Oregon Department of Consumer & Business Services

Information Management Division

Research & Analysis Section

Biennial Report on the Oregon Workers' Compensation System

Seventh Edition

January 2005

Revised November 2005

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Executive Summary

The Department of Consumer and Business Services provides regulatory oversight for many of Oregon's business functions. The department, including the Workers' Compensation Board, contains most of the administrative and adjudicative functions of the workers' compensation system. Among many other duties, the staff provides safety and health enforcement, provide consultative services, regulate the workers' compensation system, set workers' compensation insurance rates, resolve disputes, and provide information to policy makers.

This report is the seventh in a series that describes Oregon's workers' compensation system and shows the effects of legislative reform since 1987. The previous edition was published in January 2003. This edition adds statutory changes made by the 2003 legislature and provides new data through 2004. It contains 11 sections and two appendices. Each section includes descriptions of legislative changes, major findings, and numerical data. The appendices contain a summary of the changes in legislation and a summary of selected court cases.

History of legislative reform since 1987

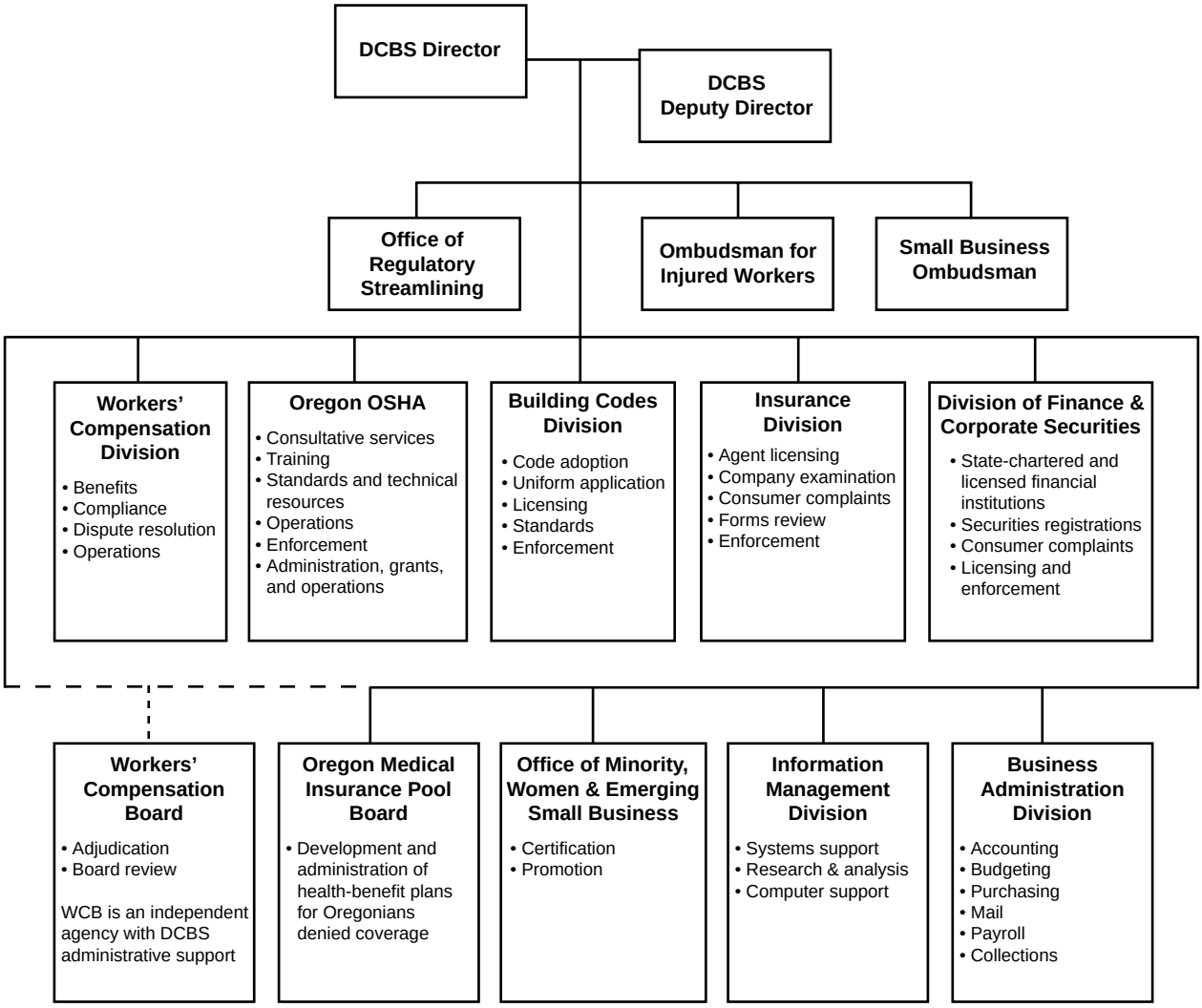
The Oregon workers' compensation system has undergone major changes over the past 18 years. In 1986, Oregon ranked 6th highest in the nation in the average workers' compensation premium rates paid by employers. It also had one of the nation's highest occupational-injury-and-illness claims rates. To improve the system, the 1987 legislature enacted House Bill 2900. This bill expanded the requirements for safety and health loss-prevention programs, increased penalties against employers who violate the state safety and health act, created the Preferred Worker Program, limited other vocational assistance, increased benefits, limited the authority of the Workers' Compensation Board, and created the Ombudsman for Injured Workers. A companion bill, HB 2271, limited mental stress claims and placed the burden of proving that a claim is compensable on the worker.

Three years later, workers' compensation costs remained high, and SAIF Corporation had canceled many small employers' policies. These conditions provided the impetus for further reforms. During a May 1990 special session, the legislature passed Senate Bill 1197 and other legislation. SB 1197 expanded requirements for safety committees, required that the department's disability standards be used at claim closure and for all subsequent litigation, required that the department create a workers' compensation claims examiner program, limited attending physicians and palliative care, allowed the use of managed care organizations, modified the Preferred Worker Program so that its costs were excluded from ratemaking, increased benefits, created claim disposition agreements, expanded the department's dispute resolution processes, created the Ombudsman for Small Business, and established the Management-Labor Advisory Committee. It also redefined compensability by stating that the injury must be the major contributing cause of the need for treatment. Also, a claim was defined as compensable only as long as the compensable condition remained the major contributing cause of the need for treatment. To allow insurers more time to investigate claims, the bill increased the period for claim acceptance or denial from 60 to 90 days. It also increased Oregon OSHA staffing.

Following the passage of SB 1197, workers' compensation premium rates fell rapidly. Rates declined by more than 10 percent each year for three years after the special session. In 1994, Oregon had the 32nd highest premium-rate ranking in the country.

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

DCBS Organizational Chart



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

The 1999 legislature allocated funds for a study of the effects of changes in the compensability language that had been added to the statute through SB 1197 in 1990 and revised through SB 369 in 1995. Legislators were interested in learning the extent to which these changes affected the costs of the workers' compensation system and the benefits paid to injured workers. The department contracted with a team of leading workers' compensation researchers. The team issued its report, *Final Report, Oregon Major Contributing Cause Study*, in October 2000.

The researchers conducted econometric analyses to estimate the legislation's effect on benefits. There were several complicating factors. First, although the study's intent was to look at the effects of changes in the compensability definitions, the researchers could not isolate the effects of these changes from the other changes in the two bills. Their analyses, therefore, measured the total effects of these two pieces of legislation. The second complicating factor was that some of Oregon's workers' compensation costs were beginning to fall prior to 1990. Finally, workers' compensation costs fell throughout the country during the early 1990s. There was no reason to assume, therefore, that Oregon's costs would not have fallen even if the legislation had not been passed.

The researchers concluded that SB 1197 and SB 369 resulted in benefit reductions of at least 13 percent. This savings was due to a drop in the number of claims; the average cost per claim remained about the same.

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

The 2001 legislature passed SB 485 partly in response to another court decision. In May 2001, the Oregon Supreme Court ruled in *Smothers v. Gresham Transfer, Inc.,* that some of the exclusive-remedy provisions in SB 369 were unconstitutional. Workers whose claims were denied because their injuries were not the major contributing cause of the need for treatment were permitted to pursue civil action against their employers. SB 485 created a process for these suits. It also revised the definitions of preexisting conditions and stated that the employer has the burden of proof in showing that the compensable condition is not the major contributing cause of the need for treatment. The legislature was concerned that the *Smothers* decision would have a significant impact on the costs of the system, so it mandated a legislative proposal for a revised system in time for the 2003 session. There had been no successful suits by 2003, and no proposals were put forward.

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

In 2003, the legislature passed SB 757. This bill significantly changed the award structure for permanent partial disability for workers injured after December 31, 2004. The new structure simplifies the rating system. It also provides larger awards to injured workers who are not able to return to work. The benefits were designed to avoid increased costs to the workers' compensation system, resulting in lower benefits to some workers who do return to work.

Ballot Measure 38

Oregon has a tradition of making important policy decisions by means of ballot initiatives. In November 2004, Oregonians voted on Ballot Measure 38. This ballot measure would have abolished SAIF Corporation on January 1, 2007. SAIF would have had to cease selling new insurance policies on January 1, 2005, and cease renewing policies on January 1, 2006. The Department of Administrative Services would sell SAIF's real and personal property. The primary financial support for the ballot measure was provided by Liberty Northwest, the state's largest private insurer.

The ballot measure failed, with 61 percent of voters opposing it.

2005 Report Highlights

The basic measures of workplace safety and health are injury and illness frequencies and claims frequencies.

- The U.S. Bureau of Labor Statistics uses an employer survey to measure injury and illness frequencies. In 2003, the Oregon total-cases incidence rate was 5.6 cases per 100 full-time workers. Incidence rates have been declining. In 1988, the total cases rate was 11.1 cases per 100 workers.
- In 2003, there were 21,832 accepted disabling claims. This is the fewest since at least 1968. The accepted disabling claims rate, which reflects both claims frequency and compensability standards, was 1.4 accepted disabling claims per 100 workers in 2003. This claims rate is 37 percent of the 1988 rate of 3.8.
- The permanent partial disability claims rate, which reflects claims severity, was 403 claims per 100,000 workers in 2003. This rate has fallen to the same extent as has the accepted disabling claims rate.
- Some caution is needed when interpreting the decline in claims rates. The Oregon Population Survey includes questions about work-related injuries. In 2002, seven percent of employed Oregonians reported that during the previous year they had suffered at least one workplace injury that required medical attention. Forty-six percent of those injured workers did not file workers' compensation claims.

Oregon OSHA provides workplace consultations and workplace safety-and-health inspections.

- OR-OSHA staff provided 2,063 consultations in 2003. This is the fewest since 1998. These consultations help employers identify hazards that could lead to workplace injuries or illnesses.
- There were 5,355 OR-OSHA inspections in federal fiscal year 2003. No violations were found in 26 percent of the inspections. Since 1988, the number of employers in OR-OSHA's jurisdiction has grown 28 percent, but the annual number of inspections has remained about the same.

The workers' compensation claims system has been fairly steady over the past few years.

- The denial rate of disabling claims was 17 percent in fiscal year 2004. It has remained relatively constant over the past decade. The denial rate of disabling occupational disease claims was 36 percent. The denial rate of aggravation claims was 40 percent in CY 2003.
- In 2001, as part of SB 485, the legislature reduced allowable time for claim acceptance or denial from 90 days to 60 days. The median number of days insurers took to accept disabling claims was 49 days in 2000. The median declined to 40 days in 2003. Ninety-three percent of claims had timely acceptance or denial in 2000. Ninety percent were timely in 2003.
- In May 2001, the Oregon Supreme Court ruled in *Smothers v. Gresham Transfer, Inc.* that workers may pursue civil action against their employers when their claims are denied because their injuries are not the major contributing cause of the need for treatment. As of December 2004, few of these cases had proceeded to trial, and none had resulted in a verdict for the claimant.

The department provides services for workers, employers, medical providers and others through its ombudsman offices and through the WCD information line.

- The office of the Ombudsman for Injured Workers serves as an independent advocate for injured workers seeking resolution of issues concerning their claims. There were over 56,700 contacts with the office in 2003. About 13,500 injured workers and 1,200 other people were assisted. The number of contacts with the office has grown about eight percent each year since 1997. The issues that prompt the most inquiries are about benefits, medical issues, claim processing, and settlements.
- The office of Small Business Ombudsman for Workers' Compensation is a resource center for employers needing information about the workers' compensation system. The office had about 4,100 inquiries in 2003.

- The Workers' Compensation Division has a telephone information line for workers, employers, insurers, medical providers, attorneys, legislators, and others. In 2003, there were about 17,200 calls to the information line, about the same as in 2002.

The department penalizes employers, insurers, and others for federal and state rule violations.

- During federal fiscal year 2003, OR-OSHA issued 3,940 citations with $2.3 million in penalties for workplace violations.
- In 2003, WCD issued 1,241 citations against insurers for failing to meet requirements for payment of compensation, claim acceptance or denial, and claim closure. The penalties totaled about $344,000.
- In fiscal year 2004, 46 investigations of workers' compensation fraud or abuse complaints were opened. Among the most frequent complaints were employees pressured by employers not to file claims, improper claims processing by insurers or medical providers, and improper reporting of claims-related documents by employers, insurers, and medical providers.

Injured workers with disabling claims receive indemnity benefits, such as temporary disability payments and permanent disability awards, and medical services. According to data from the National Council on Compensation Insurance, the cost of medical services exceeded indemnity benefits in Oregon for the first time in 2002. Controls on medical costs include the use of managed care organizations, attending physicians, and fee schedules.

- As of October 2003, there were seven managed care organizations in Oregon. These MCOs had 92 contracts with insurers and self-insured employers. These contracts covered 59 percent of Oregon employers.
- Injured workers are not usually enrolled in MCOs until their claims are accepted. In 2003, 39 percent of injured workers with accepted disabling claims were enrolled in MCOs. SAIF enrolled 70 percent of its injured workers; private insurers enrolled eight percent of their injured workers.
- The Liberty group of insurers slowed its enrollment of injured workers in MCOs in 2001 and canceled all of its MCO contracts in 2003.
- In 2003, HB 3669 expanded the role of nurse practitioners. The bill allowed them, within some limits, to treat injured workers, authorize time loss, and release workers to their jobs.
- In 2004, the department adjusted the pharmacy fee schedule. It lowered the reimbursement from 95 percent of the drug's average wholesale price to 88 percent. At the same time, it raised the dispensing fee from $6.70 to $8.70. The adjustment also restricted the prescription of four of the most used drugs.

The 2003 legislature, through Senate Bill 757, revised the award structure for permanent partial disability. The legislation applies to injuries after December 31, 2004. The new structure eliminates the distinction between scheduled and unscheduled PPD and the three-tiered structure for unscheduled PPD awards. The new structure reallocates benefits to better reflect earnings loss, providing less-generous benefits to some workers who can return to regular work and more-generous benefits to those who cannot. While the maximum PPD award was increased, the net cost to the workers' compensation system should not increase.

After the prevention of injuries, the most important goals of the workers' compensation system are returning injured workers to their jobs quickly and restoring them to their pre-injury wages. Oregon's return-to-work programs have been shown to assist in these goals. Workers who have used the department's return-to-work programs have higher employment rates and higher wages than do the workers who have not used these programs.

- Oregon's traditional vocational assistance program was scaled back in 1987. In 2003, 130 workers returned to work after completing vocational assistance. This compares with about 3,600 workers in 1987. Workers who complete vocational assistance plans have employment rates that are at least 20 percentage points higher than workers who don't receive return-to-work assistance.

- The Preferred Worker Program provides incentives for employers to hire workers with permanent disabilities who are unable to return to regular work. In 2001, 23 percent of those workers to whom cards were issued used them to gain employment. Workers who used Preferred Worker benefits have employment rates that are at least 20 percentage points higher than those who do not use their benefits.
- The use of the Employer-at-Injury Program, which provides benefits to employers who return their injured employees to work quickly, has fallen. Fewer than 6,000 workers used the program in 2003, compared to the high of more than 10,000 workers who used it in 1998. The poor economy in recent years may be a cause of the declining use of the program. The use of the EAIP often leads to rapid return to work at preinjury wages.

In 2003, staff in the Workers' Compensation Division and at the Workers' Compensation Board resolved more than 17,000 disputes through orders, stipulations, agreements, and mediation.

- In 2003, 17 percent of claim closures were appealed for reconsideration. About 4,200 reconsideration orders were written; 32 percent of these orders were appealed to the Hearings Division.
- The Vocational Rehabilitation Unit resolved 530 vocational disputes in 2003. Of these cases, 28 percent were resolved through agreements. Another 27 percent of the disputes were dismissed, often because vocational assistance benefits were released in claim disposition agreements.
- There were about 10,200 hearing requests in 2003, half the number of requests in 1987.
- Claims denial was an issue in 41 percent of the approximately 10,400 hearing orders issued in 2003. Partial denial of claims was an issue in 38 percent of the hearing orders.
- Claimant attorney fees totaled $17.1 million in 2003. Sixty-five percent of these fees were taken out of claim disposition agreements and disputed claim settlements. Insurer attorney fees totaled $27.1 million.

There was little change in the Oregon workers' compensation market in 2004.

- The insurance commissioner approved an overall rate continuance for 2005. This was the third year without a rate change. This period followed 12 years of rate cuts.
- The 2005 workers' compensation pure premium rate is 43 percent of the 1990 rate.
- Workers' compensation total system written premiums in Oregon totaled $859 million for 2004, up more than 13 percent from 2003.
- SAIF Corporation's total system market share in 2004 was 44 percent. Private insurers' corresponding share was 41 percent. The Liberty group of insurers had 21 percent of the market, 51 percent of the private insurers' share. Self-insured employer and employer groups had the remainder of the market, 14 percent.
- In 2004, there were 421 private insurers authorized to write workers' compensation insurance in Oregon. Of these, 176 insurers had positive written premium. There were 157 self-insured employers and six employer groups.
- Large deductible premium credits remain a significant portion of premiums in 2004 with estimated total credits of $50.8 million, 14 percent of written premiums for private insurers.
- Oregon's assigned-risk pool grew slowly in 2004 after growing rapidly between 2000 and 2003. In 2004, 12,761 employers were in the pool. The premium was $57.5 million, eight percent of the total written premium.

Since 1996, the Workers' Benefit Fund has provided money for a number of workers' compensation programs. The funds come from an assessment on employers and workers.

- The assessment rate is currently set at 3.4 cents per hour worked, with employers and workers each paying half.
- For fiscal year 2004, expenditures from the WBF totaled $94.1 million. Of this amount, $59.0 million was paid for the Retroactive

Assistance Program, which provides increased benefits to workers for benefit levels that are lower than current levels.

Much of the regulation of the Oregon workers' compensation system is funded by an assessment on workers' compensation premium. The assessment revenue is collected from insurers based on workers' compensation premiums earned in Oregon. For self-insured employers and self-insured employer groups, the assessment is based on simulated premiums calculated by the department. The revenue is deposited into the Premium Assessment Operating Account.

- As of January 2005, the assessment rate for insurers is 6.8 percent of premium, down from seven percent in 2004. For self-insured employers and self-insured employer groups, the assessment rate is seven percent.
- For fiscal year 2004, expenditures from the fund totaled $53.2 million.
- Passed by the 2003 legislature, House Bill 2148 and HB 5077 required the transfer of $18.2 million from the PAOA to the state's general fund.
- Also passed in 2003, HB 3630 required that SAIF create a reinsurance program for rural physicians. This program reimburses some of the cost of these physicians' medical liability costs. As created, the program is to run during 2004-2007. SAIF must pay the costs of the program, but it can reduce its assessments paid to the PAOA by up to $40 million over this period.

Safety and Health

The most widely used measures of workplace safety are injury and illness rates and claims frequencies. In part because of legislative reform, claims rates are now half of what they were in the late 1980s.

Injury and illness rates and claims rates

For more than 30 years, the U.S. Bureau of Labor Statistics has used an employer survey based on OSHA recordkeeping requirements to measure occupational injury and illness frequencies. This provides a long-running data series that shows changes in injury rates. Two recent changes, however, have made the most recent data incomparable with earlier data. BLS adopted new recordkeeping rules for its 2002 survey, including the replacement of one of its measures. In 2003, BLS adopted a new industry-classification system. As a result, the current industry injury rates are not comparable to the earlier rates.

Despite these changes, the employer survey provides valuable information about the trends in workplace injuries. In Oregon, the total cases incidence rate, a measure of all workplace injuries and illnesses, has fallen most years since 1988. It was 11.1 cases per 100 full-time workers in 1988 and 6.2 cases in 2001. Under the new reporting rules, it was 5.6 cases per 100 full-time workers in 2003. The national rate was 5.0 in 2003.

The lost-workday-cases incidence rate, a measure of more severe injuries and illnesses, was 3.2 cases per 100 full-time workers in 2001. This was 57 percent of the 1988 rate of 5.6.

The numbers and rates of compensable claims for injuries and illnesses have dropped substantially over the past 17 years. From 1987 to 2003, employment grew 43 percent. In contrast, the number of accepted disabling claims decreased 47 percent, as

Figure 1. Accepted disabling claims and employment, 1987-2003

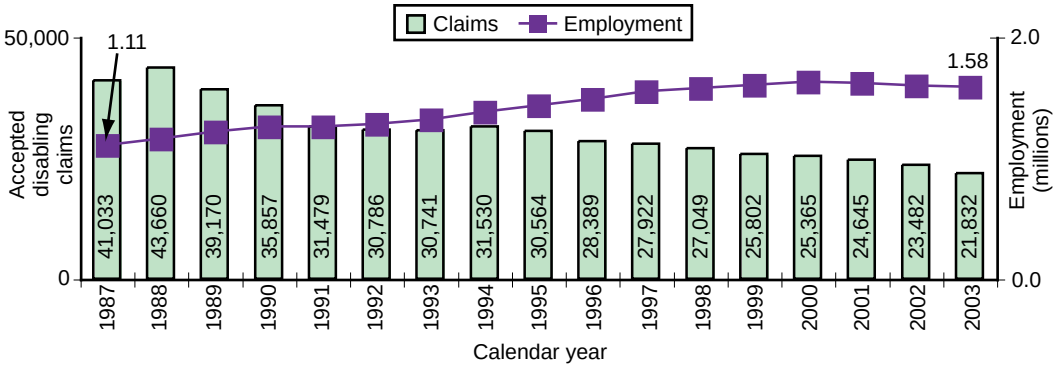
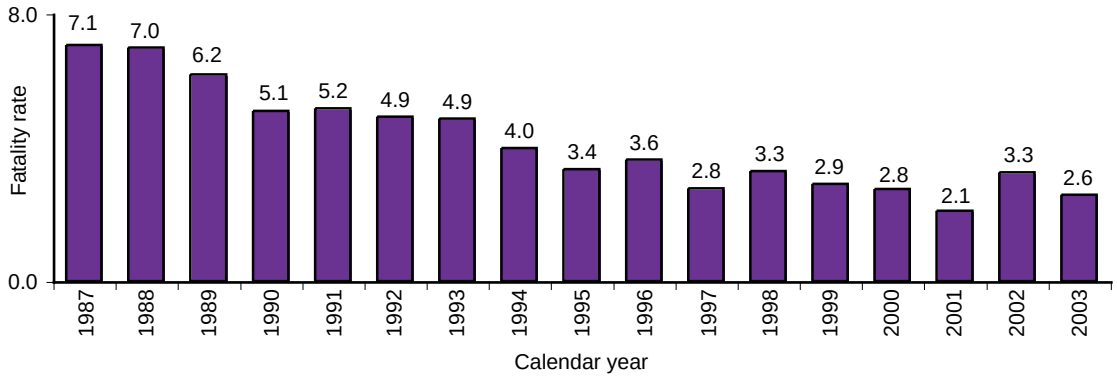


Figure 2. Compensable fatality rates per 100,000 workers, 1987-2003



did compensable fatalities. As a result, the accepted disabling claims rate declined by 62 percent during that period.

It is difficult to determine how much the emphasis on workplace safety and health has affected claims rates. Changes in the definition of compensability, insurer claims-management practices, and alterations in the economy and industrial mix affect both claims volume and rates. Also, national incidence rates have fallen at rates similar to Oregon's rates, perhaps indicating that claims rates would have fallen even without legislative reform.

Some caution is needed when interpreting the decline in claims rates. The Oregon Population Survey includes questions about work-related injuries. In 2002, seven percent of employed Oregonians reported that during the previous year they had suffered at least one workplace injury that required medical attention. Forty-six percent of these injured workers did not file a workers' compensation claim.

Despite these qualifications, the increased emphasis on safety and health, especially by the Occupational Safety and Health Division, has played a role in the reduction of workers' compensation costs in Oregon.

Occupational Safety and Health Administration

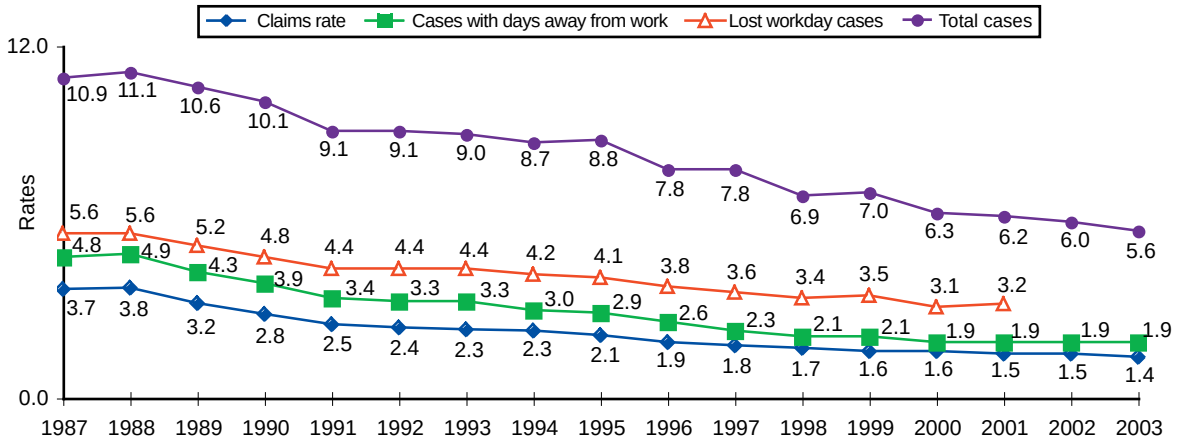
The best way to reduce the costs and suffering associated with workers' compensation claims is to reduce workplace injuries, illnesses, and fatalities. OR-OSHA provides leadership and support to business and labor through enforcement programs, voluntary services, conferences and workshops, technical resources, publications, and a resource library.

Oregon OSHA and Federal OSHA

The Federal Occupational Safety and Health Act of 1970 went into effect in 1971. The Oregon version of this legislation, the Oregon Safe Employment Act, was passed in 1973. OSEA is now administered through a state-plan agreement with federal OSHA.

As one of 23 states with state plans, Oregon OSHA submits a grant application for approval each year. The state plan must be at least as effective as federal OSHA's program for the grant to be approved. With approval, OR-OSHA receives up to 50 percent of its funding from the federal government. One of the federal requirements

Figure 3. Accepted disabling claims rates and private sector occupational injuries and illnesses incidence rates, 1987-2003



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

Reporting rule changes mean that incidence rates since 2002 are not necessarily comparable to earlier rates. The lost workday cases incidence rate is no longer computed.

for state-plan states is the formation of a strategic plan. OR-OSHA's five-year strategic plan was the first to be approved by federal OSHA and became a model for other states.

Legislative reform

Since the passage of the OSEA, other pieces of legislation have affected OR-OSHA's programs.

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

In 1999, OR-OSHA created the Small Construction Employer Safety Committee Program, which provided an alternative way for construction companies with 10 or fewer employees to meet the safety committee requirements defined in SB 1197. This successful program was expanded in 2002 to include small employers in all industries except logging. The program covers 80 percent of all private employers. (There are separate rules for safety committees in the logging industry.)

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

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

Voluntary Services

Consultative services

OR-OSHA staff provided 2,063 consultations in 2003. This function was added to the department's duties through SB 2900 in 1987 and expanded with the passage of SB1197 in 1990. The services help employers identify hazards and work practices that could cause workplace injuries or illnesses. The consultation and enforcement programs operate independently to ensure that consultative services do not provide an avenue for an inspection or other enforcement activity.

Figure 4. OR-OSHA consultations, 1988-2003

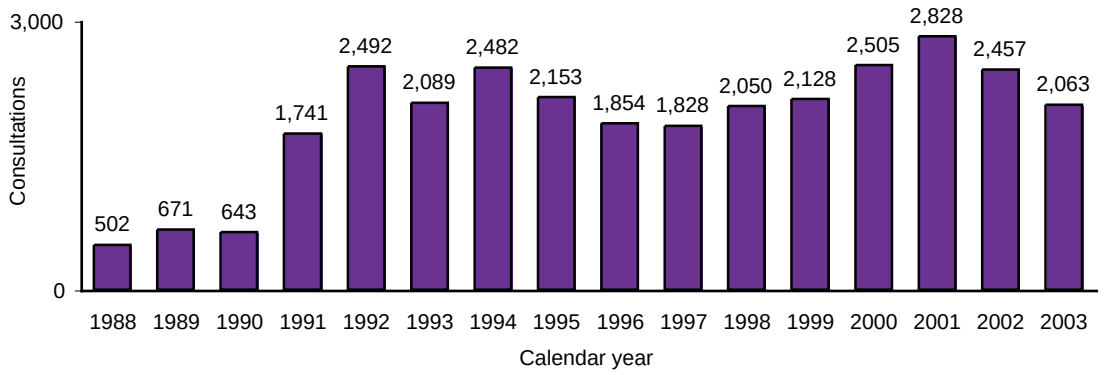
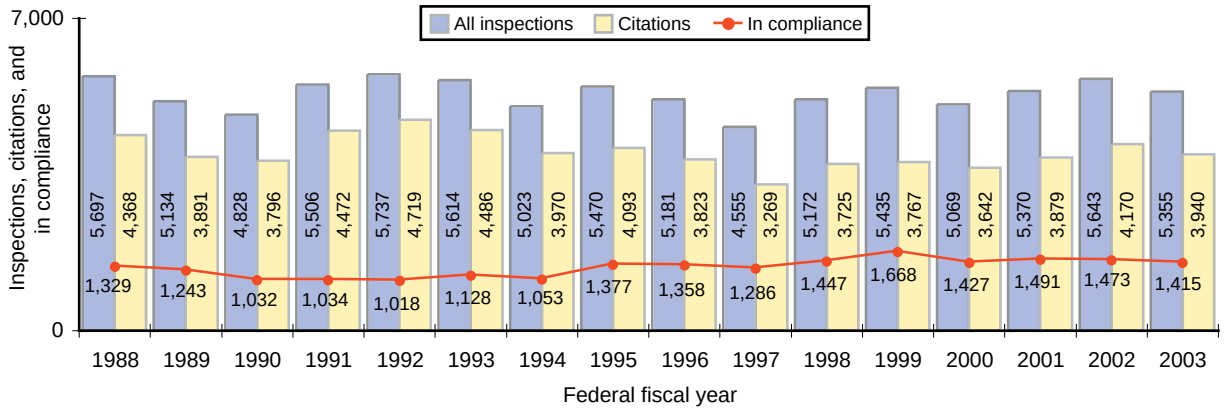


Figure 5. OR-OSHA inspections, 1988-2003



Consultations reduce hazards. A 1995 department study found that OR-OSHA consultants noted 1,528 serious hazards at 107 establishments. Subsequent inspections of the same establishments resulted in citations for 173 alleged serious violations. Therefore, these employers had reduced serious hazards by 89 percent. A companion study found that the same establishments had an 18 percent decrease in accepted disabling injury claims in the two years following the consultation.

OR-OSHA also provides training to both employers and employees. Attendance at public education and conference training sessions between 1998 and 2003 exceeded 121,000.

OR-OSHA grants

Since 1990, OR-OSHA has awarded about $2.2 million in grants to nonprofit organizations and associations to develop innovative programs for occupational safety and health training.

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

Enforcement

OR-OSHA inspections

OR-OSHA staff conducted 5,355 inspections in federal fiscal year 2003. Although the number of inspections has varied from year to year, there has been no long-term increase in inspections since at least 1988. Over the same period, the number of Oregon employers has grown by 28 percent.

Penalties assessed for employer violations of federal and state safety and health standards in federal fiscal year 2003 were $2.3 million, about the same as in recent years.

Customer service

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

Loss-prevention services

From 1989 to 1999, workers' compensation insurers provided mandatory loss-prevention services

to employers who were identified by OR-OSHA as having at least three accepted disabling claims and a claims rate above the statewide average or having at least 20 claims. In July 1999, administrative rule changes required insurers to identify employers with a claims frequency greater than the average for its industry and offer loss-prevention services. OR-OSHA continues to ensure that employers are offered these services by their workers' compensation carriers.

Partnerships with stakeholders

OR-OSHA collaborates with groups, including business organizations and labor unions, to design better safety and health programs for workers. In conjunction with the construction industry, OR-OSHA developed the Joint Emphasis Program. Its purpose is to reduce injuries and fatalities in the construction industry by designing joint training sessions and to communicate solutions to safety problems.

The Governor's Occupational Safety and Health Awards are given at a biennial conference co-sponsored by OR-OSHA and the American Society of Safety Engineers Columbia-Willamette Chapter. Individuals and organizations are nominated by peers. There are several award categories, including small business, new business, and safety committees.

Industry representatives and OR-OSHA staff, serving together on the Forest Activity Committee, developed the new Oregon Administrative Rules for safety and health in forest-related industries. The new Division 7 rules became effective December 1, 2003.

Accepted disabling claims, employment, and claims rates, 1987-2003

Year	Accepted disabling claims	Employment	Claims rate
1987	41,033	1,105,200	3.7
1988	43,660	1,161,100	3.8
1989	39,170	1,214,900	3.2
1990	35,857	1,258,600	2.8
1991	31,479	1,258,600	2.5
1992	30,786	1,280,500	2.4
1993	30,741	1,317,100	2.3
1994	31,530	1,378,800	2.3
1995	30,564	1,431,600	2.1
1996	28,389	1,487,300	1.9
1997	27,922	1,547,800	1.8
1998	27,049	1,576,100	1.7
1999	25,802	1,602,700	1.6
2000	25,365	1,627,600	1.6
2001	24,645	1,617,000	1.5
2002	23,482	1,597,100	1.5
2003	21,832	1,583,500	1.4

The number of accepted disabling claims has declined nearly every year since 1988. The number declined four percent per year during the 1990s, while employment grew. The number has declined five percent per year since 2000, while employment has shrunk. There were half as many ADCs in 2003 as in 1988.

The claims rate (the number of accepted disabling claims per 100 workers) in 2003 was 1.4, 37 percent of the 1988 value.

Note: The 2003 employment figure and claims rate are preliminary.

Permanent partial disability claims, 1987-2003

Year	PPD claims	PPD rate
1987	12,877	1,165
1988	12,336	1,062
1989	13,800	1,136
1990	13,731	1,091
1991	9,980	793
1992	9,562	747
1993	9,349	710
1994	9,529	691
1995	9,491	663
1996	9,060	609
1997	8,064	521
1998	7,764	493
1999	7,461	466
2000	7,099	436
2001	7,064	437
2002	6,914	433
2003	6,391	403

The number of accepted disabling claims for which permanent partial disability has been awarded has declined nearly every year since 1989. The PPD rate (claims with PPD awards per 100,000 workers) has declined 64 percent since 1989.

Note: PPD claims are reported by the year of the first PPD award.

Compensable fatalities, 1987-2003

Year	Compensable fatalities	Fatality rate
1987	78	7.1
1988	81	7.0
1989	75	6.2
1990	64	5.1
1991	65	5.2
1992	63	4.9
1993	64	4.9
1994	55	4.0
1995	48	3.4
1996	54	3.6
1997	43	2.8
1998	52	3.3
1999	47	2.9
2000	45	2.8
2001	34	2.1
2002	52	3.3
2003	41	2.6

There were 41 compensable fatalities in 2003, the second fewest ever recorded. The number of deaths has declined 47 percent from 1987 to 2003.

Yearly fatality counts often vary because of multiple-fatality incidents. In 2002, three incidents resulted in seven deaths. As a result, the number of fatalities was unusually high.

Note: The 2003 fatality rate is preliminary. The fatality rate is the number of compensable fatalities per 100,000 workers.

Occupational injuries and illnesses incidence rates, Oregon private sector, 1987-2003

Year	Total cases IR	Lost workday cases IR	DART rate
1987	10.9	5.6	-
1988	11.1	5.6	-
1989	10.6	5.2	-
1990	10.1	4.8	-
1991	9.1	4.4	-
1992	9.1	4.4	-
1993	9.0	4.4	-
1994	8.7	4.2	-
1995	8.8	4.1	-
1996	7.8	3.8	-
1997	7.8	3.6	-
1998	6.9	3.4	-
1999	7.0	3.5	-
2000	6.3	3.1	-
2001	6.2	3.2	-
----------> Series break			
2002	6.0	-	3.2
2003	5.6	-	3.1

Both the lost workday cases incidence rate and total cases incidence rate declined 43% between 1987 and 2001.

Beginning with the 2002 survey, the rates are based on the Occupational Safety and Health revised requirements for recording occupational injuries and illnesses. Due to the revised requirements, the rates from the 2002 survey are not comparable with those of prior years.

Also, the lost workday cases IR was replaced by the DART ("Days away from work, job transfer or restricted duty") rate. This measure is not comparable to the LWDCIR.

Note: Incidence rates are the number of cases per 100 workers.

Industry total cases incidence rates, 1987-2001

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
2000	7.2	9.0	9.2	6.1
2001	8.4	8.9	8.1	7.5

Four industry divisions had declines in total cases incidence rates between 1987 and 2001. The decline ranged from 34 percent in transportation/public utilities to 52 percent in manufacturing.

Note: Changes to the survey in 2002 and 2003 mean that rates for these years are not comparable to earlier rates. The 2003 rates are based on the new NAICS industry classification system rather than the older SIC system. Therefore, 2002 and 2003 figures are not included in this table.

OR-OSHA inspections, federal fiscal years 1988-2003

Federal fiscal year	Inspections	Workers covered by inspections	Percent in compliance
1988	5,697	147,414	23.2%
1989	5,134	167,359	24.2%
1990	4,828	158,235	21.4%
1991	5,506	164,405	18.8%
1992	5,737	201,682	17.7%
1993	5,614	248,172	20.1%
1994	5,023	263,103	21.0%
1995	5,470	227,412	25.2%
1996	5,181	195,375	26.2%
1997	4,555	182,058	28.2%
1998	5,172	152,324	28.0%
1999	5,435	168,258	30.7%
2000	5,069	165,151	28.2%
2001	5,370	197,722	27.8%
2002	5,643	196,198	26.1%
2003	5,355	217,724	26.4%

The number of OR-OSHA inspections has fluctuated, with an overall decrease of six percent from federal fiscal year 1988 to FFY 2003 (the federal fiscal year begins each October).

Inspections are classified in several ways. The broadest category identifies each inspection as either a safety inspection or a health inspection. In FFY 2002 and FFY 2003, 85 percent were safety inspections.

Some inspections result in a citation (violations of Oregon or federal standards found at the worksite) and some do not. When there are no violations of safety or health rules, the inspection is called "in compliance." The percentage of in-compliance inspection fluctuates from year to year; it was 26 percent in FFY 2003.

OR-OSHA citations, violations, and proposed penalties, federal fiscal years 1988-2003

Federal fiscal year	Citations	Violations	Penalties ($ millions)
1988	4,368	15,735	$1.9
1989	3,891	12,353	1.5
1990	3,796	14,023	2.8
1991	4,472	17,122	2.8
1992	4,719	19,409	3.2
1993	4,486	17,619	4.7
1994	3,970	15,292	4.6
1995	4,093	15,303	5.8
1996	3,823	12,434	2.9
1997	3,269	10,359	3.9
1998	3,725	11,366	2.4
1999	3,767	11,433	3.0
2000	3,642	11,094	2.3
2001	3,879	12,701	2.4
2002	4,170	12,703	2.1
2003	3,940	11,699	2.3

OR-OSHA issues a citation to an employer when one or more violations of Oregon or federal standards are found. The penalties listed are the initial or proposed penalties levied when the citation was issued and do not reflect changes made due to the settlement of an appeal.

The average number of violations per citation has changed little since 1983. The average number prior to 1996 was four violations per citation; the average since has been three.

The average number of serious violations per citation has varied even less since 1988, with the average consistently close to one.

OR-OSHA consultations, 1988-2003

Year	Number of consultations	Workers reached	Participants in voluntary compliance programs: SHARP	VPP
1988	502	N/A	-	-
1989	671	N/A	-	-
1990	943	102,739	-	-
1991	1,741	250,623	-	-
1992	2,492	342,696	-	-
1993	2,089	249,387	-	-
1994	2,482	256,604	-	-
1995	2,153	231,113	-	-
1996	1,854	233,732	4	-
1997	1,828	153,922	9	1
1998	2,050	219,565	24	2
1999	2,128	233,675	42	3
2000	2,505	241,965	50	4
2001	2,828	260,709	69	4
2002	2,457	219,430	74	6
2003	2,063	230,575	79	9

OR-OSHA's consultation services help Oregon employers identify hazards and work practices that could lead to injuries or illnesses. These services include the time-intensive process of assisting interested employers during the stages of qualifying for the SHARP or VPP program.

SHARP is a recognition program that provides incentives for Oregon employers to work with their employees to find and correct hazards, and to develop effective safety and health programs.

The Voluntary Protection Program was initiated by federal OSHA as a way to encourage employers to exceed minimum OSHA requirements. VPP is a process that defines a structured approach to working more safely. The key areas are management leadership and employee involvement, worksite analysis, hazard prevention and control, and safety-and-health training.

Safety and health training programs, 1998-2003

Year	Attendance at training sessions
1998	15,494
1999	27,104
2000	19,069
2001	26,478
2002	15,844
2003	26,290

OR-OSHA has provided education and training to over 121,000 workers and employers since 1998. These educational forums provide an opportunity to share ideas on occupational safety and health with national experts. The increases in attendance every other year are due to the Governor's Occupational Safety and Health Conference, which is held in odd-numbered years. Conferences are coordinated and presented in partnership with businesses, associations, labor unions, etc.

In 2003, in addition to the GOSH conference, there were four conferences held around Oregon. They addressed a variety of safety and health issues.

In addition to conferences, the Public Education Section offers over 500 workshops and on-site trainings annually.

OR-OSHA safety and health grant programs, 1989-2003

Biennium	Grants	Total awarded
1989-1991	11	$309,658
1991-1993	9	271,008
1993-1995	12	342,780
1995-1997	12	370,595
1997-1999	9	286,463
1999-2001	9	272,150
2001-2003	11	388,517

In existence since 1989, OR-OSHA's Training and Education Grants program has awarded 73 grants totaling $2.2 million dollars to help organizations develop education and training programs that reduce or eliminate hazards in an entire industry or in a specific work process. The maximum grant award is $40,000.

Examples of programs that have received grants are pictograms for training mentally challenged individuals about hazards in the workplace, a CD-ROM interactive training program on preventing attacks by vicious dogs, a dairy farmers' checklist and video, and lifting guidelines.

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

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

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

In 2001, Senate Bill 5507 eliminated funding for the Worksite Redesign Program. The legacy of this program remains in the projects and products developed with the grant funds such as the mobile scissors lift developed to prevent worker injuries associated with handling heavy steel parts and the automated hinge applicator developed by an employer to prevent repetitive and forceful movements while assembling doors.

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%

Prior to July 1999, insurer loss-prevention services had to be offered to employers with three or more accepted disabling claims and a claims rate above the statewide average or with at least 20 claims. OR-OSHA identified the employers. The percentage of employers meeting these conditions remained about the same from 1992 to 1996; it then declined to a low of 1.6 percent in 1999.

Since July 1999, each insurer must offer loss-prevention services to employers with a claims frequency greater than the average for the same industry. Insurers are responsible for identifying the employers who meet the criteria. OR-OSHA audits workers' compensation carriers to ensure these services are provided, but the number of employers receiving the services is no longer tracked.

Employers' safety committee citations, violations, and penalties, fiscal years 1990-2003

Fiscal year	Citations	Violations	Proposed penalties
1990	128	131	$13,040
1991	220	233	24,455
1992	891	1,022	61,455
1993	781	963	49,410
1994	752	925	60,930
1995	820	980	146,070
1996	703	858	102,835
1997	718	878	74,635
1998	848	953	139,855
1999	817	1,168	131,890
2000	679	1,046	150,305
2001	816	1,274	174,010
2002	958	1,420	179,085
2003	956	1,206	141,135

In 1990, SB 1197 required safety committees for employers with more than 10 employees and defined situations in which employers with fewer than 10 employees would be required to have safety committees.

The importance of safety committees is reinforced in OR-OSHA through a standardized approach to working with employers about safety committees.

In 1999, the Small Construction Employer Safety Committee Program was developed. This gives construction employers with 10 or fewer employees an alternative method of meeting the safety-committee requirements. During an inspection, an employer in violation of a safety committee standard is given the opportunity to sign up for this program. The violation is cited as an Order to Correct with no penalty as long as the employer fulfills the requirements. These orders are reflected in violation counts since 1999. In 2002, this program was extended to small employers in all industries except logging.

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 workers' compensation costs. Since 1987, Oregon's reforms have tightened the requirements for establishing that an injury, disease, or aggravation claim is work related.

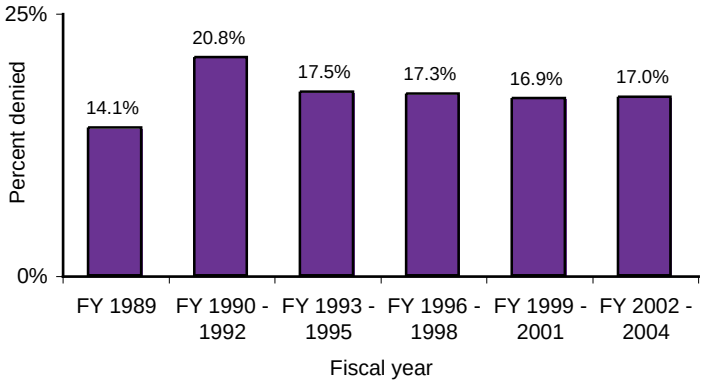
Mental stress

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

Claim denial rates

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

Figure 6. Percentage of disabling claims denied, FY 1989-2004



Definition of compensability

In 1990, SB 1197 changed the definitions of compensability of injuries and diseases. A compensable injury must 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 are excluded. Injuries arising from the use of alcohol or drugs are 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 partly responsible for the decrease in claims.

The reforms also allowed insurers to deny an 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 only. The number of aggravation claims dropped 68 percent between 1991 and 2003.

Major contributing cause

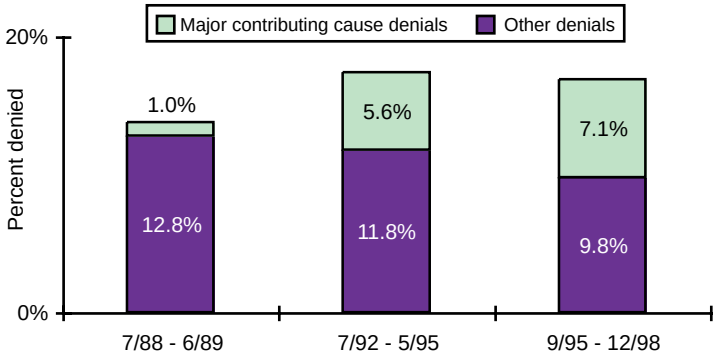
The 1999 legislature allocated funds for a study of the effects of changes in the compensability language. The primary focus was the major contributing cause language that was added to the statute through SB 1197 in 1990 and revised by SB 369 in 1995. Legislators were interested in learning how these changes affected workers' compensation costs and worker benefits. Because the statute requires physicians to determine the extent to which a medical condition is due to the compensable injury, the legislature also wanted to know if physicians could accurately make such decisions. A final goal of the study was to look at the major contributing cause language in combination with the exclusive remedy language for denied claims. In part, the legislature commissioned the study because of a case before the Oregon Supreme Court, *Smothers v. Gresham Transfer, Inc.* In this case, it was asserted that the combination of the major contributing cause language and the exclusive remedy language unconstitutionally denied injured workers with pre-existing medical conditions a legal remedy for their injuries.

The department contracted with the Workers' Compensation Center at Michigan State University to complete the study. The center 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.

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

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

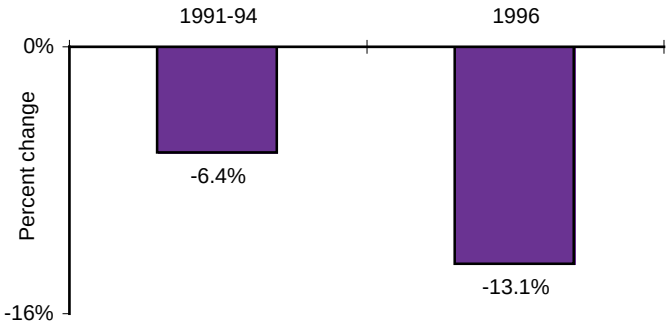
Figure 7. Major contributing cause study: percentage of disabling claims initially denied



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

Finally, the researchers conducted a law review of comparable statutes and legal decisions in other states. The review showed that the major contrib-

Figure 8. Major contributing cause study: benefit changes due to statute amendments



uting cause standard was also used in three other states. The standard was the strictest standard for compensability used by any state. Courts in other states have generally ruled that when workers' compensation benefits are denied to a certain group of claims, the claimants are not restricted by exclusive-remedy clauses. Therefore, these workers are allowed to file civil actions against their employers. This suggested that if the Oregon Supreme Court ruled in the same manner as other courts, they would find portions of Oregon's workers' compensation law unconstitutional.

Smothers v. Gresham Transfer, Inc.

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

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

It was expected that the Smothers decision would have a significant impact on workers' compensation costs. As of December 2004, few of these cases have proceeded to trial, and none have resulted in a verdict for the claimant. Some cases have reached civil settlements for confidential amounts; the numbers and dollar amounts of these cases are low.

Home health workers

In 2003, a collective bargaining agreement was reached that made home health workers eligible for workers' compensation beginning April 1, 2004. Homebound seniors and disabled people employ approximately 13,000 home health workers to help with dressing, bathing, housekeeping, and other daily activities. These workers are usually not covered by workers' compensation insurance. The bargaining agreement provides these workers the right to medical health insurance. However, no health insurer would underwrite policies without separate coverage for work-related injuries. The Oregon Department of Administrative Services, the Department of Human Services, and SAIF worked out a solution in which SAIF would underwrite the policy for these workers. DHS is paying the workers' compensation premiums, so the employing individual does not bear the cost. HB 5030 provides about $25 million dollars to DHS's biennium budget to fund the contract.

Between April and November 2004, the Workers' Compensation Division received notice of 89 workers' compensation claims for these covered home health workers.

Total reported claims, FY 1989-2004

Fiscal year	Accepted disabling	Denied disabling	Percent denied disabling	Denied non-disabling
1989	40,515	6,640	14.1%	8,022
1990	35,918	9,534	21.0%	10,551
1991	31,156	8,024	20.5%	12,426
1992	28,577	7,522	20.8%	12,930
1993	29,125	6,013	17.1%	13,414
1994	29,731	6,235	17.3%	13,251
1995	29,740	6,535	18.0%	13,377
1996	27,373	5,958	17.9%	14,118
1997	26,918	5,515	17.0%	14,759
1998	26,032	5,354	17.1%	14,962
1999	24,857	5,244	17.4%	14,683
2000	24,405	4,899	16.7%	13,742
2001	23,850	4,717	16.5%	13,876
2002	22,126	4,704	17.5%	12,990
2003	21,493	4,380	16.9%	11,751
2004	19,949	3,975	16.6%	10,320

The number of denied nondisabling claims has increased 29 percent since FY1989. In FY 1989, 45 percent of the denials were denials of disabling claims; in FY 2004, 28 percent of the denials were denials of disabling claims.

Notes: With few exceptions, insurers do not report accepted non-disabling claims to the department.

SB 914 in 2003 removed the requirement that insurers report claims to the department within 21 days of receiving the claim. This took effect January 1, 2004. This change delays reporting, which probably reduced FY 2004 claim counts by three to four percent.

Disabling occupational disease claims, FY 1989-2004

Fiscal year	Accepted	Denied	Percent denied
1989	3,980	2,041	33.9%
1990	3,496	2,761	44.1%
1991	3,068	2,115	40.8%
1992	3,101	2,293	42.5%
1993	3,212	1,941	37.7%
1994	3,289	2,039	38.3%
1995	3,384	2,083	38.1%
1996	3,247	1,926	37.2%
1997	3,349	1,905	36.3%
1998	3,180	1,685	34.6%
1999	2,766	1,597	36.6%
2000	2,890	1,479	33.9%
2001	3,210	1,582	33.0%
2002	3,142	1,780	36.2%
2003	3,186	1,597	33.4%
2004	2,852	1,613	36.1%

In fiscal years 1990-1992, the denial rate for disabling claims for occupational disease was 43 percent. The denial rate has continued to decline slowly, averaging 35 percent over the past five fiscal years.

Accepted disabling claims for mental stress, 1987-2003

Year	Accepted stress claims	Stress claims per 1,000 ADC
1987	196	4.78
1988	176	4.03
1989	87	2.22
1990	71	1.98
1991	75	2.38
1992	66	2.14
1993	71	2.31
1994	76	2.41
1995	75	2.45
1996	79	2.78
1997	66	2.36
1998	48	1.77
1999	60	2.33
2000	64	2.52
2001	53	2.15
2002	54	2.30
2003	47	2.15

The number of accepted disabling claims for mental stress dropped 56 percent between 1987 and 1989. This reduction was a result of legislative reform passed in 1987. HB 2271 restricted mental stress claims to those emerging from real and objective employment conditions that are not a part of every working scenario. There must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. Since 1989, the number of stress claims per 1,000 accepted disabling claims has remained fairly constant.

Almost a third of the accepted disabling claims for mental stress between 1995 and 2003 were the result of assaults or violent acts.

Disabling aggravation claims, 1991-2003

Year	Accepted	Denied	Percent denied
1991	2,042	1,675	45.1%
1992	2,201	1,514	40.8%
1993	2,099	1,337	38.9%
1994	1,915	1,171	37.9%
1995	1,593	907	36.3%
1996	1,565	950	37.8%
1997	1,351	993	42.4%
1998	1,172	763	39.4%
1999	1,038	730	41.3%
2000	876	618	41.4%
2001	902	575	38.9%
2002	773	535	40.9%
2003	717	483	40.3%

There were 1,200 aggravation claims in 2003. The number of claims has dropped nearly every year since 1991, and the 2003 figure is 32 percent of the 1991 figure. Forty percent of the aggravation claims were denied.

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, claims decisions and initial time-loss payments were too slow, and delays in claim closure resulted in unrecoverable overpayments by insurers. These factors contributed to a claims-processing environment that fostered litigation.

Claims examiners

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

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

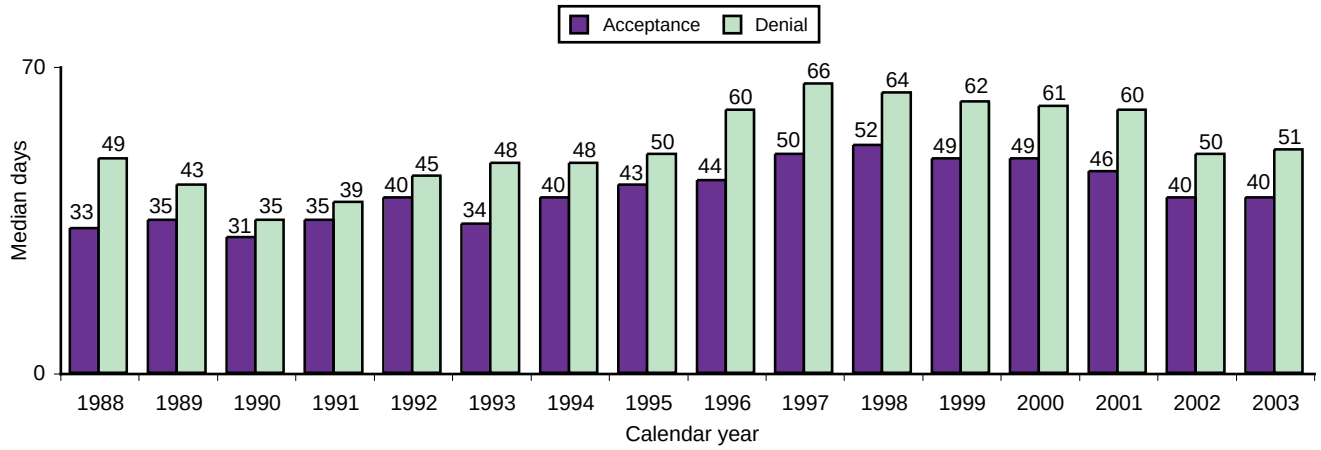
Claim acceptance or denial

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

The increased length of time until a compensability decision resulted in longer periods of uncertainty for workers and for the medical providers who had served injured workers. In 2001, as part of SB 485, the legislature reduced the allowable time for acceptance or denial from 90 back to 60 days. This has had some effect on the average time for compensability decisions. In 2003, the median number of days to accept a claim was 40.

With SB 914, the 2003 legislature dropped the requirement for insurers to notify the department within 21 days of receiving a claim. The insurers are now required to report to the department within 14 days of their acceptance decision. This was done as a part of an effort to streamline reporting requirements.

Figure 9. Median calendar days from employer knowledge to claim acceptance or denial, 1988-2003



Modified acceptances

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

In 1999, in the *Johansen v. SAIF Corporation* decision, the Court of Appeals ruled that there are no time limits for liability on a new condition, a condition other than the ones previously accepted. In SB 485, the legislature refined the procedure for these conditions. A worker must request formal written acceptance of a new or omitted medical condition. The insurer then has 60 days to accept or deny the condition. For disabling claims, the period of aggravation rights extends five years after the first closure. If compensable new conditions arise during this period, the insurer pays the claim costs. If the new condition arises after the aggravation period and the insurer doesn't voluntarily accept the claim, the worker must pursue the claim through the Workers' Compensation Board's own-motion process. If the condition is found compensable, benefits are paid from the Workers' Benefit Fund.

Temporary disability benefits

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

SB 485 does two things to protect employers and insurers from the cost of these added benefits. For employers, the supplementary benefits paid cannot be used for ratemaking, for an employer's rating, or for dividend calculations. Insurers may pay the supplemental benefits; if they do, the department reimburses the insurer for the benefits and its administrative costs from the Workers' Benefit Fund. If the insurer chooses not to pay the benefits, the department pays them directly.

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

In 2003, HB 3669 expanded the authority of nurse practitioners to approve temporary disability benefits for workers on initial claims for up to 60 days and medical services for up to 90 days. If a worker becomes medically stationary during the 90 days, the nurse practitioner must refer the worker to an "attending physician" for a determination of impairment. The bill also required the division to develop informational materials for nurse practitioners. Beginning October 1, 2004, nurse practitioners must certify that they have reviewed the materials to continue providing these expanded services.

Claims closure

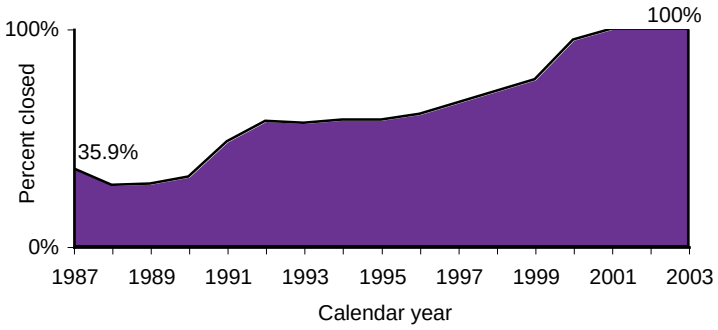
Prior to 1987, only the department could close a claim and rate permanent disability. The 1987 reforms allowed insurers to close permanent disability claims if the worker had returned to work. At the same time, the department was permitted to promulgate disability standards; the insurer had to use these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

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

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

After peaking in 1990, the median number of days from injury to first closure declined quickly, from 184 days in 1990 to 148 days in 1993. In five of the past six years, the median has been between 154 and 157 days.

Figure 10. Percentage of claims closed by insurers, 1987-2003



Insurer performance

Insurer performance, measured by the timeliness of making first payments and accepting or denying claims, improved between 1990 and 1993. Insurer performance has since leveled off.

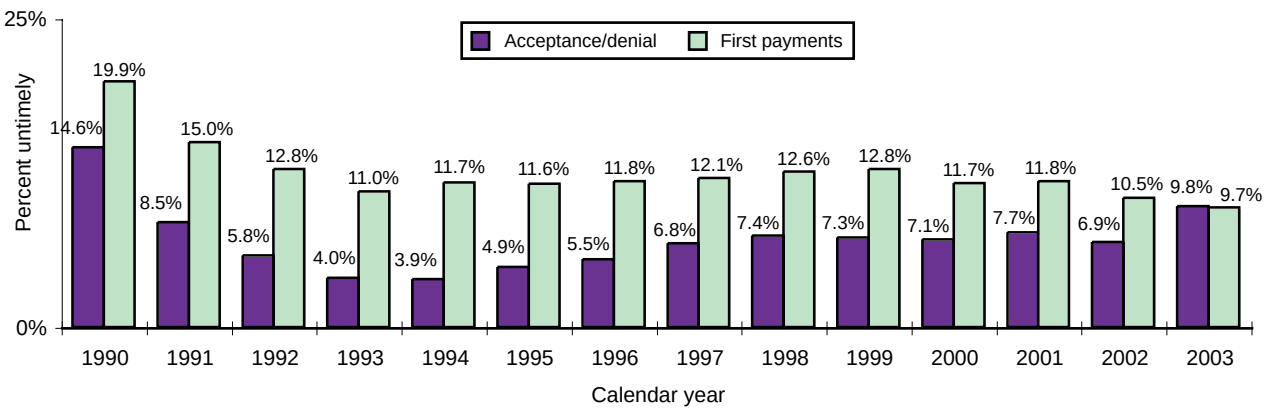
In 1990, the legislature changed the venue for penalties against insurers for unreasonable claims denial or delay in benefits. Before then, a worker seeking a penalty against an insurer had to request a hearing at the board. This was changed by SB 1197. If the sole issue is whether the insurer has unreasonably delayed benefits, the worker files a request for penalty with WCD, and the issue is resolved through an administrative process.

The department issues civil penalties to those insurers and self-insured employers who do not meet acceptable standards. The number of citations issued peaked in 2003 with more than triple the number issued in 1990. In 2003, the penalty amounts for these citations totaled almost $344,000, much more than in the past.

System abuse

Through reforms, the department expanded its efforts to eliminate abuse of the workers' compensation system. The Workers' Compensation Division has a toll-free phone line that allows the public to report abuses. WCD investigates allegations of inappropriate actions by employers, medical providers, insurers, workers, and other parties. Forty-six investigations of fraud or abuse complaints were opened in fiscal year 2004. The most frequent complaints received were employers pressuring employees not to file claims; improper claims processing by insur-

Figure 11. Insurer timeliness of acceptance or denial and of first payments, 1990-2003



ers or medical providers; and failure to report/improper reporting of claims-related documents by employers, insurers, and medical providers. (The procedure for counting investigations changed in fiscal year 2002. The current procedure excludes from counts those inquiries that did not require WCD to issue a director's order or warning notice and that were usually resolved within hours of receipt. These inquiries were typically resolved with educational counseling, referred to other agencies, or dropped after callers withdrew their complaints. In 2004, there were 144 such inquiries.)

Workers' compensation information line

The Workers' Compensation Division has a workers' compensation information line for staff to answer workers' questions about their claims, describe workers' rights and responsibilities, and help them understand the workers' compensation system. In 2003, there were more than 17,200 calls to the line. Of the callers, about 9,800 were workers and about 7,400 were insurers, medical providers, attorneys, employers, legislators, and others.

Workers' compensation claims examiners certified, FY 1991-1999

Fiscal year	Examiners certified	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 by the department. Many of the later certificates were issued for examiners being re-certified for another two-year period. At the end of the program, November 22, 1999, there were 1,342 certified examiners.

Insurers are now required to ensure the quality of their examiners.

Insurer closures and total closures, 1987-2003

Year	Insurer closures	Total closures	Percent insurer 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	35,657	58.2%
1996	20,583	33,784	60.9%
1997	20,924	31,649	66.1%
1998	22,051	30,789	71.6%
1999	22,185	28,898	76.8%
2000	26,240	27,637	94.9%
2001	26,961	26,961	100%
2002	25,411	25,411	100%
2003	23,874	23,874	100%

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

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

Time lag from injury date to first closure, 1987-2003

Year	Average days	Median days
1987	255	169
1988	260	170
1989	271	181
1990	277	184
1991	271	176
1992	241	152
1993	231	148
1994	229	151
1995	232	155
1996	228	153
1997	224	150
1998	222	156
1999	225	156
2000	230	154
2001	244	161
2002	247	157
2003	243	157

The average and median days from injury to first closure peaked in 1990. The average dropped 20 percent from 1990 to 1998; since then, it has risen nine percent to 243 days in 2003.

The median number of days has remained fairly stable over the past six years.

Insurer claim acceptance and denial, median time lag days, 1988-2003

Year	Accepted	Denied
1988	33	49
1989	35	43
1990	31	35
1991	35	39
1992	40	45
1993	34	48
1994	40	48
1995	43	50
1996	44	60
1997	50	66
1998	52	64
1999	49	62
2000	49	61
2001	46	60
2002	40	50
2003	40	51

SB 1197 in 1990 extended the time allowed for insurers to accept or deny a claim was extended from 60 to 90 days. SB 485 in 2001 reduced the allowed time to 60 days.

The median numbers of days to acceptance increased 68 percent from 1990 to 1998, but it began declining before the passage of SB 485. It was 40 days in 2003. The median for denied claims has followed a similar pattern.

An element of SB 914 dropped the requirement for insurers to report claims within 21 days of claim notice. Beginning in 2004, insurers are required to report claims to the department within 14 days of their acceptance decision. The intent was to lessen reporting requirements, perhaps leading to quicker compensability decisions.

Insurer timeliness of acceptance or denial and of first payments, 1990-2003

Year	Acceptance/denial timely	First payment timely
1990	85.4%	80.1%
1991	91.5%	85.0%
1992	94.2%	87.2%
1993	96.0%	89.0%
1994	96.1%	88.3%
1995	95.1%	88.4%
1996	94.5%	88.2%
1997	93.2%	87.9%
1998	92.6%	87.4%
1999	92.8%	87.2%
2000	92.9%	88.3%
2001	92.3%	88.2%
2002	93.1%	89.5%
2003	90.2%	90.3%

Insurer performance on timeliness of acceptance or denial of claims improved between 1990 and 1994. It has generally declined since, sliding to 90 percent in 2003.

In most years, 87 to 88 percent of first payments to claimants have been timely. In 2003, this figure improved to 90 percent.

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

Civil penalties issued, 1990-2003

Year	Citations	Penalty amount
1990	407	$158,325
1991	420	156,775
1992	506	163,101
1993	621	166,650
1994	679	197,025
1995	525	139,325
1996	491	140,850
1997	629	244,175
1998	813	254,925
1999	789	243,375
2000	844	248,875
2001	738	204,400
2002	947	301,900
2003	1,241	343,875

In 2003, the department issued 1,241 citations. The amount of these penalties exceeded $340,000.

Abuse complaint investigations, FY 1991-2004

Fiscal year	Opened	Closed
1991	243	223
1992	237	259
1993	342	398
1994	255	243
1995	250	253
1996	244	215
1997	211	194
1998	244	287
1999	231	222
2000	252	237
2001	220	259
----------> Series break		
2002	122	110
2003	60	60
2004	46	56

In FY 2004, 46 investigations were opened concerning inappropriate actions by employers, providers, insurers, workers, and other parties.

Note: In 2002, the procedure for counting investigations changed; counts prior to FY 2002 cannot be compared to more recent figures. The current procedure is to exclude from counts those inquiries that did not require issuing a director's order or warning notice and that were usually resolved within hours of receipt. In FY 2004, there were 144 such inquiries. They were typically resolved with educational counseling, referred to other agencies, or dropped after callers withdrew their complaints.

Workers' compensation information line calls for assistance, 1990-2003

Year	Worker calls	Other calls	Total calls
1990	23,263	N/A	N/A
1991	21,475	N/A	N/A
1992	15,181	N/A	N/A
1993	18,243	N/A	N/A
1994	19,678	7,575	27,253
1995	17,503	6,699	24,202
1996	16,938	7,701	24,639
1997	15,737	8,425	24,162
1998	14,960	8,098	23,058
1999	13,711	7,930	21,641
2000	12,155	6,490	18,645
2001	11,662	6,936	18,598
2002	10,000	7,056	17,056
2003	9,813	7,397	17,210

WCD has an information line to assist workers and others. In 2003, there were over 9,800 calls from workers with questions about their claims, the claims process, or the workers' compensation system. The line also received almost 7,400 calls from insurers, medical providers, attorneys, employers, legislators, and others.

Advocates and Advisory Groups

Injured workers and employers often find the workers' compensation system confusing or inaccessible. Oregon has recognized that the comprehensibility of and access to the system are essential features of success. Therefore, a number of advocates and advisory groups provide services and recommend policy.

Ombudsman for Injured Workers

The 1987 legislature created the office of the Ombudsman for Injured Workers as an independent advocate for injured workers who are seeking to resolve the disposition of their claims. Recognizing the value of the office, the legislature increased the staff during the 1990 special session. Legislation passed in 2003 clarified the supervision and control of ombudsman services and required that quarterly reports be submitted to the governor.

Since the creation of the office, the number of contacts with the office has increased nearly every year. In 2003, the office recorded over 56,700 contacts, eight percent more than in 2002. The office provided assistance to about 13,500 injured workers and 1,200 other people. The issues that prompted the most inquiries were benefits, medical issues, claims processing, and settlements.

Small Business Ombudsman

The office of Small Business Ombudsman for Workers' Compensation was created during the 1990 special session to serve as an advocate for and to educate small businesses. The aim of the SBO is to be the resource center for employers needing information about the workers' compensation system, resolving disputes between employers and insurers, providing educational seminars and trade shows, and assisting all parties. The office had 4,085 inquiries in 2003, about the annual average for the past five years.

Figure 12. Ombudsman for Injured Workers contacts, 1988-2003

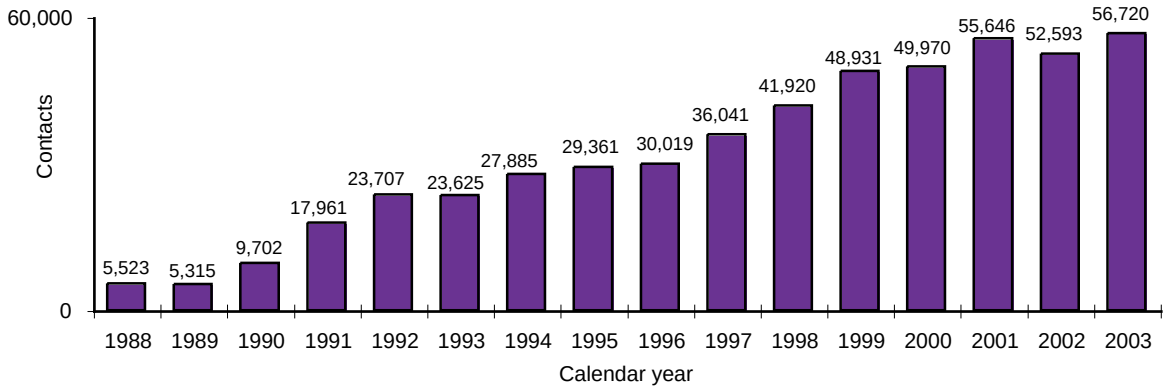
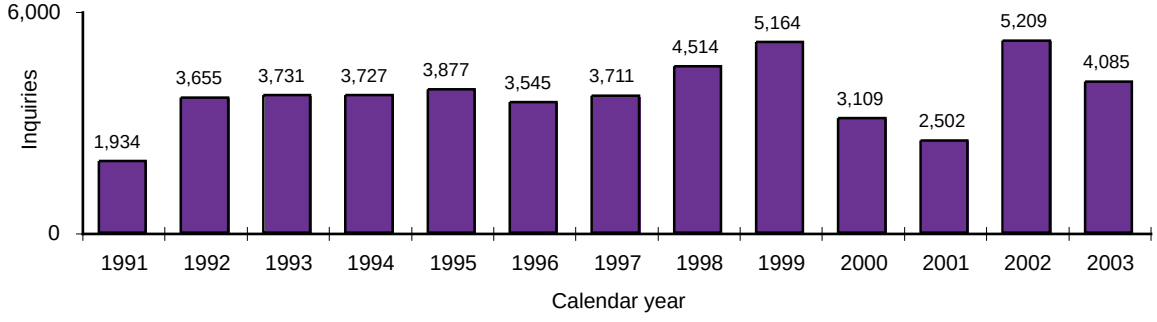


Figure 13. Small Business Ombudsman inquiries, 1991-2003



Innovations in Workers' Compensation

The 1990 special session also established the Joint Legislative Task Force on Innovations in Workers' Compensation. The task force was directed to re-examine the role of the workers' compensation system and to develop recommendations for a more fair and cost-effective system. The task force recommended a number of bills that would allow for the development of alternatives to the current workers' compensation insurance system. The principal alternative was to allow for employers to provide combined 24-hour health insurance and indemnity benefits rather than the traditional workers' compensation coverage.

Legislation to implement a 24-hour coverage pilot program was passed in August 1993. The legislation authorized the director to approve pilot plans by July 1994 and to operate the program until July 1998. By the end of 1995, there were just 14 participating employers. The department phased out the program after a 1996 program evaluation found that the low enrollment was due largely to Oregon's success in curtailing workers' compensation costs.

Medical Advisory Committee

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

Management-Labor Advisory Committee

In recognition of the success of the governor's labor-management committee in crafting the 1990 reforms, the legislature created the Management-Labor Advisory Committee. This committee reaffirms that labor and management are the principal parties in the workers' compensation system. The committee advises the department on workers' compensation matters such as administrative rules and legislation. In 1995, SB 369 reduced the membership of MLAC from 14 to 10 members and included mandatory reporting on several issues: court decisions having significant impact on the workers' compensation system, the adequacy of workers' compensation benefits, medical and system costs, and the adequacy of assessments for reserve programs and administrative costs. In 2003, the legislature removed the requirement that MLAC review temporary rules that establish disability rating standards for individual claims.

Since the 2003 session, MLAC has been studying vocational assistance and return-to-work programs, permanent total disability awards, and insurer medical exams. Legislative proposals for the 2005 session may come from these studies.

Medical Privacy Advisory Committee

The 2001 legislature created the Advisory Committee on Privacy of Medical Information and Records. The committee reviewed state and federal laws concerning the privacy of medical information. The purpose was to see if state law conflicted with federal law, especially the federal Health Insurance Portability and Accountability Act of 1996. HIPAA excludes workers' compensation medical coverage, so the committee advanced few proposals. It was later disbanded.

Ombudsman for Injured Workers activities, 1988-2003

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	-	140
1998	41,920	-	311
1999	48,931	-	420
2000	49,031	-	939
2001	55,646	-	320
2002	52,593	-	1,116
2003	56,720	-	977

The contacts with the Ombudsman for Injured Workers come primarily from injured workers, but they are also initiated by attorneys, insurance companies, employers, and others. There were over 56,700 inquiries in 2003, eight percent more than in 2002.

The aim of ombudsman outreach programs is to provide educational and informational seminars to insurance companies, labor groups, and others interested in workers' issues.

Note: The procedure for counting contacts since 1997 is to count all telephone calls, mail contacts, and walk-ins. This differs from the pre-1997 procedure, so pre-1997 counts are not comparable to the recent figures.

Ombudsman for Injured Workers, percent of inquiries by major issue group, 2000-2003

Major issue group	2000	2001	2002	2003
Attorney	1.5%	1.6%	2.0%	2.3%
Benefit	21.7%	21.9%	20.7%	19.4%
Claim processing	18.0%	17.2%	18.1%	18.2%
Denials	7.1%	6.7%	7.2%	7.0%
Medical	14.3%	14.6%	14.2%	16.2%
Orders & appeals	7.9%	7.8%	8.7%	9.6%
Settlements	12.4%	9.3%	8.4%	10.2%
Unable to contact	2.0%	3.6%	3.3%	1.3%
Work release	6.9%	6.8%	7.1%	7.3%
Other issues	8.3%	10.4%	10.4%	8.5%

From 2000 through 2003, about 54 percent of all new inquiries resulted from issues in three groups: benefits, claim processing, and medical issues. Benefits issues include time loss and insurer issues. Claims processing issues include claim acceptance and payment. Medical issues include medical treatment rights and problems with medical bills.

Small Business Ombudsman activities, 1991-2003

Year	Contacts	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	-	540
1999	5,164	-	855
2000	3,109	-	1,952
2001	2,502	-	1,824
2002	5,209	-	1,890
2003	4,085	-	-

The office of Small Business Ombudsman was created in 1990. The number of inquiries peaked in 1999 and 2002, but declined 22 percent in 2003.

Note: Data collection on outreach program contacts was discontinued in 2003.

Medical Care and Benefits

During the 1980s, the rapidly increasing cost of medical care was a major cost driver of many state workers' compensation systems. This trend was also prevalent in the general health-care market, but the problem was worse in workers' compensation because there were few cost controls. While medical providers have long been required to charge workers' compensation insurers the same fees as for other patients, there were few mechanisms to control unnecessary utilization of diagnostic tests and treatments. In 1990, the legislature implemented numerous changes.

Palliative care

In 1990, Senate Bill 1197 eliminated most palliative care after the worker becomes medically stationary. Palliative care is treatment to relieve symptoms rather than to improve the worker's underlying condition. These restrictions had an immediate impact on workers who had been receiving ongoing palliative treatment. 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 reform.

In 1995, SB 369 restored a worker's right to request approval for a broader range of care after being declared medically stationary. Workers can receive palliative care if they have permanent total disability, to monitor and care for prescription medication or a prosthetic device, or when the attending physician believes the palliative care is necessary for continued employment.

Attending physicians

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

In 2003, HB 3669 expanded the role of nurse practitioners, allowing them to perform some functions of attending physicians. It allows certified nurse practitioners to treat injured workers for up to 90 days, authorize time loss for up to 60 days, and to release workers to their jobs.

Utilization and treatment standards

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

Twenty-four-hour coverage

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

By the end of 1995, only five approved plans had enrollments, and there were just 14 participating

employers. A 1996 program evaluation found that the low enrollment was due largely to Oregon's success in curtailing workers' compensation costs. While employers remained curious about the 24-hour coverage, the declines in both workers' compensation costs and the rate of growth in group health costs had reduced their interest in the program. Enrollment was insufficient to measure the program's success, and the department phased it out.

Fee schedules

The Workers' Compensation Division has had medical services fee schedules since 1982. Over time, new schedules have been added through administrative rules. Medical fee schedules now include anesthesiology, surgery, radiology, laboratory and pathology, medicine, physical medicine and rehabilitation, evaluation and management, multi-disciplinary services and other Oregon-specific codes, durable medical equipment and medical supplies, and pharmacy. The medical fee schedules establish the maximum allowable reimbursement (ceiling) for services. From 1986 to 1995, the ceiling was set at the 75th percentile of usual and customary fees. However, with SB 369 of 1995, new fee schedules were to represent the reimbursement generally received for services provided in the general health care industry. In 1997, the department also adopted the Federal Resource Based Relative Value Schedule. The RBRVS is used to determine the maximum level of reimbursement for medical services covered by the fee schedule.

In 1999, WCD set the fee schedule for durable medical equipment and medical supplies at 85 percent of the manufacturers' suggested retail price. WCD set the fee schedule for pharmacy at 95 percent of the average wholesale price of the drug, plus a $6.70 dispensing fee. In 2004, WCD adjusted the pharmacy fee schedule to 88 percent of the AWP and an $8.70 dispensing fee. The adjustment also placed some limits on the payment for Oxycontin, Vioxx, Celebrex, and Bextra.

WCD implemented a hospital fee schedule using adjusted cost-to-charge ratios in 1991. In July 1992, the department began publishing revised CCRs semi-annually for all general, acute-care hospitals in the state. (The term "hospital," as defined by the Office for Oregon Health Policy and Research, is used to determine which facilities are legally considered hospitals. Specialty hospitals, such as rehabilitation centers, psychiatric hospitals, and juvenile hospitals, are excluded from these regulations.) The CCR is the percentage of the hospital bill for which insurers reimburse Oregon hospitals for treating injured workers. The computation of the CCR uses each hospital's audited financial statement and Medicare cost report. The ratio allows all hospitals to recover the cost of providing facility-related services to injured workers, a reasonable rate of return on their capital asset base, and an allowance for bad debt and charity losses. The CCR is revised annually based on the hospital's fiscal year and is published twice yearly.

Oregon hospitals designated as rural hospitals by the Office of Rural Health may be excluded from imposition of the CCR. This exclusion is based on a determination of economic necessity, which is determined from financial reports, or upon designation as a critical-access hospital under the Oregon Medicare Rural Hospital Flexibility Program.

Managed care organizations

The 1990 reforms introduced managed care into the Oregon workers' compensation system. SB 1197 allowed workers' compensation insurers to contract with department-certified managed care organizations and set the rules under which covered workers must obtain treatment within MCOs. Each MCO contracts with medical providers who agree to the MCO's terms and conditions. In return, these providers have the opportunity to treat the covered workers. The terms and conditions differ by MCO, but they must include treatment and utilization standards and peer review. Each panel of providers must include eight types of medical service providers: chiropractors, naturopaths, acupuncturists, osteopaths, dentists, optometrists, podiatrists, and physicians.

Insurers may enroll injured workers covered by MCO contracts in managed care. The insurers notify injured workers that they must seek any future treatment from providers who are on the MCO's panel. Since 1995, insurers are allowed to require injured workers to receive medical treatment in the MCO prior to the determination of claim acceptance or denial. If the insurer denies the claim,

however, the insurer must pay the medical costs until the worker receives notice of the denial or until three days after the denial notice is received. Insurers that do not enroll workers in an MCO are not required to pay medical services if the claim is eventually denied.

As of June 30, 2004, seven certified MCOs had contracts with workers' compensation insurers and self-insured employers. There were 92 active MCO contracts. Contracts in effect on October 1, 2003, covered 52,914 Oregon employers. The percentage of employers covered by managed care decreased 12 points from 71 percent in 2002 to 59 percent in 2003. The percentage of employees covered dropped from 73 to 58 percent. The decreases are largely attributed to the Liberty group of insurers canceling most of its MCO contracts between March and June of 2003.

The percentage of workers with accepted disabling claims who were enrolled in MCOs has ranged from 36 percent to 40 percent since 1998. In 2003, it was 39 percent. From 1998 through 2003, SAIF enrolled slightly over two-thirds of injured workers with ADCs. Self-insured employers enrolled fewer than one-third. The percentage of workers enrolled by private insurers has dropped by 16 percentage points since 1998, reaching a low of eight percent in 2003.

During 1998, the department's research staff studied the effectiveness of managed care in the Oregon workers' compensation system. The study group consisted of workers injured between July 1995 and December 1997 whose disabling claims closed during the last four months of 1997. The study included a comparison of medical, time-loss, and permanent disability costs for workers covered and not covered

Figure 14. MCO insurer contracts in effect at the end of the fiscal year, 1991-2004

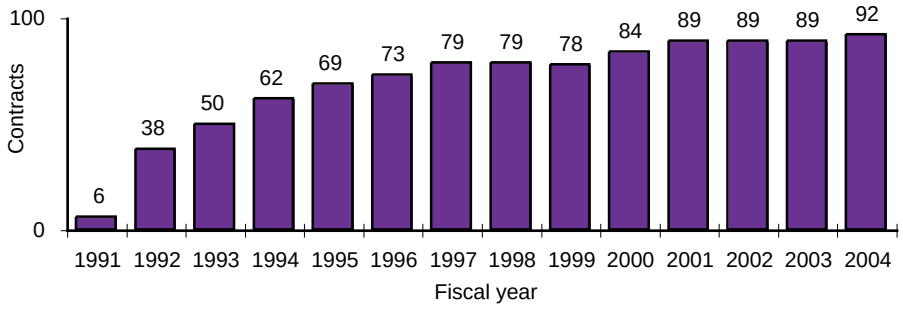


Figure 15. Percentages of workers with accepted disabling claims enrolled in MCOs, by insurer type, 1998-2003

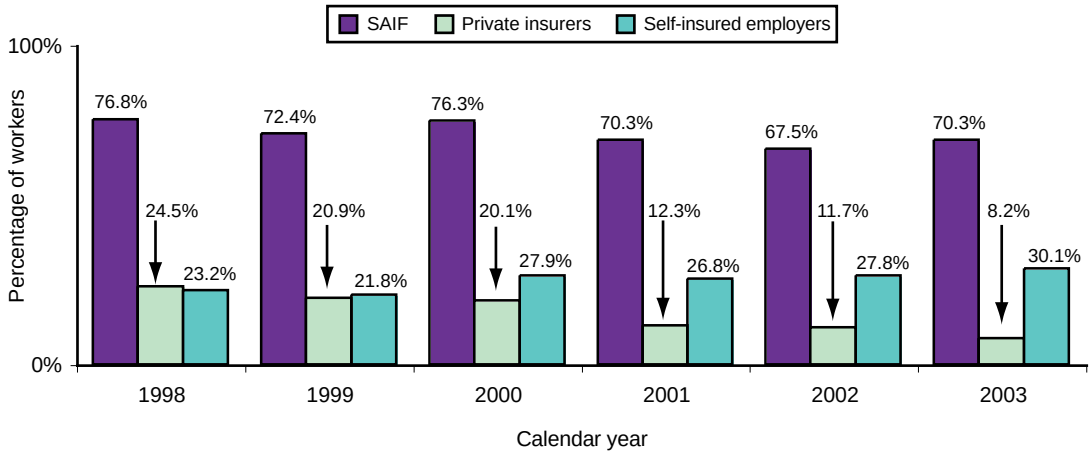
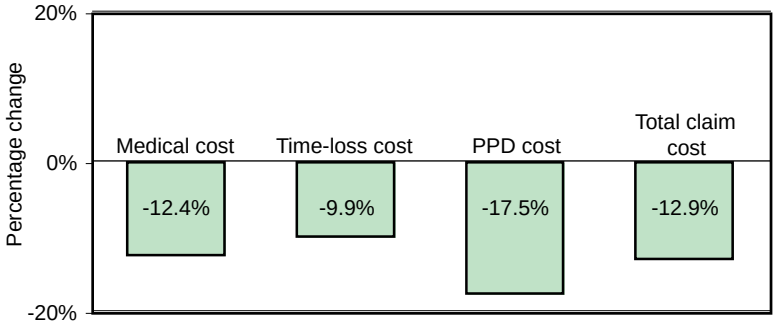
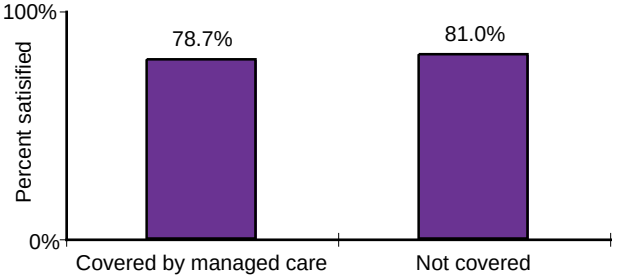


Figure 16. Percentage reduction in accepted disabling claims costs due to managed care coverage, 1998



Note: Results are from a study of workers injured between July 1995 and December 1997 whose disabling claims closed during the last four months of 1997.

Figure 17. Percentage of workers satisfied with their overall medical treatment, 1998



Note: Results are from a study of workers injured between July 1995 and December 1997 whose disabling claims closed during the last four months of 1997.

by MCO contracts. The findings indicate that, after controlling for severity and other differences, disabling claims covered by MCO contracts had lower costs. Medical costs were reduced 12 percent, time-loss costs by 10 percent, and PPD costs by 18 percent. These reductions resulted in a 13 percent savings in total costs for MCO-covered disabling claims.

The study also included a survey asking the same workers about their satisfaction with their medical treatment. There were few differences in satisfaction between the workers covered by MCO contracts and those not covered.

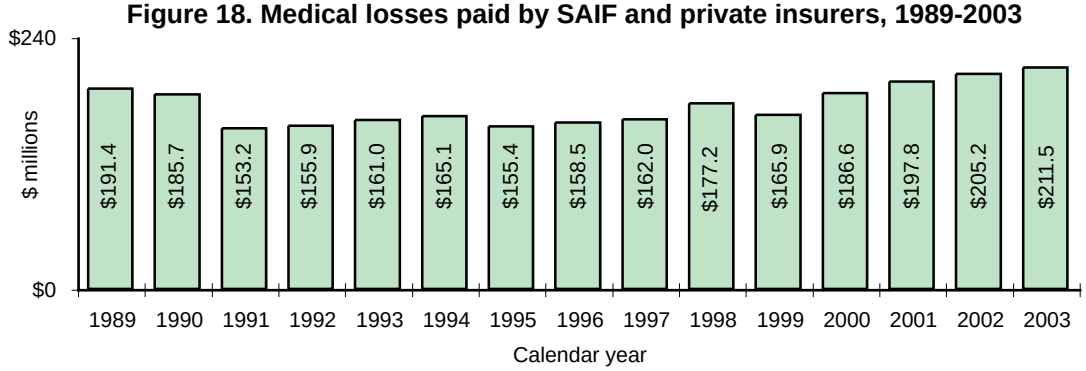
Medical costs

The medical payments made by SAIF and private insurers dropped by 20 percent between 1989 and 1991. After that, medical payments increased by one percent per year until 1999. Total payments made by these insurers continued to fall, however, so medical payments grew as a percentage of total payments, from 40 percent in 1991 to 48 percent in 1999. After this eight-year period of relative stability, medical payments jumped 27 percent between 1999 and 2003, and medical payments as a percentage of total payments rose from 48 percent to 52 percent.

Medical payments

In 1991, the Worker's Compensation Division began requiring that insurers with 100 or more accepted disabling claims report their medical payment data. WCD Bulletin 220 describes the reporting requirements. In 2003, approximately 80 percent of total medical payments were reported; nearly 90 percent of these payments were for services subject to fee schedules. On average, reimbursements for services subject to a fee schedule were 23 percent lower than the charged amounts. The majority of the difference resulted from applying fee schedule maximums that were lower than the charges. On average, reimbursements for hospital charges subject to the cost-to-charge fee schedule were 38 percent less than the charged amounts.

Figure 18. Medical losses paid by SAIF and private insurers, 1989-2003

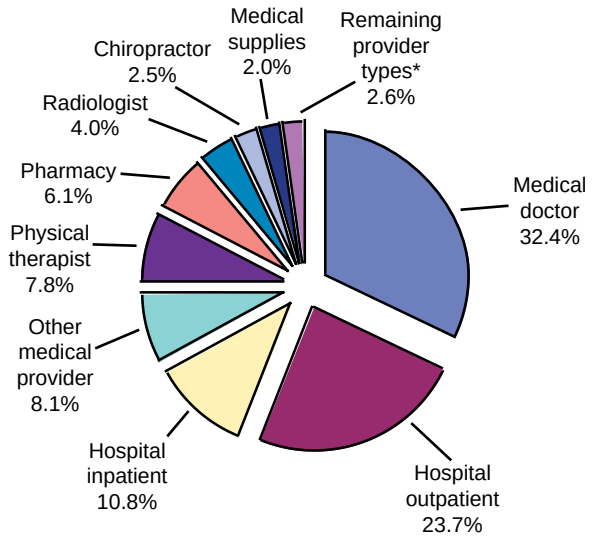


Note: Data are provided by the National Council on Compensation Insurance. Self-insured employers do not report data to the NCCI.

Department research analysts have created a model for estimating workers' compensation medical payments by accounting for unreported services. Using this model, the estimated total medical payments during the first quarter of 2002 were $59.1 million. This estimate was developed by inflating the medical payment data with NCCI market data to reflect the quarter's total medical payments. The model then estimates medical payments across provider and service types. For the first quarter of 2002, payments to medical doctors and for hospital inpatient and outpatient care accounted for 67 percent of total medical payments. Physical therapists received 8 percent, pharmacies received 6 percent, radiologists received 4 percent, and chiropractors received 3 percent. Two percent of payments were for medical supplies.

The model provides information about the services with the largest payment totals. Nearly six percent of all payments to medical providers were for therapeutic exercises to develop an injured worker's

Figure 19. Medical payments by provider type, first quarter 2002



* Remaining provider types include osteopath, occupational therapist, dentist, physician assistant, registered nurse practitioner, laboratory, podiatrist, optometrist, acupuncturist, and naturopath.

Table 1. Top 20 workers' compensation medical services, first quarter 2002

Rank	Service code	Description of service	Total payments	Percent of total
1	97110	Therapeutic exercises	$3,487,100	5.9%
2	99213	Office/outpatient visit for established patient with low to moderate severity	$2,375,200	4.0%
3	D0003	Insurer medical exams	$2,142,100	3.6%
4	97140	Manual therapy	$1,841,000	3.1%
5	360	Operating room services	$1,297,000	2.2%
6	450	Emergency room services	$972,200	1.6%
7	72148	Magnetic image; lumbar and spine without dye	$902,800	1.5%
8	N/A	Ambulatory surgical center facility fees	$868,400	1.5%
9	99214	Office/outpatient visit for new patient with moderate to high severity	$716,000	1.2%
10	73721	Magnetic image; joint of lower extremity without dye	$714,800	1.2%
11	99203	Office/outpatient visit for new patient with moderate severity	$703,000	1.2%
12	97001	Physical therapy evaluation	$630,900	1.1%
13	97530	Therapeutic activities	$602,500	1.0%
14	97035	Ultrasound therapy	$601,600	1.0%
15	99212	Office/outpatient visit for est. patient with minimal severity	$553,300	0.9%
16	72158	Magnetic image; lumbar and spine with dye	$523,400	0.9%
17	80.51	Laminotomy, excision intervert disc	$514,600	0.9%
18	99283	Emergency department visit	$512,200	0.9%
19	73221	Magnetic image; joint of upper extremity without dye	$510,700	0.9%
20	270	Medical/surgical supplies and devices	$488,800	0.8%
		Remaining services	$38,132,900	64.5%
		Total	$59,090,500	100.0%

Notes: Payment figures are rounded to the nearest hundred dollars. Figures and percents may not add to totals due to rounding. The ambulatory surgical center facility fees are estimated using payments reported by SAIF and the Liberty group of insurers.

strength, stamina, and flexibility. The presence in the list of 20 top services of manual therapy techniques, physical therapy evaluation, therapeutic activities, and ultrasound therapy illustrates the importance of physical therapy in workers' compensation medical treatment.

Office and outpatient visits also make up a large percentage of medical payments. Four types of office visits rank among the top 20 services.

Insurer medical exams also generate a large percentage of the payments. IME services, grouped together to include basic exams, reports, and specialized IME services (panel exams and exams by specialists) made up almost four percent of total medical payments.

The model also provides the top pharmacy payments by drug name, drug class, and total payments. Narcotic analgesics ranked as the top category of drugs given to injured workers, followed by anti-arthritics (also known as anti-inflammatories) and anti-convulsants (anti-seizure medications). The individual drug with the highest aggregated payment was oxycodone HCL, a narcotic analgesic (pain reliever) representing 16 percent of pharmacy payments. There is a higher use of generic drugs in workers' compensation than in the general health-care system. During first quarter of 2002, generic drugs made up 62 percent of the prescriptions written for injured workers.

Table 2. Top 25 pharmacy payments by drug name, first quarter 2002

Rank	Drug name	Drug class	Total payments	Percent of total
1	Oxycodone HCL	Narcotic analgesics	$589,100	16.3%
2	Gabapentin	Anti-convulsants	$274,700	7.6%
3	Celecoxib	Anti-arthritics	$222,300	6.2%
4	Hydrocodone bitartrate w/ acetaminophen	Narcotic analgesics	$182,800	5.1%
5	Rofecoxib	Anti-arthritics	$181,400	5.0%
6	Morphine sulfate	Narcotic analgesics	$112,300	3.1%
7	Tramadol HCL	Narcotic analgesics	$105,500	2.9%
8	Fentanyl	Narcotic analgesics	$91,500	2.5%
9	Carisoprodol	Muscle relaxants	$68,800	1.9%
10	Omeprazole	Anacids	$66,500	1.8%
11	Fluoxetine HCL	Anti-depressants	$59,100	1.6%
12	Nabumetone	Anti-arthritics	$58,900	1.6%
13	Paroxetine HCL	Anti-depressants	$55,100	1.5%
14	Venlafaxine HCL	Anti-depressants	$53,200	1.5%
15	Zolpidem tartrate	Sedative non-barbiturate	$52,200	1.4%
16	Propoxyphene napsylate w/ acetaminophen	Narcotic analgesics	$49,500	1.4%
17	Sertraline HCL	Anti-depressants	$48,500	1.3%
18	Tizanidine HCL	Muscle relaxants	$44,900	1.2%
19	Cyclobenzaprine HCL	Muscle relaxants	$42,200	1.2%
20	Oxycodone HCL w/ acetaminophen	Narcotic analgesics	$41,200	1.1%
21	Metaxalone	Muscle relaxants	$38,500	1.1%
22	Citalopram hydrobromide	Anti-depressants	$34,200	0.9%
23	Naproxen	Anti-arthritics	$29,900	0.8%
24	Ibuprofen	Anti-arthritics	$27,300	0.8%
25	Codeine phosphate w/ acetaminophen	Narcotic analgesics	$24,300	0.7%
	Subtotal		$2,553,900	70.9%
	Remaining Pharmacy		$1,050,600	29.1%
	Total		$3,604,500	100.0%

Note: Drug payment figures are rounded to the nearest hundred dollars. Figures and percents may not add to totals due to rounding.

Interim medical benefits

Prior to 2002, workers' compensation insurers were only responsible for the medical costs of the claims they accepted. Before claim acceptance, therefore, it was uncertain who was responsible for medical bills. Some medical providers may have been reluctant to treat injured workers, or they may have delayed some types of treatment, until after an insurer's compensability decision. As a result, injured workers' recovery may have been delayed.

In 2001, SB 485 addressed this concern in two ways. First, the bill reduced the time allowed for insurers to accept or deny a claim from 90 to 60 days. Second, it amended the law regarding the payment of some medical services prior to the initial acceptance or denial of a claim.

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

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

The department does not collect data to measure the effect of this legislative change.

MCO contracts with insurers and self-insured employers, FY 1991-2004

Fiscal year	Insurers	Self-insured employers	Total
1991	3	3	6
1992	16	22	38
1993	20	30	50
1994	25	37	62
1995	28	41	69
1996	32	41	73
1997	35	44	79
1998	36	43	79
1999	33	45	78
2000	35	49	84
2001	37	52	89
2002	34	55	89
2003	32	57	89
2004	32	60	92

At the end of FY 2004, seven certified managed care organizations had contracts with insurers and self-insured employers. These MCOs had 92 contracts with insurers and self-insured employers.

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

Employers and employees covered by managed care organizations, 1993-2003

Date	Employers		Employees	
Jan 1993	26,211	38.3%	393,900	30.7%
Nov 1993	28,320	40.0%	462,500	35.1%
Dec 1994	33,083	44.8%	484,000	35.1%
Oct 1996	40,128	51.8%	648,500	43.6%
Oct 1997	47,200	59.3%	901,900	58.3%
Oct 1998	52,608	64.7%	969,200	61.5%
Oct 1999	52,048	63.7%	993,600	62.0%
Oct 2000	57,532	68.3%	1,121,000	68.9%
Oct 2001	58,884	69.3%	1,117,000	69.1%
Oct 2002	62,457	71.3%	1,164,000	72.9%
Oct 2003	52,914	59.0%	912,000	57.6%

As of October 2003, 59 percent of Oregon employers and 58 percent of workers were covered by MCOs. In 2003, the Liberty group of insurers canceled most of its contracts and disenrolled all workers covered by those contracts. Largely as a result of this, the percent of employers covered by MCOs fell by 15 percent, and the percent of employees dropped by 22 percent.

Note: The October 2002 data includes estimated data from the Liberty group.

Employees with accepted disabling claims enrolled in MCOs, 1998-2003

Year	SAIF	Private insurers	Self-insured employers	Total
1998	76.8%	24.5%	23.2%	39.8%
1999	72.4%	20.9%	21.8%	37.1%
2000	76.3%	20.1%	27.9%	40.1%
2001	70.3%	12.3%	26.8%	35.6%
2002	67.5%	11.7%	27.8%	36.5%
2003	70.3%	8.2%	30.1%	39.1%

The percentage of claimants with accepted disabling claims who have been enrolled in MCOs has varied between 36 and 40 percent. The decline in enrollment by private insurers largely reflects the Liberty group's decisions.

Note: The 2002 private insurer figure includes estimated data from the Liberty group.

SAIF and private insurers' total paid and medical paid, 1989-2003

Year paid	Total paid ($ millions)	Medical paid ($ millions)	Medical percent of total
1989	$427.8	$191.4	44.7%
1990	418.0	185.7	44.4%
1991	379.9	153.2	40.3%
1992	380.2	155.9	41.0%
1993	376.1	161.0	42.8%
1994	383.0	165.1	43.1%
1995	360.9	155.4	43.1%
1996	358.1	158.5	44.3%
1997	352.7	162.0	45.9%
1998	367.1	177.2	48.3%
1999	347.5	165.9	47.7%
2000	380.8	186.6	49.0%
2001	415.8	197.8	47.6%
2002	405.6	205.2	50.6%
2003	404.6	211.5	52.3%

Medical services are an increasing percentage of total claim costs. In 2002, medical expenditures made up more than 50 percent of total costs. Between 1999 and 2003, medical expenditures grew six percent per year; indemnity expenditures grew by less than two percent per year.

Note: Data are provided by the National Council on Compensation Insurance. Self-insured employers do not provide data to NCCI.

Indemnity Benefits

Prior to legislative reform in 1987, Oregon had inadequate permanent disability benefits. The initial reforms increased these benefits and provided a benefit structure with higher awards for those more severely injured workers. In 2003, SB 757 created a new permanent disability award structure that simplifies the former structure and better replaces wage loss for workers who cannot return to work.

Indemnity benefits

Indemnity benefits for workers with accepted disabling claims include temporary disability payments, permanent disability awards, fatality awards, and claim disposition agreements. The average cash benefit for 2003 was $8,664. This is 28 percent higher than the 1987 figure. Over the same period, the average weekly wage, which is used to set many benefits, increased 89 percent. Declines in the average days of temporary disability, the average degrees of permanent partial disability, and the number of permanent total disability awards have largely offset automatic inflation increases for time loss and PPD benefit increases.

In the 1980s, permanent total disability claims accounted for a significant portion of indemnity dollars. By 1993, however, the number of new PTD claims had declined to 13. PTD benefits were affected by law amendments that standardized permanent disability ratings and redefined gainful employment. The creation of CDAs in 1990 and changes in claims-management practices also reduced the number of PTDs. CDAs are settlements between claimants and insurers that must be approved by the Workers' Compensation Board. In exchange for cash settlements, claimants may give up their future rights to all benefits other than medical benefits and benefits for new compensable conditions. In 2003, workers received $203.5 million in indemnity payments. Of this amount, $34.6 million was in settlements through CDAs; $3.3 million was paid as PTD awards.

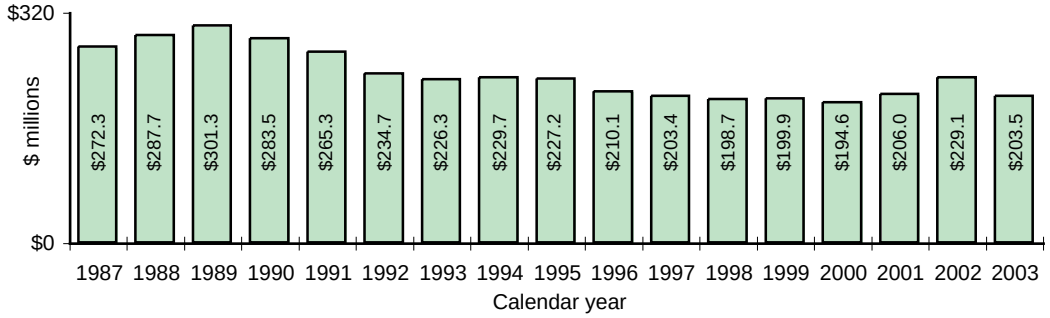
National rankings and comparisons

States can be ranked using seven categories of maximum indemnity benefits. Oregon's ranking for temporary total disability benefits is now in the 86th percentile. This high percentile ranking is in part a result of 2001 legislation that raised the ceiling on TTD. After the implementation of SB 485, about 10 percent of workers with a disabling claim received increased payments.

In January 2004, Oregon's maximum benefits were also above the national median for PTD awards, survivor's benefits for spouses with children, and burial allowances. The benefits were below the median for survivor's benefits for spouses without children.

Since 1987, the legislature has increased the value of a degree of permanent partial disability, both for scheduled and unscheduled injuries. The value of a scheduled degree — for limbs, vision, and hearing — has increased by 347 percent, from $125 in 1987 to $559 per degree. Maximum benefits for unscheduled disabilities — to the back and other body parts and systems — have risen to an even greater degree. Oregon's national ranking for maximum PPD was in the tenth percentile in 1988. With the benefit increases in 1995 in SB 369, the maximums were near the national median. The benefit increases since 1995 have kept these rankings in the 40th to 50th percentile.

Figure 20. Cash benefits paid to workers for accepted disabling claims, 1987-2003



Although the national median for maximum benefits has been useful in comparing PPD benefits among states, it is insufficient to measure the generosity of benefits. Oregon has been one of few states that computes PPD benefits without regard to the worker's weekly wage. Other states provide larger maximum benefits only for high-wage workers. For this reason, when the worker's wage is taken into account, Oregon's maximum benefits for low-wage workers appear relatively generous compared to most other states.

For unscheduled benefits, the maximum has other deficiencies as a measure of generosity. Since 1991, Oregon has been one of few states with a tiered structure of benefits for unscheduled disability. The intent was to increase compensation to the more severely injured workers. About three-quarters of workers with unscheduled PPD awards receive only the bottom-tier benefits, which have been among the lowest in the country. Unlike the maximums, the bottom-tier benefit levels have failed to keep pace with inflation. To address this, the 1999 and 2001 legislatures increased bottom- and middle-tier unscheduled benefits at higher rates than top-tier benefits.

In 2001, the RAND Institute for Civil Justice conducted a study for New Mexico. The study provided a multi-state evaluation of the adequacy and equity of cash benefits, especially PPD. Oregon was included in a group of four comparison states. The study matched injured workers with uninjured workers who had the same employers and similar wages. From this, the researchers derived estimates of post-injury wage losses and the proportions of lost wages that were replaced by indemnity benefits.

None of the states studied met the researchers' standards for adequate replacement of wage losses by PPD benefits. The researchers defined adequate replacement as the replacement of two-thirds of lost wages over a 10-year period following injury. No state's indemnity benefits replaced as much as half of the estimated 10-year earnings losses. Oregon's overall rate of pre-tax wage replacement was 42 percent, second to New Mexico's rate. The study did note that workers' post-injury earnings losses were lower in Oregon than in the most of the four other states. The researchers concluded that this is largely a product of Oregon's emphasis on return-to-work incentives. These programs reduce the length of occupational disability.

Permanent partial disability awards

While statutory benefits have increased, the average degrees awarded has declined. Scheduled awards have declined by more than half since 1987 to 17 degrees. Unscheduled awards have declined by about one third to 48 degrees. Because of the benefit increases, however, average dollars awarded for scheduled PPD claims have more than doubled since the low point in 1989. Conversely, the average dollars for unscheduled PPD continued to decline until benefit increases began to take effect from the 1991 legislation. Since 1992, average unscheduled benefits per claim have increased by 62 percent.

Determining whether injured workers are actually receiving higher and more equitable benefits subsequent to reform is not straightforward. Several factors complicate the use of the change in average degrees and dollars awarded to draw conclusions about average benefits to injured workers. Claims settled by CDAs before claim closure are not included in the PPD data. These claims involve cases for which permanent partial disability is compensated. The standardization of disability ratings and the changes in injury severity and return-to-work patterns probably contribute to the decline in average degrees awarded.

Senate Bill 757, revision of the PPD award structure

Passed during the 2003 legislative session, Senate Bill 757 redefines how permanent partial disability awards are determined. The changes apply to claims for injuries occurring on or after January 1, 2005:

- Injuries to all body parts will be rated in relation to the whole person
- Workers with permanent disability will receive an impairment benefit based on the statewide average weekly wage multiplied by the percentage of impairment

- Workers unable to return to work will receive a work disability benefit based on the impairment modified by age, education, adaptability factors, and earnings at the time of injury
- Wage-based work disability rates will be limited to a range between 50 and 133 percent of the statewide average weekly wage.

For these claims, there is no longer a distinction between scheduled or unscheduled awards. Also, awards will no longer be measured in degrees.

The legislation is intended to improve awards in several ways. The wage-based work disability benefits better replace lost wages for workers who have not returned to work. The system is simplified by eliminating the distinction between scheduled and unscheduled awards and by eliminating the three-tiered system for unscheduled awards. The new benefit structure was also designed so that there would be no increase in total costs to the system, even though the maximum benefit is much higher: $251,555.

Indemnity benefits paid to injured workers for accepted disabling claims, 1987-2003

Year	Benefits paid ($ millions)	Average benefits per claim
1987	$272.3	$6,781
1988	287.7	7,010
1989	301.3	6,900
1990	283.5	7,238
1991	265.3	7,400
1992	234.7	7,456
1993	226.3	7,351
1994	229.7	7,471
1995	227.2	7,206
1996	210.1	6,874
1997	203.4	7,165
1998	198.7	7,117
1999	199.9	7,390
2000	194.6	7,543
2001	206.0	8,122
2002	229.1	9,298
2003	203.5	8,664

Indemnity benefits include temporary disability payments, PPD awards, CDAs, and PTD and fatality indemnity benefits. These benefits exclude non-cash benefits such as medical costs, vocational rehabilitation costs, and attorney fees. The indemnity benefits declined throughout the 1990s as the number of claims declined. The amounts increased in 2001 and 2002.

Average cash benefits remained fairly constant through the 1990s. They have increased at a rate of four percent per year since 1998.

Indemnity benefits by type, 1995-2003

Year	Time loss ($ millions)	PPD ($ millions)	PTD ($ millions)	Fatal ($ millions)	CDA ($ millions)
1995	$111.1	$59.9	$4.3	$9.9	$42.0
1996	95.8	59.7	3.3	13.0	38.3
1997	92.6	55.1	5.1	12.9	37.7
1998	93.2	54.6	4.2	14.7	32.0
1999	92.8	53.3	5.3	14.8	33.7
2000	93.9	54.6	1.7	10.7	33.7
2001	104.5	58.9	-1.0	10.5	33.1
2002	107.9	59.3	5.6	18.4	37.9
2003	99.0	59.6	3.3	7.0	34.6

Of the $204 million in 2003 indemnity benefits, 49 percent were temporary disability payments, 29 percent were PPD awards, and 17 percent were CDA payments.

Notes: Data are reported by the year of the award, except for time-loss data, which are reported by the year of the claim closure.

Some claims are settled with a CDA before claim closure. The time-loss payments made on these claims are not reported to the department. The time-loss figures include estimates of these amounts.

The PTD figures reflect net awards (grants minus rescissions). In 2001, the number of rescissions exceeded the number of grants.

Temporary disability paid, 1987-2003

Claim closure year	Average days	Average time loss paid	Median days
1987	90	$3,768	21
1988	85	3,588	21
1989	95	3,968	23
1990	98	4,165	22
1991	89	4,041	21
1992	80	3,731	20
1993	74	3,517	20
1994	68	3,300	19
1995	64	3,179	19
1996	60	2,986	17
1997	56	2,913	16
1998	57	3,078	18
1999	57	3,207	18
2000	54	3,135	17
2001	58	3,573	19
2002	61	3,795	20
2003	60	3,798	20

The average number of days of temporary disability declined 40 percent between 1987 and 2000. It has risen since, but the 60-day average in 2003 is still just two-thirds of the 1987 average. The increased use of return-to-work programs is one reason for the decline. The decline in the median number of paid days is not as great as the decline in the mean. This indicates the number of long-term open claims has declined; many of these claims are probably settled with CDAs before claim closure.

The decline in the average number of days paid has offset the statutory increases in the benefits. The average amount of time loss paid in 2003 was $3,798, nearly the same amount paid in 1987.

Note: The data is reported by the year of the claim closure. Claims with multiple closures are reported multiple times.

Permanent partial disability cases, average dollars and degrees, 1987-2003

Year	Scheduled PPD dollars	Scheduled PPD degrees	Unscheduled PPD dollars	Unscheduled PPD degrees
1987	$3,939	36.1	$6,783	69.4
1988	3,898	33.6	6,711	68.0
1989	3,623	28.4	6,492	65.2
1990	3,760	27.6	6,336	63.6
1991	4,280	23.5	5,710	57.3
1992	4,969	20.8	5,547	55.5
1993	5,313	20.0	5,944	57.9
1994	5,513	18.8	5,967	55.9
1995	6,055	19.0	5,939	53.0
1996	6,146	17.6	6,131	52.0
1997	6,635	17.3	6,417	49.9
1998	6,582	16.2	6,992	49.7
1999	6,792	15.9	6,962	47.7
2000	7,336	16.5	7,582	48.8
2001	8,155	17.1	7,644	46.7
2002	8,117	16.3	8,067	47.8
2003	8,624	16.5	9,006	48.5

The average degrees awarded has declined since 1987. Scheduled awards have declined 54 percent and unscheduled awards have declined 30 percent. CDAs, the standardization of disability standards, and changes in return-to-work patterns were factors in the decline during the early 1990s. There has been little change since 1998.

Average PPD dollars have increased as the benefit schedule has changed. Average scheduled awards have more than doubled; unscheduled awards have increased 33 percent.

Note: Averages are computed by tallying each claim's awards. Averages will change as claims are litigated or reopened.

Permanent total disability awards, 1987-2003

Year	Grant	Rescind	Net awards
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	25	11	14
2000	14	6	8
2001	13	14	-1
2002	23	3	20
2003	14	6	8

The number of permanent total disability awards declined dramatically between 1988 and 1992. The creation of CDAs in 1990 was the primary cause of this decline.

PTD grants can be made by insurers or by the department through the appeal process. These counts include the reinstatement of awards that were rescinded by insurers or during earlier appeals. Of the 14 grants in 2003, six were reinstatements of earlier awards.

Oregon percentile ranking for maximum temporary disability and permanent disability benefits, 1988-2004

Year	TTD	Scheduled PPD	Unscheduled PPD	PTD
1988	68	10	6	70
1994	73	33	8	73
1996	71	48	46	75
1998	74	46	47	74
2000	74	49	46	74
2002	88	50	38	66
2004	86	43	40	64

Temporary total disability benefits are set at two-thirds of workers' weekly wages, between maximum and minimum limits. For injuries since January 1, 2002, the maximum is 133 percent of the average weekly wage. The AWW applies to benefits paid during the fiscal year. This provides an inflation escalator. The 2002 change increased Oregon's percentile for maximum TTD benefits from the 74th percentile to the 88th.

Permanent partial disability benefits are based on dollars per degree formulas. These benefits have been raised during most legislative sessions. The increases in 1995 through SB 369 brought the maximum benefits near to national medians. Increases since 1995 have kept them near the medians.

Permanent total disability benefits are set at two-thirds of workers' weekly wages, between maximum and minimum limits. The maximum values have been above the national median since 1988.

Note: National data are from the US Department of Labor.

Oregon percentile ranking for survivors' benefits, 1988-2004

Year	Death - no child	Death - child	Burial
1988	28	86	78
1994	25	88	43
1996	27	88	67
1998	22	91	81
2000	26	91	85
2002	24	87	75
2004	18	84	72

Survivors' benefits are based on the average weekly wage for the injury year. Oregon's benefits have remained fairly constant relative to national levels since 1988.

Note: National data are from the US Department of Labor.

Maximum PPD benefits, since July 1986

Dates of injury	Maximum scheduled PPD	Maximum unscheduled PPD	Maximum PPD
July 1986 - June 1987	$24,000	$32,000	-
July 1987 - June 1990	27,840	32,000	-
July 1990 - June 1991	58,560	32,000	-
July 1991 - June 1992	58,577	60,503	-
July 1992 - June 1993	60,601	62,592	-
July 1993 - June 1994	63,631	65,723	-
July 1994 - June 1995	66,722	68,915	-
July 1995 - Dec. 1995	67,402	69,617	-
Jan. 1996 - Dec. 1997	80,640	130,400	-
Jan. 1998 - Dec. 1999	87,168	138,224	-
Jan. 2000 - Dec. 2001	98,168	149,033	-
Jan. 2002 - Dec. 2004	107,328	162,272	-
----------> Series break			
Jan. 2005 - present	-	-	$251,555

In 2003, SB 757 revised the PPD award structure, effective January 2005. It eliminated the distinction between scheduled and unscheduled PPD. The new structure reallocates benefits to better reflect earnings loss, providing less-generous benefits to some workers who can return to regular work, and more-generous benefits to those who cannot. The maximum PPD award was increased, but there is not expected to be any initial increased cost to the entire workers' compensation system.

Return-to-Work Assistance

The fundamental goals of the workers' compensation system include returning injured workers to their jobs quickly and enabling them to earn wages close to their pre-injury wages. Oregon statute does this in three ways. First, the disability benefits structure includes incentives to get injured workers back to work. Second, statute prohibits employment discrimination and provides reemployment and reinstatement rights to injured workers. The Bureau of Labor and Industries enforces those laws, as well as other civil rights. Third, the workers' compensation system assists injured workers with three employment programs.

After studying these programs since the end of the 2003 legislative session, the Management-Labor Advisory Committee is drafting legislation to improve access to the programs, increase participation, and streamline processes.

Oregon's return-to-work programs

Since the 1970s, Oregon's return-to-work programs have gone through numerous changes. The current programs are the vocational assistance program, the Preferred Worker Program and the Employer-at-Injury Program.

The vocational assistance program requires that insurers provide formal plans for returning disabled workers to suitable jobs. For injuries after 1985, the program is paid for through employers' insurance premiums. The Preferred Worker and EAIP programs provide incentives to employers who choose to hire injured workers. The program costs are paid by the Workers' Benefit Fund. In contrast to vocational assistance, the WBF is supported from taxes paid equally by workers and their employers. The Preferred Worker Program targets workers who have recovered from their injuries, while the EAIP focuses on workers who are still recovering.

The department measures return to work in part by examining employment and wage data as reported to the Oregon Employment Department. The measure is a snapshot of the wages in the 13th quarter after the disabling injury or exposure. This is a point by which time most workers have recuperated and used return-to-work programs.

The measure is the percentage point difference in employment and wage-recovery rates between the workers with disabling claims who have used return-to-work programs and those who have not used the programs. Positive numbers mean that workers who used return-to-work programs have had higher employment rates and wages in the fourth year after injury. The employment rate in 2004 of workers injured in 2000 who used return-to-work program was 11 percentage points higher than workers without these programs. Wages for these workers were 14 percentage points higher.

Research also indicates that participation rates in return-to-work programs affect the overall economic impact of the programs. The use of return-to-

Figure 21. Employment and wage advantage for return-to-work program users, FY 1997-2004

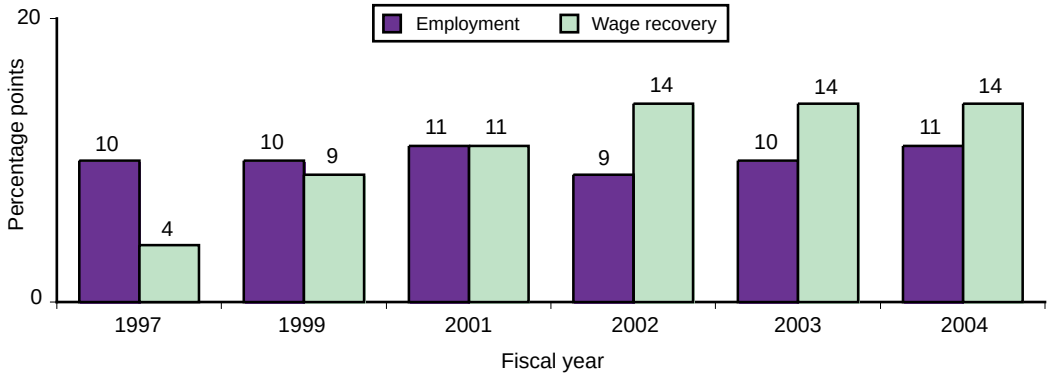
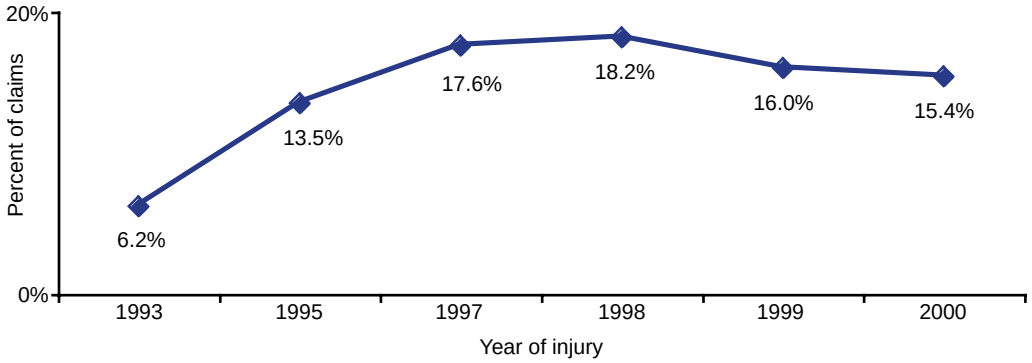


Figure 22. Percent of closed accepted disabling claims from 1993-2000 with use of return-to-work programs by fourth year post-injury



work programs expanded rapidly after the introduction of the Employer-at-Injury Program, but it has leveled off recently.

Following are profiles of each return-to-work program.

Vocational assistance

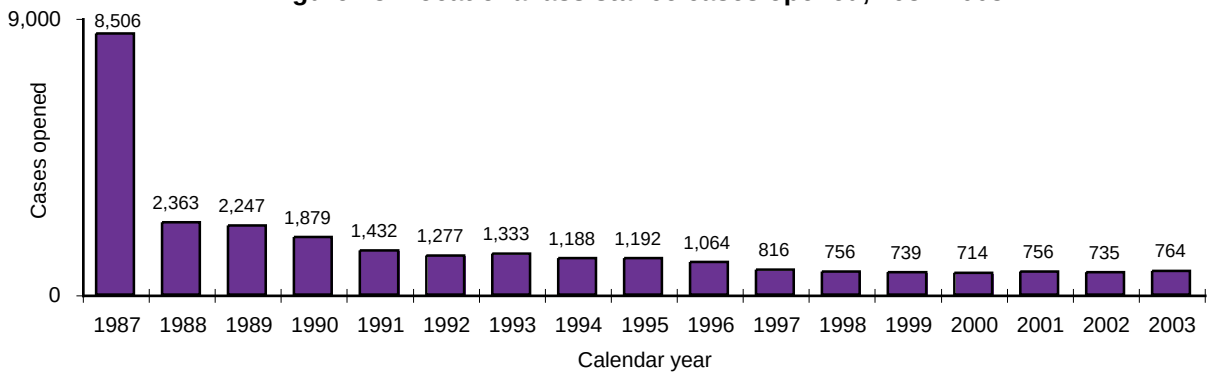
Insurers provide vocational assistance, usually through professional rehabilitation organizations, to help disabled workers who have recuperated from their injuries overcome barriers to successful return to work. In 1987, more than 8,500 workers were eligible for vocational assistance plans to return to work. Total reported benefits stood at $36.5 million, excluding the costs of eligibility determinations. The average cost of vocational assistance benefits was just over $4,000.

With HB 2900 of 1987, the legislature significantly restricted eligibility for this program by introducing a new test: substantial handicap. In general, substantial handicap means that injured workers are eligible for vocational assistance if a permanent disability prevents re-employment in any job that pays at least 80 percent of the job-at-injury wage. One effect has been to exclude many minimum-wage earners from eligibility.

HB 2900 also removed from eligibility those workers whose five-year aggravation rights had expired. In 1995, the legislature further restricted eligibility for vocational assistance for aggravation claims.

Because of these legislative amendments, there have been fewer workers with new vocational assistance cases. The number of new cases declined from 8,506 in 1987 to 1,192 in 1995. The number has been around 750 each year since 1998. Total costs of benefits have also declined, to an annual cost of less than $10 million. Under current law, the typical eligible worker gets a training plan followed by direct employment (placement) services. In the past, many more workers returned to work through

Figure 23. Vocational assistance cases opened, 1987-2003



direct employment plans because they did not need retraining. Now, few workers receive just placement services under vocational assistance. As a result, the reduction in costs has not been as steep as the reduction in the number of eligible workers.

Benefits available under vocational assistance include time-loss payments (worker subsistence) during training; purchases of goods and services such as tuition; and professional rehabilitation services such as plan development, counseling and guidance, and placement. For cases closed in 2003, time-loss payments totaled $5.2 million, expenditures for purchases totaled $1.7 million, and expenditures for professional services were $2.9 million.

Eligible workers are not required to use vocational assistance benefits. Since at least 1987, about half of eligible workers have received a plan following their eligibility determinations. Since 1994, only about one-third of workers have completed their cases—defined as placement in a job or receipt of maximum services. Maximum service is 16 months of training (21 months for exceptional cases), plus four months of direct employment services. Prior to 2002, the average training length had been about nine months. Since 2002, the average training length has been 10 months.

Since 1994, at least 40 percent of cases have ended with a claim disposition agreement. With CDAs, workers release their rights to vocational assistance and most other disability benefits in exchange for lump-sum settlements. The CDA was legalized in 1990. In general, workers who settle their claims have low post-injury employment rates and wages. Many of those workers do not use Preferred Worker benefits.

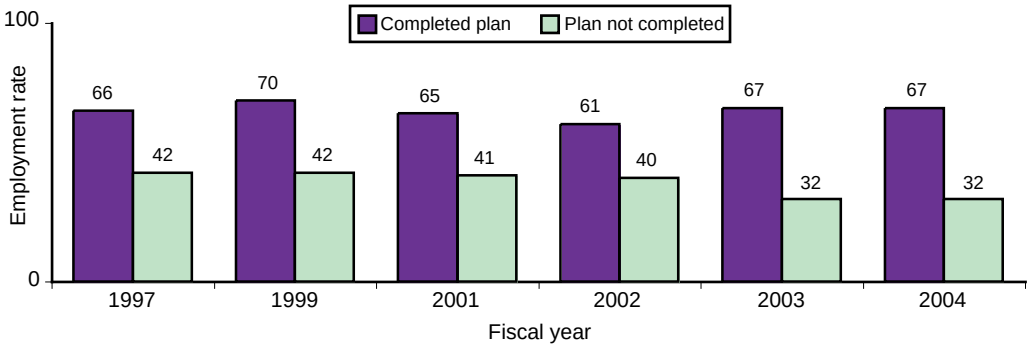
The de-emphasis of the vocational assistance program has resulted in few workers returning to work because of the program: just 130 cases in 2003 compared to over 3,600 in 1987. However, workers who completed a vocational assistance plan have had better employment outcomes than similar workers who did not complete their plans. Employment rates have been at least 20 percentage points higher for these workers. Wage-recovery rates have shown similar advantages for workers who complete their plans.

Preferred Worker Program

Although incentives such as wage subsidies and worksite modifications have been available for many years, the current version of the Preferred Worker Program was formed during the 1990 special session. Clarifications were added in 1995 through SB 369. The program's objective is to sustain disabled workers in employment following their recovery from injuries and illnesses.

A worker automatically receives a Preferred Worker identification card when the insurer reports that the worker has a work-related permanent disability that prevents return to regular work. Workers may also request qualification as Preferred Workers from the department. The card informs prospective employers that the workers may be eligible for the program's benefits. Since 1995, workers may not release these benefits through a claim disposition agreement.

Figure 24. Employment rates for vocational assistance cases, FY 1997-2004



The number of workers identified as Preferred Workers has been declining at a rate similar to the decline in permanent disability claims. The 2,152 Preferred Workers identified in fiscal year 2004 is a record low. Since 1990, most workers who received vocational assistance have also received Preferred Worker cards, but most Preferred Workers have not been eligible for vocational assistance. Under the pre-1987 statute, most Preferred Workers would have been eligible for vocational assistance.

Use of the Preferred Worker Program is at the option of the injured worker as well as the prospective employer. The program does not include placement benefits. A Preferred Worker has three years from identification to start using the program's benefits. In recent years, not quite 25 percent of Preferred Workers have used the program to get a job.

An eligible employer choosing to hire a Preferred Worker is exempt from workers' compensation premiums on the worker for three years. If the worker moves to another job within that period, the premium exemption may be transferred to the new employer. The department reimburses insurers for all claim costs, including administrative expenses, for any claims Preferred Workers file during the premium-exemption period.

Three other benefits are available for Preferred Workers and hiring employers. Wage subsidies provide 50-percent reimbursement for six months; higher benefits are available for exceptional levels of disability. Worksite modifications alter worksites within Oregon to accommodate the workers' restrictions. Obtained employment purchases provide uniforms, licenses, etc., required for employment.

The department, not insurers, delivers benefits under the Preferred Worker Program. This is done through agreements with Preferred Workers and their employers. Total contract (agreement) counts illustrate the demand for the benefits. The number of new contracts reached 3,341 in fiscal year 1996. A steady decrease in activity since then has been met by elimination of some positions within the department. The count of total contracts for fiscal year 2004 was 1,471, up 150 from the previous year's count, which was the lowest on record.

Figure 25. Preferred Worker contracts started, FY 1988-2004

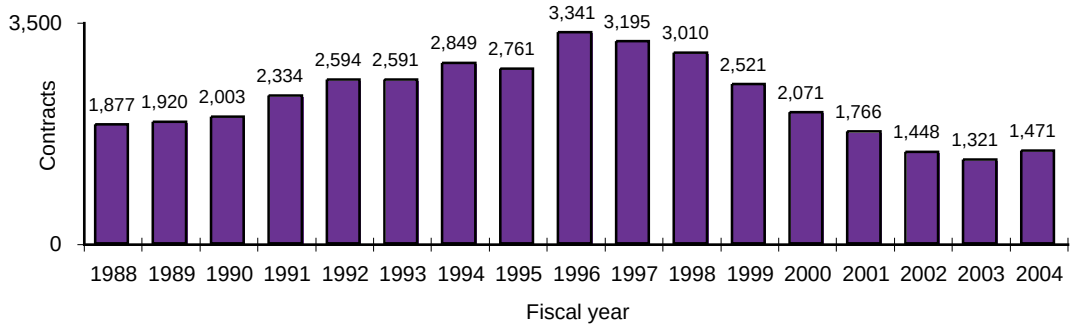
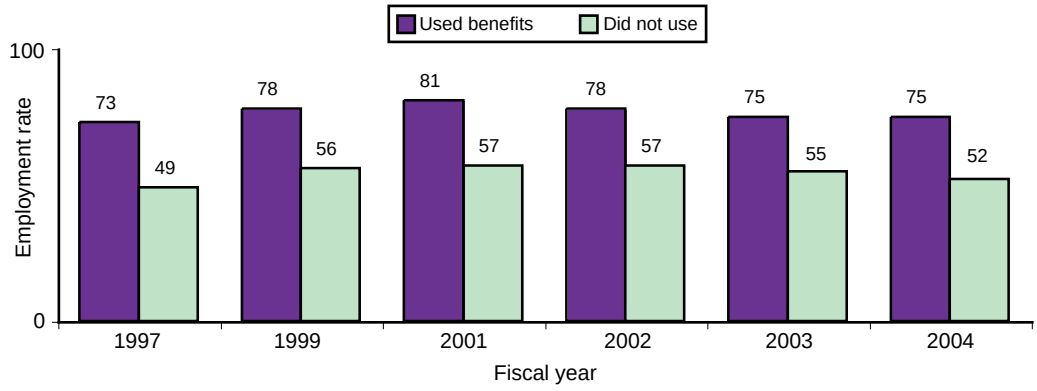


Figure 26. Employment rates for Preferred Workers, FY 1997-2004



In fiscal year 2004, $8.2 million was spent on the Preferred Worker Program. Of this amount, $2.7 million was spent on claim cost reimbursements, $3.1 million was spent on wage subsidies, $2.2 million was spent on worksite modifications, and $0.2 million was spent on purchases. The average cost for benefits was $12,500 per Preferred Worker who used the programs benefits.

During the 13th quarter after injury, employment rates have been at least 20 percentage points higher for Preferred Workers who used the program's benefits than for those who didn't. (These figures exclude workers who were also eligible for vocational assistance.)

The Employer-at-Injury Program

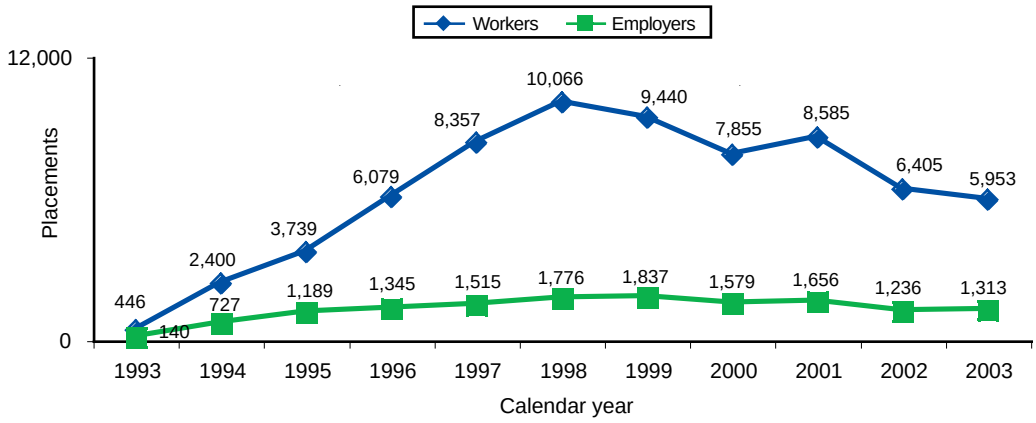
In 1993, the department used its administrative authority to create the Employer-at-Injury Program. The EAIP is available to employers of injured workers who have open claims and who have not been released to regular work but who can return to light-duty, transitional jobs. Insurers arrange placements, for which they receive a flat fee of $60 per placement. Assistance to employers generally consists of a 50 percent wage subsidy for a period of up to three months. Worksite modifications and early-return-to-work purchases are also available, but they are little used.

A statutory change in 1995 permitted extension of the program to include workers with nondisabling as well as disabling claims. Since then, about half of the placements in restricted-duty jobs have been for nondisabling claims. By getting workers back to a job shortly after their injuries, the EAIP has precluded many nondisabling claims from becoming disabling.

Insurers may reduce or discontinue time-loss benefits if a worker refuses modified work, including an EAIP placement. Effective mid-2001, Senate Bill 485 conferred upon injured workers the right to refuse modified work under certain conditions: The job requires a commute that is beyond the worker's physical ability; it is more than 50 miles away; it is not with the employer at injury or not at that employer's worksite; or, it is inconsistent with the employer's practices or a collective bargaining agreement.

The peaks for EAIP activities came in 1998, when the department approved 10,066 placements, and 1999, during which 1,837 employers used the program. The trend has since been downward. In 2003, there were 5,953 placements with 1,313 employers. Changes in administrative rules, the modified-work amendments of SB 485, and economic conditions have contributed to declining activity within this program.

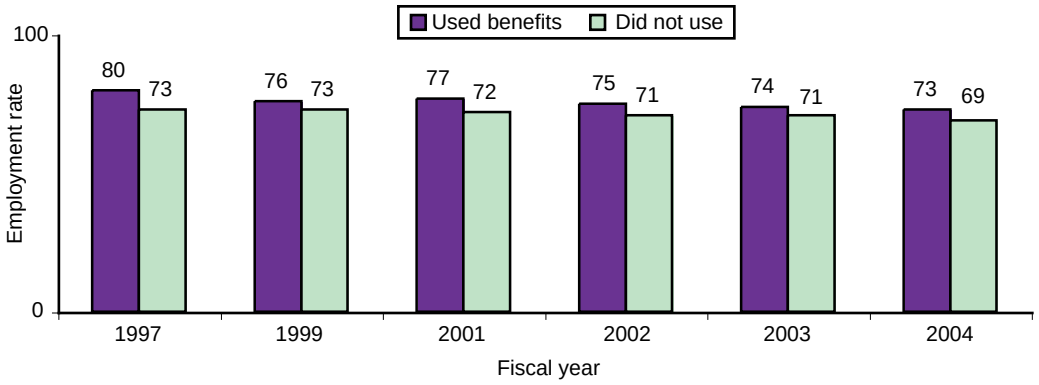
Figure 27. Employer-at-Injury Program, placements approved, 1993-2003



The average cost of benefits has grown from $830 per placement in 1993 to $1,493 in 2003. Placement costs are sensitive to wage trends as well as duration of disability and administrative rule changes. Total expenditures for the program in 2003 were $9.6 million.

During the 13th quarter after injury, employment and wage recovery rates have been higher for workers who used the program's benefits compared to similar workers who didn't.

Figure 28. Employment rates for the Employer-at-Injury Program, FY 1997-2004



Vocational assistance, 1987-2003

Year	Workers	Reported costs ($ millions)	Average cost per closed case
1987	8,506	$36.5	$4,166
1988	2,363	29.8	5,081
1989	2,247	21.6	7,422
1990	1,879	20.9	8,995
1991	1,432	25.5	11,127
1992	1,277	20.2	11,486
1993	1,333	17.9	11,982
1994	1,188	15.3	11,681
1995	1,192	14.8	11,108
1996	1,064	14.2	11,861
1997	816	12.0	12,778
1998	756	10.8	13,259
1999	739	9.0	13,085
2000	714	9.2	15,173
2001	756	9.2	15,105
2002	735	9.9	15,753
2003	764	9.7	16,500

In 1987, more than 8,500 workers were eligible for vocational assistance plans to return to work after their initial claims or claim aggravations. Total reported costs stood at $36.5 million, not including the costs of eligibility determinations.

House Bill 2900, effective 1988, limited eligibility to workers who could pass a new test for substantial handicap. It also removed from eligibility those workers whose five-year aggravation rights had expired. One result has been a reduction in the number of workers eligible for vocational assistance.

Total reported costs have also declined, though the trend since 1999 is up. Total costs remain a relatively small fraction of 1987 costs.

The current average cost per closed vocational assistance case is about four times higher than in 1987.

Vocational assistance case characteristics, 1987-2003

Year	Direct employment plans	Training plans	Cases closed by CDA	Return-to-work cases
1987	3,141	1,054	0	3,604
1988	1,944	873	0	2,337
1989	753	738	0	1,015
1990	347	747	74	831
1991	212	931	450	895
1992	110	723	519	618
1993	61	616	574	449
1994	58	503	542	345
1995	50	504	620	357
1996	39	497	571	359
1997	22	439	426	250
1998	6	382	413	218
1999	5	313	295	165
2000	4	290	230	175
2001	4	271	253	159
2002	7	277	272	144
2003	7	258	261	130

One reason for the large increase since 1987 in average costs per worker is that far fewer workers have been receiving the less costly direct employment (placement) plans.

Senate Bill 1197 of 1990 legalized compromise and release of worker rights and employer liabilities, including vocational assistance. Claim disposition agreements have become a much-used means to end a worker's eligibility for vocational assistance in exchange for a cash settlement.

Relatively few workers immediately return to work after the completion of their vocational assistance plans. However, research by the department indicates that workers who complete plans have employment rates at least 20 percentage points higher than similar workers who don't receive or complete a plan.

Preferred Worker Program, FY 1991-2004

Fiscal year	ID cards issued to workers	Workers using benefits	Percent of ID cards with benefit use
1991	4,189	1,523	36%
1992	3,548	1,116	32%
1993	3,104	990	32%
1994	3,351	981	29%
1995	3,627	1,114	31%
1996	4,223	1,102	26%
1997	3,535	957	27%
1998	2,938	759	26%
1999	2,814	605	22%
2000	2,469	573	23%
2001	2,316	534	23%
2002	2,595	Available July 2005	
2003	2,242	Available July 2006	
2004	2,152	Available July 2007	

Senate Bill 1197 of 1990 created the current Preferred Worker Program, which features identification cards for workers eligible to offer the program's benefits to employers. The number of identification cards issued by the department has declined. The trend is associated with the decline in the number of workers receiving permanent partial disability benefits.

Preferred Workers have three years to begin using benefits. Since 1999, less than one-quarter of Preferred Workers have been using the program's benefits to become reemployed. However, Preferred Workers who use the benefits have employment rates at least 20 percentage points higher than similar workers who don't use the program's benefits.

Preferred Worker contracts started, FY 1988-2004

Fiscal year	Premium relief and exemption	Wage subsidies	Worksite modifications	Purchases
1988	312	1,272	293	0
1989	744	1,041	133	2
1990	833	1,000	135	35
1991	1,046	999	201	88
1992	1,043	957	379	215
1993	1,005	965	396	225
1994	979	1,040	513	317
1995	976	1,007	372	406
1996	1,110	1,149	496	586
1997	1,019	1,097	469	610
1998	908	1,012	450	640
1999	725	818	373	605
2000	633	700	341	397
2001	570	622	262	312
2002	440	495	230	283
2003	410	472	206	233
2004	473	513	240	245

Benefits available under the Preferred Worker Program include premium exemption, wage subsidy, worksite modification, and obtained employment purchases. Premium exemption replaced premium relief as a result of Senate Bill 1197 (1990). Activation of premium exemption is usually a prerequisite for use of the other benefits, and a Preferred Worker may access benefits for three years following activation of premium exemption.

The department provides benefits to Preferred Workers and their employers. Workload may be measured by total contracts started. The trend for these statistics has been a decline of 50 percent or more from the peaks reached in the mid- to late-1990s. Contract starts went up for all benefit types in 2004.

Research by the department indicates the average cost for benefits is about $12,500 per Preferred Worker who uses the program's benefits.

Employer-at-Injury placements approved, 1993-2003

Year	Workers	Employers	Average cost per placement
1993	446	140	$830
1994	2,400	727	$1,268
1995	3,739	1,189	$1,326
1996	6,079	1,345	$1,245
1997	8,357	1,515	$1,180
1998	10,066	1,776	$1,160
1999	9,440	1,837	$1,124
2000	7,855	1,579	$1,210
2001	8,585	1,656	$1,284
2002	6,405	1,236	$1,427
2003	5,953	1,313	$1,493

In 1993 the department created the Employer-at-Injury Program, to get injured workers back to work while they recover from their injuries. Effective 1996, SB 369 expanded eligibility to include nondisabling claims.

Use of the program peaked in the late 1990s. The trend since then has been declining use, probably due to rule changes, new rights for workers to refuse modified work under SB 485 of 1999, and economic conditions.

The average cost of benefits has grown from $830 per placement in 1993 to $1,493 in 2003. Because wage subsidy is by far the most used benefit, placement costs are sensitive to wage trends as well as the duration of disability and administrative rule changes.

Disputes

An important objective of the workers' compensation system is to provide a fair administrative system for the delivery of benefits to injured workers. The ideal system has an impartial forum for the resolution of disputes.

Litigation is the exercise of legal rights for redress of complaint. Workers, employers, and insurers are legal parties to workers' compensation claims, and they have the right to due process of the law in the compensation proceedings. They have the right to representation by attorneys.

Workers have rights to appeal matters concerning their claims—such as letters of denial and notices of closure. They can also dispute the provision of medical treatment. Employers and insurers have rights to dispute medical treatment and fees. They may dispute findings by attending physicians concerning the impairment that results from workplace injuries. In general, they have rights to defend against workers' claims. Medical providers have standing in medical service proceedings, including approval of treatment and fees by insurers. Parties to a claim and parties to medical service proceedings also have the right to dispute and appeal orders by the Workers' Compensation Board and the Office of Administrative Hearings at the Court of Appeals. They may petition for review by the Oregon Supreme Court, although the court's review is discretionary.

Reforming the litigation system

During the 1980s, there was a growing number of claims with disputes about the amount of permanent disability benefits payable to injured workers. Workers were requesting more hearings at the Workers' Compensation Board. Written standards or rules for determining permanent disability benefits had been available since 1980, but their use at hearings was optional. Parties presented their evidence at the Hearings Division and at further review by the Workers' Compensation Board and through the court system. Resolution of disputes was not swift or efficient. The key goals of the early reform included reducing litigation and speeding up the process.

To reduce litigation, the legislature enacted HB 2900 in 1987 and SB 1197 during the 1990 special session. SB 369 in 1995 and several more recent bills have further changed the dispute-resolution system. HB 2900 created the Office of Ombudsman for Injured Workers. The ombudsman helps reduce litigation by resolving complaints. The legislation also required fact-finding about disability, emphasizing objective medical evidence. Uniform standards for permanent disability may reduce the need for litigation. Also, dispute resolution may involve evidence from an examination provided by a neutral medical arbiter or reviewer.

HB 2900 also included provisions to speed litigation. It reduced the time to request a hearing on a claim closure from a year to 180 days, required all hearings and board review to be scheduled for a date within 90 days of the request, required that orders be issued within 30 days of the hearing or review, and required that hearings and review be postponed only in extraordinary circumstances beyond the control of the requesting party. Also, the Hearings Division was required to create an expedited claim service to informally resolve claims for which compensability isn't at issue, the contested amount is $1,000 or less, or the only issues are attorney fees or penalties.

SB 1197 reduced litigation by creating new administrative review processes and allowing claim disposition agreements.

The legislature, in SB 369, allowed Hearings Division judges and the board to impose attorney sanctions for appeals that are frivolous, made in bad faith, or made for harassment purposes. (Previously, only the courts could sanction attorneys.) In the next eight years, there were only 82 sanction requests, about 0.3 percent of hearing and board-review orders. Sanctions were awarded in only nine cases, about 11 percent of the requests. The average sanction was about $300.

The closure appeal period was further reduced by SB 369 to 60 days to request reconsideration and 30 days to request a hearing. The SB 369 provisions

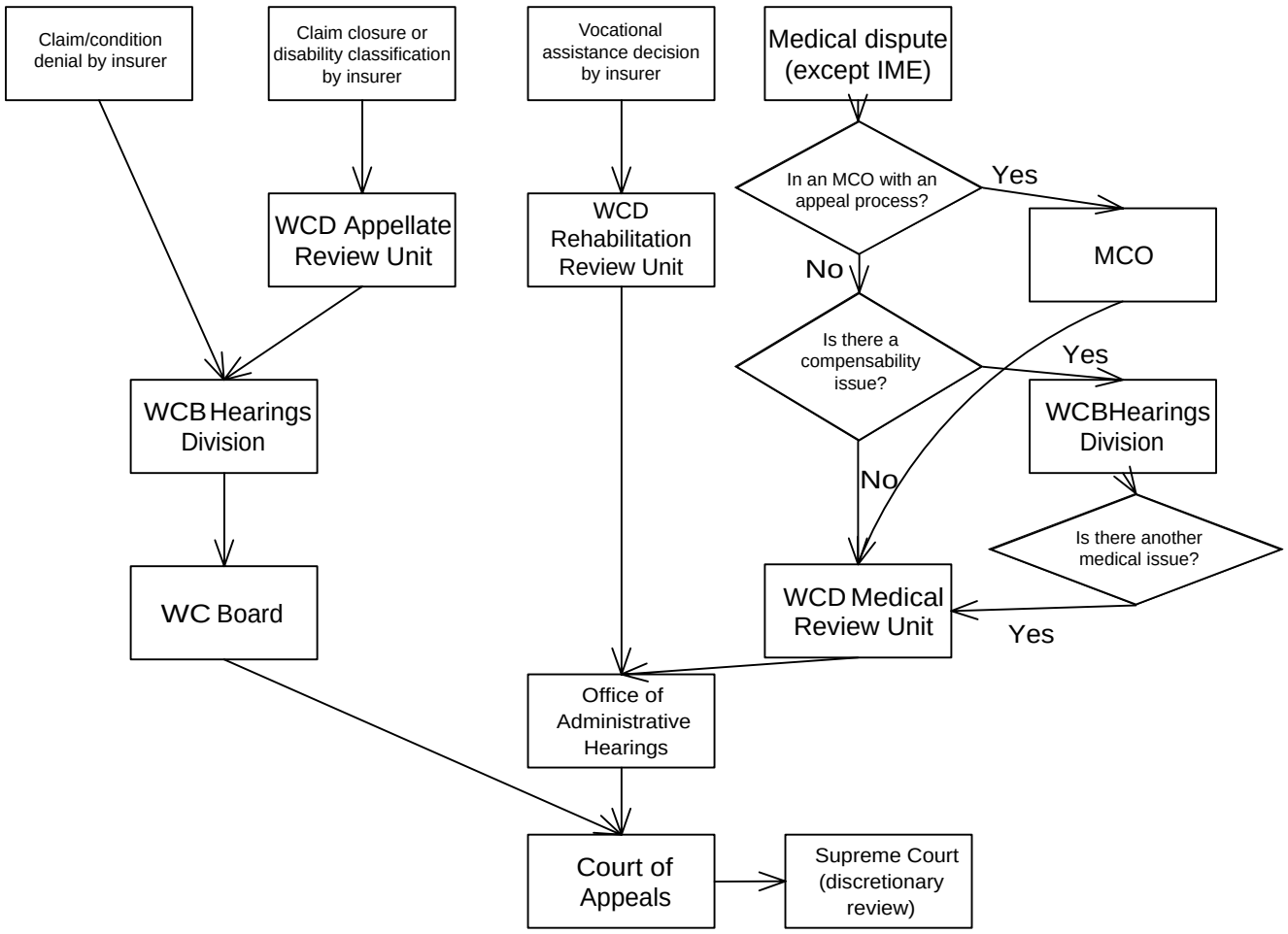
limiting post-reconsideration evidence also had the effect of speeding litigation by reducing postponements and other delays to obtain additional evidence.

In part because of these reforms, Oregon has a bifurcated dispute-resolution system:

- The Workers' Compensation Board provides review for some types of dispute. The board's Hearings Division and the board-review function represent two levels in the Oregon litigation process. Hearings has original jurisdiction on compensability and certain other matters concerning a claim. It also has review jurisdiction over claim closure issues (appeal of reconsideration orders). Hearing decisions by administrative law judges can be appealed to board review, and board-review decisions (by at least two members) can be appealed to the Court of Appeals. The board also approves claim disposition agreements. The board may, on its own motion, re-open a claim for certain benefits after aggravation rights have expired.
- The Workers' Compensation Division's Reemployment and Dispute Resolution Services Section provides administrative review for most other types of dispute. Within RDRS, the Appellate Review Unit resolves disputes involving claim closures, the Medical Review Unit resolves medical disputes, and the Vocational Assistance Unit resolves vocational disputes.

The system, however, is more complex than this. Workers may have disputes in different venues at the same time. For instance, they may be disputing vocational assistance decisions while appealing

Figure 29. Appeal paths of some types of disputes



PPD awards. When an injured worker has a dispute with a managed care organization, dispute resolution may begin with the MCO's appeals process. MCOs develop these processes with the approval of the Workers' Compensation Division. Also, appeals of WCD orders on reconsideration are appealed to the Workers' Compensation Board. Other WCD orders go to the Office of Administrative Hearings for a contested case hearing. Most orders by the WCB and OAH are subject to court review.

Disputes resolved by the Workers' Compensation Division

Reconsideration of claim closures

Prior to 1990, there were voluntary administrative review processes to resolve disputes over claim closures. These processes were used infrequently. The 1990 reforms made the review processes mandatory.

For injuries that occurred in mid-1990 and later, a party disputing a claim closure must seek departmental reconsideration before proceeding to hearing. If the extent of the worker's impairment is not disputed, the process must be completed in 18 work days. When impairment is disputed or medical information is insufficient to determine impairment, a medical arbiter is appointed to examine the worker. In this case, an additional 60 days is allowed. No additional medical evidence may be used in subsequent litigation.

With SB 369 in 1995, the legislature made four changes to the reconsideration process:

- the request must be made within 60 days of closure
- a hearing request must be made within 30 days of the reconsideration order
- hearing issues are limited to those that were raised at, or arose out of, the reconsideration
- in subsequent litigation, evidence is limited to that provided at reconsideration.

Since 1995, requests for reconsideration have fallen. The long-term trend of decreases in both claim closures and the percentage of disputed closures (reconsideration request rate) have contributed to this decline.

However, since 2000, the percentage of disputed closures has increased. In 2001, insurers assumed total responsibility for claim closures and the legislature amended claims processing law; these statutory changes may have caused the increase in the reconsideration request rate. Senate Bill 757 (2003) made changes in claim closure for workers injured in 2005. The increased complexity of claim processing may result in continued growth in disputes.

There has been other legislation concerning reconsiderations since 1995. In 1997, the legislature (SB 118) eliminated the possibility (raised in *Guardado*

Figure 30. Requests for reconsideration, 1991-2003

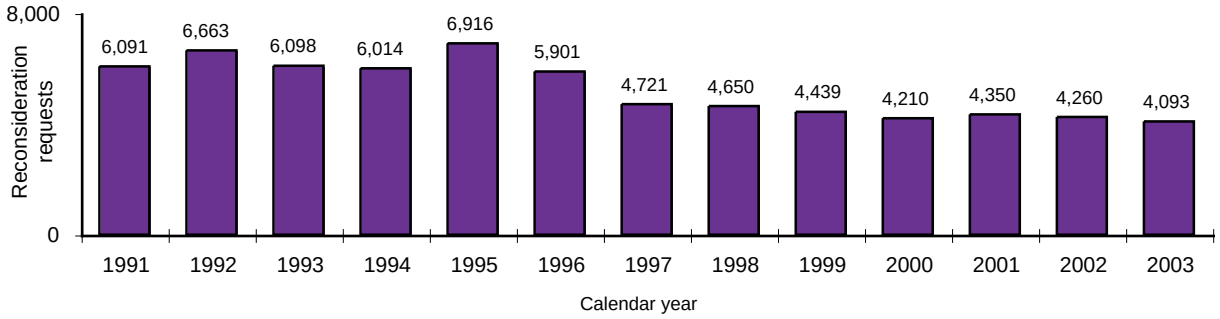
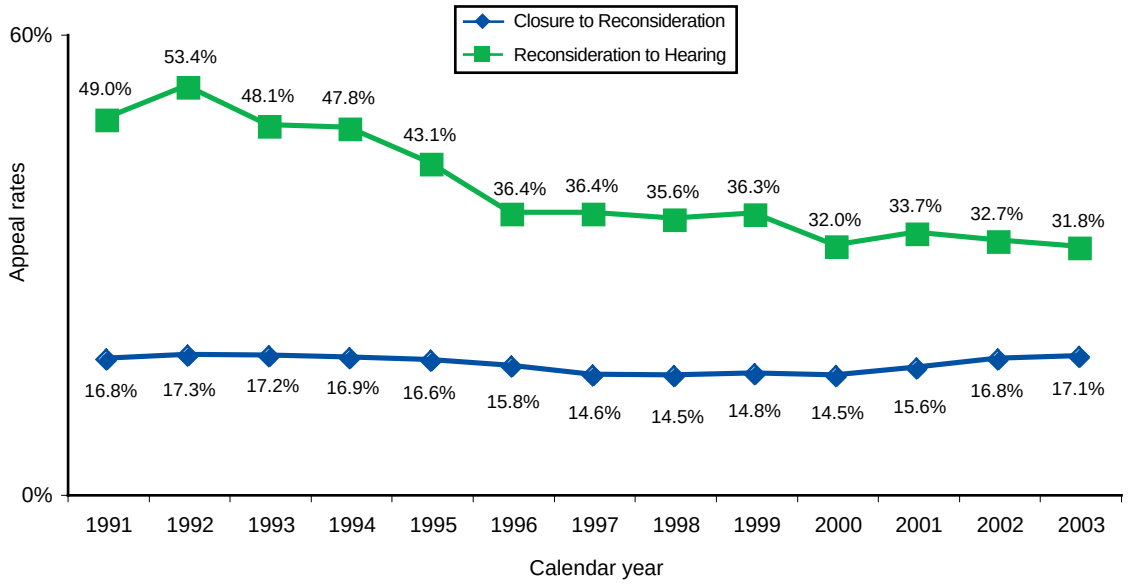


Figure 31. Appeal rates of claim closures and reconsideration orders, 1991-2003



v. J.R. Simplot Co., 1995) that one closure could have two reconsiderations, one requested by each party.

In 2000, the Oregon Supreme Court (*Koskela v. Willamette Industries, Inc.*), in an exception to the evidence limitation, ruled that in permanent total disability cases a worker must be allowed to testify about willingness to work and efforts to obtain employment. In 2001, in SB 485, the legislature addressed evidentiary concerns by providing for a worker deposition at reconsideration. The insurer-paid deposition is limited to testimony and cross examination about a worker's condition at closure.

In 2003, through SB 285, the legislature permitted insurers to request reconsideration of their own notices of closure, in particular when they disagree with findings on impairment by attending physicians. Through the first half of 2004, insurers had requested reconsideration of 68 notices of closure.

Reconsideration orders may be appealed to the WCB Hearings Division. Overall, the trend for appealed orders has been down. Currently, less than one third of orders are appealed. This is down considerably from the 50 percent appeal rates registered in the first years of administrative reconsideration of claim closure.

Medical disputes

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

The number of medical-dispute-resolution requests peaked in 1992 at 1,518. Following the Court of Appeal's decision in *Jefferson v. Sam's Café* in 1993, the department lost jurisdiction over disputes involving proposed medical treatment. As a result, the number of requests fell to 466 in 1994. SB 369 restored this jurisdiction, and the number of requests rose again. SB 369 also required that disputes concerning the actions of a managed care organization regarding the provision of medical services, peer review, or utilization review are handled through the medical-dispute-resolution process. In 2003, 12 percent of the requests concerned MCO issues.

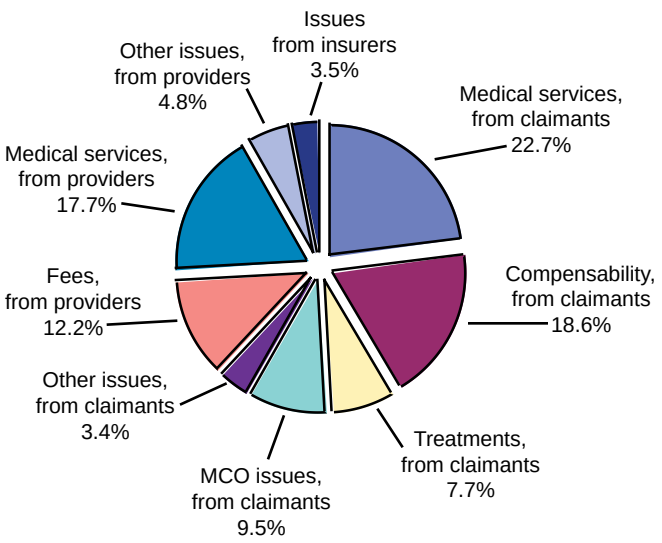
With SB 728, the 1999 legislature specified that the Hearings Division had jurisdiction over disputes concerning the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service. Compensability issues are resolved before other medical issues such as medical services or the appropriateness of treatment are considered. Those cases in which compensability or causality are found are then returned to the Medical Review Unit for resolution of the medical service dispute.

In 2003, the number of compensability cases rose to 265, an increase of 160 percent from 102 cases in 1999. Compensability cases represented nearly 20 percent of all 2003 medical-dispute-resolution requests.

The medical-dispute process differs from many of the other processes in that the injured worker may not be directly involved in the dispute. In 2003, 35 percent of the medical-dispute requests were from medical providers. Most of these requests concerned disputes about fees and disagreements between the provider and insurer about the services to which the injured worker was entitled.

Medical-dispute orders, other than orders involving insurer medical exams or compensability issues, can be appealed through the contested-case hearings process at the Office of Administrative Hearings. (IME and compensability disputes are appealed to the Hearings Division). In 2003, eight percent of the orders were appealed.

Figure 32. Medical disputes, by issue and requester, CY 2003



Vocational assistance disputes

In contrast to medical disputes, vocational assistance disputes frequently used mediation and arbitration processes prior to the reforms. The Rehabilitation Review Unit strives to resolve disputes by mediating agreements among the parties. When that is not possible, RRU issues an administrative review order. Senate Bill 369 of 1995 changed these processes somewhat, most notably by transferring jurisdiction for appeals of RRU orders, from the Hearings Division to administrative law judges who are now part of the Office of Administrative Hearings.

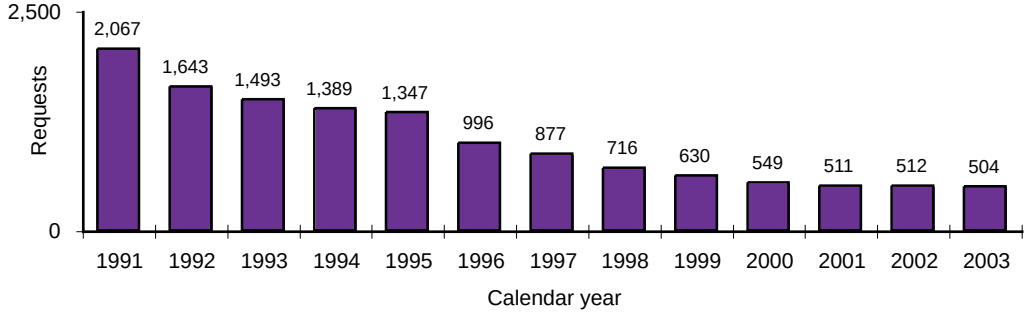
The number of requests for vocational-dispute resolution fell by about 75 percent between 1991 and 2003. Most of the decline is the result of the decline in the number of eligibility determinations for vocational assistance.

About one quarter of vocational eligibility determinations have at least one dispute. Most disputes follow an insurer's denial of eligibility for vocational assistance; the other disputes concern vocational training programs, the quality of professional services, or worker purchases.

In 2003, 28 percent of the vocational disputes were resolved through agreements. Another 27 percent were dismissed, often due to a claim disposition agreement. The remainder of the resolutions required a formal administrative order. The insurer prevailed in almost two thirds of those orders.

In 2003, about one quarter of orders were appealed.

Figure 33. Requests for vocational dispute resolution, 1991-2003



Appeals of administrative orders

The process for appealing administrative review orders is the contested case hearing. With SB 369, the legislature transferred jurisdiction for appeals of vocational service dispute orders and most medical service dispute orders from the Workers' Compensation Board to the Workers' Compensation Division. With this change, the number of requests for contested case hearing by WCD jumped from 90 in 1994 to 274 in 1995.

Prior to 1998, Appellate Review Unit orders concerning timeliness of reconsideration requests and jurisdictional questions were appealed to administrative law judges within WCD. However, a 1998 Court of Appeals decision, *James Jordan v. Brazier Forest Products*, determined that all ARU decisions were reconsideration orders and, therefore, had to be appealed to the board. Now, most requests for contested-case hearings are appeals of medical-dispute or vocational-dispute orders.

In 1999, HB 2525 revised the contested-case-hearings process. It created a centralized officer panel within the Employment Department, now known as the Office of Administrative Hearings. The panel consists of the administrative law judges from several agencies. Since January 2000, contested cases not specifically under WCB jurisdiction have been heard by this panel.

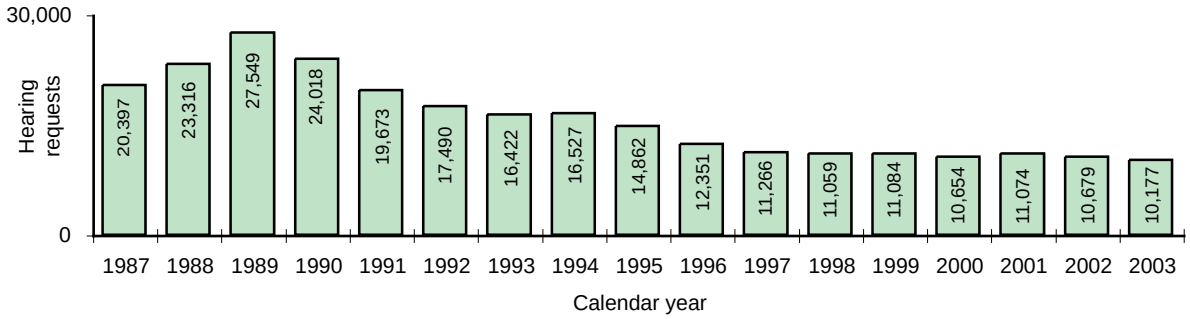
In 2003, there were 159 requests for contested-case hearing by OAH on workers' compensation-related issues. These contested-case orders may be appealed to the Court of Appeals. Four percent of the 2003 orders were appealed.

Worker-requested medical examinations

In 2001, SB 485 provided for a medical exam as part of a compensability denial at hearings. The injury must have occurred since January 1, 2002; the request for a hearing to WCB must be timely; and the denial must be based on an insurer medical examination with which the worker's attending physician disagreed. In these cases, the worker can ask the WCD Benefit Consultations Unit to provide the name of a physician who will conduct a new independent exam. The worker has the burden of proving that he is eligible for the exam. The insurer pays the costs of the exam and the physician's report. The physician's report then becomes a part of the hearing record.

In the first two years that these exams have been available, there have been 168 requests. Of these, 111 were approved. The average cost of an examination and report is an estimated $600.

Figure 34. Requests for hearing, 1987-2003



Disputes resolved at the Workers' Compensation Board

Hearing requests

Prior to reform, hearing requests increased for more than 20 years, reaching a peak in 1989. Since the first reforms, the number dropped substantially: The number in 1997 was just 41 percent of the peak number. Since then, requests have leveled off at 10,000-11,000 per year.

A primary reason for declining hearing requests was the reconsideration process, which cut the hearing request rate on initial disabling claim closures from 21 percent in 1989 to five percent since 2001. SB 369 also reduced litigation by requiring that workers believing that a condition has been omitted from a notice of acceptance must notify the insurer and not allege a de facto denial in a hearing request.

The median request-to-order time lag for hearings dropped almost 50 percent from 1987 to 1988; since 1991 it has averaged about 125 days for all order types. That lag for board review dropped by 80 percent from 1989 to a record-low 110 days in 2001. The lag for Court of Appeals, on the other hand, increased by 63 percent from 1989's 281 days to 2002's 458 days.

Cases pending before the Hearings Division peaked in June 1987 at 15,664. By June 2000, the number had dropped by 65 percent to 5,400. Four years later, the number of pending cases was up slightly, at 5,600.

Mediation

The 1995 legislature provided for private-party mediation in responsibility disputes, but this service hasn't been used. However, the board since mid-1996 has offered trained administrative-law-judge mediators and facilities, at no cost, to help settle disputes without formal litigation.

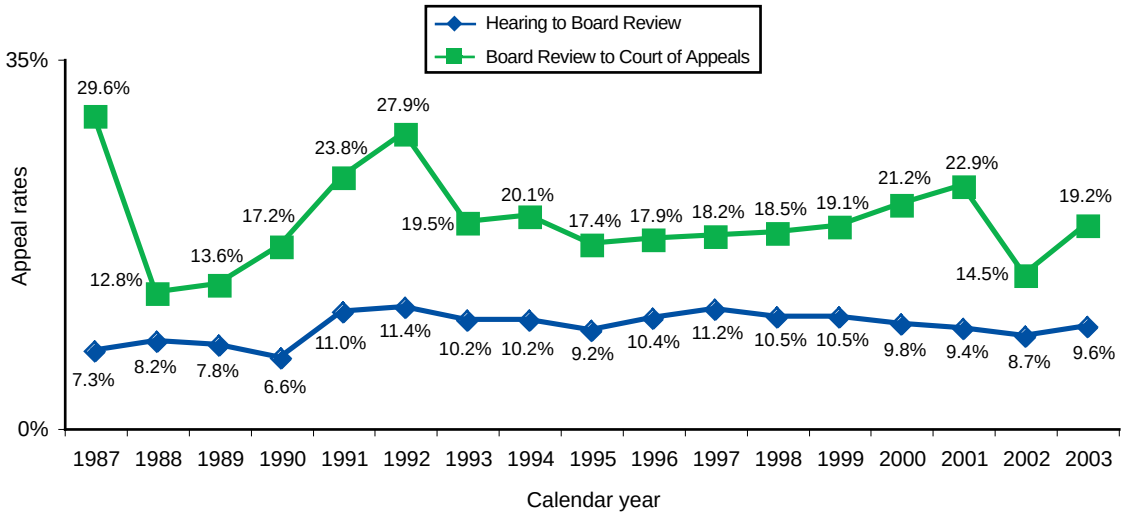
The board has completed nearly 250 mediations per year. Most mediated cases are complex: mental stress claims, occupational disease claims, claims about permanent total disability, and claims with additional issues such as employment rights or other civil actions (tort, contract, etc.). Also, the average mediation deals with 1.5 hearing requests. Nearly 88 percent of mediations result in settlement.

The board also has an agreement with the Court of Appeals to mediate cases pending before the court.

Appeal rates

Reducing litigation means reducing appeal rates from each review level. The appeal rate of reconsideration orders has dropped from 53 percent in 1992 to 32 percent in 2003. Annual appeal rates of hearings orders averaged seven percent for 1987-1990, 11 percent for 1991-1999, and nine percent for 2000-2003. The appeal rate of board-review orders dropped from 1987's 30 percent to 13 percent the next year, partially in response to HB 2900 (1987) which changed the court review standard from de novo to "substantial evidence." Since 1992, the rate has generally been 17-23 percent, well below the 1987 rate.

Figure 35. Appeal rates of WCB hearing orders and board review orders, 1987-2003



Note that law changes may temporarily increase appeal rates, as new and sometimes precedent-setting reform issues arise and decisions are appealed.

Issues litigated

The composition of issues litigated has changed significantly with reform. Extent of permanent disability was by far the most frequent hearing issue in 1987, with 46 percent of the cases, but this percentage dropped to only six percent in 2003. The primary reasons are fewer accepted disabling claims, director-prescribed disability standards, required reconsideration of claim closures, and claim disposition agreements.

On the other hand, the issue of partial denial has risen from nine percent of hearing cases in 1987 to over 38 percent for 2001-2003. One reason for the increase is that the legislature specifically provided for major-contributing-cause denials in SB 369. (Most post-acceptance compensability disputes that don't involve aggravation of the accepted condition are classified as "partial denial.")

Claim disposition agreements

The 1990 legislation allowed workers to compromise and release claim benefits other than medical services in claim disposition agreements. In 1995, SB 369 prohibited the release of Preferred Worker benefits. Since 1992, an average of over 3,200 CDAs per year have been approved by the board. The average agreement in 2003 was almost $13,600.

CDAs significantly reduce the subsequent potential for litigation because workers relinquish rights for most benefit types. Return-to-work studies show that workers who choose CDAs often have difficulty returning to work.

Claimant attorney fees

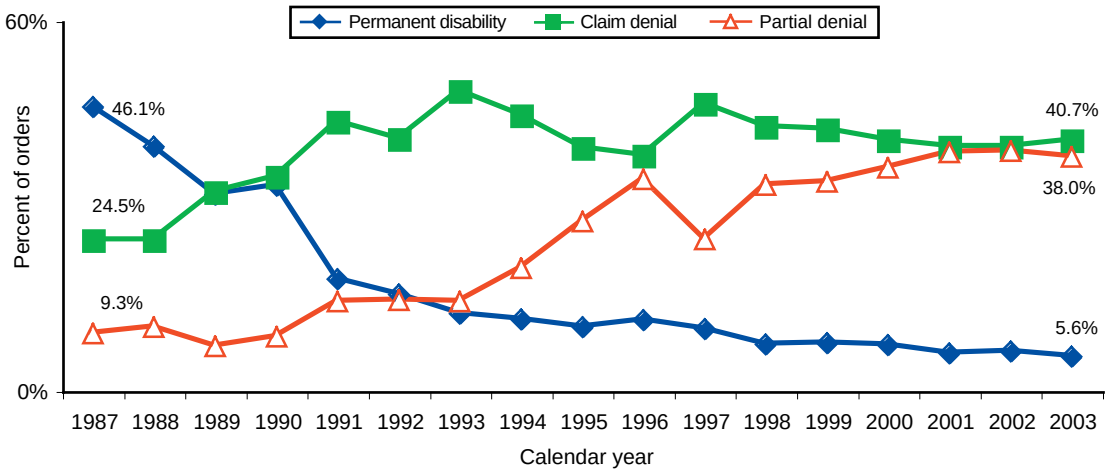
One reason to reduce litigation is that workers retain more of their awards when they pay less in attorney fees. The 1990 law change limited penalty-related attorney fees to half of the penalty amount.

In 1995 (SB 369) the legislature made three changes that further reduced attorney fees. It limited fees in responsibility disputes, prohibited the Hearings Division from awarding penalties and fees for matters arising under the director's jurisdiction, and limited fees for the reversal of a denial prior to a hearing decision to those cases where the denial is based on the compensability of the underlying condition.

In 1999, for the first time in nearly 10 years, the board changed its rules to increase the maximum claimant attorney fees that are payable out of increased awards, in disputed claim settlements, and in CDAs.

In 2003, with SB 620, the legislature reversed the 1990 law change by providing for penalty-related fees proportional to the benefit and limited them to $2,000 except in extraordinary circumstances. It also required a fee when a dispute is settled prior to a contested-case hearing.

Figure 36. Hearing issue relative frequencies, 1987-2003



Total claimant attorney fees jumped by almost 49 percent from 1987 to 1991. However, the total of $17.1 million in 2003 was 80 percent of that in 1991. Fees in 2003 included $886,000 at reconsideration, $8,989,000 at hearing, $721,000 at board review, and $6,535,000 for CDAs.

Lump-sum settlements (CDAs and disputed claim settlements) have accounted for a growing share of total claimant attorney fees, rising from 25 percent in 1989 to near 65 percent in 2001-2003.

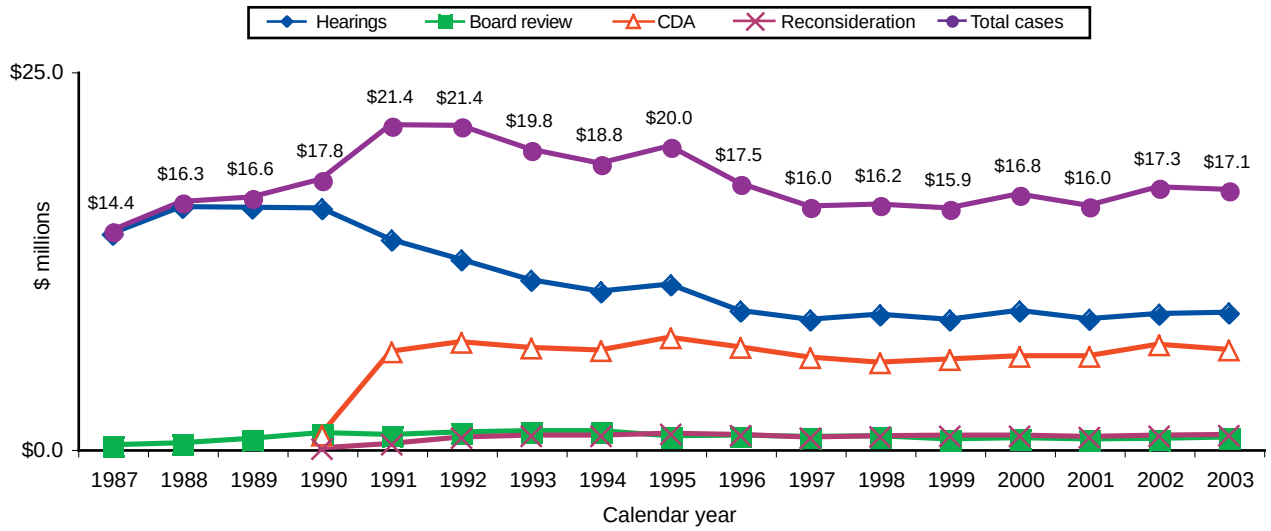
Board own motion

Legislation in 1987 limited worker benefits under own-motion authority to time-loss and medical services. In 2001 (SB 485) the legislature expanded benefits by providing for:

- reopening for treatment provided in lieu of hospitalization to enable return to work
- claims for new or omitted medical conditions after aggravation rights have expired
- permanent disability awards in new/omitted medical condition cases.

Total own-motion orders jumped by 85 percent from 1987 to the peak in 1991, but decreased steadily afterwards to a 2002 value that's only 21 percent of the peak value. Year 2003 counts were up 63 percent over 2002, in significant part due to the 2001 law changes.

Figure 37. Claimant attorney fees, 1987-2003



Reconsideration requests and orders, 1991-2003

Year	Requests on closures	Requests on disabling classifications	Reconsideration request rate	Total orders issued	Percent of orders appealed to hearings
1991	6,066	25	16.8%	5,953	49.0%
1992	6,590	73	17.3%	6,507	53.4%
1993	6,011	87	17.2%	6,027	48.1%
1994	5,915	99	16.9%	6,022	47.8%
1995	6,764	152	16.6%	6,547	43.1%
1996	5,773	128	15.8%	6,255	36.4%
1997	4,621	100	14.6%	4,764	36.4%
1998	4,527	123	14.5%	4,554	35.6%
1999	4,313	126	14.8%	4,521	36.3%
2000	4,078	132	14.5%	4,225	32.0%
2001	4,208	142	15.6%	4,244	33.7%
2002	4,072	188	16.8%	4,281	32.7%
2003	3,888	205	17.1%	4,177	31.8%

The department provides administrative review of decisions made by insurers regarding claim closures and classifications of claims as disabling or nondisabling. Effective 2004, insurers may also appeal claim closures when they disagree with findings on impairment by attending physicians.

Since 1995, the number of requests for reconsideration of claim closures has declined along with the number of claim closures. The rate of requests for reconsideration also declined, though since 2000 the trend has been upward. The overall trend for appeal of reconsideration orders has been down.

Medical dispute requests and orders, 1990-2003

Year	Requests	Orders	Request to order median days
1990	1,172	310	28
1991	1,386	969	112
1992	1,518	1,412	63
1993	876	987	44
1994	466	467	33
1995	741	469	39
1996	716	856	120
1997	878	816	61
1998	801	816	89
1999	904	819	84
2000	994	939	115
2001	1,181	1,222	69
2002	1,054	917	81
2003	1,360	1,290	88

Medical-dispute-resolution requests and orders peaked in 1992, then declined sharply after a court decision limited the department's jurisdiction. SB 369 reversed this decision and the numbers increased. In 1999, SB 728 gave authority for determining the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service to the Hearings Division. In 2003, the number of medical dispute requests and orders rose by almost 30 and 40 percent, respectively.

Medical dispute issues, by year of request, 1997-2003

Year	Fees	Medical services	Treatments	Palliative care	MCO issues	Changes of attending physician	Insurer medical exams	Compensability	Interim medical benefits
1997	34.7%	31.2%	24.1%	4.9%	-	3.6%	1.4%	-	-
1998	4.1%	59.6%	26.5%	3.7%	0.1%	5.0%	1.0%	-	-
1999	5.4%	52.1%	17.1%	6.3%	1.5%	3.7%	2.7%	11.2%	-
2000	9.5%	43.6%	9.7%	5.7%	5.9%	2.1%	1.4%	22.1%	-
2001	22.8%	39.6%	8.7%	3.1%	8.2%	2.4%	1.1%	14.1%	-
2002	15.7%	38.9%	11.8%	3.2%	9.3%	1.8%	1.0%	18.2%	0.1%
2003	13.2%	40.7%	10.7%	2.0%	12.4%	0.7%	0.5%	19.5%	0.4%

SB 728 in 1999 gave responsibility for disputes in which the compensability of the underlying medical condition is at issue to the Hearings Division. These cases were 19 percent of all 2003 medical-dispute-resolution requests.

In 2002, SB 485 amended the law regarding payment for interim medical benefits (medical services provided before a claim's initial acceptance or denial).

Vocational dispute requests and resolutions, 1991-2003

Year	Requests	Resolutions	Request to resolution median days
1991	2,067	2,137	41
1992	1,643	1,725	29
1993	1,493	1,519	25
1994	1,389	1,373	24
1995	1,347	1,304	28
1996	996	1,037	35
1997	877	881	32
1998	716	715	26
1999	630	681	28
2000	549	563	35
2001	511	480	35
2002	512	530	63
2003	504	530	56

The department provides administrative review of vocational disputes brought by workers. The number of requests has fallen by about 75 percent from 1991 to 2003. The decline resulted chiefly from the decrease in the number of vocational assistance cases.

The median number of days to resolve a dispute reached a high point in 2002, declining somewhat to 56 days for disputes resolved in 2003. The goal is to resolve all disputes within 60 days.

Vocational dispute resolutions, by outcome, 1999-2003

Year	Agreements	Insurer prevail orders	Worker prevail orders	Other orders	Dismissals
1999	26.7%	30.5%	7.0%	1.2%	34.6%
2000	25.6%	27.6%	6.4%	1.8%	38.6%
2001	32.9%	17.4%	10.7%	2.5%	36.5%
2002	31.3%	21.7%	13.0%	2.3%	31.7%
2003	27.9%	28.5%	15.9%	0.8%	27.0%

The department strives to resolve vocational disputes through agreements, which generally have accounted for less than a third of resolutions. Since 2000, the percentage of dismissals has decreased, and worker-prevail orders have increased.

Appeals of administrative orders, 1994-2003

Year	Requests	Orders	Request to order mean days
1994	90	107	172
1995	274	169	125
1996	311	373	117
1997	273	279	89
1998	209	191	124
1999	182	183	152
2000	130	133	195
2001	153	163	207
2002	133	158	149
2003	159	135	134

Since 1995, WCD orders about vocational and medical service disputes have been appealed to administrative law judges who are not on staff at the Workers' Compensation Board. This led to an increase in requests.

In 1998, a Court of Appeals decision precluded reconsideration orders concerning timeliness and jurisdiction from this contested-case track. The court ruled that they should be appealed to the board, as are other reconsideration orders. This cut the number of requests. There were 159 requests in 2003, about half the number in 1996.

Issues on appeal of administrative orders, 1999 - 2003

Year	Compliance	Medical	Vocational assistance	Other
1999	7.1%	61.0%	31.3%	0.5%
2000	6.9%	53.1%	36.2%	3.8%
2001	6.5%	60.1%	31.4%	2.0%
2002	9.0%	43.6%	41.4%	6.0%
2003	8.8%	50.3%	40.3%	0.6%

For workers' compensation issues, over 90 percent of contested case hearings requested of the Office of Administrative Hearings concern medical or vocational dispute orders by WCD.

Hearing requests, orders, time lags, and appeal rates, 1987-2003

Year	Requests	Orders	Request to order median days	Appeal rate
1987	20,397	23,680	224	7.3%
1988	23,316	26,386	114	8.2%
1989	27,549	24,890	116	7.8%
1990	24,018	25,073	147	6.6%
1991	19,673	21,368	133	11.0%
1992	17,490	19,580	125	11.4%
1993	16,422	16,888	119	10.2%
1994	16,527	15,751	121	10.2%
1995	14,862	16,798	124	9.2%
1996	12,351	13,341	120	10.4%
1997	11,266	11,596	122	11.2%
1998	11,059	11,271	121	10.5%
1999	11,084	10,846	124	10.5%
2000	10,654	10,935	128	9.8%
2001	11,074	10,269	126	9.4%
2002	10,679	10,830	128	8.7%
2003	10,177	10,429	136	9.6%

Hearing requests peaked in 1989. The number of requests in 1997 was 41 percent of the 1989 count; for 2003, it was just 37 percent of that figure.

Hearing requests have dropped for three primary reasons: fewer injuries and accepted disabling claims; law changes that have reduced litigation about permanent disability; and other reform measures implemented to reduce litigation.

HB 2900 in 1987 required that hearings be scheduled within 90 days and an order published within 30 days of the hearing or review. The median time between request and order fell from 224 days in 1987 to 114 days in 1988. In 2003, it was 136 days, the highest time lag since 1990.

Notes: Counts include settlements that were received without a prior hearing request. Appeal rates are based on all hearing order types, not just appealable orders.

Percentage of hearing orders involving selected issues, 1987-2003

Year	Permanent disability	Claim denial	Partial denial	Insurer penalty
1987	46.1%	24.5%	9.3%	14.6%
1988	39.7%	24.5%	10.4%	16.4%
1989	31.9%	32.3%	7.3%	16.6%
1990	33.3%	34.8%	8.8%	14.6%
1991	18.2%	43.7%	14.5%	10.0%
1992	15.7%	40.9%	14.7%	7.5%
1993	12.6%	48.7%	14.5%	10.3%
1994	11.6%	44.7%	19.9%	12.5%
1995	10.4%	39.4%	27.5%	12.1%
1996	11.5%	38.2%	34.4%	8.4%
1997	10.1%	46.6%	24.6%	5.9%
1998	7.6%	42.9%	33.4%	7.2%
1999	7.8%	42.5%	33.9%	7.8%
2000	7.5%	40.7%	36.2%	7.4%
2001	6.1%	39.7%	38.7%	8.1%
2002	6.4%	39.7%	38.9%	6.6%
2003	5.6%	40.7%	38.0%	7.2%

Permanent disability was the most frequent hearing issue until 1989, when whole claim denial replaced it. For 2001-2003, permanent disability was an issue in only six percent of hearings. Since the late 1980s, partial denial has risen from nine percent of hearings to over 38 percent, second to whole claim denial.

The primary reasons for the relatively frequency change of permanent disability were HB 2900 in 1987 (disability standards, reduced own-motion authority, court review standard), SB 1197 in 1990 (department reconsiderations, medical arbiters, and CDAs), and SB 369 in 1995 (limitations on issues and evidence, and the definition of "gainful employment").

Notes: This table does not include all issues. Also, orders may deal with multiple issues.

Workers' Compensation Board mediations, 1996-2003

Year	Mediations completed	Percent settled	Percent of settlements resolved by DCS
1996	128	84.4%	80.9%
1997	250	91.6%	82.0%
1998	233	90.1%	86.6%
1999	216	89.8%	83.5%
2000	280	89.3%	86.6%
2001	248	85.5%	92.5%
2002	285	86.3%	84.9%
2003	241	86.3%	88.4%

The board's mediation program began in June 1996.

A mediation is considered settled by a disputed claim settlement if any included case is so closed.

Issues in WCB mediations, 1996-2003

Year	Disease	Mental disease	Compensability	Non-WCB issues
1996	50%	31%	N/A	N/A
1997	50%	30%	90%	40%
1998	44%	30%	98%	47%
1999	63%	37%	N/A	46%
2000	41%	32%	97%	43%
2001	49%	36%	99%	51%
2002	42%	27%	95%	54%
2003	41%	20%	99%	45%

"Disease" means compensability of an occupational disease; it includes mental disease.

"Non-WCB issues" includes employment rights, Workers' Compensation Division issues, torts, contracts, and other civil actions.

The cases resolved by mediation almost always include compensability as an issue. Nearly half of the cases include non-WCB issues.

Board review requests, orders, time lags, and appeal rates, 1987-2003

Year	Requests	Orders	Request to order median days	Appeal rates
1987	1,719	1,222	259	29.6%
1988	2,151	991	306	12.8%
1989	1,944	1,576	548	13.6%
1990	1,653	3,067	458	17.2%
1991	2,346	2,064	264	23.8%
1992	2,230	2,487	255	27.9%
1993	1,726	1,931	256	19.5%
1994	1,599	1,814	238	20.1%
1995	1,553	1,655	204	17.4%
1996	1,381	1,676	163	17.9%
1997	1,307	1,229	160	18.2%
1998	1,187	1,358	134	18.5%
1999	1,141	1,147	125	19.1%
2000	1,076	1,166	118	21.2%
2001	966	860	110	22.9%
2002	939	818	209	14.5%
2003	996	1,023	161	19.2%

The number of requests for board review peaked in 1991. Requests have dropped primarily because the number of hearing opinion and orders (judge's decision on the merits) has dropped from the maximum of 6,931 in 1988 to 2,387 in 2003.

HB 2900 in 1987 required a board review to be scheduled within 90 days and an order published within 30 days of the review.

The appeal rate of board-review orders dropped immediately from the 1987 peak, largely because the 1987 legislature (HB 2900) changed the court's review standard from de novo to "substantial evidence."

Note: Counts exclude crime-victim and third-party cases, reconsideration orders, and on-remand orders. Appeal rates are based on all board-review order types, not just orders on review.

Board own-motion orders, 1987-2003

Year	BOM orders
1987	612
1988	724
1989	703
1990	962
1991	1,135
1992	1,003
1993	927
1994	845
1995	751
1996	659
1997	616
1998	639
1999	593
2000	555
2001	431
2002	243
2003	395

In 1987 the legislature (HB 2900) limited worker benefits by own motion. The number of BOM orders peaked in 1991.

The 2001 legislature (SB 485) provided for benefits when treatment is in lieu of hospitalization, new and omitted medical condition claims, and permanent disability. This may account for the increase in orders in 2003 over 2002.

Court of Appeals requests, decisions, and time lags, 1987-2003

Year	Requests	Decisions	Request to decision median days
1987	362	287	335
1988	127	283	323
1989	214	108	281
1990	528	178	298
1991	491	332	293
1992	695	247	321
1993	377	285	295
1994	365	239	286
1995	288	172	299
1996	300	175	288
1997	224	160	318
1998	251	130	330
1999	219	126	343
2000	247	98	376
2001	197	102	426
2002	119	111	458
2003	196	64	457

Appeals to the court peaked in 1992; in 2003, the number of appeals was just 28 percent of the peak.

The primary reasons for the subsequent decline are the decreasing numbers of orders on review and the change in the court's review standard.

Time lags for court decisions climbed for six straight years between 1996 and 2002 to the highest value on record. The 2002 and 2003 court time lags equate to 1.25 years.

Notes: Decisions exclude court dismissals and remands where the court did not rule on the primary issue or direct a resolution. Time lags exclude dismissals.

Median time lag (days) from injury to order, 1987-2003

Year	Hearings	Board	Court
1987	758	1,067	1,496
1988	677	1,098	1,606
1989	602	1,320	1,512
1990	617	1,169	1,770
1991	659	978	1,512
1992	655	1,047	1,549
1993	598	966	1,443
1994	561	870	1,402
1995	574	817	1,490
1996	532	763	1,247
1997	502	723	1,484
1998	488	716	1,330
1999	485	685	1,446
2000	506	721	1,238
2001	496	714	1,281
2002	549	811	1,311
2003	541	780	1,369

Times from injury to order have declined substantially since 1987, in large part due to the changing issue mix. Whole-claim denial is generally the first possible issue in a claim and hearings the first level of appeal.

Notes: Data are for all order types other than Court of Appeals dismissals. The 2003 court lag of 1,369 days equates to 3.7 years.

Disputed claim settlements at hearing and board review, 1987-2003

	Hearing		Board	
Year	DCS cases	Amount ($ millions)	DCS cases	Amount ($ millions)
1987	3,778	$18.2	N/A	N/A
1988	4,139	21.6	N/A	N/A
1989	4,365	22.5	N/A	N/A
1990	5,374	29.1	N/A	N/A
1991	6,021	32.6	N/A	N/A
1992	4,942	25.7	64	$0.980
1993	4,700	24.8	84	1.166
1994	4,100	20.8	64	0.778
1995	4,455	22.2	52	0.521
1996	4,001	19.1	55	0.608
1997	3,846	19.0	49	0.622
1998	3,921	20.3	35	0.374
1999	3,721	19.6	40	0.398
2000	4,019	22.8	55	0.706
2001	3,899	21.2	68	0.854
2002	3,931	23.1	68	0.860
2003	3,703	22.1	71	0.898

The number of DCSs at hearing has dropped significantly since the peak in 1991, but their relative significance has risen. Between 1987 and 2003, DCSs grew from 16 to 36 percent of all hearing orders and from 26 to 74 percent of all settlements. Attorney fees for DCSs have increased from 23 to 48 percent of all hearing claimant attorney fees.

The number of DCSs has been fairly constant.

Note: Since 2000, the board figures include on-remand DCSs.

Claim disposition agreements, 1990-2003

Year	CDA requests	CDA approval orders	Amount ($ millions)
1990	559	359	$6.9
1991	2,869	2,822	45.6
1992	3,229	3,202	47.0
1993	3,301	3,283	42.5
1994	3,230	3,243	41.7
1995	3,767	3,924	48.6
1996	3,526	3,561	45.0
1997	3,293	3,265	44.3
1998	3,037	3,073	37.7
1999	3,092	3,073	39.7
2000	3,155	3,142	39.9
2001	3,105	3,131	39.2
2002	3,223	3,205	44.9
2003	3,009	3,035	41.2

SB 1197 authorized claim disposition agreements in 1990. In 2003, 3035 CDAs were approved, the fewest since 1991. This decline probably results from the decline in the number of claims. $41 million was paid in 2003 for CDAs. This figure includes $6.5 million in claimants' attorney fees.

Claimant attorney fees and defense legal costs, 1987-2003

Year	Claimant attorney fees ($ millions)	Defense legal costs ($ millions)
1987	$14.4	N/A
1988	16.3	N/A
1989	16.6	$23.4
1990	17.8	26.1
1991	21.4	26.9
1992	21.4	28.2
1993	19.8	27.2
1994	18.8	25.7
1995	20.0	27.4
1996	17.5	25.3
1997	16.0	24.3
1998	16.2	24.2
1999	15.9	24.2
2000	16.8	23.9
2001	16.0	25.7
2002	17.3	25.3
2003	17.1	27.1

Claimant attorney fees peaked in 1991 and 1992 at almost 48.6 percent above 1987 fees.

Defense legal costs peaked in 1992, and were rising again in 2003.

Notes: Fees exclude those awarded in own-motion cases and at the Court of Appeals.

Defense legal costs differ from claimant attorney fees in several ways: they include all costs, in addition to fees; they are the actual amounts paid rather than the amounts in rule; they are not reversible on appeal; there may be fees paid to multiple attorneys on a single dispute.

Claimant attorney fees, 1987-2003

Year	Hearings ($ thousands)	Board ($ thousands)	CDA ($ thousands)	Recons. ($ thousands)
1987	$14,187	$226	-	-
1988	15,967	335	-	-
1989	15,953	656	-	-
1990	15,902	1,007	$900	$1
1991	13,796	905	6,419	276
1992	12,505	1,067	7,054	727
1993	11,145	1,165	6,634	858
1994	10,400	1,140	6,465	835
1995	10,859	826	7,346	962
1996	9,100	857	6,675	903
1997	8,518	753	5,996	738
1998	8,863	802	5,664	821
1999	8,537	612	5,908	843
2000	9,128	693	6,118	866
2001	8,540	612	6,111	777
2002	8,914	626	6,878	855
2003	8,989	721	6,535	886

SB 369 in 1995 limited attorney fees in responsibility disputes, prohibited hearing-awarded fees for issues before the director, and limited fees for reversal of denials before hearing.

In early 1999 the board increased the maximum amount of fees that may be awarded out of increased disability awards, disputed claim settlements, and claim disposition agreements.

SB 620 changed penalty fees from one-half of the penalty to fees proportional to the benefit. The maximum fee is $2,000.

In 2003, 38 percent of all fees came from CDAs.

Claimant attorney fees from lump-sum settlements, 1989-2003

Year	Hearing DCS ($ thousands)	Board DCS ($ thousands)	Lump Sum ($ thousands)	Lump sum percentage
1989	$4,049	$98	$4,147	25.0%
1990	5,222	151	6,273	32.5%
1991	6,107	136	12,662	59.2%
1992	4,978	164	12,196	57.1%
1993	4,708	222	11,564	58.4%
1994	4,105	143	10,713	56.9%
1995	4,376	106	11,828	59.2%
1996	3,787	129	10,591	60.4%
1997	3,629	121	9,746	60.9%
1998	3,954	57	9,675	59.9%
1999	3,787	67	9,762	61.4%
2000	4,338	168	10,624	63.2%
2001	4,145	149	10,405	64.9%
2002	4,407	170	11,455	66.3%
2003	4,318	196	11,049	64.5%

Lump-sum attorney fees are from claim disposition agreements and disputed claim settlements. (CDA attorney fees are shown in the previous table.) Lump-sum fees increased from 25 percent of all attorney fees in 1989 (before CDAs) to 66 percent in 2002.

In 1987, DCSs accounted for 23 percent of all hearing fees. This percentage peaked in 2002 at 50 percent.

Note: The 1989-1991 board DCS figures are estimates.

Maximum out-of-compensation attorney fees

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

The maximum claimant attorney fees payable from workers' increased compensation were raised effective February 1999. These limits also apply to reconsideration orders.

Insurance and Self-Insurance

Under Oregon law, every employer is required to provide workers' compensation coverage for its employees. Employers have three insurance options: self-insurance, insurance through a private insurance company, or insurance through the state fund (SAIF Corporation). The department's Workers' Compensation Division regulates self-insured employers. The department's Insurance Division provides financial, rate, solvency, and trade-practices regulation of insurance companies including SAIF, while the Workers' Compensation Division regulates benefits, coverage, and claims practices.

In the late 1980s, the Oregon workers' compensation insurance market was under financial strain. Premiums and systems losses were at all-time highs, and SAIF was losing a million dollars each week. As a result, SAIF canceled the policies of thousands of small employers. Many employers were unable to get new policies from private insurers and ended up in the assigned risk pool. This situation was one of the principal reasons for the 1990 reforms.

Oregon's 1990 reforms allowed employers to exclude some claims costs from their loss experience. Employers are allowed to reimburse up to $500 in medical costs for nondisabling claims. These costs are excluded from their rating experience. The eligibility for board's own motion relief (aggravation more than five years after the first claim closure) was restricted. These costs are paid from the Workers' Benefit Fund and are excluded from the employers' loss experience.

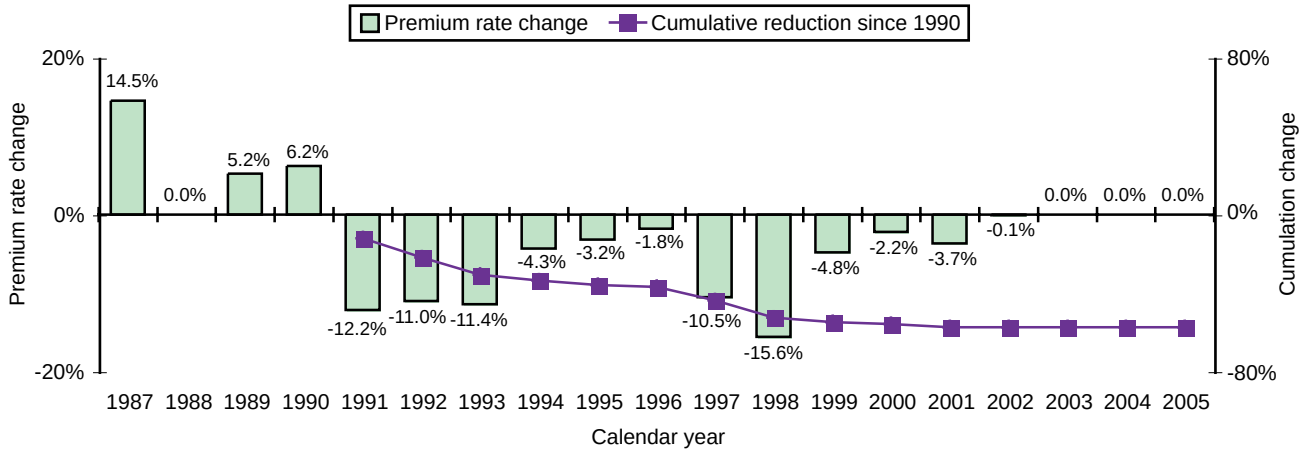
The reforms also provided employer incentives to lower some claims costs by limiting claim duration. Through the Preferred Worker Program, employers are encouraged to hire injured workers who have not returned to work. Employers do not pay premiums for these workers for three years. If any of these workers have a new compensable injury during that time, the claims costs are paid from the Workers' Benefit Fund and excluded from rate making. The Employer-at-Injury Program is another program that encourages employers to bring their injured workers back to work. In addition to lowering claim costs through quicker return to work, this program provides employers with wage subsidies and other benefits.

These changes have had a major effect on insurance rates. Oregon has not had a rate increase for 15 consecutive years. No other state has this track record.

Workers' compensation premiums and rates

Oregon has employed a competitive rate-making system for workers' compensation insurance since July 1, 1982. Under this system, the National Council on Compensation Insurance develops

Figure 38. Pure premium rate changes, 1987-2005



pure premium rates for each of the almost 600 rating classifications, based on expected losses. These rates are subject to the approval of the insurance commissioner. Pure premium covers benefit costs only, based on claims from recent injuries. In addition, each insurer determines an additional percentage for operational expenses, taxes, and profit, and files this expense loading factor with the insurance commissioner.

Overall pure premium rates have been unchanged for the past three years. They had declined in each of the 12 previous years. The largest reductions were in 1991-1993, 1997, and 1998. In these years, the annual reductions were more than 10 percent. As a result, the CY 2005 pure premium rate is 43 percent of the CY 1990 rate.

Every two years, the department studies the rates in other states. An index is then created that applies each state's rates to Oregon's distribution of occupations. Using this measure, Oregon's average premium rate ranking was 6th highest in the nation in 1986. After these early reforms, it dropped from 8th highest in 1990 to 32nd highest in 1994. Oregon's ranking was 42nd highest in 2004.

Workers' compensation total system written premiums totaled $859.0 million in 2004. (The department defines total system written premiums as the premium written by insurers, plus a simulated premium that the department calculates for each self-insured employer to set its workers' compensation assessment, and estimated premium from large-deductible premium credits.) Premiums have grown steadily since 1999, when they were $607.6 million. The average annual growth rate since 1999 has exceeded 7 percent.

Insurers can pay dividends to their policyholders. Dividends depend on premiums and insurers' profitability in previous years. Between 1998 and 2000, SAIF paid $492 million in dividends. It has paid very little in dividends since. On average, private insurers have paid dividends equal to two to three percent of their earned premiums each year.

The loss ratio (defined as incurred losses divided by earned premiums) is one measure of an insurer's financial status. SAIF's loss ratio was 123.3 percent in 2004. SAIF's loss ratio has been above 100 percent in five of the past six years. Its loss ratio has been volatile over the years, due in part to substantial adjustments to its reserves. Private insurers' loss ratio was 88 percent. The combined loss ratio for SAIF and private insurers in 2004 was 107.6 percent.

There have been changes over time in the distribution of the costs that premiums cover. The percent of premiums paying for medical benefits increased from 33 percent in 1989 to 43 percent in 2004, while the percentage paying for indemnity benefits decreased from 46 percent to 35 percent. Insurer overhead expenses were 22 percent of premiums in 2004.

Figure 39. Workers' compensation premium breakdown, calendar years 1989 and 2004

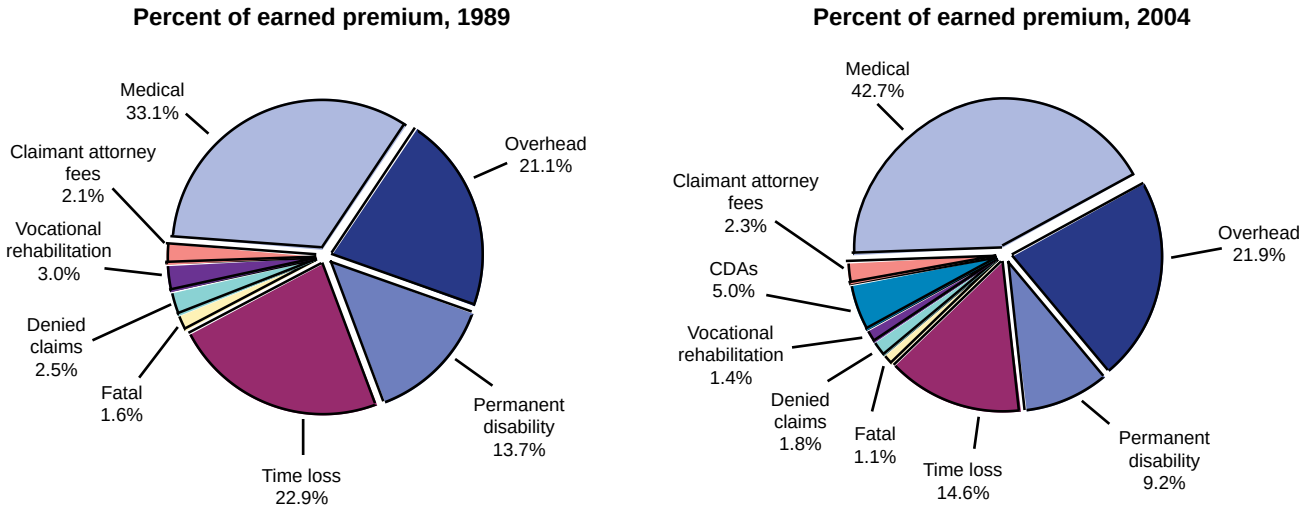
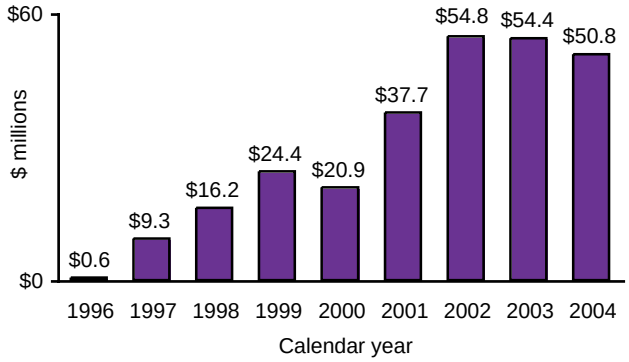


Figure 40. Earned large deductible premium credits, 1996-2004



Premium adjustment program for contractors

In 1990, SB 1197 allowed the department to establish a contracting classifications premium adjustment program. It provides employers subject to contractor class premium rates with the economic incentive to enhance workplace safety through lower premiums. More than 2,200 employers participated during the first five years of the program. (The program is continuing, but recent data are not available.)

Large-deductible premium policies

In 1996, large-deductible premium policies were added as an option to workers' compensation in Oregon. Under deductible policies, insurers administer the workers' compensation claims and pay the claims costs. Employers reimburse insurers for claims costs up to the specified deductible amount. In return for purchasing policies with a deductible, employers pay lower premiums. Insurers and employers are assessed on earned premium prior to deductible credits.

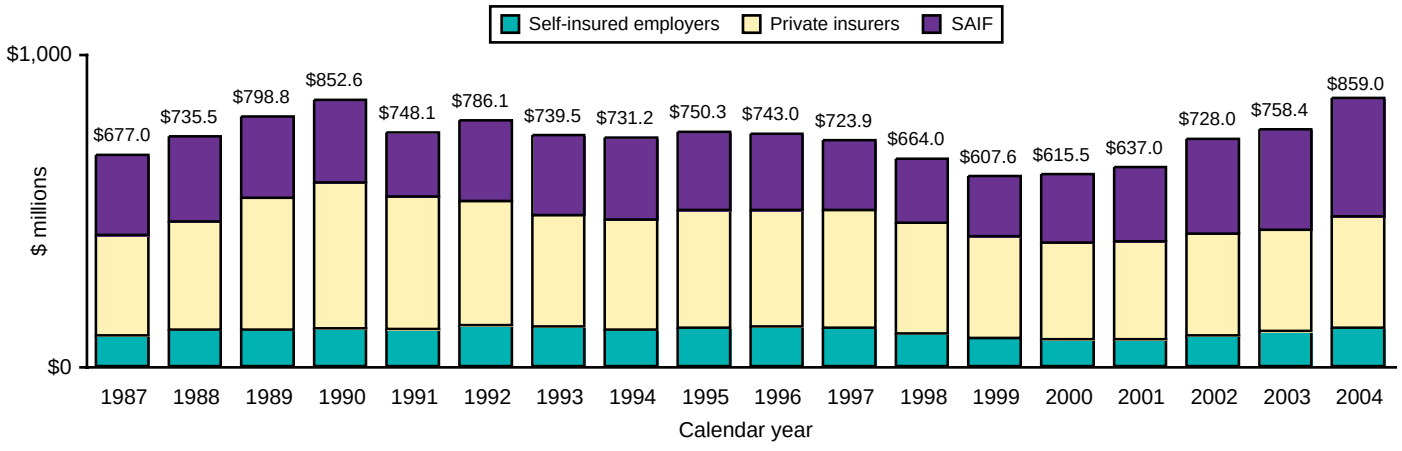
Few credits were applied in 1996, but the program has grown rapidly since. An estimated $50.8 million credits were applied in 2004. This amount was 14 percent of private insurers' written premium. (The state's two largest insurers, SAIF and Liberty Northwest, do not write large-deductible premium policies.)

Self-insured employers and groups

There were 157 self-insured employers active in Oregon for at least part of 2004. These employers must meet specific financial criteria and must obtain excess workers' compensation insurance from an authorized company. This excess insurance protects the self-insured employer in the event of a catastrophic claim. In addition, the self-insured employer must have deposits with the Workers' Compensation Division. These deposits protect injured employees in the event of the employer's bankruptcy.

There are also six employer groups, combining over 1,100 employers. Employers can form groups if all of the employers in the group are members of an organization, the employers in the group constitute at least 50 percent of the employers in the organization (unless the number of covered workers in the group exceeds 500, in which case the employers in the group must constitute at least 25 percent of the employers in the organization), and

Figure 41. Total system written premiums, by insurer type, 1987-2004



the grouping of employers is likely to improve accident prevention, improve claims handling for the employers, and reduce expenses. Employers who are members of the group are jointly liable for one another's workers' compensation claims.

Market share

Workers' compensation market share can be determined using total system written premiums, including the estimated premiums for self-insured employers and for large-deductible premium credits. In 2004, the market share of SAIF and the Liberty group was 65 percent. SAIF's share of the market was 44 percent, and the Liberty group's share was 21 percent. SAIF's market share was its highest since 1978. Over the past several years, the market has been at its most concentrated level in at least 20 years.

Although 421 private insurers were authorized to write workers' compensation insurance in Oregon, only 176 reported positive premium written in 2004. Private insurers, including the Liberty group, had 41 percent of the market. Self-insured employers made up 14 percent of the market.

Oregon Workers' Compensation Insurance Plan (Assigned Risk Pool)

When the legislature created SAIF in 1965 it provided that, if requested by either SAIF or NCCI, the insurance commissioner must promulgate an assigned-risk plan to make workers' compensation insurance available to employers unable to obtain coverage in the voluntary market. The law was amended in 1979 to implement a plan. In 1980, the commissioner adopted rules constituting the Oregon Workers' Compensation Insurance Plan and establishing the state's Assigned Risk Pool. As a result, SAIF no longer acted as insurer of last resort.

Under Oregon's assigned-risk plan, SAIF and Liberty Northwest act as service providers. Premium rates paid by employers for coverage reflect state pure premium rates and an expense load factor, for administrative costs, recommended by NCCI and subject to the commissioner's approval. Reinsurance is provided by the National Workers' Compensation Reinsurance Pool, with the cost borne by all insurers in proportion to their share of all Oregon workers' compensation premiums written.

Due primarily to SAIF's cancellation of thousands of small employer policies in 1990, Oregon's assigned-risk plan premium, as a percentage of voluntary market premium, increased from three percent in 1987 to 11 percent in 1991. In subsequent years, programs such as the AOI Compwise program and the NCCI Take-Out Credit Program helped to lower the number of employers assigned to the pool. As a result, the pool premium declined to three percent of written premium in 2000. The pool again increased rapidly between 2000 and 2003. The growth slowed in 2004. There are about 12,800 employers in the pool; the premium was about eight percent of the written premium.

A tiered rating plan was first mandated in 1991 for assigned-risk plan employers too small to qualify for experience rating plans. Under the plan, small employers receive a premium discount. Most of the employers in the assigned risk plan received a non-experience-rated credit of 11 percent. In 1994, a second-tier credit was added to the assigned-risk plan for new small businesses. The additional credit is for 15 percent. The tiered rating plan has resulted in savings in premium of about $1 million a year.

Oregon Insurance Guaranty Association

The Oregon Insurance Guaranty Association is an insurance organization that pays claims costs when one of its member insurers becomes insolvent. Membership is mandatory for all private insurers. The OIGA collects assessments from its members to cover these costs.

In 2003, HB 3051 changed the method for generating these assessments. It authorizes the insurers to recoup the assessments by assessing each policyholder an amount based on the policyholder's premium.

Workers' compensation premiums and rate changes, 1987-2005

Year	Total system written premiums ($ millions)	Annual pure premium rate changes	Cumulative rate changes since 1990
1987	$677.0	14.5%	
1988	735.5	0.0%	
1989	798.8	5.2%	
1990	852.6	6.2%	
1991	748.1	-12.2%	-12.2%
1992	786.1	-11.0%	-21.9%
1993	739.5	-11.4%	-30.8%
1994	731.2	-4.3%	-33.7%
1995	750.3	-3.2%	-35.9%
1996	743.0	-1.8%	-37.0%
1997	723.9	-10.5%	-43.6%
1998	664.0	-15.6%	-52.4%
1999	607.6	-4.8%	-54.7%
2000	615.5	-2.2%	-55.7%
2001	637.0	-3.7%	-57.3%
2002	728.0	-0.1%	-57.4%
2003	758.4	0.0%	-57.4%
2004	859.0	0.0%	-57.4%
2005	N/A	0.0%	-57.4%

Workers' compensation pure premium rates have decreased 57 percent between 1991 and 2005. Total system written premiums decreased by $245 million between 1990 and 1999; they increased $251 million between 1999 and 2004, an annual growth rate of over seven percent.

Notes: Although self-insured employers do not pay premiums, the department calculates a simulated premium for each self-insurer. Figures here include these simulated premiums. They also include large-deductible premium credits.

Workers' compensation average premium rate ranking, 1986-2004

Year	Rate ranking
1986	6th
1988	8th
1990	8th
1992	22nd
1994	32nd
1996	34th
1998	38th
2000	34th
2002	35th
2004	42nd

Oregon's average premium rate ranking improved from sixth-highest in the nation in 1986 to 38th highest in 1998. In 2004, the ranking dropped to 42nd highest.

Note: The premium rate ranking is based on the manual rates in the 50 states applied to Oregon's mix of occupations. The use of other occupational distributions will produce different rankings.

Premium adjustment program for contracting employers, 1991-1995

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

More than 2,200 employers participated during the first five years of the program.

Note: The National Council on Compensation Insurance has not provided data since 1995.

Large-deductible premium credits, 1996-2004

Year	Premium credits ($ millions)	% of private insurer written premium
1996	$0.6	0.2%
1997	9.3	2.5%
1998	16.2	4.6%
1999	24.4	7.5%
2000	20.9	6.8%
2001	37.7	12.0%
2002	54.8	16.8%
2003	54.4	16.8%
2004	50.8	14.3%

Large-deductible premium credits are credits on employers' workers' compensation premium. Participating employers repay to insurers their claims costs up to the deductible amounts. The use of these credits grew rapidly through 2002.

Workers' compensation market share, by insurer type, 1987-2004

Year	SAIF	Private insurers	Self-insured employers
1987	37.9%	47.7%	14.4%
1988	37.0%	47.1%	15.9%
1989	32.5%	52.8%	14.7%
1990	31.1%	54.8%	14.1%
1991	27.3%	56.9%	15.8%
1992	32.7%	50.5%	16.7%
1993	34.7%	48.0%	17.2%
1994	36.0%	48.1%	15.9%
1995	33.2%	50.4%	16.3%
1996	32.6%	50.4%	17.0%
1997	30.9%	52.3%	16.8%
1998	31.0%	53.2%	15.8%
1999	31.4%	53.7%	14.9%
2000	35.7%	50.2%	14.0%
2001	37.2%	49.3%	13.5%
2002	41.7%	44.9%	13.4%
2003	42.5%	42.8%	14.7%
2004	44.3%	41.4%	14.3%

In 2004, as measured by total system written premiums, SAIF had 44 percent of the market, its highest percentage since 1978. Private insurers' share dropped to 41 percent. The Liberty group of insurers had 21 percent of the market, 51 percent of the private insurer premium.

SAIF Corporation financial characteristics, 1987-2004

Year	Total system written premiums ($ millions)	Loss ratio	Dividends ($ millions)
1987	$256.3	114.4	$0.5
1988	272.2	134.8	0.6
1989	259.8	104.8	0.0
1990	265.4	69.3	20.4
1991	204.6	72.6	17.7
1992	257.4	3.7	22.6
1993	256.8	121.0	32.6
1994	262.9	69.2	29.7
1995	249.3	82.4	80.2
1996	242.2	125.6	50.1
1997	223.6	66.6	69.8
1998	205.7	40.6	121.1
1999	191.0	140.4	211.5
2000	220.0	166.2	159.4
2001	237.0	94.5	0.1
2002	303.4	108.9	-0.6
2003	322.0	109.5	0.2
2004	380.2	123.3	2.0

SAIF's written premium grew by almost 15 percent per year between 1999 and 2004. The 2004 premium was $380.2 million, the largest amount ever reported by SAIF.

SAIF's loss ratio (incurred losses divided by earned premiums) has been above 100 percent for five of the past six years. SAIF had a low loss ratio in 1992 due to a substantial downward revision in prior accident years' outstanding reserves arising from the reforms in SB 1197 in 1990.

Between 1998 and 2000, SAIF paid $492 million in dividends. Little has been paid since. The 2002 negative dividend figure represents uncashed dividend checks credited back to SAIF.

Private insurers' financial characteristics, 1987-2004

Year	Total system written premiums ($ millions)	Loss ratio	Dividends ($ millions)
1987	$323.1	84.6	$3.0
1988	346.5	80.0	7.1
1989	421.8	83.3	8.4
1990	467.0	69.0	7.6
1991	425.5	61.9	10.0
1992	397.2	65.6	14.3
1993	355.2	66.1	10.1
1994	351.6	72.8	12.5
1995	378.4	68.2	12.5
1996	374.8	66.8	10.3
1997	378.4	62.2	9.4
1998	353.6	71.3	10.3
1999	326.0	69.4	11.6
2000	309.1	78.4	10.3
2001	314.0	88.7	8.4
2002	327.0	66.7	6.0
2003	324.7	91.2	3.1
2004	355.7	88.0	2.6

Private insurers' written premium grew by less than four percent per year between 2000 and 2004. The 2004 premium was $355.7 million.

The loss ratio for all private insurers was 88.0 percent in 2004. The average over the past six years has been 80.4 percent.

Private insurers have usually paid back between two and three percent of written premium in dividends.

WC insurance plan (Assigned Risk Pool) characteristics, 1987-2004

Year	Covered employers	Pool premium ($ millions)	Percent of total premium
1987	1,935	$19.4	3.4%
1988	1,872	20.1	3.3%
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	18,008	53.1	8.7%
1995	17,982	49.1	7.9%
1996	13,627	34.5	5.6%
1997	12,771	24.7	4.2%
1998	11,369	21.3	3.8%
1999	9,739	17.3	3.4%
2000	7,414	16.5	3.2%
2001	8,533	25.2	4.9%
2002	10,981	42.4	7.4%
2003	12,421	55.6	9.4%
2004	12,761	57.5	8.4%

After declining during the late 1990s, the Assigned Risk Pool grew rapidly between 2000 and 2003, from three percent to nine percent of the total premium. Although there was some increase in 2004, pool premium as a percentage of written premium declined somewhat.

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 saved employers over $10 million between policy years 1991 and 1998.

Note: The National Council on Compensation Insurance has not provided data since 1998.

Workers' Benefit Fund

The 1995 passage of HB 2044 created the Workers' Benefit Fund and altered the structure of the workers' compensation accounts. Effective January 1, 1996, the WBF contains these former workers' compensation programs: Handicapped Worker, Reemployment Assistance, Reopened Claims, and Retroactive programs. It also includes the Noncomplying Employer and Rehabilitation programs. The NCE and Rehabilitation programs formerly were included within the Premium Assessment Operating Account (a major account of the DCBS Fund). They are funded by the workers' compensation premium assessment, so transfers from the PAOA are made quarterly to the WBF to cover the NCE and Rehabilitation program expenditures. WBF assessment revenue funds the other programs.

Prior to the passage of SB 484 during the 1997 legislative session, assessment rates were set so that the fiscal-year ending fund balance would be approximately two quarters of expenditures and rate volatility would be minimized. SB 484 altered the target to four quarters of expenditures. This language was set to expire at the end of calendar year 1999, but SB 213, enacted in 1999, codified the fund balance change for the assessment-funded programs.

Senate Bill 485, passed during the 2001 session, added a component to the WBF. It allows wages from multiple jobs to be considered in time-loss computations. Previously, only the wages from the job at injury could be used. This provision was effective for claims for injuries since January 1, 2002. A new program was established within the WBF to report expenditures associated with SB 485 multiple jobs.

Effective July 1, 2001, the WBF also funds a portion of the DCBS operating costs associated with the administration of WBF programs. The department's fiscal year 2004 budget includes a transfer of $3.7 million from the WBF to the Premium Assessment Operating Account for the reimbursement of administrative costs.

The WBF assessment rate is currently set at 3.4 cents per hour. Employers and workers each pay half of the assessment.

Figure 42. Workers' Benefit Fund expenditures and transfers, fiscal year 2004

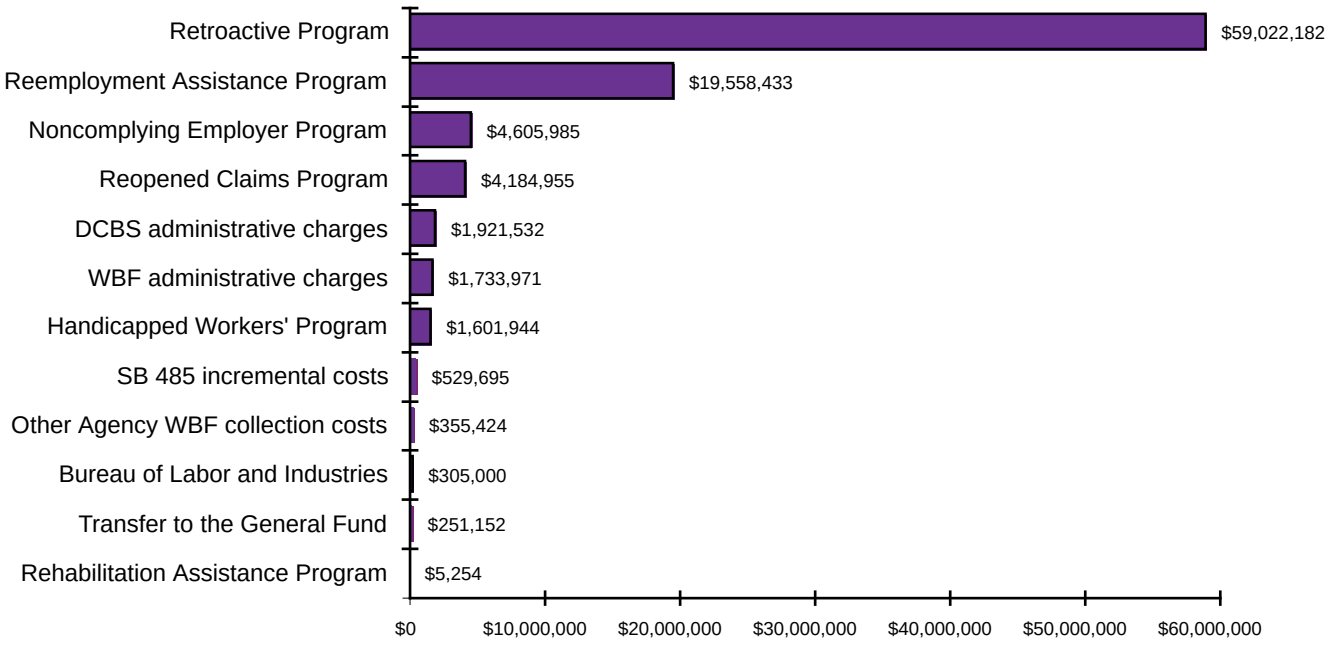
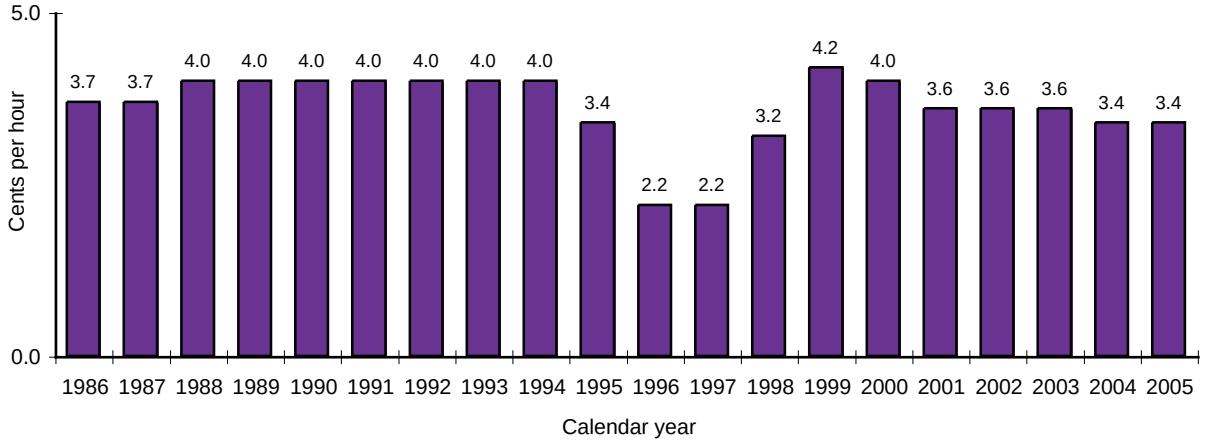


Figure 43. Oregon WBF (Cents-Per-Hour) assessment rate, 1986-2005



Handicapped Workers' Program

Senate Bill 1197, passed during the 1990 special session, increased the level of incentives offered under the Reemployment Assistance Program and phased out the Handicapped Workers' Reserve. No new applications were accepted after May 1, 1990. Therefore, the program expenditures have been slowly declining. Nevertheless, $1.6 million was paid in fiscal year 2004, and expenses on existing claims will be incurred for years to come.

Rehabilitation Assistance Program

The Rehabilitation Assistance Program was created to reimburse providers for vocational assistance services and to pay temporary disability compensation during vocational training. It is limited to claims for injuries that occurred prior to January 1, 1986. There were no expenditures from FY 2000 through the third quarter of FY 2004. However, SAIF submitted a request for reimbursement under this program for the last quarter of FY 2004. Some payments may occur from this program in the future.

Reemployment Assistance Program

The Reemployment Assistance Program provides incentives for hiring workers injured on the job. The major incentive programs currently available are the Preferred Worker Program and the Employer-at-Injury Programs. The Reemployment Assistance Program also includes several other programs.

The Preferred Worker Program is designed for injured workers who suffer a permanent disability and who are unable to return to regular work. Under the program, if an injured worker is hired as a Preferred Worker and has a new injury during the first three years of re-employment, then the Reemployment Assistance Program pays the claims costs, including administrative costs. The program also pays wage subsidies, direct employment purchases, and work-site modifications. In fiscal year 2004, $8.2 million were spent on the Preferred Worker Program.

The Employer-at-Injury Program provides incentives for employers to return workers to the job prior to claim closure. Since 1995, employers with injured workers who have either disabling or nondisabling claims can use the program. Workers who have not been released to regular work but who can return to light-duty transitional jobs are eligible. Expenditures totaled $9.6 million in FY 2004.

The Worksite Redesign Program was started in 1995. It provided research and product grants for redesigning a work place or station to lessen the occurrence of on-the-job injuries and illnesses. It was eliminated, however, by the 2001 legislature in SB 5507. Nevertheless, contractual obligations continue to be paid in FY 2004, and a small amount in FY 2005 is expected to conclude payments from the program.

The Reemployment Assistance Program also provides money to the Oregon Health Sciences University Center for Research on Occupational and Environmental Toxicology. The funds pay some of the center's expenses. Of the 3.4 cents per hour assessment, 1/16 of a cent is paid to CROET. In FY 2004, this totaled $1.6 million.

Retroactive Assistance Program

The Retroactive Assistance Program is the largest WBF program. In FY 2004, the program had $59.0 million in expenditures. It pays benefit increases to workers or their beneficiaries for benefit levels that are lower than current levels.

Effective October 1, 2003, the Retroactive Program benefits were increased by 0.924 percent for injuries prior to July 1, 2002. The maximum PTD benefit remained at 90 percent of the average weekly wage. This decision gives those workers who were injured prior to July 1, 2002, a cost-of-living adjustment. The benefit decisions also recognized the fatal benefit increase mandated by SB 369, for surviving spouses without children, and the administrative decision to grant a similar increase to surviving spouses with children effective October 1, 1996.

Reopened Claims Program

This program was created by the 1987 legislature to fund payments authorized by the Workers' Compensation Board for claims reopened more than five years after their first closure. The program reimburses temporary-disability and medical-benefit costs for claimants with injuries prior to January 1, 1966. It only provides reimbursements for temporary-disability costs for claimants with more recent injuries. In addition, provisions in SB 485 permit the Workers' Compensation Board to grant permanent partial disability benefits for new or omitted medical conditions.

Noncomplying Employer Program

The department has the responsibility for enforcing the laws and rules related to employer workers' compensation coverage. An employer who violates the law by not having workers' compensation insurance is called a noncomplying employer. The department pays the costs of injured workers employed by noncomplying employers. It then recovers claims costs from those employers and levies monetary penalties against them. The remaining program expenditures are financed by a transfer from the Premium Assessment Operating Account. In FY 2004, the program had $4.6 million in expenditures.

Handicapped Workers' and Rehabilitation Assistance Program expenditures, fiscal years 1987-2004

Fiscal year	Handicapped Workers' Program ($ millions)	Rehabilitation Assistance Program ($ millions)
1987	$9.8	$30.4
1988	12.1	17.8
1989	11.8	11.0
1990	10.7	5.1
1991	9.0	4.3
1992	6.4	2.0
1993	4.5	1.2
1994	3.8	0.7
1995	2.6	-0.1
1996	1.8	0.5
1997	2.1	0.0
1998	2.0	0.0
1999	2.2	0.0
2000	1.7	0.0
2001	1.3	0.0
2002	1.3	0.0
2003	1.4	0.0
2004	1.6	0.0

The Handicapped Workers' Program was created by the legislature in 1981 and provides reimbursement to employers or insurers for costs in excess of $1,000 for injuries suffered or caused by previously disabled workers. SB 1197, enacted during the 1990 special session, restricted the Handicapped Worker Program to cases for which application for reimbursement had been made prior to May 1, 1990. The program paid $1.6 million in FY 2004.

The Rehabilitation Assistance Program was created to pay for vocational assistance services and temporary disability compensation during vocational training. It is limited to claims for injuries prior to January 1, 1986. There had been no expenditures from this program since the first quarter of FY 2000. In the last quarter of FY 2004, however, SAIF requested reimbursement for three claimants under this program and a small amount was paid. Hence, there may be more payments in the future.

Reemployment Assistance Program expenditures, fiscal years 1991-2004

Fiscal year	Reemployment Assistance Program ($ millions)
1991	$7.6
1992	9.1
1993	10.5
1994	15.4
1995	18.6
1996	25.1
1997	33.3
1998	28.8
1999	29.3
2000	26.4
2001	28.9
2002	20.5
2003	17.1
2004	19.6

The Reemployment Assistance Program funds employment incentives through the Preferred Worker and Employer-at-Injury programs.

Reemployment Assistance Program expenditures peaked at $33.3 million in FY 1997. Part of the reduction can be attributed to a reduction in the number of PPD claims. With few exceptions, a worker must have a PPD award to be eligible for benefits from the Preferred Worker Program.

Total Reemployment Assistance Program expenditures reflect certain programmatic costs that are not explicitly identified in the detailed Reemployment Assistance Program tables.

Expenditures for the Preferred Worker portion of the Reemployment Assistance Program, fiscal years 1991-2004

Fiscal year	Wage subsidy ($ millions)	Worksite modification ($ millions)	Obtained employment purchases ($ millions)	Claim cost reimbursements ($ millions)
1991	$3.1	$0.7	$0.1	$0.0
1992	3.2	1.9	0.1	0.4
1993	2.8	2.0	0.1	1.1
1994	3.5	2.8	0.3	1.9
1995	3.7	2.5	0.3	2.6
1996	3.8	2.7	0.5	3.1
1997	4.9	3.1	0.6	3.2
1998	4.4	3.4	0.7	3.2
1999	4.6	2.6	0.6	3.7
2000	3.8	2.3	0.4	3.4
2001	3.9	2.0	0.3	3.0
2002	2.9	1.9	0.3	3.1
2003	2.7	1.7	0.2	2.4
2004	3.1	2.2	0.2	2.7

The Preferred Worker Program was created by HB 2900 in 1987. It provides the opportunity for assistance for many injured workers with PPD awards who have not returned to regular work. Expenditures for the program were $8.2 million in FY 2004.

Benefits of the program include wage subsidy, worksite modifications, and payment for items needed for employment, such as tools. The program also reimburses insurers for claims costs if the worker suffers a new injury.

Expenditures for the other components of the Reemployment Assistance Program, fiscal years 1991-2004

Fiscal year	Employer-at- Injury Program ($ millions)	Worksite redesign ($ millions)	CROET ($ millions)	Rehabilitation facilities ($ millions)
1991	$0.0	$0.0	$0.0	$3.2
1992	0.0	0.0	0.0	3.2
1993	0.0	0.0	0.0	4.3
1994	1.8	0.0	1.3	3.6
1995	3.9	0.0	1.4	3.8
1996	5.3	0.0	2.2	3.5
1997	10.1	0.1	3.2	3.8
1998	9.9	1.2	1.7	3.4
1999	11.6	1.0	1.5	3.2
2000	10.4	0.6	1.4	3.4
2001	10.6	1.3	1.6	6.1
2002	10.4	0.4	1.6	0.0
2003	8.4	0.1	1.6	0.0
2004	9.6	0.2	1.6	0.0

The Employer-at-Injury Program is available to employers with injured workers who have not been released to regular work but who can return to light-duty jobs. In 1995, SB 369 expanded the program to cover workers with nondisabling claims. This led to increased expenditures.

The Worksite Redesign program, started on August 1, 1996, funded research and product grants. Funding for this program ended with the close of the 1999-2001 biennium, but some residual costs remain.

In accord with ORS 656.630, a portion of WBF assessment revenue is paid to the OHSU Center for Research on Occupational and Environmental Toxicology for payment of operational expenses.

Rehabilitation Facilities expenditures were a reimbursement of workers' compensation premium payments made by Sheltered Workshops (Rehabilitation Facilities).

Noncomplying Employer, Reopened Claims, and Retroactive Assistance Program expenditures, fiscal years 1991-2004

Fiscal year	Noncomplying Employer Program ($ millions)	Reopened Claims Program ($ millions)	Retroactive Assistance Program ($ millions)
1991	$6.7	$4.2	$43.8
1992	6.7	4.1	45.4
1993	6.9	3.8	47.4
1994	6.8	3.4	48.5
1995	5.5	3.9	50.2
1996	3.6	2.7	54.5
1997	4.8	3.6	60.1
1998	3.8	3.9	61.3
1999	4.4	3.4	66.3
2000	4.5	4.1	63.2
2001	3.8	3.6	64.6
2002	4.2	3.9	66.3
2003	4.2	4.0	64.0
2004	4.6	4.2	59.0

Under Oregon law, people who are injured while working for a NCE have the same right to medical care and compensation as do other workers. Claims for employees of NCEs are sent to DCBS by either workers or their attorneys when they want to recover medical costs or time-loss wages. Noncomplying Program expenditures peaked in 1993 at $6.9 million. Since FY 1997 expenditures have averaged about $4 million per year. Johnston and Culbertson Inc. has handled NCE claims since August 1, 1998.

The Reopened Claims Program was established by the 1987 legislature and provides reimbursement to insurers, self-insured employers and self-insured employer groups for costs arising from specific claim costs associated with board's own-motion orders. Expenditures from the Reopened Claims Program were $4.2 million in FY 2004, the highest level since FY 1991. FY 2003 and FY 2004 expenditures include additional costs to this program occasioned by SB 485.

The Retroactive Program provides increased benefits to workers or their beneficiaries for benefit levels that are lower than current benefits. Expenditures peaked in 1999 and 2002 at $66.3 million. Increases in program expenditures are attributable mainly to growth in the average weekly wage, which drives the annual benefit level increase. However, reduced expenditures in recent years are a function of a reduction in the pool of beneficiaries due to lower claim volume and stricter acceptance criteria.

Multiple Wage Job Program expenditures, fiscal years 2002-2004

Fiscal year	Multiple Wage Jobs Program ($ millions)
2002	$0.0
2003	0.3
2004	0.5

Expenditures for the Multiple Wage Jobs Program arise from SB 485, passed in 2001. It provides payment of supplemental temporary disability benefits for workers employed in more than one job at the time of injury. It also reimburses the administrative costs of handling these payments.

Workers' Compensation Premium Assessment

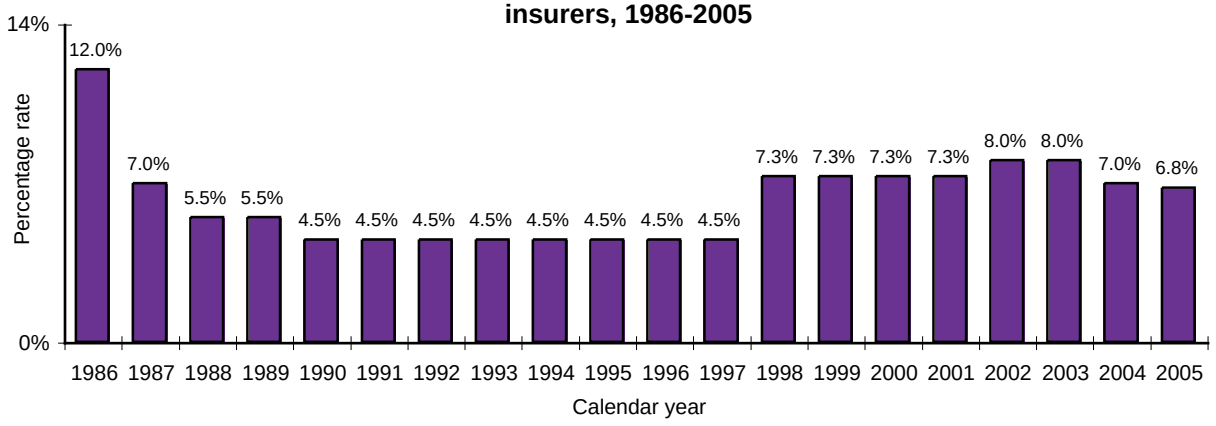
Much of the regulation of the Oregon workers' compensation system is funded by an assessment on workers' compensation premium. The assessment revenue is collected from insurers based on workers' compensation premiums earned in Oregon. (For self-insured employers and self-insured employer groups, the assessment is based on the simulated premium calculated by the department.) The revenue is deposited into the Premium Assessment Operating Account. The PAOA is also funded by some fines and penalties, federal grant moneys, investment income, other miscellaneous revenues, and a transfer of funds from the Workers' Benefit Fund to reimburse some of the WBF administrative costs. The fund is used to pay for many of the operations of the Workers' Compensation Division, Workers' Compensation Board, OR-OSHA, and some of the duties of the Insurance Division, the Director's Office, and the department's support divisions. The current rules for setting the assessment rate were established in 1999 by Senate Bill 592.

As of January 2005, the assessment rate for insurers is 6.8 percent of premium, down from 7.0 percent in 2004. For self-insured employers and self-insured employer groups, it is 7.0 percent. The rate for self-insured employers and self-insured employer groups is higher than that for insurers to fully fund the Self-Insured Employer Adjustment Reserve and the Self-Insured Employer Group Adjustment Reserve. The rate for self-insured employers has been the same as for insurers, but it was not lowered for 2005. This is because of recent defaults by several self-insured employers.

These 2005 rates are the lowest since the period 1988-1997, when the rates were lowered to draw down the PAOA fund balance. The fund is managed to meet the cash-flow needs of the account; accommodate the timing of receipts and expenditures; ensure stable funding for legislatively approved programs and services during uncertain economic times; and minimize the volatility of fees and assessments. The department's current policy is to slowly draw down the fund without rate volatility until the ending balance is approximately equal to six months of expenditures.

In FY 2004, there were $53.2 million in expenditures from the PAOA. $58.5 million was gathered through premium assessment. In addition, $1.8 million was earned in investment income, $1.8 million was gathered in fines and penalties, and $5.4 million was gotten in federal funds. The fund also received money transferred to the account from other accounts and transferred money to the Workers' Benefit Fund to cover some of its administrative costs and to pay for the Noncomplying

Figure 44. Workers' compensation premium assessment rate, insurers, 1986-2005



Employer Program. Also, $1.6 million was paid to OHSU. The money paid from PAOA matches the money paid to OHSU from the WBF.

The PAOA was also affected in FY 2004 by three bills from the 2003 legislature. House Bill 2148 and HB 5077 required the transfer of $18.2 million from the PAOA to the state's general fund. HB 3630 required that SAIF create a reinsurance program for rural physicians. This program reimburses some of the cost of these physicians' medical liability costs. As created, the program is to run during 2004-2007. SAIF must pay the costs of the program, but it can reduce its assessments paid to the PAOA by $40 million over this period. SAIF's assessments were reduced by $0.3 million in FY 2004. It is expected to be lowered by $39.7 million for FY 2005-2007.

Premium assessment rates, 1986 - 2005

Calendar year	Insurers	Self-insured employers	Self-insured employer groups
1986	12.0%	-	-
1987	7.0%	7.2%	7.2%
1988	5.5%	5.5%	5.7%
1989	5.5%	5.5%	5.7%
1990	4.5%	4.5%	4.7%
1991	4.5%	4.5%	4.7%
1992	4.5%	4.5%	4.7%
1993	4.5%	4.5%	4.7%
1994	4.5%	4.5%	4.7%
1995	4.5%	4.5%	4.7%
1996	4.5%	4.5%	4.7%
1997	4.5%	4.5%	4.7%
1998	7.3%	7.3%	7.5%
1999	7.3%	7.3%	7.5%
2000	7.3%	7.3%	7.5%
2001	7.3%	7.3%	7.5%
2002	8.0%	8.0%	8.2%
2003	8.0%	8.0%	8.2%
2004	7.0%	7.0%	7.2%
2005	6.8%	7.0%	7.0%

For insurers, the premium assessment rate is a percentage of workers' compensation premiums earned in Oregon. For self-insured employers, it is a percentage of the simulated premium that the department calculates for each self-insured employer.

The rates for 1988-1997 were set low in order to draw down the PAOA balance.

The 2005 rate for self-insured employers and self-insured employer groups is higher than for insurers to fully fund the Self-Insured Employer Adjustment Reserve and Self-Insured Employer Group Adjustment Reserve. The rate for self-insured employers was not lowered in 2005 because of recent defaults by some self-insured employers.

Premium Assessment Operating Account expenditures, with funding sources, fiscal years 1986-2004

Fiscal year	Expenditures ($ millions)	Assessment revenue ($ millions)	Investment income ($ millions)	Other revenue and transfers ($ millions)	Fund balance draw down ($ millions)
1986	$64.8	$67.9	$3.1	-$6.2	$0.0
1987	59.4	66.5	3.9	-10.9	0.0
1988	53.2	44.5	4.3	4.4	0.0
1989	45.2	38.7	4.6	2.0	0.0
1990	42.0	39.6	7.0	-4.5	0.0
1991	48.9	38.8	7.4	2.7	0.0
1992	48.6	34.6	5.5	8.5	0.0
1993	49.7	33.7	4.6	9.8	1.7
1994	51.0	31.7	5.0	10.4	3.9
1995	51.0	31.6	5.7	11.1	2.6
1996	54.7	32.1	7.2	9.1	6.3
1997	53.0	31.5	4.3	7.2	10.0
1998	48.9	32.9	2.4	6.8	6.8
1999	51.8	46.9	2.1	2.7	0.0
2000	56.6	42.3	2.3	7.4	4.6
2001	56.3	42.9	3.3	7.1	3.0
2002	52.6	48.7	1.6	2.3	0.0
2003	51.1	58.2	1.5	-8.7	0.0
2004	53.2	58.5	1.8	-11.3	4.1

In fiscal year 2004, $53.2 million was spent from the PAOA to regulate the workers' compensation system. Assessments generated $58.5 million in revenue. The fund balance was reduced by $4.1 million.

Also in FY 2004, HB 2148 and HB 5077 required the transfer of $18.2 million from the PAOA to the state's general fund. HB 3630 required that SAIF create a reinsurance program for rural physicians. This program reimburses some of the cost of these physicians' medical liability costs. SAIF must pay the costs of the program, but it can reduce its assessments paid to the PAOA by $40 million over this period. SAIF's assessments were reduced by $0.3 million in FY 2004.

Premium Assessment Operating Account year-end balance, fiscal years 1986-2004

Fiscal year	Ending balance ($ millions)
1986	$27.9
1987	43.8
1988	46.3
1989	50.1
1990	61.2
1991	67.1
1992	68.1
1993	66.4
1994	62.5
1995	60.0
1996	53.6
1997	43.6
1998	36.8
1999	41.3
2000	36.8
2001	33.8
2002	39.0
2003	55.5
2004	51.4

At the end of fiscal year 2004, the Premium Assessment Operating Account had a balance of $51.4 million. The PAOA is managed to meet the cash flow needs of the account, accommodate the timing of receipts and expenditures, ensure stable funding for legislatively approved programs and services during uncertain economic times, and minimize the volatility of fees and assessments. The department's current policy is to slowly draw down the fund without rate volatility until the ending balance is approximately equal to six months of expenditures.

Appendices

Appendix 1 - Workers' Compensation Reform Legislation

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

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

During late 2000 and early 2001, the Oregon Supreme Court issued several rulings covering portions of the workers' compensation statute. In *Smothers v. Gresham Transfer, Inc.*, the court limited the exclusive remedy provisions in SB 369. The 2001 legislature passed SB 485 to address this and to make other changes. The 2003 legislature reformed the permanent disability award structure and expanded the responsibilities for nurse practitioners.

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

1991

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

1995

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

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

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

1997

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

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

1999

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

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

2001

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

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

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

Chapter 625, 2001 laws Amended tax law to transfer the administration of the Farmworker Housing Tax Credit from OR-OSHA to the Oregon Department of Housing and Community Services. Also amended housing law to declare that it is the policy of the state to ensure adequate housing for farmworkers. (HB 3172)

Chapter 868, 2001 laws Amended tax law to remove the December 31, 2001, sunset of the Farmworker Housing Construction tax program and made the program permanent. Also increased the amount of the credit to 50 percent of the eligible costs, extended the period for claiming the credits to 10 years, increased the annual cap on certified project costs to $7.5 million, and allowed the owner or operator to transfer up to 80 percent of the credit amount to project contributors. (HB 3173)

2003

654.035 (2) Revised the authority for the director to adopt rules, regulations, codes, or special orders related to worker safety for construction involving steel erection. Prohibited the director from requiring the use of fall protection for workers engaged in certain steel erection activities at heights lower than the fall-protection trigger heights for steel erection required by federal regulation. (HB 3010)

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 first communicate objections in writing to the insurer or self-insured employer. Precluded a worker who failed to comply with this requirement from taking the matter up at a hearing. (SB 369)

1997

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

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

1999

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

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

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

2001

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

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

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

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

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

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

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

2003

626.027 (27) Added translators and interpreters who provide services through agents or brokers to the list of non-subject workers. (SB 924)

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) (Now 656.268 (5)(a))

656.268 (14) Allowed for insurer offsets against awards for overpayments. (HB 2900) (Now 656.268 (13))

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) (Now 656.726 (4)(f))

1990

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

656.214 (5) and 656.726 (3)(f) Required the department's disability evaluation standards to be used for the initial rating and for all subsequent litigation; altered the definition of earning capacity to be used in calculating disability. (SB 1197) (656.726 (3)(f) is now 656.726 (4)(f))

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

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

656.726 (3)(f)(B) Mandated that impairment be established by a preponderance of medical evidence based on objective findings. (SB 1197) (Now 656.726 (4)(f)(B))

656.726 (3)(f)(C) Required the director to adopt temporary rules amending the standards for the evaluation of disabilities when the director determines that the standards do not adequately address the worker's disability. (SB 1197) (Now 656.726 (4)(f)(C))

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 claim disposition agreement. (HB 3040) (Now 656.622(4)(c))

1993

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

1995

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

656.018 (6) Clarified that the exclusive remedy provisions and the liability limitations of this chapter apply whether or not the injuries or diseases were compensable. (SB 369) (This was struck down in part in 2001 by the Oregon Supreme Court in the Smothers decision.) (Now 656.018 (7))

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

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

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

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

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

656.262 (14) Required that injured workers cooperate with the insurer or self-insured employer in the investigation of claims for compensation. (SB 369) (Now 656.262 (13))

656.262 (15) Required that if a worker does not cooperate, the director is to suspend the compensation due; authorized the insurer or self-insured employer to deny the claim if the non-cooperation continues for another 30 days. (SB 369) (Now 656.262 (14))

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

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

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

656.726 (3)(f)(D) Required that impairment be the only factor to be considered in evaluating a worker's disability if the worker has returned to, or the attending physician has released the worker to, regular work at the job held at the time of injury. (SB 369) (Now 656.726 (4)(f)(D))

1997

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

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

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

1999

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

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

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

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

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

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

2001

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

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

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

656.262 (6)(a) & (7)(a) and 656.308 (2)(a) Reduced the time an insurer has to accept or deny a claim from 90 days to 60 days after the employer knows of the claim. The bill also reduced the time the insurer has to accept or deny a claim for aggravation or new or omitted condition to 60 days after the insurer receives written notice of these claims. (SB 485)

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

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

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

2003

656.054 (2) and 656.735 (3) Removed the penalty against noncomplying employers issued after claim closure. (SB 233)

656.210 (5)(b) Provided that if an insurer or self-insured employer chooses not to pay supplemental disability benefits for a worker employed in more than one job, the department will administer and pay the benefits directly or assign the administration to a paying agent. (SB 914)

656.262(11)(a) Allowed attorney fees when an insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial. The fee is based on the results achieved and the time devoted to the case. (SB 620)

656.262(13) Removed the requirement that insurers and self-insured employers report disabling claims to the department within 21 days of the employer knowledge. (SB 914)

656.265 (4)(c) Added an exemption to the requirement for reporting claims within 90 days if the worker can establish that the worker had good cause not to give timely notice. (SB 932)

705.175 Authorized the department to issue warrants for amounts owed to the department and authorized the debt to become a lien on real property. (HB 3177)

Chapter 760 Section 4, 2003 laws Required the department conduct an evaluation of its claims reporting requirements. The results must be presented to MLAC. (SB 914)

Advocates and Advisory Groups

1987

656.709 (1) Created the Office of Ombudsman for Injured Workers. (HB 2900)

1990

656.709 (2) Established the Small Business Ombudsman for workers' compensation. (SB 1197)

656.790 Created the Workers' Compensation Management-Labor Advisory Committee to 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 form a more fair, just, and cost-effective system. (SB 1198)

1995

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

656.790 (2) Mandated MLAC reporting to the legislature such findings and recommendations as the committee finds appropriate, including court decisions having significant impact on the workers' compensations system; adequacy of workers' compensation benefits; medical and system costs; and adequacy of assessments for reserve programs and administrative costs. (SB 369) (Now 656.790 (3))

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. (SB 222)

2001

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

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

2003

656.709 (1) and (2) Required the injured worker ombudsman and the small business ombudsman to provide quarterly written reports to the governor. The reports must include summaries of the services provided during the quarter and recommendations for improvements. (HB 2522)

656.726 (4)(f)(C) Removed the requirement that the department submit its temporary rules to MLAC for review at its next meeting. (SB 234)

Medical Benefits and Care

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) (Now 656.245 (2)(a))

656.245 (4) Allowed the director to exclude from compensability any medical treatment deemed to be unscientific or unproven. (HB 2900) (Now 656.245 (3))

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

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

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

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

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

1990

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

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

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

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

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

1991

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

1993

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

656.313 Modified the procedure for payment of medical services in disputed workers' compensation settlement proceedings. Required insurers to pay providers at one-half the rate established by ORS 656.248 in amounts not to exceed 20 percent of the total present value of the settlement amount. Where less than one-half payment can be made, all affected providers are to be paid proportionally. (HB 3111)

1995

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

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

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

1997

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

1999

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

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

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

2001

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

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

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

2003

656.005 (12)(c) Included nurse practitioner in the definition of consulting physician. (HB 3669)

656.245 (2)(b)(C) Allowed a nurse practitioner to provide medical services for 90 days from the first visit on the claim and authorize the payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the claim. The nurse practitioner must refer the worker to an attending physician for the determination of impairment. (HB 3669)

656.245 (6) Authorized a nurse practitioner who is not a member of a managed care organization to provide the same level of services as a primary care physician to workers enrolled in the MCO, subject to certain restrictions. (HB 3669)

Chapter 811 section 29, 2003 laws Required that the department develop and make available to nurse practitioners informational materials about the workers' compensation system, including, but not limited to, the management of indemnity claims, standards for authorization of temporary disability benefits, return to work responsibilities and programs, and general workers' compensation rules and procedures for medical service providers. (HB 3669)

Chapter 811 section 30, 2003 laws Required that nurse practitioners certify that they had reviewed the department's informational materials. (HB 3669)

Chapter 811 section 31, 2003 laws Required that insurers, self-insured employers, and self-insured employer groups provide the department with any information needed to assess the impact of HB 3669. (HB 3669)

Indemnity Benefits

1987

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

1990

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

1991

656.214 (**Note**) Established the value for a degree of scheduled disability as 71 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 to two the number of classes of beneficiary children younger than 18: instances in which there is a surviving spouse of a deceased worker and instances in which there is not. (SB 369)

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

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

1997

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

1999

656.202, 656.204, and 656.206 Changed workers' compensation benefits for spouses and some children of fatally injured workers: increased the remarriage allowance to 36 times the monthly benefit; eliminated the 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 the $5 weekly beneficiary payment for PTD claims. (HB2022)

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

2001

656.210 (1) Raised the maximum temporary total disability benefit to 133 percent of the average weekly wage. (SB 485)

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

656.214 (Note) Provided that the department pay workers who lost PPD benefits because of a 1999 transcription error out of the Workers' Benefit Fund. (SB 485)

2003

656.214 (1) Defined impairment as the loss of use or function of a body part or system due to the compensable injury or disease, expressed as a percentage of the whole person. Defined work disability as impairment modified by age, education, and adaptability to perform a given job. Redefined permanent partial disability as permanent impairment with or without work disability resulting from a compensable injury or disease. (SB 757)

656.214 (2) Set permanent partial disability awards. If the worker has returned to work or has been released to work, the award is for impairment only. Otherwise, the award is for impairment and work disability. The impairment award is the product of 100 times the impairment value and the average weekly wage. The work disability award is the impairment value, modified by the age, education, and adaptability factors multiplied by 150 times the worker's weekly wage. The weekly wage is limited to the range 50-133 percent of the average weekly wage. (SB 757)

656.214 (3) Defined maximum PPD awards in terms of impairment percentages rather than degrees. (SB 757)

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) (Now 656.622 (4))

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) (Now 656.622 (4))

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

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

1995

656.335 Repealed this section. Insurers are no longer required to provide disability prevention services. (SB 369)

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

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

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

2001

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

Disputes

1987

656.268 (4)(f) Provided for penalties if insurer claim-closure actions were unreasonable. (HB 2900) (Now 656.268 (5)(d))

656.268 (6)(b) Reduced the time allowed to request a hearing from one year to 180 days following claim closure. (HB 2900) (Now 656.268 (5)(c))

656.278 Restricted the power and jurisdiction of the Workers' Compensation 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 for a date no later than 90 days after receipt of request. The hearing or review shall not be postponed except for extraordinary circumstances beyond the control of the requesting party. (HB 2900)

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

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

656.298 (6) Changed de novo review by the Court of Appeals to substantial evidence review. (HB 2900) (Now 656.298 (7))

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

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

1990

656.236 Allowed for compromise and release settlements (claim 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) (Now 656.248 (12))

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) (Now 656.262(11))

656.268 (4)(e) & (6)(a) Required mandatory reconsideration of a disputed insurer notice of closure or a department determination order and required the 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 (6)(a) is now 656.268 (6)(d).)

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) (Now 656.268 (5)(e))

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-case 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) (Now 656.268 (5))

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

656.283 (1) Removed vocational assistance disputes from Hearings Division jurisdiction. (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 in any other forum. Appeals of director's orders go to contested-case hearing before the director and then to the Court of Appeals. (SB 369)

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

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

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

656.313 (1)(a) Authorized the stay of compensation payments when an employer or insurer appeals a director's order on vocational assistance. (SB 369)

656.319 (6) Authorized hearing for failure to process a claim or incorrect processing if 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 Hearings Division administrative law judges from awarding penalties or attorney fees for matters arising out of contested-case hearings by the director. (SB 369)

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

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

1997

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

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

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

1999

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

656.704 (2) Created a centralized Hearing Officer Panel consisting of the administrative law judges of several agencies. Appeals of the department's administrative orders 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 disputes 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 chairperson of the Workers' Compensation Board manages and supervises board and Hearings Division. (SB 654)

2001

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

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

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

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

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

2003

656.262 (16) Authorized administrative law judges to determine what is required of injured workers to reasonably cooperate with the investigation of a claim in which there are more than one potentially responsible employers or insurers. In such cases, penalties for untimely claim denial cannot be imposed. (SB 63)

656.268 (5) and (6) Allowed insurers and self-insured employers to request the reconsideration of a claim closure. The request for reconsideration must be based on disagreement with the findings used to rate impairment. It must be made within seven days of the closure. (SB 285)

656.283 (4) Authorized administrative law judges to postpone hearings in which there are one or more potentially responsible employers or insurers. In such cases, penalties for untimely claim denial cannot be imposed. (SB 63)

656.385(1) Allowed attorney fees when a claimant finally prevails in a medical dispute or a vocational dispute. (SB 620)

656.718 (3) Defined the composition of a WCB panel. (SB 286)

656.726 (4)(f) Redefined the criteria for the evaluation of disabilities in terms of permanent impairment and work disability. (SB 757)

656.740 (2) Changed the appeal period for contesting a nonsubjectivity determination from 30 days to 60. (SB 233)

Insurance

1987

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

656.622 (8) Excluded claim costs incurred as a result of an injury sustained by a Preferred Worker during the first two years of hire from data used for ratemaking or individual employer rating. (HB 2900) (Now 656.622 (10))

1990

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

656.427 Amended insurance coverage termination procedures to improve continuous coverage for employers and to minimize the number of noncomplying employers. (SB 1198)

656.622 (8) Extended from two to three years after the date of hire the exclusion from ratemaking for Preferred Worker claim costs; changed the program to a premium exemption program. (SB 1197) (Now 656.622 (10))

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

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

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

1991

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

1993

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

1997

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

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

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

1999

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

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

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

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

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

2001

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

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

2003

656.407 (2) and (3) Modified the types of security deposits required by self-insured employers. (SB 233)

646.427 Modified the reporting requirements for an insurer's termination of a guaranty contract. (SB 233)

Workers' Benefit Fund and Premium Assessment

1987

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)

1997

656.790 Increased the Workers' Benefit Fund reserves to 12 months of anticipated expenditures. (SB 484) (Now 656.506)

1999

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

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

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

2001

656.445, 656.506 (4), 656.605 (2)(a), 734.360, 734.510, 734.570, 734.630, 734.635, and 734.695 Established the director's authority to advance payments from the Workers' Benefit Fund to injured workers when an insurer has defaulted on its obligations to pay claims but has not yet been placed in liquidation by the court. After liquidation proceedings are completed and the insurer placed in receivership, the Oregon Insurance Guaranty Association will refund the Workers' Benefit Fund any moneys advanced. (SB 977)

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

2003

Chapter 781, 2003 laws Required SAIF to create a reinsurance program for medical liability insurance for rural doctors. SAIF was allowed to write off the cost of the program as an expense against its assessment. (HB 3630)

Appendix 2 - Worker's Compensation Court Cases

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

1991

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

1992

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

1993

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

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

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

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

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

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

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

1994

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

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

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

1995

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

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

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

1996

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

SAIF Corporation v. Walker, 145 Or App 294 (1996) The Court of Appeals considered the meaning of the change in the definition of an aggravation in SB 369. The court reviewed the legislative history and determined that a symptomatic worsening is not sufficient to establish an aggravation; instead, proof of pathological worsening is required. The Supreme court affirmed the decision in 2000.

1997

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

1998

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

1999

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

O'Neil v. National Union Fire, 152 Or App 497 (1999) The Court of Appeals ruled that the department's contested-case hearing procedures had been

followed as written. The claimant had argued that the department was required to conduct a full-scale contested-case procedure at a contested-case hearing; the department had instead followed a more limited procedure. The court determined that this procedure is consistent with ORS 656. 327(2).

2000

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

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

2001

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

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

Smothers v. Gresham Transfer, Inc., 332 Or 83 (2001) The Supreme Court ruled that the exclusive remedy provisions of ORS 656.018 are unconstitutional. When a workers' compensation claim is denied for failure to prove that the work-related incident was the major contributing cause of the injury or condition, the claimant could be left without a legal remedy. Under these circumstances, the employee may take civil action against his employer. (The process for these actions was set out by the 2001 legislature in SB 485. The bill also required that MLAC develop a proposal for a new process prior to the 2003 legislative session.)

2002

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

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

Icenhower v. SAIF Corporation, 180 Or App 297 (2002) The Court of Appeals ruled that the Hearings Division retained jurisdiction on penalties after all other issues in the case had been resolved. (ORS 656.262(11) gives the director exclusive jurisdiction over penalty-only cases.)

Talley v. BCI Coca Cola Bottling, 184 Or App 129 (2002) The Court of Appeals ruled that the Hearings Division had jurisdiction to consider a

claimant's request for a hearing concerning the employer's notice of closure issued after the claimant's authorized training program had ended. The court stated that this was a matter concerning a claim, as stated in ORS 656.283(1).

Machuca-Ramirez v. Zephyr Engineering, Inc., 184 Or App 565 (2002) The Court of Appeals ruled that the permanent partial disability award in a notice of closure was not the lower limit on the PPD award and that the employer could appeal an ALJ decision that reinstated the original award after an order on reconsideration reduced the award to zero. The court said this appeal was not an appeal of the notice of closure.

2003

French-Davis v. Grand Central Bowl, 186 Or App 280 (2003) The Court of Appeals ruled that the board had erroneously dismissed a claimant's request for a hearing to challenge the insurer's failure to close the claim. ORS 656.319(6) states that the request must be filed within two years after the inaction occurred. The insurer argued that the limitation began on the date the claim was accepted. The court agreed with the claimant that it began on the date the claimant first requested closure.

Nichols v. Liberty Northwest, 186 Or App 664 (2003) The Court of Appeals ruled that a claim for a tooth that was cracked while eating candy was compensable. The court ruled that because the claimant was eating while working, the injury arose out of and in the course of his employment.

Basmaci v. The Stanley Works, 187 Or App 337 (2003) The Court of Appeals ruled that the submission of Form 827, the first medical report of a claim, did not fulfill the requirements for a request for acceptance of a new medical condition.

Braden v. SAIF Corporation, 187 Or App 494 (2003) The Court of Appeals ruled that the board erred when reviewing a claim compensability case. The board had decided that the claim was for a combined condition, that the claim should be accepted for a period and then denied after the condition was not longer the major contributing cause for the need for treatment. The court agreed with the claimant that the insurer must accept a combined condition claim before the combined condition could be denied.

Gavlik v. American Medical Response, 189 Or App 294 (2003) The Court of Appeals ruled that the claim from an emergency medical technician who stopped at a roadside accident was compensable. The worker came upon the accident while on on-call status.

McAleny v. SAIF, 191 Or App 105 (2003) The Court of Appeals reversed the board's finding that the claimant's knee injury (which occurred during a medical arbiter exam regarding his accepted knee claim) did not arise out of and in the course of his employment. Reasoning that the carrier was statutorily required to pay for the medical arbiter exam, which might be used to protect the carrier's legal position, the court concluded that the arbiter exam did not serve claimant's personal interest unconnected to work, but rather was "an integral part of the claim verification process."

SAIF Corporation v. Dubose, 335 Or 579 (2003) The Supreme Court ruled that the phrase in ORS 656.262(15), "the worker shall not be granted a hearing … unless the worker first requests and establishes at an expedited hearing …" means that the claimant must request a hearing, not that she must request an expedited hearing. It is up to the board to set the expedited hearing. This ruling reversed the Court of Appeals.

2004

Cloud v. Klamath County School District, 191 Or App 610 (2004) The Court of Appeals upheld the board's finding that the claimant's accepted condition was not solely caused by, and not merely a symptom of, the preexisting degenerative condition. Therefore, the degenerative condition was excluded from the calculation of whether the accepted condition was the major contributing cause for the need for treatment.

Stockdale v. SAIF Corporation, 192 Or App 289 (2004) The Court of Appeals ruled that an insurer could both accept and deny parts of a combined condition in the same document as long as the denial date was later than the acceptance date. It said this practice was consistent with ORS 656.262(6)(c), which contains the phrase "… later denying the combined … condition."

Ake v. SAIF Corporation, 192 Or App 617 (2004) The Court of Appeals ruled that the claimant was entitled to appeal a denial of an aggravation claim regardless of whether the insurer was obligated to issue the denial.

Lederer v. Viking Freight, Inc., 193 Or App 226 (2004) The Court of Appeals ruled that a doctor does not need to explicitly authorize temporary disability benefits when an "objectively reasonable" insurer or self-insured employer would understand that the medical reports imply such authorization.

Trujillo v. Pacific Safety Supply, 336 Or 349 (2004) The Supreme Court upheld a Court of Appeals ruling that the claimant did not have the right to give oral testimony concerning his base functional capacity at hearing. The functional capacity was used in part to determine his PPD award. The Supreme Court said that the claimant did not have a constitutional right to present new evidence at a hearing when he had foregone the opportunity to present written evidence at reconsideration.

Logsdon v. SAIF Corporation, 336 Or 349 (2004) The Supreme Court upheld a Court of Appeals ruling that the claimant did not have the right to cross examine doctors at hearing. He wished to cross examine them regarding his medically stationary date. This date is used in determining time-loss benefits. The Supreme Court said that the claimant did not have a constitutional right to present new evidence, including oral testimony, at a hearing when he had bypassed the opportunity to present written evidence at reconsideration.

Day v. Advanced M&D Sales, Inc., 336 Or 511 (2004) The Supreme Court ruled that the filing of a workers' compensation claim and the receipt of benefits does not bar a worker from later claiming that he was not a subject worker. The case involves a person who was employed part of the time as a salesperson and part of the time as an independent contractor. He was a subject worker while working as a salesperson, not while a contractor. This ruling reversed the ruling by the Court of Appeals.

Freightliner LLC v. Holman, 195 Or App 716 (2004) The Court of Appeals concluded that the plain meaning of the statute indicated that an occupational disease claim must be filed by one year from the latest of four specified events. The court observed that nothing in the language of the statute indicated that the specified event must already have transpired at the time of claim filing. The court affirmed the board's order that had held that claimant's occupational disease claim for hearing loss was not void because neither of the events described in subsection (1)(b) (the date the claimant becomes disabled or is informed by a physician that he is suffering from an occupational disease) had occurred when he filed his claim.

Appendix 3 - Workers' Benefit Fund Revenues and Expenditures

Workers' Benefit Fund revenues, expenditures, and transfers, fiscal year 2004

Revenues	**FY 2004**
Assessments [1]	$87,596,364
Investment income	7,603,178
Fines and penalties	269,088
Other income	316,258
Non-Complying Employer Program [2]	2,702,624
Total	**$98,487,512**
Expenditures	
Handicapped Worker Program	$1,601,944
Non-Complying Employer Program	4,605,985
Reemployment Assistance Program [3]	19,558,433
Rehabilitation Program	5,254
Reopened Claims Program	4,184,955
Retroactive Program	59,022,182
SB 485 multiple wage jobs	529,695
SB 485 other costs [10]	n/a
Other agency WBF collection costs [4]	324,160
Central support services chargeback [9]	1,921,532
Total	**$91,754,140**
Transfers	
NCE/Rehab. [5]	$1,853,966
WBF administrative cost [6]	(1,733,971)
Bureau of Labor and Industries [7]	(305,000)
Transfer out - other [8]	(31,264)
Total	**($216,269)**
Net cash flow	**$6,517,103**
Ending fund balance	**$171,588,259**

[1] The WBF assessment rate is 3.4 cents effective January 1, 2004.

[2] Non-Complying Employer Program revenues includes NCE recoveries, NCE fines and penalties, and NCE interest.

[3] OHSU/CROET transfers and/or expenditures are equal to 1/16 cent per worker per hour and are included with total Reemployment expenditures.

[4] Expenditures paid to other state agencies for collection of WBF assessment rate revenue.

[5] Net NCE/Rehab expenditures are transferred from the Premium Assessment Operating Account.

[6] Quarterly transfer from the WBF to the PAOA to cover direct costs associated with WBF programs.

[7] In accord with the legislatively approved budget for 2003-2005, a transfer of $305,000 was made to the Bureau of Labor and Industries in FY 2004.

[8] Transfer - out to Central Support Services for collection costs associated with WBF assessment revenue and NCE recoveries.

[9] This represents the indirect portion of the WBF Administrative Cost, and is reflected as an expenditure.

[10] This represents the Reopened Claims Program and Reemployment Assistance Program components of SB 485, which are not identifiable on DCBS quarterly financial statements.

Column detail may not add to totals due to rounding.

Appendix 4 - Premium Assessment Operating Account Revenues and Expenditures

Workers' Compensation Premium Assessment Operating Account revenues, expenditures, and transfers, fiscal year 2004

Revenues	**FY 2004**
Assessments [1]	$58,513,903
Fines and penalties [2]	$1,826,335
Investment income	$1,842,440
Federal funds [2]	$5,361,033
Other [2]	($18,193,666)
SAIF reinsurance pool credit [11]	($321,581)
Total	**$49,028,464**
Expenditures	
Administration [3]	$57,805,642
Self-insured empl. res. [2]	$335,728
Chargeback [6]	($7,057,925)
Oregon Health Sciences University [4]	$1,552,592
Total	**$52,636,037**
Adjustments/transfers	
Non-complying employer [5]	($1,853,966)
Insurance Division [7]	($325,203)
WBF administrative expenses [9]	$1,733,971
BOLI transfer [10]	($101,000)
Misc. transfers/adjustments [8]	$31,268
Total	**($514,930)**
Net cash flow	**($4,122,503)**
Ending fund balance	**$51,383,684**

For the purposes of this analysis, self-insured employer reserves are included in the Administrative Fund.

[1] The premium assessment rate was 8.0 percent through 2003, and 7.0 percent effective 1/1/2004.

[2] This includes a negative financial statement accrual for the future transfer to the General Fund from WCD and PAOA in accordance with Chapter 734, Oregon Laws 2003 (HB 2148).

[3] Includes Department and Board administrative costs, expenditures of Federal funds, capital outlay, and Central Support costs.

[4] OHSU/CROET transfers and/or expenditures are equal to 1/16 cent per worker per hour.

[5] Net Non-Complying Employer expenditures are transferred to the Workers' Benefit Fund.

[6] Chargeback expenditures reflect Central Support chargeback recoveries, from non-PAOA account, DCBS entities. Chargeback expenditures also include indirect costs from the WBF.

[7] Transfer to Insurance Division in the first quarter of each fiscal year to fund workers' compensation activities.

[8] Miscellaneous transfers and adjustments are from actual quarterly financial statements.

[9] Quarterly transfer from the WBF to the PAOA to cover direct administrative costs associated with WBF programs.

[10] Quarterly transfer to the Bureau of Labor and Industries.

[11] Annual premium assessment credit for SAIF in accordance with Section 781, Oregon Laws 2003 (HB 3630).

Column detail may not add to totals due to rounding.

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