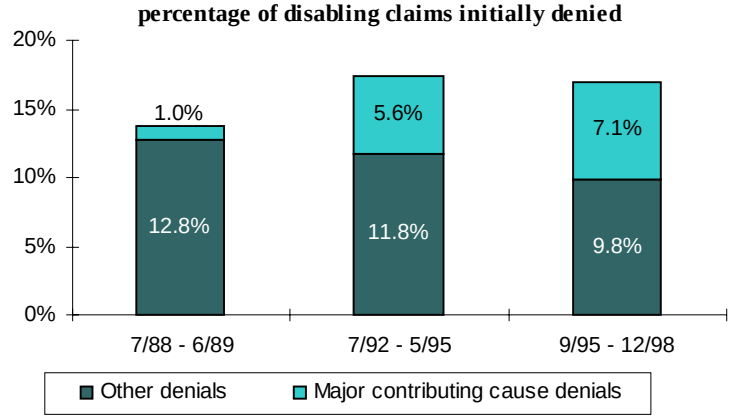
Major contributing cause

The 1999 legislature allocated funds for a study of the effects of changes in the compensability language. The primary interest was the major contributing cause language that was added to the statute through SB 1197 in 1990 and revised through SB 369 in 1995. The 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. It has been asserted in a case before the Oregon Supreme Court, Smothers v. Gresham Transfer, Inc., that the combination of the major contributing cause language and the exclusive remedy language unconstitutionally denies injured workers with pre-existing medical conditions a legal remedy for their injuries. As of December 2000, the Supreme Court had not issued its decision.

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 a large amount of the department's claims and cost data from the mid-1980s through the late-1990s. There is no database that indicates why claims are denied. Therefore, in order to determine how often major contributing cause language is used to deny claims, the researchers looked at over 1,500 denials in the claims files of five insurers and self-insured employers. They also looked at national injury rate data and national workers' compensation cost data to compare trends in Oregon with national trends. They also conducted a survey of physicians to learn their perspectives. Finally, they conducted a law review of Oregon's statute and comparable statutes and legal decisions in other states.

Figure 10. Major contributing cause study: percentage of disabling claims initially denied



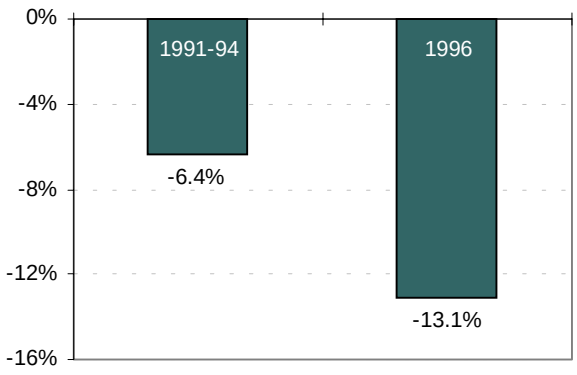
The researchers found that since the passage of SB 369, about 42 percent of the denials have cited major contributing cause language as the reason for the denial. Prior to 1990, the denial rate of disabling claims was under 14 percent; after 1995 it was nearly 17 percent (see Figure 10). The researchers concluded that many of the claims denied because of major contributing cause would have been denied for other reasons under the pre-SB 1197 language. Because of this, it is very difficult to know the financial effects of these statutory changes.

The researchers conducted econometric analyses to estimate the size of the benefit changes caused by the legislation. One of the complicating factors in this analysis was the national trend of lower workers' compensation costs that occurred 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 part 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 SB 369 resulted in a reduction of at least another 6.7 percent (see Figure 11). This savings was due to a drop in the number of claims; the average cost per claim remained about the same.

In the physician survey, physicians reported that the major contributing cause standard is practical. They emphasized that it requires medical expertise.

The law review showed that the major contributing cause standard used in Oregon is also used in three other states. It is 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 suggests that if the Oregon Supreme Court rules in the same manner as these other courts, they will find the current workers' compensation law unconstitutional.

Figure 11. Major contributing cause study: benefit changes due to statute amendments



Statistics

Total reported claims, FY 1989-2000

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	24,323	4,760	16.4%	13,853

The number of denied nondisabling claims has increased 73 percent since FY 1989. In FY 1989, 45 percent of the denials were disabling claim denials; in FY 2000, 26 percent of the denials were disabling claim denials.

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

Accepted disabling stress claims, 1987-1999

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

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.

Disabling occupational disease claims, FY 1989-2000

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	2,773	1,396	33.5%

In fiscal years 1990-1992, the denial rate for disabling occupational disease claims was 43 percent. The denial rate has remained fairly constant over the past four years.

Statistics

Disabling aggravation claims, 1991-1999

Year	Accepted	Denied	Percent denied
1991	1,847	1,842	49.9%
1992	2,100	1,594	43.2%
1993	2,012	1,419	41.4%
1994	1,868	1,221	39.5%
1995	1,563	941	37.6%
1996	1,544	963	38.4%
1997	1,323	1,023	43.6%
1998	1,148	776	40.3%
1999	979	701	41.7%

The number of aggravation claims dropped 54 percent between 1991 and 1999. The denial rate which dropped steadily between 1991 and 1995 has shown a slight increase thereafter.

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 time loss 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.

Permanent disability claims

A number of provisions were enacted to make the evaluation of permanent disability more consistent. The department was required to promulgate standards for the evaluation of disabilities. Those standards must be used for the initial rating and for all subsequent litigation of a claim. The mandated use of standards for the evaluation of permanent disability is an important factor in the declining number of awards of permanent partial disability on appeal. In 1999, 13 percent of PPD degrees were awarded through litigation, down from 39 percent in 1987.

For many years, only the department could close a claim and rate permanent disability. The 1987 reforms allowed insurers to close permanent disability claims, as long as the worker had returned to work. This authority was expanded in 1990 to permit insurers to close a claim when the worker's attending physician releases the employee to return to work. The percentage of claims closed by insurers has increased since 1988, reaching 77 percent in 1999. The reforms also permitted insurers to terminate time loss payments earlier in the life of a claim, increased the allowed amount of time for insurer acceptance or denial of a claim, and permitted insurers to offset overpayments against subsequent benefits.

The 1999 legislature shifted responsibility for two important functions from the department to insurers and self-insured employers. SB 220 holds insurers and self-insured employers responsible for all claims closures effective July 1, 2001. (Note: The Workers' Compensation Division has moved the cutoff date forward to January 1, 2001.) The legislature also mandated that the department phase out its claim closure activities in a manner that minimizes disruption for all concerned.

The other function for which responsibility was taken out of the department's hands was the certification of claims examiners. SB 1197, which was enacted by the 1990 special legislative session, required the department to 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. SB 221 shifted the responsibility for certification to insurers, self-insured employers, and third party administrators, charging them with administering standards for certification which the department is required to specify by rule. The department is empowered to impose a civil penalty against the insurers if they employ uncertified examiners. The department's certification program was terminated in November 1999, at which point there were 1,342 certified examiners.

Figure 12. Percentage of claims closed by insurers, 1987-1999

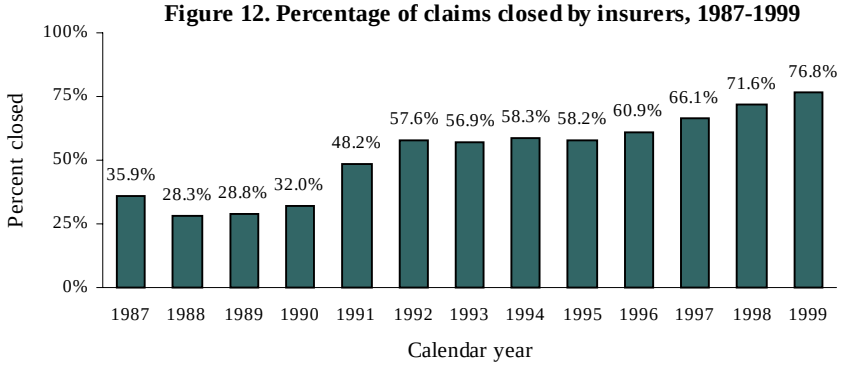
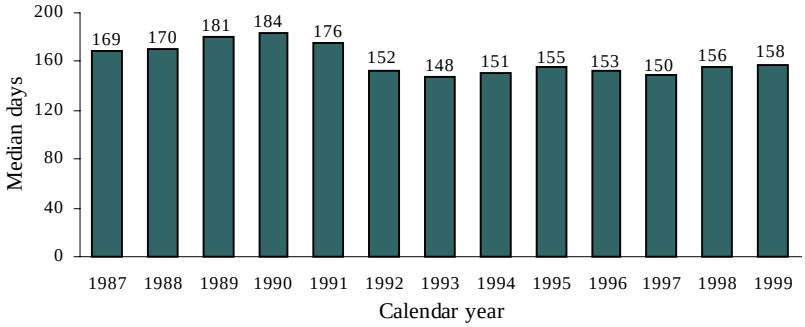


Figure 13. Median days from injury to first closure, 1987-1999



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 in 1998 was double the number issued in 1990. In each of the past three years, the penalty amounts for these citations have totaled about $250,000.

Concerned about increases in denial rates, the department conducted a denied disabling claim study in late 1991 and early 1992. As a result of that examination, the SAIF Corporation changed its claims handling procedures. The examination also revealed the need for reasonable investigation standards; in June 1992, the department promulgated standards for all workers' compensation insurers.

Modified notice of acceptance

The 1997 legislature passed one bill that affected the claims process. By HB 2971, insurers and self-insured employers are required 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.

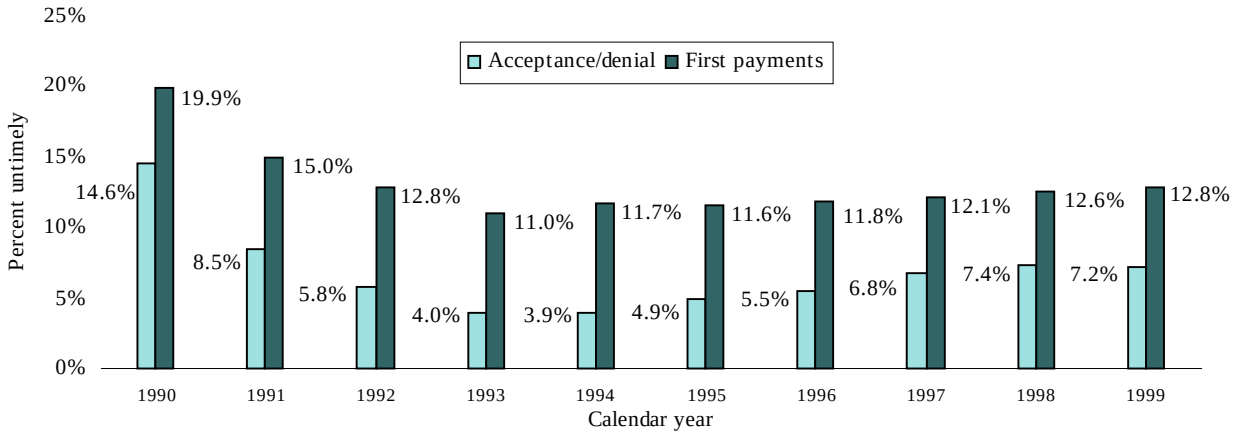
Time lags and insurer timeliness

After peaking in 1990, the average number of days from injury to first closure declined 20 percent, from 277 days in 1990 to 222 days in 1998. It increased to 232 days in 1999. The median number of days from injury to first closure has remained fairly constant since 1992. The average number of time loss days paid declined 44 percent from 1990 to 1999; the median changed little since 1992. (From mid-1995, the average time loss days is affected by the limit of 14 days on retroactive time loss imposed by the 1995 legislature.)

The reforms, through 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. The median number of days to accept a claim has increased from 31 days in 1990 to 49 days in 1999. Over the same period, the median number of days to deny a claim has increased from 35 days to 62 days. These increases result in longer periods of uncertainty for workers and for the medical providers who have provided medical services to the injured workers.

Insurer performance, measured by the timeliness of making first payments, acceptance or denial of a claim, filing the first report of injury

Figure 14. Insurer performance on acceptance or denial and on first payments, 1990-1999



(Form 801), and requesting claim determination (Form 1503), improved between 1990 and 1993. Insurer performance has declined slightly since 1993. (It should be noted that the 1995 legislature substituted the mailing date for the receipt date for purposes of timeliness.)

Workers' Compensation information line

The department has an injured worker hotline, the "workers' compensation information line," that answers workers' questions about their claims, describes workers' rights and responsibilities, and helps them understand the workers' compensation system. The number of calls to the information line exceeded 13,700 in 1999. It also received 7,930 calls from insurers, medical providers, attorneys, employers, legislators, and others.

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. From fiscal years 1991 through 2000, over 2,500 investigations of fraud or abuse complaints were opened. In fiscal year 2000, the most frequent complaints received were failure to report/improper reporting of claims-related documents by employers, insurers, and medical providers; workers collecting benefits while working or able to work; improper claims processing by insurers or medical providers; and employer pressure to not file a claim or harassment of workers for filing a claim.

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. The certification process was eliminated by SB 221. At the end of the program, November 22, 1999, there were 1,342 certified examiners.

Insurer closure actions, 1987-1999

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%

The percentage of claims closed by insurers has grown steadily since 1988, reaching 77 percent in 1999. SB 220, passed in 1999, phases out the department's role in closing claims. By January 1, 2001, insurers, self-insured employers and third part administrators will handle all claims closures.

Note: Total closures exclude miscellaneous insurer orders.

Insurer closures, by benefit type, 1987-1999

Year	TTD	Percent	PPD	Percent
1987	18,153	53.8%	0	0.0%
1988	14,194	41.9%	0	0.0%
1989	13,742	44.3%	311	2.2%
1990	13,415	46.0%	1,469	10.3%
1991	15,827	60.3%	2,656	25.9%
1992	15,731	67.9%	4,145	42.9%
1993	15,021	65.9%	4,235	45.0%
1994	15,448	67.5%	4,744	49.4%
1995	14,548	62.5%	5,166	55.0%
1996	14,235	65.1%	5,033	56.5%
1997	14,048	68.1%	5,131	63.7%
1998	14,765	74.5%	5,878	76.0%
1999	14,784	77.6%	5,984	80.8%

Insurer PPD closures increased from 2 percent of all PPD closures in 1992 to 81 percent of all PPD closures in 1999. All closures will be by insurers, self-insured employers and third party administrators from January 1, 2001.

Statistics

Time lag from injury date to first closure, 1987-1999

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	232	158

The average and median days from injury to first closure peaked in 1990. The average dropped 20 percent from 1990 to 1998 and rose a little in 1999. The median number of days has remained fairly constant since 1992.

Time loss days paid, 1990-1999

Closure year	Average days	Median days
1990	101	21
1991	92	19
1992	81	17
1993	76	18
1994	72	18
1995	68	18
1996	62	16
1997	58	15
1998	58	17
1999	57	17

The average time loss days paid declined 44 percent between 1990 and 1999. The median number of time loss days paid has varied only slightly since 1992.

Insurer claim acceptance and denial, median time lag days, 1988-1999

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

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 number of days for acceptance increased 58 percent between 1990 and 1999; the median number of days for denial increased 77 percent over the period.

Statistics

Insurer timeliness of first payments, 1990-1999

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%

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

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

Insurer timeliness of acceptance or denial, 1990-1999

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%

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

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

Insurer timeliness of filing forms 801 and 1503, 1990-1999

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%

Insurer performance on timeliness of filing reports of occupational injury or disease (Form 801) and requests for determinations (Form 1503) improved greatly between 1990 and 1993. Performance has declined slightly since 1993.

Statistics

Workers' compensation information line calls for assistance, 1990-1999

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

In 1999 there were 13,711 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 7,930 calls from insurers, medical providers, attorneys, employers, legislators, and others.

Civil penalties issued, 1990-1999

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	790	248,725

In 1998, the department issued the largest number of citations since at least 1990. The number of citations was almost double the number in 1990. The amount of these penalties exceeded $250,000. The number and amount of penalties fell slightly in 1999.

Abuse complaint investigations, FY 1991-2000

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

The number of complaints received of inappropriate actions by employers, providers, insurers, workers, and other parties peaked in fiscal year 1993. It dropped 25 percent the next year and has shown only a slight variation since then.

Medical

During the 1980s, one of the major cost drivers of the workers' compensation system, in Oregon and throughout the nation, was the rapidly increasing cost of medical care. 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 effective 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.

Fee Schedules

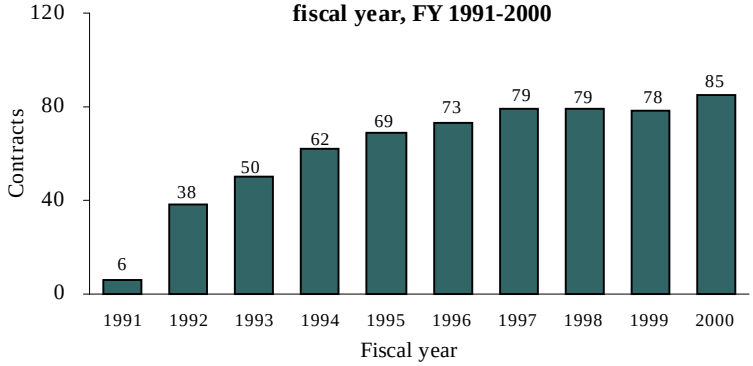
The department has had medical services fee schedules since 1982. These schedules have been subsequently expanded through administrative rules. Medical fee schedules now include anesthesiology, surgery, radiology, laboratory and pathology, medicine, physical medicine, evaluation and management, multidisciplinary services, durable medical equipment, 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 are 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 (RBRVS) 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 (CCRs) 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 of Health Policy to decide what facilities are legally considered hospitals in the state; specialty hospitals, such as rehabilitation centers, psychiatric hospitals, or juvenile hospitals are excluded from these regulations. The CCR is the percent of the amount 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 (HCFA 2552). The ratio allows all hospitals to recover the cost of providing facility-related services to injured workers plus 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 currently published twice yearly under WCD Bulletin 290. In March of every year, 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.

Medical payment reporting

In 1991, the department began requiring that the insurers with the largest numbers of claims report their medical payment data to the department. In 1999, approximately 82 percent of total medical payments were reported to the department; over 80 percent of these payments were for services subject to fee schedules. On average, reimbursements for services subject to the fee schedule were reduced 18 percent. A portion of those reductions was due to disallowing treatment for non-compensable conditions, although the majority of the reduction results from applying the fee schedule maximums. On average, hospital charges subject to the cost-to-charge fee schedule were reduced by more than 35 percent.

Figure 15. MCO insurer contracts in effect at the end of the fiscal year, FY 1991-2000



Managed care organizations

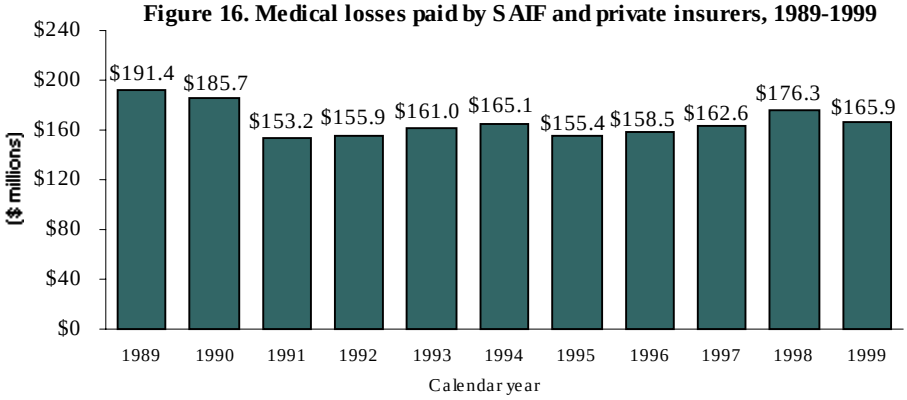
The reforms introduced managed care into Oregon's workers' compensation system by limiting the types of providers who qualify to be attending physicians; allowing workers' compensation insurers to contract

with department-certified managed care organizations (MCOs); and requiring workers covered by such contracts to obtain treatment within the MCO (except under certain conditions). 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.

Most MCOs in Oregon contract with medical providers who agree to terms and conditions established by the MCOs in return for the opportunity to treat injured workers covered by the MCOs. The terms and conditions differ by MCO, but they must include treatment and utilization standards, as well as 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, 2000, there were eight certified MCOs in Oregon that had contracts with workers' compensation insurers and self-insurers. In total, there were 85 insurer and self-insurer MCO contracts in effect at that time. Contracts in effect October 1, 1999, covered 52,048 Oregon employers and 62 percent of the state's covered work force.

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

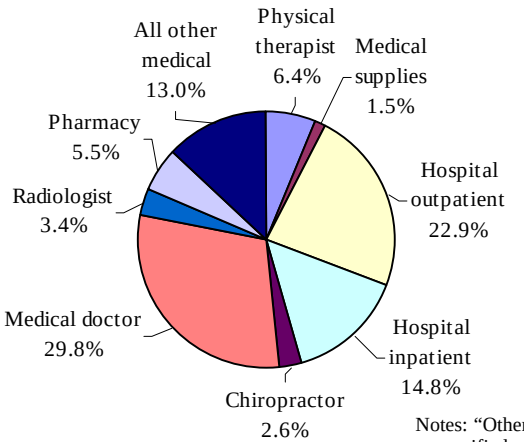
Figure 16. Medical losses paid by SAIF and private insurers, 1989-1999



The department conducted a study during 1998 of the effectiveness of managed care in Oregon's workers' compensation system. The study group consisted of workers injured since July 1995 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, TTD, and PPD costs than claims not covered. Medical costs were reduced 12 percent, TTD 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.

Figure 17. Medical payments by provider type, 2000



Notes: "Other medical" includes other and unspecified provider types. Percentages derived from data reported under WCD Bulletin 220.

Palliative Care

The 1990 reforms 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 some 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. Although only SAIF's data are available for pre-reform comparisons, the restrictions on palliative care contributed to the 20 percent decrease in medical costs between 1989 and 1991.

Attending physicians

The 1990 legislation also placed limits on who can be an attending physician. Outside MCOs, a chiropractor cannot be the worker's attending physician except for 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. In 2000, hospitals and medical doctors each received about a third of the workers' compensation medical payments. Physical therapists and pharmacies each received about 6 percent, radiologists 3 percent and chiropractors 3 percent of the payments. Based on SAIF's payment data, the most dramatic change in the distribution of medical payments by provider type affected chiropractors. The proportion received by chiropractors dropped from 16 percent of total payments prior to 1990 to 3 percent after 1990.

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. Financial support of $336,000 to develop and launch the program was obtained by the department through a grant from the Robert Wood Johnson Foundation. The approved pilot plans linked the medical benefits of workers' compensation and group health insurance. The goal of these plans was to enhance the delivery and improve the cost effectiveness of medical services for workers and employers.

The pilot plan provided a broad network of participating doctors and hospitals. Enrolled employees used the network for all medical services. For convenience and consistency of care, most plans asked employees to choose a general practitioner as their primary care physician. For most medical care, employees paid a modest copayment when the treatment was received and the 24-hour plan paid the remainder. Employees paid no copayment, however, if the treatment was for a work-related condition. Doctors and hospitals submitted the insurance claims to the 24-hour plan and received a uniform payment for both work-related and other services.

By the end of 1995, only five of the approved plans had enrollments, with just 14 participating employers. A 1996 evaluation of the program 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 control of both workers' compensation and group health costs had reduced their interest in participating. They also noted one of the major advantages to participating in the pilots was the ability to direct injured workers to selected medical providers immediately. However, the 1995 legislation permitting treatment at MCOs from the day of injury removed this advantage. Total program enrollments were not sufficient for a valid statistical evaluation of the pilot plans, and the department phased out the program.

Statistics

Managed care organizations, employers and employees covered, 1993-1999

Date	Employers		Employees	
1-93	26,211	(38.3%)	393,900	(30.7%)
11-93	28,320	(40.0%)	462,500	(35.1%)
12-94	33,083	(44.8%)	484,000	(35.1%)
10-96	40,128	(51.8%)	648,500	(43.6%)
10-97	47,200	(59.3%)	902,900	(58.3%)
10-98	52,608	(64.7%)	971,200	(61.5%)
10-99	52,048	(63.7%)	991,800	(62.0%)

Sixty-two percent of Oregon workers and 64 percent of employers are covered by MCOs.

MCO contracts with insurers and self-insured employers, FY 1991-2000

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	36	49	85

At the end of FY 2000, there were 85 MCO contracts in effect with insurers and self-insured employers. Eight certified MCOs have contracts with insurers and/or 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, 1989-1999

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	162.6	46.1%
1998	367.1	176.3	48.0%
1999	347.5	165.9	47.7%

Between 1989 and 1991, medical payments by SAIF and private insurers fell by 20 percent. Since then, the payments have remained fairly constant. Also, between 1989 and 1991, medical payments declined from 45 percent to 40 percent of all payments by these insurers. The percentage has grown since, reaching 48 percent in 1998 and 1999.

Average medical cost after closure, 1990-1999

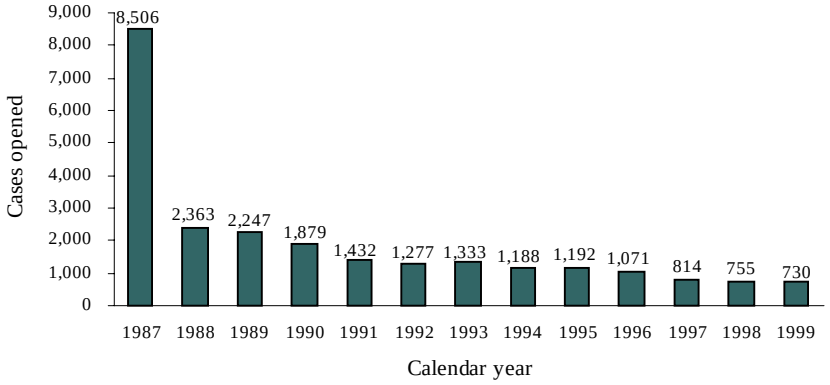
Year	SAIF	Non-SAIF
1990	$273	N/A
1991	179	$119
1992	162	160
1993	189	146
1994	173	165
1995	201	167
1996	190	156
1997	178	176
1998	220	211
1999	190	191

The average medical cost after closure dropped more than 30 percent following the 1990 reforms.

Return-to-work assistance

A fundamental goal of the Oregon workers' compensation law is to return injured workers to work as quickly as possible. This is also an effective strategy to reduce workers' compensation claims costs. The Oregon workers' compensation system has had numerous 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, two primary programs have been used: vocational assistance to help workers overcome barriers to successful return to work, and the Reemployment Assistance Program (including Preferred Worker and Employer-at-Injury Programs) to provide incentives to employers who hire injured workers.

Figure 18. Vocational assistance cases opened, 1987-1999



Vocational assistance

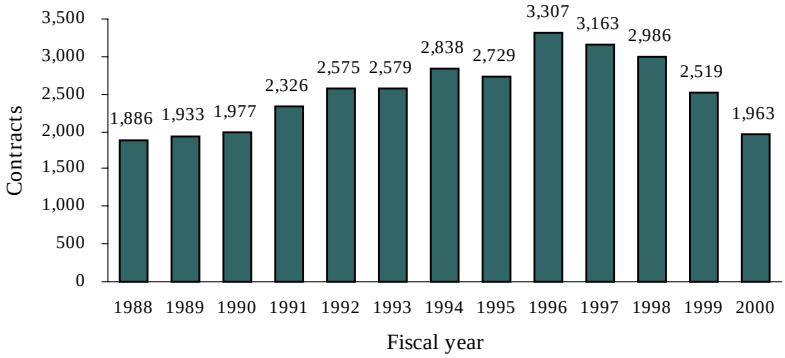
In 1987, the legislature significantly restricted eligibility for vocational assistance: workers who can return to their employer at injury or to any other job that pays at least 80 percent of their job at injury do not receive vocational assistance. As a result, the number of new vocational assistance cases decreased by 91 percent from 1987 to 1999, and the total cost of closed cases decreased by 77 percent during the same period. Costs decreased at a slower rate because the workers most in need of vocational assistance, those who qualify for more costly retraining, continue to be served. Although return-to-work cases were only 164 in 1999 compared to 3,680 in 1987, return-to-work rates for completed vocational cases are at historically high levels.

In 1990, the Handicapped Workers Reserve, which provided reimbursement of some claims costs as an incentive to employers to hire disabled workers, was phased out, while incentives under the Preferred Worker Program were enhanced. 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. By SB 369 in 1995, the legislature restricted eligibility for vocational assistance under aggravation reopenings; and extended eligibility for the Employer-at-Injury Program to accepted nondisabling claims, one result of which has been to preclude many nondisabling claims from becoming disabling. Annual changes to administrative rules have further expanded benefits under the Reemployment Assistance Program. Overall, the effect of legislation has been to de-emphasize vocational assistance for injured workers and to expand and refine employer incentives to return injured workers to work.

Preferred Workers

Workers automatically receive a Preferred Worker card when they have a permanent partial disability, have not refused suitable employment with their employer at injury, and cannot return to regular work. An employer hiring a Preferred Worker is eligible to receive exemption from workers' compensation premiums for the worker for a period of three years, plus at least one of the following forms of assistance: wage subsidy, worksite modification, or obtained employment purchases. If the worker sustains a new injury, the claims costs are reimbursed by the department to the insurer. The number of Preferred

Figure 19. Preferred Worker contracts started, FY 1988-2000



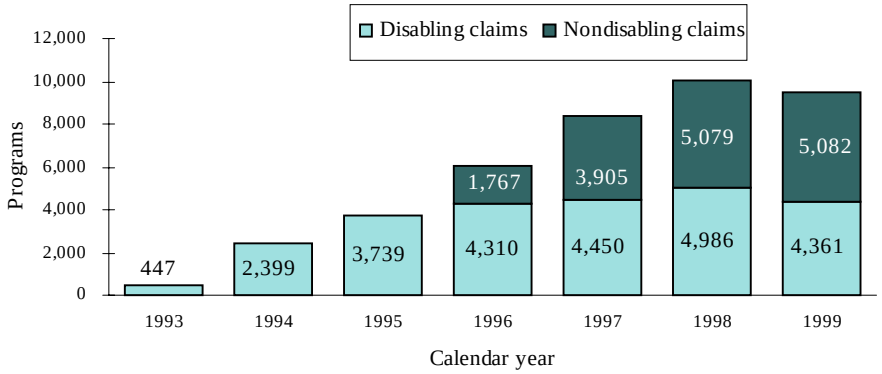
Worker contracts increased 75 percent from 1988 to 1996, dropping along with PPD cases in recent years. Not quite one-third of the workers who receive Preferred Worker cards are expected to use the card to find a job. During the ten years of the premium exemption incentive, almost 9,400 workers have been hired using the card.

The Employer-at-Injury Program is available to workers who have an open claim, have not been released to regular work, and who can return to a light duty job. Assistance includes wage subsidy, worksite modification, and early-return-to-work purchases. Following six years of steady growth in use of the program, 1999 brought a leveling off in worker placements and expenditures for light duty. The decline came mostly from fewer programs for disabling claims. In 1999, there were 4,361 programs for disabling injuries and 5,082 for medical-only (nondisabling) injuries.

Studies

A 1995 department study of the labor market experience of injured 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 than workers who cannot. Similar results were found for Preferred Workers who used their benefits and disabled workers who completed a vocational training plan. Workers who settled their claims by a Claim Disposition Agreement (CDA) had significantly lower return-to-work rates.

Figure 20. Employer-at-Injury programs approved, 1993-1999



In 1990, workers' reinstatement rights were strengthened, though with new restrictions, to assist injured workers to return to work with their employer at injury. SB 369 added further restrictions to reemployment and reinstatement rights. These provisions are monitored by the Oregon Bureau of Labor and Industries.

A current study, in progress, looks at wage records reported to the Employment Department through the first quarter of 1998, for disabled workers with injuries in 1991 and 1992. Among workers who were determined able to return to regular work, about two-thirds were employed in 1998, four to six years after injury. Faring even better were workers who returned to light duty through the Employer-at-Injury Program: nearly three-quarters were employed in 1998. For other workers who were unable to return to their regular work—generally because of the severity of their disabilities—use of return-to-work assistance was associated with higher rates of reemployment. This finding held true both for the use of Preferred Worker benefits and completion of a training plan under vocational assistance. Workers who settled their open claim via a CDA had the lowest long-term reemployment rate, at 37 percent. Statistics on average days from injury to settlement and average medical costs suggest that this group of injured workers had injuries as complex as those suffered by Preferred Workers. However, the workers making up this group were not identified as Preferred Workers, and thus were ineligible to receive reemployment assistance.

Statistics

Preferred Worker contracts started, FY 1988-2000

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	2,986	11.6
1999	2,519	10.6
2000 (prelim)	1,963	8.9

The number of Preferred Worker contracts started increased 75 percent from 1988 to 1996, dropping in recent years along with PPD cases. Total dollars spent on assistance since 1988, including wage subsidy, worksite modification, obtained employment purchases, premium exemption and premium relief, stand at $96 million.

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

Preferred Worker contract costs, FY 1988-2000

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	3.3	2.9	4.7
1999	2.5	3.5	4.0
2000	2.1	3.1	3.4

Despite a recent decline, expenditures for worksite modifications have increased fivefold compared to 1988. Obtained employment purchases totaled $3.7 million from 1988 to 2000. 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 1991-2000

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	4,189	1,100
1997	3,499	951
1998	2,920	733
1999	2,801	535
2000	2,419	359

For workers who receive a Preferred Worker card, not quite one-third 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.

Employer-at-Injury programs approved, 1993-1999

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	10,065	1,781	11.8
1999	9,443	1,835	10.6

Following six years of steady growth in use of the program, 1999 brought a leveling off in worker placements and expenditures for light duty, but the decline came mostly from fewer programs for disabling claims.

Statistics

Vocational assistance, 1987-1999

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	1,760	20.4
1993	1,333	1,494	18.0
1994	1,188	1,291	15.1
1995	1,192	1,296	14.5
1996	1,071	1,130	13.8
1997	814	844	11.1
1998	755	733	10.2
1999	730	650	8.8

The number of new cases opened dropped by 91 percent from 1987 to 1999, while the total cost of closed cases decreased by 77 percent. 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, 1987-1999

Year	DEP plans	Training plans	RTW rates
1987	3,334	1,041	74.0%
1988	2,050	852	73.8%
1989	786	717	68.3%
1990	362	731	69.6%
1991	213	908	78.3%
1992	111	703	79.8%
1993	61	595	78.0%
1994	58	467	78.8%
1995	52	466	85.3%
1996	37	450	90.7%
1997	20	378	83.7%
1998	6	338	85.0%
1999	4	292	84.5%

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

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

Handicapped Workers Reserve claims and costs, FY 1987-2000

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

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

Benefits - permanent disability

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 (PPD) benefits to injured workers, to provide a benefit structure that compensates those more severely injured with more equitable awards, and to ensure that injured workers receive their benefits faster.

National Rankings

Of seven maximum indemnity benefit categories capable of national percentile ranking, four of Oregon's exceeded the national median as of January 2000. Those categories below the national median include scheduled and unscheduled PPD, both of which are now very close to the median values; 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. From 1992 until repeal under SB 369 in 1995, the value of a degree was tied to the statewide average weekly wage, thus providing an annual adjustment for PPD benefits. Since then, the legislature has enacted increases at each session, taking effect at two-year intervals.

The value of a scheduled degree (for bodily extremities, vision, and hearing) has increased from $125 in 1987 to the current value of $511.29 per degree. As a result, scheduled PPD benefits increased by 309 percent, and Oregon's national percentile ranking for maximum scheduled PPD rose from the tenth percentile in 1988 to the 49th in 2000. Benefits for unscheduled disabilities (to the back and other body parts and systems not named in statute) have also risen, by 366 percent for maximum benefits, from 1987 to 2000. 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. In 2000 it dropped slightly to the 46th percentile. Also noteworthy is the establishment in 1991 of a tiered structure for unscheduled disability, which compensates the more severely injured at higher degree values. The 1995 legislature redefined the tiers to make higher benefits available to more workers.

Average PPD awards

Although the national median for maximum benefits has been a useful tool, comparing PPD benefits among states is difficult. Most states compute PPD benefits as a function of the individual worker's weekly wage, not the fixed amounts used in Oregon. 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 low-wage workers appear relatively generous compared to most other states. For unscheduled benefits, however, the maximum is a poor indicator of benefit generosity because only about one percent of claims qualify for upper-tier benefit values. About 72 percent of Oregon unscheduled claims fall into the lowest tier, and benefits for these claims are among the lowest in the country. Unlike maximums, benefit levels in the lowest tier have failed to keep

Figure 21. Maximum PPD benefits, FY 1987-2000

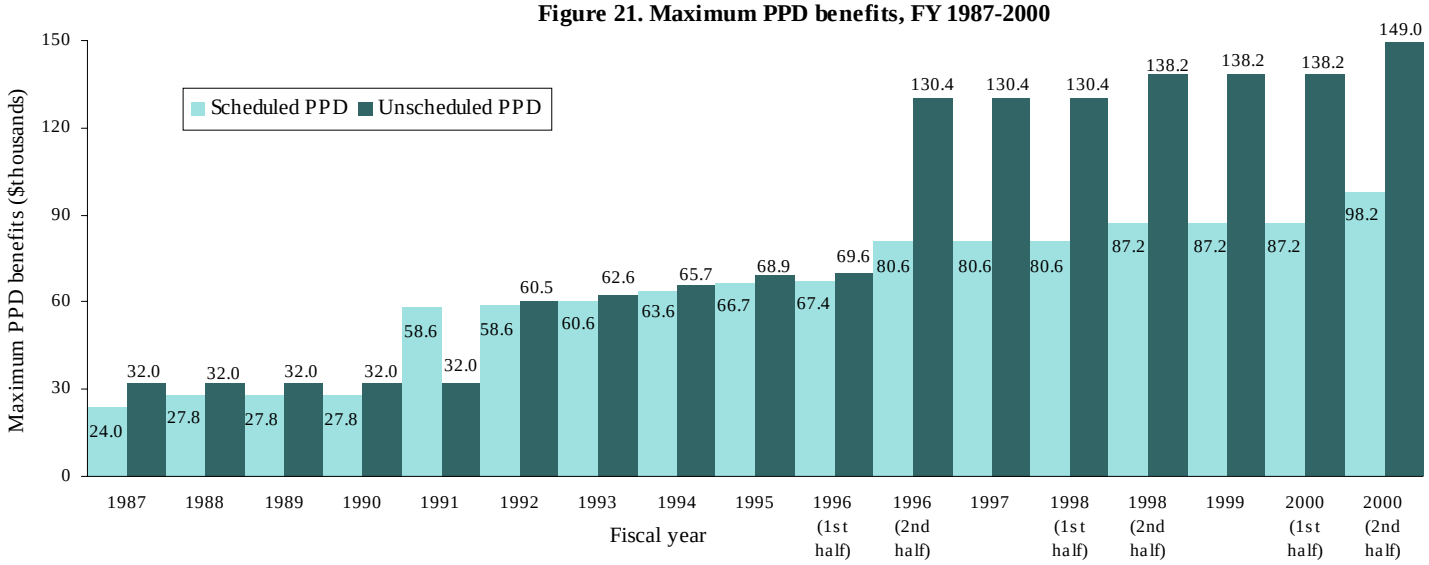
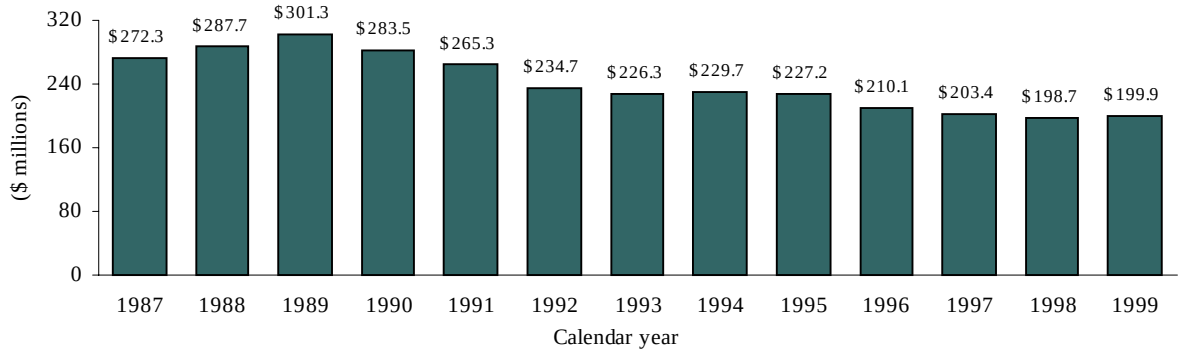


Figure 22. Cash benefits paid to workers for accepted disabling claims, 1987-1999



pace with inflation over the past two decades. Determining whether injured workers are actually receiving higher average and more equitable benefits subsequent to reform is not straightforward. The average degrees awarded for both scheduled and unscheduled PPD awards have decreased: scheduled by more than half to about 16 degrees currently, and unscheduled by about one third, to 48 degrees. Average dollars awarded for scheduled PPD have increased by 88 percent since 1989's low point. Conversely, the average dollars for unscheduled PPD continued to decline until benefit increases began to take effect following the 1991 legislation. A primary reason for this is that most unscheduled PPD is awarded at the bottom tier value for degrees, and values for the lowest tier of benefits have increased relatively slowly. There are a number of factors, however, that complicate the use of the change in average degrees and dollars awarded to draw conclusions about average benefits to injured workers. Claims settled by claims 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 possible changes in injury severity and return-to-work patterns may also contribute to the decline in average degrees awarded.

Examining the median lag times from date of injury to initial closure or other orders for increased PPD, as well as the number of cases reaching each appeal level, provides insight into whether injured workers are receiving their benefits faster. The median lag times in 1999 from date of injury to initial closure and to reconsideration order are significantly shorter than the lag times from injury to hearings or board review. Also, the number of cases reaching these appeal levels has decreased dramatically. For example, 42 percent of unscheduled degrees were awarded on appeal in 1987, compared to around 10 percent at reconsideration or appeal currently. The implication is that injured workers, on average, are receiving their benefits faster.

Indemnity dollars

Historically, permanent total disability claims, although small in number, have been a large portion of indemnity dollars. From 1988 to 1999, the net number of PTD awards declined 93 percent, compared to an overall decrease in disabling claims of 41 percent. Law amendments affecting PTD benefits include the mandates for standards for evaluating permanent disability, the legalization of claims disposition agreements, and the redefining of gainful employment. Changes in insurer claims management practices, shifts in Oregon's industrial mix, and increased emphasis on workplace safety and health are other contributing factors.

Combined cash benefits for time loss, PPD awards, claims disposition agreements, and PTD and fatality indemnity benefits is one measure of benefits available to injured workers. Average cash benefits paid to injured workers per accepted disabling claim increased by 10 percent, from $6,781 in 1987 to $7,456 in 1992, but have been up and down since. Average cash benefits stand at $7,390 in 1999. Decreases in average days of time loss 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.

Statistics

Oregon percentile ranking for maximum benefits, 1988-2000

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

In 2000, Oregon's maximum indemnity benefits were above the national median in four of the seven benefit categories. Those below the median included compensation for scheduled PPD, unscheduled PPD (both very close to the median), and death with no children.

Maximum PPD benefits, FY 1987-2000

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

Between fiscal years 1987 and 2000, maximum scheduled PPD benefits increased 309 percent and unscheduled benefits increased 366 percent.

Average degrees for permanent partial disability cases, 1987-1999

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	16.3	49.8
1999	15.9	48.0

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, 1987-1999

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	6,645	6,426
1998	6,601	7,000
1999	6,815	7,000

Average scheduled PPD dollars awarded have increased by 88 percent 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 the 1998 and 1999 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, 1987-1999

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

The net number of PTDs decreased by 93 percent between 1988 and 1999. 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, 1987-1999

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

Average cash benefits paid (current dollars) increased 10 percent from 1987 to 1992, but the trend line has been down and up since. Cash benefits include time loss, PPD, CDA, PTD and fatality indemnity benefits, but exclude non-cash benefits such as medical, vocational rehabilitation, and attorney fees.

Litigation and administrative dispute resolution

During the period preceding reform, more claims each year required some form of litigation. Two key goals of reform were to ensure that injured workers receive the benefits and services to which they are entitled, without litigation when possible, and to resolve litigated disputes faster. A number of provisions, particularly with regard to permanent disability ratings, were enacted to reduce litigation. For example, the department was required to establish standards for the evaluation of permanent disability that are to be consistently applied by the department and insurers when they close claims and at 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 Dispute Resolution Section provides assistance through informal and formal mediation and negotiation. When these processes do not resolve the dispute, the department issues an administrative order that can be appealed as a contested case hearing before the director or the Hearings Division, depending on which forum has jurisdiction.

Before the 1990 reforms, the department had some alternative dispute resolution processes available to resolve disputes administratively. There was a voluntary reconsideration process available for parties who disagreed with the disability benefit amount awarded at closure. This process was rarely used until it was made mandatory by the 1990 reforms.

Claim closure disputes

By SB 1197 in 1990, the legislature required that a party seek departmental reconsideration of a claim closure before proceeding to a hearing. By law, the mandatory reconsideration process can take only 18 working days if there is no dispute over impairment findings. When there is a dispute about impairment findings, 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 it finds that medical information available is insufficient to determine disability. In 1999, 66 percent of the reconsideration cases 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. This reduces the use of forensic medical experts. 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 1999, there were 25 of these penalties.

By SB 369 of 1995, the legislature made four changes to the reconsideration process: it required the request for reconsideration of a closure to be within 60 days of the closure; it required the hearings request to be within 30 days of the reconsideration; at hearing, it prohibited contesting an issue that was not raised at reconsideration or 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 that in a small number of cases this prohibition of additional evidence at hearings was an unconstitutional deprivation of workers' rights to due process. Specifically, in PTD cases at hearings, 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 appealable period. Since 1995, the number of reconsideration requests has fallen 36 percent. This decline is due to declines in the number of claim closures and in the percentage of closures for which reconsiderations are requested.

The 1997 legislature made two changes to the reconsideration process. In 1995, the decision in Guardado v. J.R. Simplot Company, 137 Or App 95, 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 included modified time frames for conducting the reconsideration. The 18-working-day requirement now begins when all parties request a reconsideration or waive their rights to a request. Also in 1997, by SB 119, the legislature provided additional time to allow workers to attend rescheduled medical arbiter examinations, suspending all disability benefits. If the worker fails to attend and cooperate with the arbiter examination without good cause, the worker will not have a further opportunity to attend and will forfeit the suspended benefits. The reconsideration record will be closed and the order on reconsideration issued, based on the existing record. Issues arising out of the reconsideration order may be addressed and resolved at a hearing at the Workers' Compensation Board.

Medical disputes

Prior to 1990, there were voluntary administrative review processes in

place to help resolve disputes about medical treatment and fees. These processes were used infrequently. The 1990 reforms made the review processes mandatory before a contested case hearing can be requested. The intent of the legislature was to resolve the majority of these matters with medical experts so that only the most adversarial cases would go to hearing. Court decisions affecting the department's jurisdiction in some of these issues reduced the use of these processes.

By SB 1197, the 1990 reforms 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 still receive palliative care under certain conditions: if they 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. Disputes about the necessity for palliative care are filed with the department.

The number of medical dispute resolution requests peaked in 1992 at 1,518. Following the Court of Appeal's decision in Meyers v. Darigold,123 Or App 217, 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.

By SB 728, effective October 23, 1999, the 1999 legislature transferred to the Hearings Division responsibility for disputes when compensability of the underlying medical condition is at issue or when 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 where compensability or causality are accepted at the Hearings Division are then sent back to the Medical Review Unit (MRU) for resolution of the medical service dispute. At MRU they are recorded again as fresh requests. The number of medical dispute resolution requests grew by about 100 in 1999 over 1998. Most of this increase is due to the addition of compensability and causality cases.

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 1999, 14 percent of the requests involved MCOs.

Medical dispute orders, other than orders involving Insurer Medical Examinations (IME), can be appealed through the contested case hearings process. (IME disputes are appealed to the Hearings Division.) In 1999, 13 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 the resolution of vocational disputes fell 69 percent from 1991 to 1999. Most of the decline is the result of the decline in the number of vocational assistance cases. The percentage of vocational assistance cases (eligible and ineligible) that had at least one vocational dispute remained at about 20 percent until it dropped to 16 percent in 1999.

The Rehabilitation Review Unit attempts to resolve disputes through agreements. In 1999, 61 percent of the vocational disputes filed with the department were dismissed or resolved through agreements; 39 percent required a formal administrative order. The median time to resolve a vocational dispute was 28 days. Of the 1998 and 1999 orders issued, 21 percent were appealed to the director.

In 1990, the legislature changed the forum for penalties against insurers for unreasonable claims denial or delay in benefits. Before SB 1197, a worker seeking a penalty against an insurer had to request a hearing at the board. If the hearings referee assessed a penalty, the worker received the entire amount, and the insurer was required to pay the worker's attorney fees. Under SB 1197, two changes were made. First, if the sole issue is whether the insurer has unreasonably delayed benefits, the worker no longer proceeds to a hearing at the board. Instead, the worker files a request for penalty with WCD, and the issue is resolved through an administrative process. The second change is the way in which attorney fees are addressed. Under SB 1197, the insurer pays just the penalty, which is shared equally by the worker and the attorney. The insurer does not pay an additional attorney fee. This change offers less incentive for attorneys to litigate delays of a few days. At the same time, the department has enhanced its insurer audit and penalty activities, assessing civil penalties for delays in payments to workers.

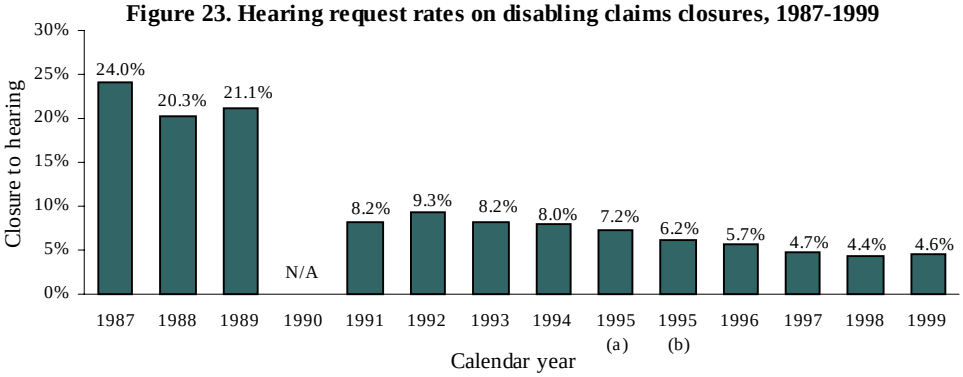
Contested case hearings

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 in law, the number of requests for contested case hearings jumped from 90 in 1994 to 274 in 1995. The number peaked in 1996 before falling to 181 requests in 1999. Most contested case hearings involve appeals of medical dispute orders or vocational assistance dispute orders. In 1995, most of the orders at contested case hearings were vocational assistance disputes, but as the number of vocational assistance disputes has fallen, so has the number appealed. 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 Appellate Review Unit decisions were reconsideration orders and, therefore, appealable to the board. This eliminated the flow of appeals from ARU to contested case hearings.

In 1999, HB 2525 revised the contested case hearings process. It created a centralized Hearing Officer panel within the Employment Department. The panel consists of the administrative law judges from several agencies. Effective January 2000, contested case hearings are sent to this panel.

Figure 23. Hearing request rates on disabling claims closures, 1987-1999



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

1995 is split into six-month periods to show the effects of SB 369.

The 1999 rate is preliminary.

Workers' Compensation Board

The reforms included a number of provisions to speed the process of formal litigation. The 1987 legislature reduced the time allowed to request a hearing following claim closure from one year to 180 days. As mentioned above, the appealable 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 cannot 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; this reduces 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. The 1995 legislature went one step further. It provided for mediation by a private party when the only issue to be resolved is insurer responsibility. This service has not been used.

Mediation

For years the Workers' Compensation Board's Hearing Division has helped parties settle disputes — on an ad hoc basis as well as through mass settlement conferences. With formal mediation, the board now offers the parties the help of trained administrative law judge (ALJ) mediators. This mediation program is voluntary. About 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 that have a claim for permanent total disability benefits, and cases that also include claims under ORS Chapter 659 (civil rights and unlawful employment practices), the Americans with Disabilities Act, or other employment-related issues. Over 40 percent of mediations include issues in addition to workers' compensation issues. Many of the latter collateral issues are settled in conjunction with the workers' compensation case settlement. 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 hearings requests increased for more than 20 years, reaching its peak of 27,549 in 1989. The number has since fallen, and the number of requests in 1997 was 11,266, 41 percent of the 1989 figure; requests thereafter have leveled off at slightly above 11,000. One of the reasons for the decline has been the reconsideration process, which has cut the hearings request rate on initial disabling claim closures. The appeal rate on claim closures has fallen from 21 percent in 1989 to less than 5 percent in 1999. The 1999 rate reflects a reconsideration request rate on initial closures of 15 percent and a hearing request rate of 31 percent on reconsideration orders.

The number of pending cases at hearings 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. The median time lag from hearings request to order dropped almost 50 percent from 224 days in 1987 to 114 days in 1988; thereafter it has been fluctuating between 116 and 147 days, being around 122 days most of the time. The board review median time lag from request to board order in 1999 declined to 125 days, a 77 percent reduction since the peak in 1989.

The goal of reducing litigation included the goal of 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 31 percent in 1999. The hearings appeal rate has been between 9 percent and 11 percent each year from 1991 through 1999. The appeal rate of board orders has been between 18 percent and 20 percent since 1993, well below 28 percent appeal rate of 1992. (Note: The 1987 reform legislation changed the review standard to be adopted by 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 hearings has changed significantly subsequent to reform legislation. In 1987, permanent disability was at issue in 46 percent of the hearings cases; by 1999, the percentage had dropped to 8 percent. Claim denial was at issue in 25 percent of the orders in 1987. After peaking at 49 percent in 1993, it dropped to 43 percent in 1999. In 1987, insurer penalties were at issue in 15 percent of the orders; in 1999 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.

Figure 24. Requests for hearing, 1987-1999

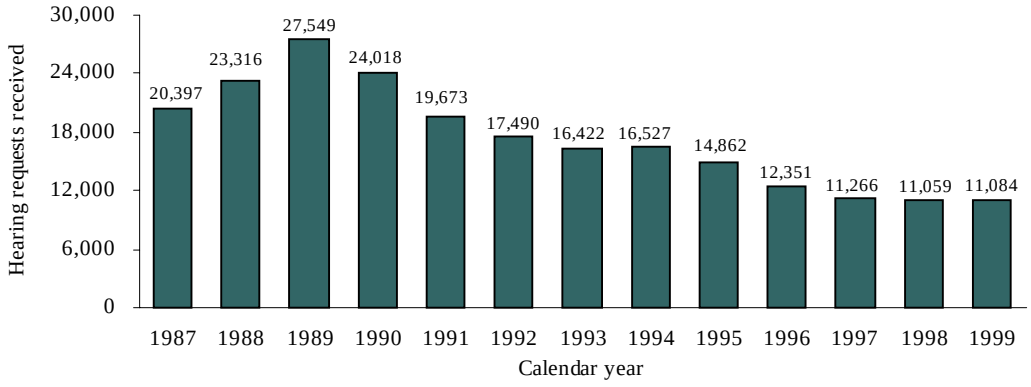
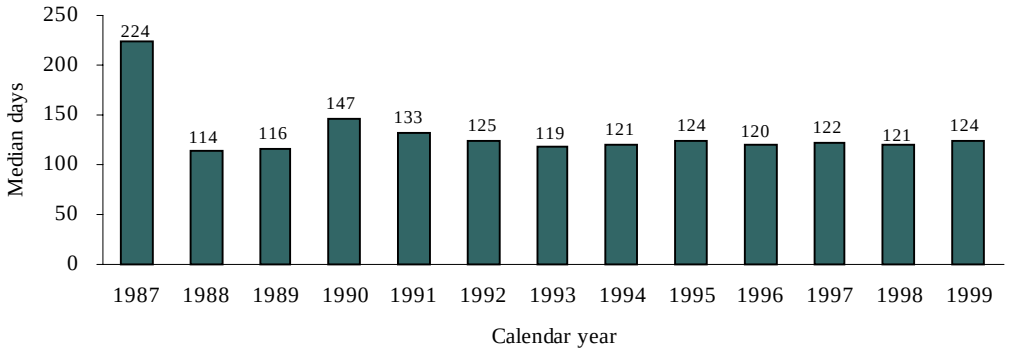


Figure 25. Median time lag, hearing request to order, all cases, 1987-1999



Claim 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 or CDAs) 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 fiscal year 2000, 3,049 CDA requests were filed and 3,078 approving orders were issued. The settlements for fiscal year 2000 amounted to $37.6 million, an average of $12,218 per agreement.

One reason for reducing litigation is that claimants retain a higher proportion of their overall awards when they pay less in attorney fees. In 1995, by SB 369 the legislature made three changes that worked to reduce 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 DCBS 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. In the reconsideration process, attorney fees are limited to 10 percent of the increased award. Attorney fees paid in 1999 resulting from reconsiderations totaled almost $918,500; proceedings before the Hearings Division and on board review amounted to $9.15 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 around $16 million in the last three 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. In February 1999 (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. The maximum is 25 percent of the increase, not to exceed: (a) Awards at Hearings - permanent total disability, $12,500 from $4,600; permanent partial disability, $4,600 from $2,800; temporary disability, $1,500 from $1,050; disputed claim settlements, 25 percent of the first $17,500 (from $12,500) and 10 percent of the remainder; and (b) Awards on Board Review - permanent total disability, $16,300 from $6,000; permanent partial disability, $6,000 from $3,800; temporary disability, $5,000 from $3,800; and, claim disposition agreements, 25 percent of the first $17,500 (from $12,500) and 10 percent of the remainder.

Two additional provisions in 1995 by SB 369 were expected to directly 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 provision 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 hearings request.

Appellate decisions

A number of appellate decisions have tended to narrow the scope of reform, particularly in terms of the director's authority to resolve disputes administratively. Some of the major decisions are listed below. It is important to note that of these decisions, all but four (SAIF v. Herron, U-Haul of Oregon v. Burtis, Altamirano v. Woodburn Nursery, and Welliver Welding Works v. Farmen) were reversed by the 1995 legislature in SB 369.

Court Cases

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.

Safeway Stores v. Heather 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 a referee may consider at a hearing on the same issue.

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 the preceding reconsideration.

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 "wishes," otherwise, the dispute may go to hearings.

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.

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 delays 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.

England v. Thunderbird, 315 Or 633 (1993):
The Supreme Court ruled that disability rating rules, adopted by the Department of Insurance and Finance pursuant to 1987 law changes, were invalid because they failed to consider all factors used to determine loss of earning capacity.

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.

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.

Suzanne 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.

Stone v. Whittier Wood Products, 124 Or App 117 (1993):
The Court of Appeals ruled that longstanding 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.

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.

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.

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.

More recent cases concerning interpretations of legislative reform include the following:

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. To reverse this ruling, SB 369 contained language stating that the payment of permanent disability did not preclude insurers from contesting compensability. In Delux Cabinet Works v. Messmer, 140 Or App 548 (1996), the Court of Appeals stated that this language, despite the legislature's intent, did not reverse the earlier court decision that the failure to appeal did preclude later denials. By HB 2971, the 1997 legislature revised the law to specifically overturn the Messmer decisions.

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.)

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.

SAIF Corporation v. Shipley, 326 Or 557 (1998):
The Supreme Court dismissed 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.

O'Neil v. National Union Fire, 152 App 497 (1998):
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).

Koskela v. Willamette Industries, Inc., 331 Or 362 (2000):
The Oregon Supreme Court ruled that, for a small number of cases, the SB 369 amendment of ORS 656.283(7) to prohibit at hearing evidence that was not a part of the reconsideration process was an unconstitutional deprivation of a worker's due process rights. Specifically, in PTD cases, a worker should have the opportunity to provide oral testimony about his willingness to work and his efforts at finding work.

Smothers v. Gresham Transfer, Inc., (2000, currently before the Supreme Court):
The Oregon Supreme Court has heard arguments that the combination of the major contributing cause language and the exclusive remedy language unconstitutionally denies injured workers with pre-existing medical conditions a legal remedy for their injuries. As of December 2000, the Supreme Court has not issued its decision.

Statistics

Reconsideration requests and orders, 1991-1999

Year	Requests received	Orders issued	Time lag days (mean)
1991	6,137	5,996	65
1992	6,678	6,518	45
1993	6,099	6,027	58
1994	6,019	6,033	61
1995	6,924	6,568	62
1996	5,907	6,301	66
1997	4,724	4,795	68
1998	4,653	4,585	70
1999	4,450	4,543	71

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.

Medical dispute requests and orders, 1990-1999

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	879	817	61
1998	802	816	89
1999	905	820	85

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, are the reason for the increase in disputes in 1999.

Medical dispute requests, by issue, 1990-1999

Year	Change of attending physician	Fees	IME	Palli-ative	Treat-ment	Medical service
1990	92	756	73	159	92	-
1991	95	803	58	204	226	-
1992	81	815	31	209	382	-
1993	51	438	23	70	294	-
1994	36	254	33	44	99	-
1995	63	312	23	45	298	-
1996	36	310	16	84	236	34
1997	32	306	12	43	212	274
1998	40	33	8	30	214	477
1999	31	49	24	55	172	574

In December 1996, the new category "Medical Service" was added to bring the issue categories more in line with statute. Many issues formerly called "Palliative" or "Fees" are now categorized as "Medical Service."

Statistics

Vocational dispute requests and orders, 1991-1999

Year	Requests	Orders	Request to order lag days (median)
1991	2,068	2,139	41
1992	1,644	1,725	29
1993	1,493	1,519	25
1994	1,390	1,375	24
1995	1,348	1,303	28
1996	996	1,037	35
1997	877	881	32
1998	718	716	26
1999	640	681	28

The number of requests for the resolution of vocational disputes has fallen 69 percent from 1991 to 1999. 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 throughout this period until dropping to 16 percent in 1999.

Administrative penalties for claims processing delays, FY 1991-2000

Fiscal year	Penalty requests	Penalties assessed
1991	468	208
1992	438	165
1993	443	140
1994	350	173
1995	320	101
1996	398	128
1997	347	122
1998	311	81
1999	275	82
2000	234	80

For the past seven years, one-third of the requests for penalties resulted in penalties.

Contested case hearings, requests and orders, 1994-1999

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	190	124
1999	181	183	152

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 42 percent between 1996 and 1999.

Contested case hearings requests, by issue, 1995-1999

Decision level appealed	1995	1996	1997	1998	1999
Benefits Section	15	23	24	25	7
Compliance Section	25	19	20	10	13
Dispute Resolution Section					
Appellate Review Unit	39	55	52	2	-
Medical Review Unit	67	132	90	102	104
Rehabilitation Review Unit	117	61	77	70	56
Miscellaneous	11	21	10	0	1

In 1995, most of the requests were appeals of vocational assistance disputes. As the number of vocational assistance disputes fell, so did the number appealed. A 1998 court decision determined that all Appellate Review Unit decisions were reconsideration orders and, therefore, appealable to the board. This eliminated the flow of appeals from ARU to contested case hearings.

Statistics

Hearings request rates on claim closures, 1987-1999

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	17.1%	48.1%	8.2%
1994	16.7%	47.8%	8.0%
1995 (1st half)	16.3%	44.3%	7.2%
1995 (2nd half)	16.9%	36.9%	6.2%
1996	15.8%	36.1%	5.7%
1997	14.6%	32.4%	4.7%
1998	14.5%	30.6%	4.4%
1999	14.8%	30.9%	4.6%

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 from 17 percent to 15 percent, and the percentage of reconsideration orders appealed to hearings has dropped from over 50 percent to 31 percent in 1999. As a result, the percentage of closures that are appealed to hearings has dropped to five percent.

Hearings requests, orders, and appeal rates, 1987-1999

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%

Requests for hearings peaked in 1989. The numbers have fallen since, with requests in 1999 just 40 percent of the 1989 figure. The appeal rate for board review of hearings orders has changed very little since 1991.

Note: The requests and orders include stipulations received without a prior hearing request (about 6 percent of total requests and 5 percent of orders).

Percentage of hearings orders involving selected issues, 1987-1999

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%

Due to the introduction of the mandatory reconsideration process for disputed claim closures, the percent of hearings in which permanent disability was an issue fell sharply from 1990 to 1991. In 1999, less than 8 percent of the hearing orders involved permanent disability.

Statistics

Disputed claim settlements (DCS) at hearings, 1987-1999

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

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

Claims disposition agreements, FY 1991-2000

Fiscal year	CDA requests	CDA approval orders	Amount ($ millions)
1991	2,307	1,729	$28.5
1992	3,075	2,965	46.7
1993	3,492	3,383	46.1
1994	3,292	3,216	41.9
1995	3,487	3,399	43.1
1996	3,854	4,037	49.2
1997	3,304	3,250	44.4
1998	3,136	3,184	40.9
1999	3,172	3,124	39.1
2000	3,049	3,078	37.6

Except for the fiscal year in which CDAs were first introduced, the number of requests for CDAs and the total dollar amount awarded were the lowest in FY 1999; the number of approvals was lowest since FY 1992.

Board review requests, orders, and appeal rates, 1987-1999

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	17.8%
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%

The number of requests for board review peaked in 1991; the 1999 number of requests was 49 percent of the 1991 figure. The percentage of board orders appealed peaked at 30 percent in 1987. In 1999, 19 percent of board orders were appealed.

Statistics

Court of Appeals requests and orders, 1987-1999

Year	Requests	Orders
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

Court requests peaked in 1992. In 1999, the number of requests was 32 percent of the 1992 figure.

Note: Orders exclude remands where the court did not rule on the primary issue.

Median time lag days from request to order, 1987-1999

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

The median time lag for hearing orders in 1999 was 55 percent that of 1987, and the board review lag has fallen 77 percent since its peak in 1989.

Note: The time lags are for all order types.

Median time lag days from injury to order, 1987-1999

Year	Hearings	Board	Court
1987	758	1,067	N/A
1988	677	1,098	1,606
1989	602	1,320	1,497
1990	617	1,169	1,752
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

The time lags from injury to order have declined substantially since 1987.

Statistics

Board own motion orders and reopened claims reserve costs, 1987-1999

Year	B.O.M. orders	Reserve 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

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.

Claimant attorney fees and defense legal costs, 1987-1999

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	21.3	28.2
1993	19.8	27.2
1994	18.8	25.7
1995	20.0	27.4
1996	17.6	25.3
1997	16.1	24.3
1998	16.2	24.1
1999	16.0	24.0

The $16 million in attorney fees from claimants' compensation 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. (See text for details.) Defense legal costs in 1998 and 1999 were just above the record low value of 1989.

Claimant attorney fees, by appeal level, 1987-1999

Year	Hearings ($ millions)	Board ($ millions)	CDA ($ millions)	Recon ($ millions)
1987	$14.2	$0.2	-	-
1988	16.0	0.3	-	-
1989	16.0	0.7	-	-
1990	15.9	1.0	$0.9	$0.0
1991	13.8	0.9	6.4	0.3
1992	12.5	1.1	7.1	0.7
1993	11.1	1.2	6.6	0.8
1994	10.4	1.1	6.5	0.8
1995	10.9	0.8	7.3	1.0
1996	9.1	0.9	6.7	1.0
1997	8.5	0.8	6.0	0.8
1998	8.9	0.8	5.7	0.9
1999	8.5	0.6	5.9	0.9

In 1999, 53 percent of the claimant attorney fees came from Hearings and 37 percent from CDAs.

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.

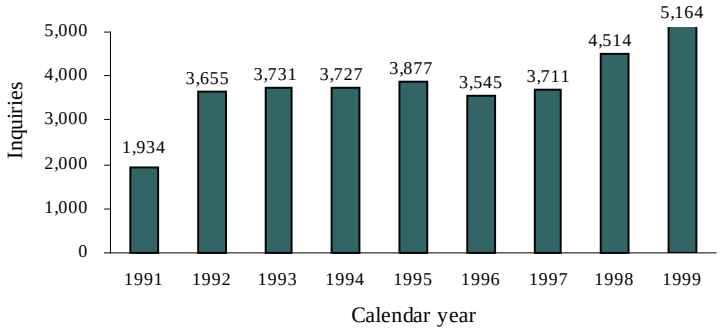
Ombudsman for Injured Workers

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 includes a count of all incoming and outgoing telephone calls, in addition to mail contacts and walk-ins; each case may have several contacts, especially telephone calls, both incoming and outgoing. However it is seen that even on this basis there has been a 36 percent increase of contacts over the last three years. In 1999 and 2000 the issues that prompted the most inquiries were benefits, medical issues, claim processing, and settlements.

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 over 5,000 inquires in 1999. It had also conducted more than 160 outreach programs from 1991 through 1997. Contacts for outreach programs have been increasing rapidly over the last few years.

Figure 27. Small Business Ombudsman inquiries, 1991-1999



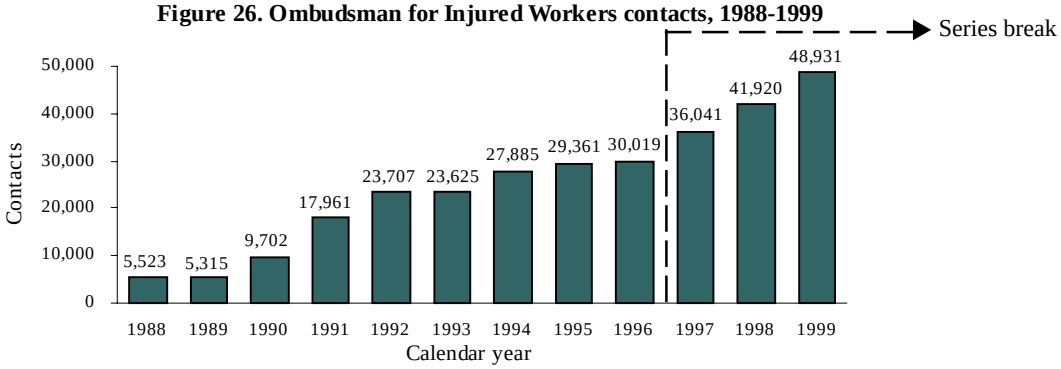
Management-Labor Advisory Committee

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.

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, just, and cost-effective system. In its report to the sixty-sixth Legislative Assembly, 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 a combined 24-hour health insurance benefits and indemnity benefits coverage rather than the traditional workers' compensation coverage.

Figure 26. Ombudsman for Injured Workers contacts, 1988-1999



Statistics

Ombudsman for Injured Workers activities, 1988-1999

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

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, so that pre-1997 counts cannot be compared to the recent counts. However, it is seen that contacts have increased rapidly in the last three years.

Ombudsman for Injured Workers, percent of inquiries by major issue group, 1999 & 2000

Major Issue Group	1999	2000
Attorney	2.1%	1.5%
Benefit	22.5%	21.9%
Claim processing	11.9%	16.5%
Denials	7.8%	7.4%
Medical	15.2%	14.6%
Orders & appeals	8.7%	7.9%
Settlements	12.1%	13.0%
Unable to contact	0.3%	1.8%
Work release	7.7%	7.0%
Other issues	11.8%	8.5%
Total	100.0%	100.0%

Looking at inquiries grouped by issue, benefit issues were the most frequent in both 1999 and 2000. Medical, claim processing, and settlements are the next most important issues.

Small Business Ombudsman activities, 1991-1999

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

This program was implemented in the fall of 1990. The number of inquiries increased through 1995, then declined in 1996. It has since increased 46 percent. Outreach program contacts have increased rapidly over the last three years, the count doubling itself from 1997 to 1999.

Appendix - Oregon workers' compensation reform legislation

The road to significant workers' compensation legislative reform has been long and arduous. The legislative reform of Oregon's system began during the 1987 legislative session with the passage of two bills, HB 2271 and HB 2900. These early legislative reforms, together with signs of financial strain on the workers' compensation insurance market, provided the impetus for further major reform efforts by the passage of SB 1197 and SB 1198 during a special session of the Oregon legislature in May 1990. Refinements to the reforms were enacted during the 1991 and 1993 legislative sessions. In 1995, SB 369 clarified some of the earlier legislative intent that had been subject to several court rulings. Small reforms were implemented in 1997. Along the road to reform, the department also has implemented administrative reforms, not explicitly provided for by legislation, that have contributed to reductions in accident frequency, claims cost control, and resource efficiencies. 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, and that employers with ten or fewer employees establish safety committees if the employer has experienced 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 such an employer: 1) has not had a complaint filed in the prior two years, or a serious accident; 2) receives a consultation once every four years and corrects any hazards found within 90 days; and 3) has a minimum of four hours training annually on agricultural safety rules and procedures at a course conducted or approved by DCBS. (HB 3019)

654.176 (1) Exempted small agricultural employers (10 or fewer employees) from OR-OSHA safety committee requirements unless such an 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)

1997

656.796 Repealed this section. Abolished the State Advisory Council on Occupational Safety and Health (SACOSH). 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, 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, and that employers may designate attorneys to act as representatives during inspections. (HB 2830)

Insurance

1987

656.262 (5) Allowed employers to pay for medical services up to $500 for nondisabling claims, and 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 the officers and directors thereof, 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, and changed 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 which 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 who is responsible for workers' compensation coverage and 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) & 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 is established as a pilot project where eligibility for such agreements will end January 1, 2002. The bill also requires a status and project report to the Seventy-First Legislative Assembly. (HB 2450)

656.430(7) Removed the "same industry" requirement to be included in a self-insured employer group. (SB591)

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 director to use rulemaking process to establish workers' compensation premium assessments. (SB592)

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 of the Department of Consumer and Business Services to license one or more rating organizations for workers' compensation insurance under the Insurance Code. Specifies 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)

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 & 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) The legislature directed the agency 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)

Claims processing

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 injured workers not eligible for time loss benefits during periods of time while incarcerated for a crime. (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 time loss payments are not due or may be suspended by insurers. (SB 1197)

656.262 (6) Increased the amount of time for insurer acceptance or denial of a claim from sixty to ninety days. (SB 1197)

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 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 effectively end access to claims histories by employers, information services, commercial interests, and others using that information to discriminate against injured workers in hiring. Information will still be 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 limitations on the liability provisions of this chapter apply whether the injuries or diseases were compensable or not. (SB 369)

656.126 Authorized offset of out-of-state compensation paid for the same injury or illness as in Oregon, from Oregon compensation. (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 injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. (SB 369)

656.262 (15) Required the director to suspend for non-cooperation, all or part of compensation due a worker, and authorized the insurer or self-insured employer to deny the claim if the non-cooperation continued 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 became medically stationary if the accepted injury ceased 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 failed to seek medical treatment for a period of 30 days or failed to attend a closing examination. (SB 369)

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

656.726 (3)(f)(D) Required that impairment be the only factor to be considered in evaluating a workers 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 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) Made insurers and self-insured employers responsible for closing all claims and for determining the extent of permanent disability. (SB 220)

656.268 (Note) The department will phase out the department's own claim closure activities. Insurers and self-insured employers will assume responsibility for closing all claims no later than June 30, 2001. (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)

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 medi-

cally 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 (MCOs). 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. 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)

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 no longer required to provide Disability Prevention Services. (SB 369)

656.340 Clarified when vocational eligibility must be determined following aggravation and the eligibility criteria thereof. 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)

Benefits - permanent disability

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: (1) where there was a surviving spouse of the deceased worker and, (2) where there was 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, 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. (SB 460)

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.)

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. (The approval requirement for insurers' attorney fees was repealed by SB 1197.) (HB 2900)

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) and **(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 submission at hearing, 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" 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 request 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 chairperson of the Workers' Compensation Board to manage and supervise Board and Hearings Division. (SB 654)

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)