Oregon Department of Consumer & Business Services

Information Management Division

Research & Analysis Section

Biennial Report on the Oregon Workers' Compensation System

Ninth Edition

December 2008

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Department of Consumer & Business Services
Cory Streisinger, Director

Workers' Compensation Division
John Shilts, Administrator

Occupational Safety & Health Division
Michael Wood, Administrator

Workers' Compensation Board
Abigail Herman, Chair

Insurance Division
Teresa Miller, Acting Administrator

Ombudsman for Injured Workers
Jennifer Flood

Ombudsman for Small Business
David Waki

Information Management Division
Dorothy Oliver, Administrator

DCBS Communications Section
Kiki Hammond, Designer
Mark Peterson, Editor

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-378-8254

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Introduction

This report is the ninth in a series that describes Oregon's workers' compensation system and shows the effects of legislative changes since 1987. This edition adds statutory changes made by the 2007 Legislature, summaries of recent court decisions, and the latest available data.

Numerous commentators have singled out Oregon's system as a national model of labor-management cooperation, leading to innovative programs that produce desirable outcomes for workers and affordable costs for employers. The results of that cooperation can be seen in 2007 legislative actions.

Among other actions, the 2007 Legislature passed bills that expanded the authority of certain care providers to serve as attending physicians; streamlined a number of regulatory processes; made permanent earlier provisions applying to disability benefits and medical services by nurse practitioners; allowed for payment of appeal-related costs to injured workers; simplified proof of coverage for insurers and employers; and mandated a study of death benefits. These bills are discussed in the summary of legislation (Appendix 1) and their respective topical chapters.

In part because of the work of Oregon OSHA, claims rates are declining. As measured by the Bureau of Labor Statistics' employer survey, the Oregon total-cases incidence rate was 5.2 cases per 100 full-time workers in 2007; this rate is 49 percent of the 1989 rate. The safety and health chapter contains more safety data.

Included among the bills passed by the 2007 Legislature that affected safety and health are bills that mandate comprehensive analysis on assaults to health care employees; require all employers to have a safety committee or hold safety meetings; and increase the time in which a worker can file a retaliation complaint with the Oregon Bureau of Labor and Industries from 30 days to 90 days.

The medical chapter also includes a discussion of research studies about the role of various care providers in the workers' compensation system.

As discussed in the return-to-work chapter, Oregon has innovative and effective return-to-work programs. Injured workers who complete vocational assistance plans, use Preferred Worker benefits, or use the Employer-at-Injury Program have higher post-injury employment rates and wages than similar workers who do not use these programs.

Finally, as discussed in the insurance chapter, Oregon has one of the nation's least expensive workers' compensation systems. Oregon conducts a study every two years that compares the premium rates for its major industries to the premium rates in other states. Based on this methodology, Oregon's rates in 2008 ranked 39th of 51 jurisdictions — which means Oregon's premium rates are the 13th lowest in the nation. Because of the system's successes, such as declining injury rates and workers getting back to work earlier, there has not been an increase in the workers' compensation pure premium rate since 1990. In 2009, the pure premium rate will be about 38 percent of the 1990 rate.

Lessons from the Oregon Workers' Compensation System

An independent national research organization recently recognized Oregon's workers' compensation system as a model that could provide valuable lessons for other states.

"When considering changing their workers' compensation systems, state policymakers often want to learn more about the system in Oregon – a state with a reputation for achieving certain desirable outcomes, including reasonable income benefits that are typically delivered accurately and promptly with lower litigation levels, and employer costs that are affordable and stable," according to the Workers' Compensation Research Institute (WCRI) study, called "Lessons from the Oregon Workers' Compensation System." The study outlines the following four key lessons for other states from Oregon's workers' compensation system:

- cooperation between management and labor through the Management-Labor Advisory Committee
- accurate and timely benefits for injured workers
- reduced litigation over benefits
- return-to-work programs that help get injured workers back to work faster

More detail on each of these areas can be found in the topical sections of this report. For more information on the Workers' Compensation Research Institute study, go to: http://www.wcrinet.org/result/OR_lessons_result.html.

Department of Consumer and Business Services

OUR MISSION

To protect and serve Oregon's consumers and workers while supporting a positive business climate in the state.

WHAT WE DO

DCBS is Oregon's largest regulatory agency. The department administers state laws and rules and protects consumers and workers in the areas of workers' compensation, occupational safety and health, financial services, insurance, building codes, and targeted contracting opportunities for small businesses.

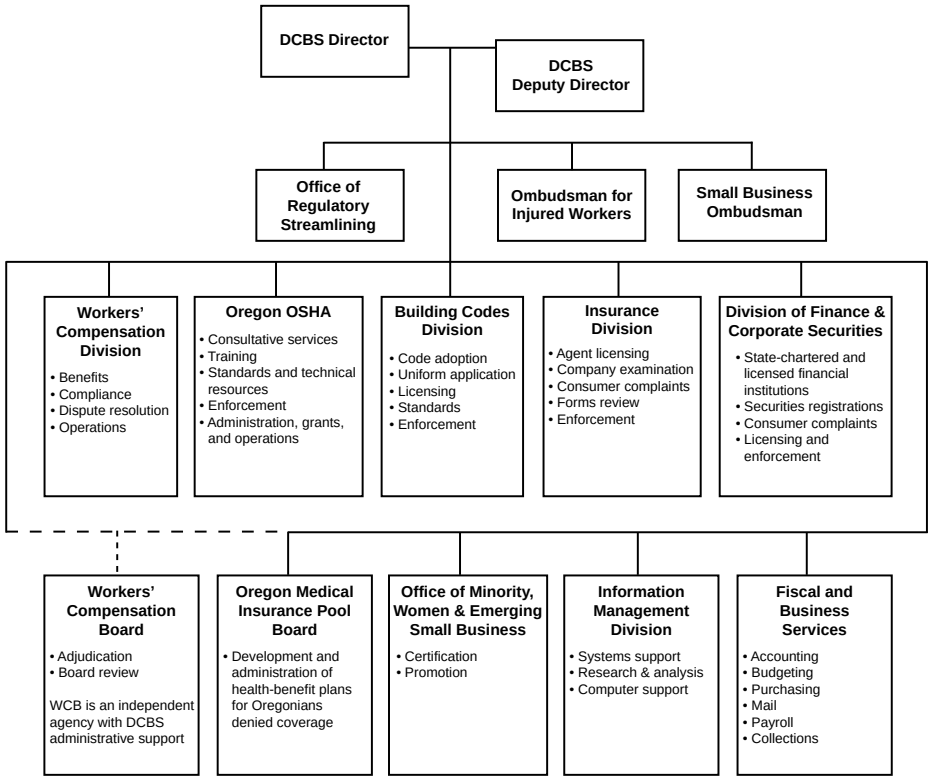
WHAT WE VALUE

- ✓ A commitment to public service
- ✓ Integrity, expertise, and personal responsibility
- ✓ Collaborative, creative efforts to find solutions
- ✓ Effectiveness and accountability in our people and our programs
- ✓ Excellent customer service
- ✓ Effective communication
- ✓ Respect for the diverse community of DCBS and Oregon

OUR GOALS

- ✓ To protect consumers and workers in Oregon
- ✓ To regulate in a manner that supports a positive business climate
- ✓ To be accountable to the public we serve, with excellent service to our customers

DCBS Organizational Chart



History of Workers' Compensation in Oregon

Early history

The 1913 Oregon Legislative Assembly gave Oregon its first workers' compensation law; it became effective July 1, 1914. The law set up the State Industrial Accident Commission, consisting of three trustees, to oversee the Industrial Accident Fund. Employers in hazardous occupations had to decide whether to be part of the fund. Contributors to the fund could not be sued; instead, suits were brought against the commission. Employers who did not contribute had no common-law defenses, and the Employer Liability Act made them vulnerable to unlimited damages for worker injuries or illnesses. Employers in non-hazardous occupations also could contribute to the fund and get the benefits.

In 1965, the Legislature overhauled the law. Most employers came under the Workmen's Compensation Law, effective Jan. 1, 1966. Two years later, all employers that employed subject workers came under this law. Employers could buy the commission's insurance, self-insure, or insure with private companies. The State Industrial Accident Commission was renamed the Workmen's Compensation Board, and its insurance function was given to the State Compensation Department, the forerunner of SAIF Corporation.

The federal Occupational Safety and Health Act of 1970 gave rise to the Oregon Safe Employment Act in 1973. Its purpose was to ensure safe and healthful working conditions and to reduce the burden — in terms of lost production, lost wages, medical expenses, disability compensation payments, and human suffering — caused by occupational injury and disease.

The 1977 Legislature created the Workers' Compensation Department, which took on the administrative functions previously under the Workmen's Compensation Board. The board continued supervising the Hearings Division, functioning as an appellate body. Today, the Workers' Compensation Division is part of the Department of Consumer and Business Services. The department also contains other divisions involved in workers' compensation and workplace safety: Oregon OSHA, the Insurance Division, the Ombudsman for Injured Workers, and the Small Business Ombudsman. The Workers' Compensation Board is an independent agency that relies on DCBS for administrative support.

History since 1987

The Oregon workers' compensation system has undergone major changes over the past two decades. In 1986, Oregon ranked sixth 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 incidence 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's safety and health act, created the Preferred Worker Program while limiting other vocational assistance, increased benefits, limited the authority of the Workers' Compensation Board, and created the office of the Ombudsman for Injured Workers. A companion bill, HB 2271, limited mental stress claims and placed on the worker the burden of proving that a claim is compensable.

Three years later, 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, increased benefits, allowed claim disposition agreements, expanded the department's dispute resolution processes, increased Oregon OSHA staffing, created the Ombudsman for Small Business, and established the Management-Labor Advisory Committee. To allow insurers more time to investigate claims, the bill increased the period for claim acceptance or denial from 60 days to 90 days. It also redefined compensability by stating that

the injury must be the major contributing cause of the need for treatment. In addition, it stated that a claim was compensable only as long as the compensable condition remained the major contributing cause of the need for treatment.

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.

The 1993 legislative session made only minor changes to the Oregon workers' compensation system. These included HB 2282, which addressed the regulation of employee leasing companies, and HB 2285, which dealt with Oregon's 24-hour health plan, a pilot project that combined group health coverage and workers' compensation medical coverage. HB 3069 amended the public records law to restrict access to claims history information in certain circumstances when the information could be used to discriminate against injured workers.

By the end of 1994, several court decisions had interpreted 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 to only compensable claims, not to denied claims. The exclusive remedy provision states that an employee injured on the job is entitled to workers' compensation benefits but may not sue the employer for damages. Partly in response to these decisions, the 1995 Legislature passed SB 369. This bill emerged as an 80-page reform of the workers' compensation system. It 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.

The 1997 and 1999 legislatures made few 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. In 1999, the Legislature passed HB 2830, which required Oregon OSHA to revise its method for scheduling workplace inspections and to notify certain employers of an increased likelihood of inspection. The Legislature also 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.

In addition, the 1999 Legislature allocated funds for a study of the effects of changes in the compensability language in SB 1197 and SB 369. 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 concluded that the effects of the changes in the compensability definition could not be isolated but that the overall provisions of SB 1197 and SB 369 resulted in benefit reductions of at least 13 percent. This savings was due to the decline in the number of claims.

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. Policymakers decided the functions were not needed because of the decline in disabling claims and the availability of private-sector vocational programs.

The 2001 legislative session also saw the passage of SB 485, the most comprehensive workers' compensation bill since 1995. The bill was created 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 disability or 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 pre-existing 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. The impact of the Smothers decision has been far less than foreseen.

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 wages 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 days 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 permanent partial disability award structure for workers injured since Jan. 1, 2005. The new structure simplified the rating system. It also provided larger awards to injured workers who are unable 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.

The 2005 Legislature revised Senate Bill 757 by enacting House Bill 2408, which provided that a worker receives only impairment benefits, not work disability benefits, when the worker is released to regular work by the attending physician or returns to regular work. The law applies to claims with dates of injury on or after Jan. 1, 2006.

SB 386, also effective Jan. 1, 2006, modified the standard for establishing or rescinding permanent total disability benefits. The bill set an earnings threshold to determine what constitutes gainful employment that is linked to the federal poverty guidelines. The bill also allows workers to appeal any notice of closure that reverses their permanent total disability awards to the Hearings Division of the Workers' Compensation Board; workers' benefits continue while notices of closure are appealed.

The 2005 Legislature also addressed the process for insurer-requested independent medical examinations. SB 311 required insurers to select an independent medical examination provider from a list developed by the Department of Consumer and Business Services.

2007 legislative session

The 2007 Legislature passed HB 2756, which expanded the authority of certain care providers to serve as attending physicians. The law change allows chiropractors, podiatrists, naturopaths, and physician assistants to act as attending physicians for up to 60 days or 18 visits, whichever comes first. These provider groups can also authorize time loss for up to 30 days and manage a worker's return to work during that period.

HB 2218 and SB 253 streamlined a number of regulatory and dispute resolution processes. HB 2244 and HB 2247 made permanent earlier provisions applying to permanent partial disability benefits and medical services by nurse practitioners. Another streamlining measure, SB 559 (effective July 1, 2009) simplifies proof of coverage for insurers and employers by removing the requirement for guaranty contract filing. Instead, it requires the insurer to provide policy information to the department as proof of coverage.

SB 404 allowed for payment of appeal-related costs to injured workers, and also allowed attorneys to file liens for fees out of additional compensation when the worker had signed a fee agreement and the attorney was instrumental in obtaining the outcome of the claim. SB 835 mandated an interim study of death benefits and a report to the 2009 Legislative Assembly. These bills are discussed in the summary of legislation (Appendix 1) in their respective topical chapters.

A number of bills passed the 2007 Legislature that affected health and safety. HB 2022 mandated comprehensive data collection and analysis on assaults to health care employees. HB 2222 removed specific safety committee requirements from the law, which gives the director authority to write rules to require all employers to have a safety committee or hold safety meetings. HB 2259 increased the time in which a worker can file a retaliation complaint with the Oregon Bureau of Labor and Industries from 30 days to 90 days.

2008 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 estimate injury and illness frequencies. In 2007, the Oregon total-cases incidence rate was 5.2 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 2007, there were 23,433 accepted disabling claims. The accepted disabling claims rate, which reflects both claims frequency and compensability standards, was 1.3 accepted disabling claims per 100 workers in 2007. This is 35 percent of the 1988 value.

Oregon OSHA provides workplace consultations and inspections.

- Oregon OSHA staff provided 2,099 consultations in 2007, similar to the number done in recent years. These consultations help employers identify hazards that could lead to workplace injuries or illnesses.
- There were 5,049 Oregon OSHA inspections in federal fiscal year 2007. No violations were found in 25.5 percent of the inspections. Since 1988, the number of employers in Oregon OSHA's jurisdiction has grown by about 45 percent, while the annual number of inspections has remained about the same.
- The Safety and Health Achievement Recognition Program (SHARP) provides incentives for Oregon employers to work with their employees to correct hazards and to develop effective safety and health programs. In 2007, 126 Oregon companies from diverse industries had been certified as SHARP employers.

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

- The denial rate of disabling claims was 14 percent in fiscal year 2008, similar to the previous two years but lower than 2005 and prior years. The denial rate of disabling occupational disease claims was 31 percent in 2008.
- Insurers made timely compensability decisions 91 percent of the time, and timely first benefit payments 90 percent of the time in 2007.

The department provides services for workers, employers, medical providers, and others through its ombudsman offices and through the Workers' Compensation Division 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 about 11,500 inquiries to the office in 2007. The issues that prompt the most inquiries are benefits, medical, 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 received 3,785 inquiries in 2007.
- The Workers' Compensation Division has a telephone information line for workers, employers, insurers, medical providers, attorneys, legislators, and others. In 2007, there were more than 12,300 calls to the information line.

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

- During federal fiscal year 2007, Oregon OSHA issued 3,759 citations against employers with $2.4 million in penalties for workplace violations.
- In 2007, WCD issued 915 citations against insurers for failing to meet requirements for payment of compensation, claim acceptance or denial, and claim closure. The penalties totaled more than $575,000.

Injured workers with disabling claims receive indemnity benefits, such as temporary disability payments and permanent disability awards, and medical services. The amount paid for indemnity benefits has remained fairly constant over the past decade, while the amount paid for medical benefits has increased.

- About 46 percent of paid benefits in 2007 were indemnity benefits; in contrast, in 1995, more than 56 percent of benefits were indemnity benefits.
- In 2007, 42 percent of indemnity benefits for accepted disabling claims were temporary disability benefits, 28 percent were permanent partial disability benefits, and 21 percent were settlements.
- Injured workers are not usually enrolled in managed care organizations until their claims are accepted. In 2007, 42 percent of injured workers with accepted disabling claims were enrolled in MCOs. SAIF enrolled 66 percent of its injured workers, private insurers enrolled 7 percent of their injured workers, and self-insured employers enrolled 34 percent.
- In 2007, an estimated $319.4 million was paid for workers' compensation medical services. The three largest service categories were physical medicine, evaluation & management, and surgery.

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 are effective in achieving these goals. Workers who have used the department's return-to-work programs have higher employment rates and higher wages than workers who have not used these programs.

- The Preferred Worker Program provides incentives for employers to hire workers with permanent disabilities who are unable to return to regular work. As of July 2008, 26 percent of the workers issued cards in 2004 had 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.
- Use of the Employer-at-Injury Program, which provides benefits to employers who return their injured employees to work quickly, has increased since 2005; more than 7,700 workers used the program in 2007.
- Oregon's traditional vocational assistance program was scaled back in 1987. In 2007, about 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 percent higher than workers who do not receive return-to-work assistance.

In 2007, the Workers' Compensation Division and the Workers' Compensation Board resolved more than 16,000 disputes through orders, stipulations, agreements, and mediation.

- In 2007, 16 percent of claim closures were appealed for reconsideration. More than 4,000 reconsideration orders were written; 23 percent of these orders were appealed to the Hearings Division.
- The Vocational Rehabilitation Unit resolved 446 vocational disputes in 2007. Of these cases, 28 percent were resolved through agreements. Another 43 percent of the disputes were dismissed, often because vocational assistance benefits were released in claim disposition agreements.
- There were more than 9,300 hearing requests in 2007, a third of the number of requests in 1989.
- Claims denial was an issue in 38 percent of the approximately 9,300 hearing orders issued in 2007. Partial denial of claims was an issue in 41 percent of the hearing orders.
- Claimant attorney fees totaled $19.2 million in 2007. Sixty-four percent of these fees were taken out of claim disposition agreements and disputed claim settlements. Insurer attorney fees totaled $29.7 million.

Although the 1990 reforms changed the Oregon workers' compensation system dramatically, the market has been fairly steady during recent years.

- The insurance commissioner approved overall pure premium rate reductions of 2.3 percent for 2008 and 5.9 percent for 2009.
- The 2009 workers' compensation pure premium rate is 38 percent of the 1990 rate.
- Workers' compensation total system written premiums in Oregon totaled $1,193 million for 2007, up 21 percent from 2006. Much of this increase is due to a one-time accounting adjustment by SAIF Corporation.
- SAIF Corporation's share of the market in 2007 was 49 percent. Private insurers' market share was 39 percent. Self-insured employer and employer groups had the remainder of the market, 12 percent.
- Oregon's assigned risk pool shrank slightly in 2007 after mild growth between 2003 and 2006. In 2007, more than 12,000 employers were in the pool.

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.

- As of January 2009, the assessment rate is 2.8 cents per hour worked, with employers and workers each paying half. This is unchanged from the rate in effect during 2007 and 2008.

Much of the regulation of the Oregon workers' compensation system is funded by an assessment on workers' compensation premiums. 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 2009, the assessment rate for insurers, self-insured employers and self-insured employer groups, is 4.6 percent of premiums, unchanged from 2008.

Safety and Health

The most widely used measures of workplace safety are injury and illness rates and claims rates. These rates are now less than 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 (BLS) has used an employer survey based on OSHA recordkeeping requirements to estimate occupational injury and illness frequencies. This provides a long-running data series showing changes in injury rates over time. However, due to new recordkeeping rules adopted by BLS (2002) and a new industry classification system (2003), the current incidence rates may not be comparable with the earlier rates.

Despite these changes, the employer survey still provides valuable information about trends in workplace injuries. In Oregon, the total-cases incidence rate, a measure of all workplace injuries and illnesses, has fallen since 1988. The rate was 11.1 cases per 100 full-time workers in 1988 and 6.2 cases in 2001, before the new rules took effect. Under the new reporting rules, Oregon's total-cases incidence rate in the private industry was 5.1 cases per 100 full-time workers in 2007. The national rate was 4.2 in 2007.

The main measure of workers' compensation claims filing, the disabling claims rate, was 1.3 accepted disabling claims per 100 workers in 2007. Since 1998, Oregon has experienced a steady decline in the accepted disabling claims rate. Despite increasing employment in Oregon, the number of accepted disabling claims has fallen nearly every year. Compensable fatalities have also declined; the 35 deaths in 2007 were the third-fewest ever recorded.

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, claims-filing practices, and alterations in the economy, industrial landscape, and workforce size affect both

Figure 1. Accepted disabling claims and employment, 1987-2007

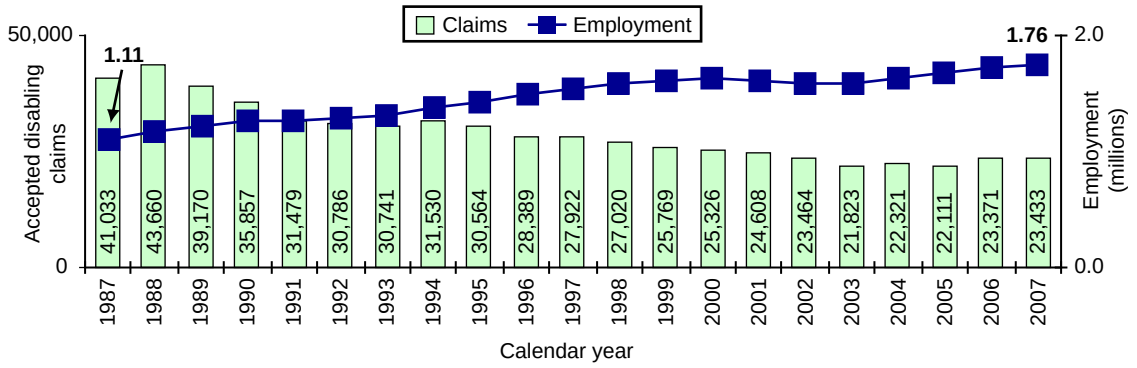


Figure 2. Compensable fatality rates per 100,000 workers, 1987-2007

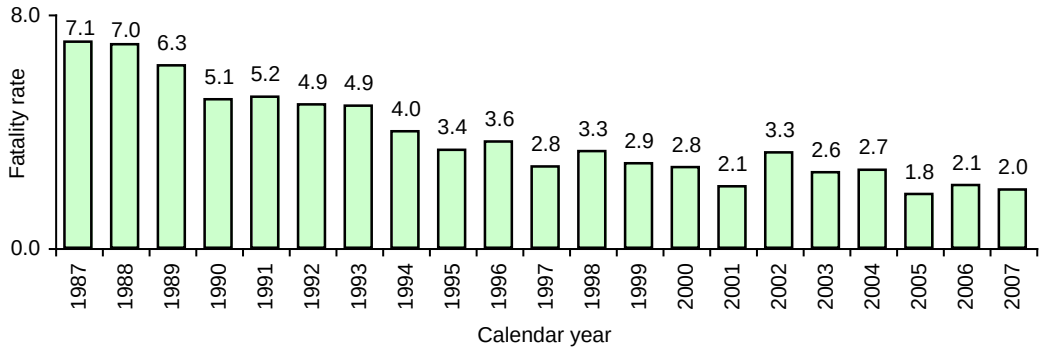
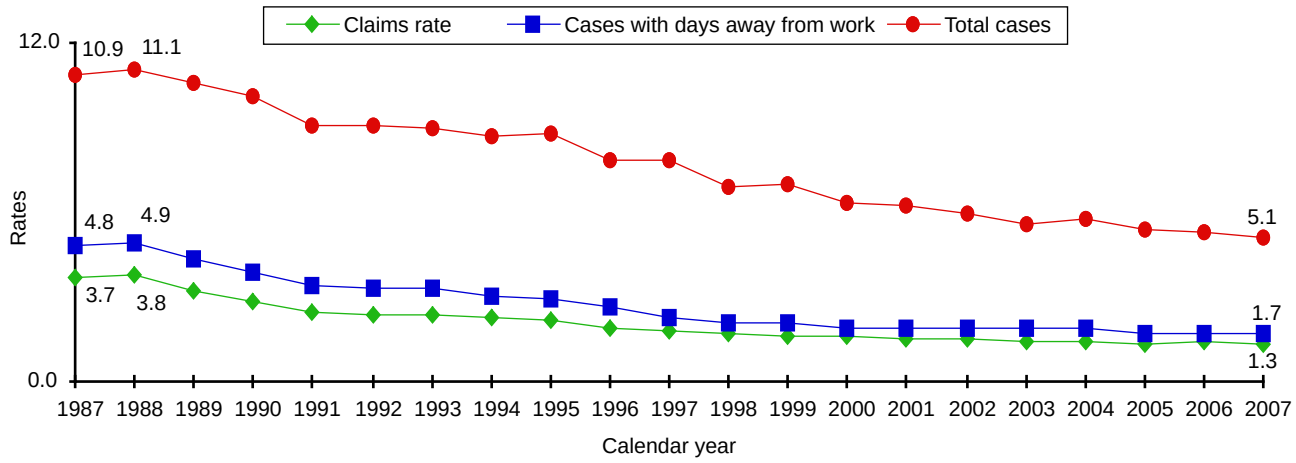


Figure 3. Accepted disabling claims rates and private sector occupational injuries and illnesses incidence rates, 1987-2007



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 total-cases incidence rate is the total number of injuries and illnesses per 100 full-time private sector workers.

claims volume and rates. Comparatively, national incidence rates have fallen at rates similar to Oregon's, perhaps indicating that claims rates would have fallen, even without legislative reform. Despite these qualifications, the increased emphasis on safety and health, especially by Oregon OSHA, has played an important 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. Oregon 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 (OSEA), was passed in 1973. The OSEA is now administered through a state-plan agreement with federal OSHA.

In May 2005, through the long-standing efforts of Oregon OSHA, Oregon became the 17th state to gain final approval for meeting the requirements of the 1970 federal act. This approval means that federal OSHA has formally relinquished enforcement authority in areas under Oregon OSHA jurisdiction. Many states that have received this recognition employ rules that are identical to federal requirements. In contrast, Oregon has designed its safety standards based on Oregon's unique working conditions. Therefore, the approval of a plan that differs substantially from the federal program is an important achievement. Even with final state plan approval, federal OSHA continues to fund a portion of Oregon OSHA's budget and annually monitors its performance through the five-year strategic plan.

Legislative reform

Since the passage of the OSEA, other pieces of legislation have affected Oregon OSHA's programs. Between 1987 and 1991, the Oregon Legislature significantly 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 of workplaces.

The 1999 Legislature passed HB 2830, which directed Oregon OSHA to notify certain employers of the increased likelihood of an inspection and to focus Oregon OSHA enforcement activities on the most unsafe workplaces. In 2005, at Oregon OSHA's request, HB 2093 removed the accepted disabling claims rate as one of the criteria used by Oregon OSHA when identifying employers who will receive this notification. This legislation provided the director with the authority to determine the most unsafe industries and workplaces to be notified of the increased likelihood of an inspection.

In 1990, SB 1197 required employers with more than 10 employees, and certain employers with fewer than 10 employees, to establish safety committees. However, in 2007 the Legislature passed HB 2222, which removed all of the specific safety committee requirements from the law. It gave the Department of Consumer and Business Services the authority to write rules requiring all employers to establish and administer safety committees or hold safety meetings. HB 2222 also allows for alternate forms of safety committees and meetings to meet the special needs of small employers, agricultural employers, and employers with mobile work sites.

Many of the legislative changes have affected agriculture. In 1995, small agricultural employers without any serious accidents and who followed specified training and consultation schedules were exempted from scheduled inspections. In 1997, Oregon OSHA was authorized to enforce the law requiring operators of farmworker camps to provide seven days of housing in the event of camp closure by a government agency. Prior to this legislative change, the Bureau of Labor and Industries enforced the law. The 1999 Legislature exempted corporate farms with only family-member employees from occupational safety and health requirements. HB 3573 (2001) created the Farmworker Housing Development Account and directed that the money collected from civil penalties imposed for the nonregistration of farmworker camps be put into the account.

Voluntary Services

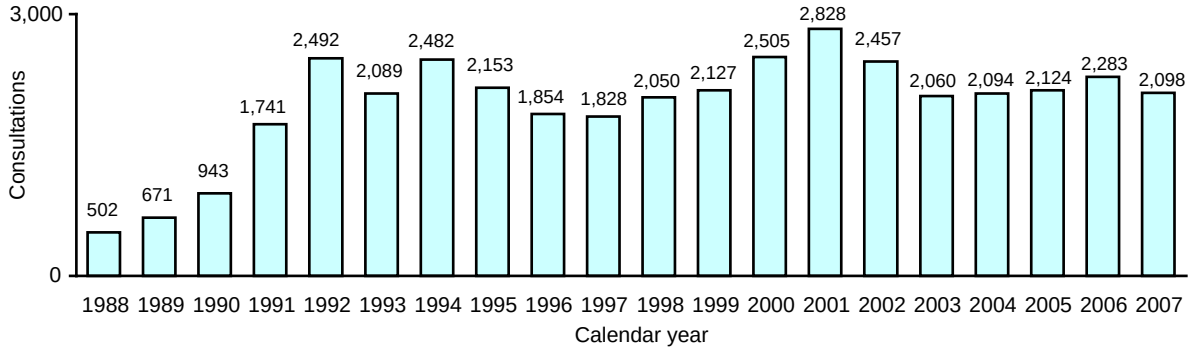
Consultative services

Oregon OSHA staff members provided 2,098 consultations in 2007. This function was added to the department's duties through SB 2900 in 1987 and expanded with the passage of SB 1197 in 1990. Consultative services help Oregon employers identify hazards and work practices that could lead to injuries or illnesses. Employers are provided recommendations for correcting identified hazards and for improving their safety and health programs. Consultative services also include the time-intensive process of assisting interested employers as they work toward Safety and Health Achievement Recognition Program (SHARP) recognition, and evaluating worksites for qualification in the Voluntary Protection Program.

Safety and Health Achievement Recognition Program

The Safety and Health Achievement Recognition Program (SHARP) recognizes employers who reach specific benchmarks in managing their occupational safety and health program. SHARP provides employers assistance and tools for effectively

Figure 4. Oregon OSHA consultations opened, 1988-2007



managing workplace safety, focusing on management commitment, and employee participation. Companies that use SHARP to implement a safety and health management system often experience a reduction in injuries and illnesses, and, in turn, reduce their workers' compensation insurance premiums. The program was implemented in 1996 with four employers certified. By the end of 2007, the program had grown to 126 employers.

Voluntary Protection Program

Federal OSHA developed the Voluntary Protection Program (VPP) as a way to recognize employers who demonstrate excellence in safety and health management. To be considered for VPP recognition, a company's safety and health management system must excel in all areas, including management leadership, employee involvement, worksite analysis, hazard prevention and control, and safety and health training. VPP worksites must also have a three-year average injury and illness rate at or below the rates of other employers in the same industry. At the end of 2007, there were 16 Oregon worksites participating in VPP.

Oregon OSHA grants

Since 1990, Oregon OSHA has awarded about $2.6 million in grants to nonprofit organizations and associations to develop innovative programs for occupational safety and health training. The programs are designed to reduce or eliminate hazards in an entire industry or in a specific work process. Examples of programs that have received grants are homebuilders' manuals and videos in Russian, Spanish, and English; an educational program for nurses to prevent ergonomic injuries; a dairy farmers' checklist and video; and lifting guidelines.

In 2008, Oregon OSHA awarded $1.04 million in grants to a rural critical care hospital and a long-term care facility to develop model sites for safe patient handling. This was done in collaboration with the Oregon Coalition for Healthcare Ergonomics as a means to address the growing problem of health care worker injuries and their associated costs.

Safety and Health Training Programs

Oregon OSHA also provides training to both employers and employees. Attendance at public education and conference training sessions between 1998 and 2007 exceeded 230,000. These educational forums provide an opportunity to share ideas on occupational safety and health with national experts.

Most Oregon OSHA conferences are coordinated and presented in partnership with businesses, associations, labor unions, etc. Every other year, Oregon OSHA and the American Association of Safety Engineers work together to present the Governor's Occupational Safety and Health Conference (GOSH). In 2007, in addition to the GOSH conference, there were six other conferences held around Oregon that addressed a variety of safety and health issues.

In 2007, the Public Education Section offered more than 740 workshops and on-site trainings on 78 different topics related to safety and health in the workplace.

Partnerships with stakeholders

Oregon OSHA collaborates with groups, including business organizations and labor unions, to design better safety and health programs for workers. Oregon OSHA has 36 active partnerships with organizations and individuals who have an interest in workplace safety and health. Many of the partnerships take the form of stakeholder advisory committees that assist in the development of new rules, provide input on agency direction on current issues, foster outreach and education with specific industries, and sponsor conferences.

For example, Oregon OSHA worked with the Oregon Collaboration for Healthy Nail Salons to provide education on environmental health hazards in the nail salon industry. The joint effort resulted in two informative publications, including one translated into Vietnamese, that specifically targeted workers in the industry, as well as an extensive public information outreach effort to the affected workers.

Oregon OSHA also adopted a formal alliance policy to acknowledge some of the collaborations with industry or labor groups. Agreements were recently signed with the Oregon Homebuilders Association, Oregon Restaurant Association, and Oregon Coalition for Healthcare Ergonomics.

Enforcement

Oregon OSHA inspections

Oregon OSHA conducted 5,049 inspections in federal fiscal year 2007. More than 10,000 violations of safety and health standards were cited on 3,759 citations. Penalties assessed for these employer violations in federal fiscal year 2007 were $2.4 million, which is consistent with previous years.

Inspections at employer worksites in Oregon are based primarily on inspection targeting lists, complaints, accidents (including fatalities), and referrals. Seventy-one percent, about 3,600 inspections, were initiated from several targeting lists. Complaints received by Oregon OSHA about the safety or health conditions at Oregon worksites resulted in 805 inspections, 16 percent of the total. Accidents and fatalities at Oregon worksites resulted in 209 inspections, 4 percent of the total.

Although the number of inspections has varied from year to year, there has been no long-term increase in inspections since at least 1988. During the same period, the number of Oregon employers has grown 35 percent.

Loss-prevention services

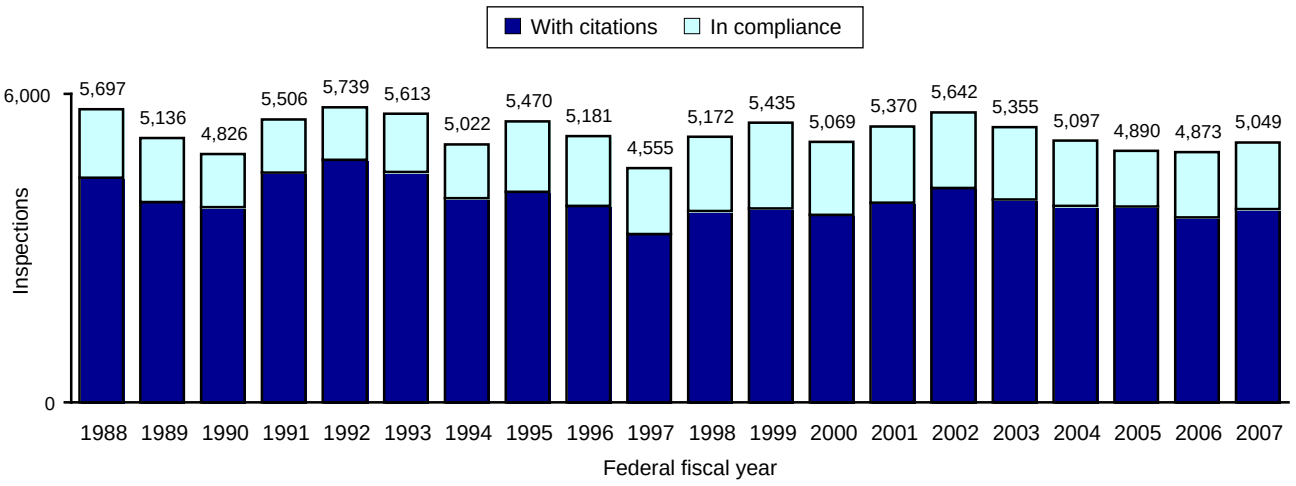
From 1989 to 1999, workers' compensation insurers provided mandatory loss-prevention services to employers Oregon OSHA identified as having at least three accepted disabling claims and a claims rate above the statewide average or having at least 20 claims. In July 1999, administrative rule changes required insurers to identify employers with a claims frequency greater than the industry average and offer loss-prevention services. Oregon OSHA conducts inspections of insurers' and self-insured employers' loss-prevention activities to ensure that employers are offered loss-prevention services. These services include assistance in developing written loss-prevention plans, workplace hazard surveys, identification of resources to reduce hazards, and assistance in evaluating safety and health training needs.

Customer service

One factor in the success of Oregon OSHA's enforcement activities is the performance of its compliance officers. The department surveys employers that Oregon OSHA inspected, allowing employers to rate the performance of compliance officers. On average, more than 90 percent of completed questionnaires show "good" to "very good" ratings for compliance officers in their general knowledge of the job, professional and personal attributes, and ability to explain the reason for the inspection, and the rights and responsibilities of the inspected employer. In addition, the majority of respondents indicate a belief that their inspection will result in a reduction of workplace hazards.

Oregon OSHA's consultation services also receive high marks in customer service. Among employers surveyed in FY 2007, nearly all (97 percent) rated their consultant as "good" or "excellent" in regard to helpfulness, expertise, timeliness, accuracy, availability of information, and overall service.

Figure 5. Oregon OSHA inspections, 1988-2007



Accepted disabling claims, employment, and claims rates, 1987-2007

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	27,020	1,576,100	1.7
1999	25,769	1,602,700	1.6
2000	25,326	1,627,600	1.6
2001	24,608	1,616,400	1.5
2002	23,464	1,596,100	1.5
2003	21,823	1,585,800	1.4
2004	22,321	1,636,300	1.4
2005	22,113	1,683,100	1.3
2006	23,371	1,734,400	1.4
2007	23,433	1,763,800	1.3

The number of accepted disabling claims has increased slightly over the past two years. Prior to that, the number declined nearly every year after 1988. There were just over half as many ADCs in 2007 as in 1988. During the same period, employment grew by 51 percent.

The claims rate was at a record low in 2007, with 1.3 accepted disabling claims per 100 workers. This was 35 percent of the 1988 value.

Permanent partial disability claims, 1987-2007

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	9,476	662
1996	8,904	599
1997	8,049	520
1998	7,759	492
1999	7,342	458
2000	6,954	427
2001	7,015	434
2002	6,730	422
2003	6,266	395
2004	6,369	389
2005	6,386	379
2006	6,580	379
2007	6,844	388

Permanent partial disability indicates the severity of workplace injuries. The number of accepted disabling claims for which permanent partial disability has been awarded declined nearly every year between 1987 and 2003, with the average annual decline rate of about 5 percent. The greatest decline occured in 1991; the number of PPD claims dropped by 27 percent compared to the previous year. The number of accepted disability claims for which PPD has been awarded, on the contrary, increased by the average annual rate of 2 percent. The PPD rate, the number of claims with PPD awards per 100,000 workers, has declining by 1 percent since 2003; the average rate of decline for the years prior to 2003 was 7 percent. Again, the greatest decline took place in 1991, when the PPD rate dropped by 27 percent as well.

Note: PPD claims are reported by the year of the first PPD award. The counts do not include PPD claims resolved by claim disposition agreements prior to the closure date. Historical data will change by small amounts.

Compensable fatalities, 1987-2007

Year	Compensable fatalities	Fatality rate
1987	78	7.1
1988	81	7.0
1989	76	6.3
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
2004	45	2.7
2005	31	1.8
2006	37	2.1
2007	35	2.0

There were 35 compensable fatalities in 2007, the third fewest ever recorded. The number of deaths has declined an average of 4 percent per year since 1987. The fatality rate, the number of compensable fatalities per 100,000 workers, has declined by an average rate of 6 percent per year.

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.

Occupational injuries and illnesses incidence rates, Oregon private sector, 1987-2007

Year	Total cases IR	Cases with days away from work	DART rate
1987	10.9	4.8	-
1988	11.1	4.9	-
1989	10.6	4.3	-
1990	10.1	3.9	-
1991	9.1	3.4	-
1992	9.1	3.3	-
1993	9.0	3.3	-
1994	8.7	3.0	-
1995	8.8	2.9	-
1996	7.8	2.6	-
1997	7.8	2.3	-
1998	6.9	2.1	-
1999	7.0	2.1	-
2000	6.3	1.9	-
2001	6.2	1.9	-
----------> Series break			
2002	6.0	1.9	3.2
2003	5.6	1.9	3.1
2004	5.8	1.9	3.1
2005	5.4	1.7	2.9
2006	5.3	1.7	2.8
2007	5.1	1.7	2.8

Incidence rates are the number of cases per 100 workers. Beginning with the 2002 BLS survey, incidence rates are based on revised requirements for recording occupational injuries and illnesses. Due to the revised requirements, the rates since the 2002 survey may not be comparable with those of prior years.

The total-cases incidence rate is a measure of all recordable workplace injuries and illnesses. The cases-with-days-away-from-work incidence rate shows the cases that resulted in absences from work. The DART (Days away from work, job transfer, or restricted duty) rate is a broader measure. In addition to days away from work, it includes cases that result in changes or restrictions in duty. All four of these rates fell about 10 percent between 2003 and 2007.

Industry total-cases incidence rates, 2003-2007

Year	Agriculture, forestry, fishing	Construc-tion	Manufac-turing	Transporta-tion and warehousing
2003	6.9	7.4	7.0	10.0
2004	8.9	7.9	7.4	7.1
2005	5.8	8.0	7.5	6.5
2006	6.4	6.3	7.0	9.0
2007	7.2	6.8	6.5	7.9

Beginning with the 2003 survey, the industry rates are based on the North American Industry Classification System. Prior data were based on the Standard Industrial Classification codes, which are not comparable.

Two of the four industry divisions shown here had declines in total-cases incidence rates between 2005 and 2007. The decline in the construction industry was 15 percent; the decline for the manufacturing industry was 13 percent. The agriculture, forestry, fishing industry had an increase of 24 percent, and the transportation and warehousing industry's rate increased 22 percent.

Oregon OSHA inspections, federal fiscal years 1988-2007

Federal fiscal year	Inspections	Workers covered by inspections	Percent in compliance
1988	5,697	147,414	23.3%
1989	5,136	167,432	24.2%
1990	4,826	164,052	21.4%
1991	5,506	163,813	18.8%
1992	5,739	206,170	17.7%
1993	5,613	245,901	20.1%
1994	5,022	262,589	20.9%
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	5,642	196,193	26.1%
2003	5,355	217,724	26.4%
2004	5,097	207,463	24.9%
2005	4,890	274,457	22.2%
2006	4,873	355,103	26.2%
2007	5,049	244,111	25.5%

The number of Oregon OSHA inspections per federal fiscal year fluctuates (the federal fiscal year begins each October). The average number of inspections per year from 1988-2007 is 5,235.

Inspections are classified in several ways. The broadest category identifies each inspection as either a safety inspection or a health inspection. In federal fiscal year 2007, 82 percent were safety inspections.

Some inspections result in a citation (violations of Oregon or federal standards found at the worksite). When there are no violations of safety or health rules, the inspection is called "in compliance." The percentage of in-compliance inspections was 26 percent in federal fiscal year 2007.

Oregon OSHA citations, violations, and proposed penalties, federal fiscal years 1988-2007

Federal fiscal year	Citations	Violations	Penalties ($ millions)
1988	4,368	15,735	$1.9
1989	3,892	12,364	1.5
1990	3,794	14,009	2.8
1991	4,472	17,118	2.8
1992	4,721	19,424	3.2
1993	4,485	17,611	4.7
1994	3,970	15,292	4.6
1995	4,093	15,302	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	11,700	2.3
2004	3,827	11,804	2.4
2005	3,805	11,376	2.0
2006	3,595	10,003	2.4
2007	3,759	10,479	2.4

Oregon 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.

Oregon OSHA consultations, 1988-2007

Year	Number of consulta-tions	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	2,127	233,675	42	3
2000	2,505	241,965	50	4
2001	2,828	260,695	69	4
2002	2,457	219,418	75	6
2003	2,060	230,245	80	9
2004	2,094	229,130	86	8
2005	2,124	187,449	104	9
2006	2,283	221,157	107	13
2007	2,098	214,310	126	16

Oregon OSHA's consultative services help Oregon employers identify hazards and work practices that could lead to injuries or illnesses. Employers are provided recommendations for correcting identified hazards and for improving their safety and health programs. Consultative services also include the time-intensive process of assisting interested employers as they work toward SHARP recognition, and evaluating worksites for qualification in the Voluntary Protection Program.

The Safety and Health Achievement Recognition Program (SHARP) is a recognition program that provides guidance and tools for developing an effective safety and health program. The program focuses on the implementation of a system based on management commitment and employee participation.

The Voluntary Protection Program (VPP) was developed by federal OSHA as a way to recognize employers who demonstrate excellence in safety and health management. The key areas are management leadership, employee involvement, worksite analysis, hazard prevention and control, and safety and health training.

Safety and health training programs, 1998-2007

Year	Attendance at training sessions
1998	15,494
1999	27,104
2000	19,069
2001	26,478
2002	15,844
2003	26,290
2004	20,892
2005	27,154
2006	22,751
2007	30,053

Oregon OSHA has provided education and training to more than 230,000 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 (GOSH), which is held in odd-numbered years. Conferences are coordinated and presented in partnership with businesses, associations, labor unions, etc.

In 2007, in addition to the GOSH conference, there were six conferences held around Oregon. They addressed a variety of safety and health issues.

In addition to conferences, in 2007 the Public Education Section offered over 740 workshops and on-site trainings on 78 different topics related to safety and health in the workplace.

Oregon OSHA safety and health grant programs, 1989-2007

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
2003-2005	8	297,626
2005-2007	2	66,753

In existence since 1989, Oregon OSHA's Training and Education Grants program has awarded 83 grants totaling $2.6 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.

The following are examples of programs that have received grants: homebuilders' manuals and videos in Russian, Spanish, and English; an educational program for nurses to prevent ergonomic injuries; a dairy farmers' checklist and video; and lifting guidelines.

Employers' safety committee citations, violations, and penalties, fiscal years 1990-2007

Fiscal year	Citations	Violations	Proposed penalties
1990	128	131	$13,040
1991	219	231	24,355
1992	892	1,024	61,555
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
2004	1,089	1,438	142,340
2005	1,034	1,379	111,380
2006	947	1,125	118,775
2007	961	1,151	131,225

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. In 2007, HB 2222 removed all of the specific safety committee requirements from the law and gave the Department of Consumer and Business Services the authority to write rules that require all employers to establish and administer safety committees or hold safety meetings. HB 2222 also allows for alternate forms of safety committees and meetings to address the special needs of small employers, agricultural employers, and employers with mobile work sites.

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

Compensability

The Oregon workers' compensation system is a no-fault system. In other words, the compensability of a claim is not dependent upon demonstrating that either side in a dispute is negligent. One purpose of a no-fault system is to compensate injured workers for work-related claims. Limiting claims to those that arise out of and in the course of employment reduces workers' compensation costs.

Definition of compensability

The definition of a compensable claim has been revised numerous times over the years. 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.

SB 1197 (1990) changed the definition of compensability for injuries and diseases; the language was revised by SB 369 (1995). A compensable injury or disease must be established by medical evidence supported by objective findings. The determination of a claim's compensability involves establishing the relative contributions of different causes of an injury or disease and deciding which cause is the primary one. Oregon is one of the few states in the country that has this major contributing cause standard. If an injury combines with a pre-existing condition, the consequential condition is compensable only if the qualifying injury is the major contributing cause of the disability or need for treatment; it remains compensable only for the period during which it remains the major contributing cause. For diseases, employment must be the major contributing cause, and the compensable disease must be caused by substances or activities to which an employee is not ordinarily exposed. These new compensability definitions were partly responsible for the decrease in the number of accepted claims in the early 1990s.

There are several factors that limit the compensability of a claim. Injuries from recreational and social activities primarily for the worker's personal pleasure are not compensable. Injuries arising from the use of alcohol or drugs are not compensable if it is proven that the drug or alcohol use was the major contributing cause. If the employer permitted, encouraged, or had knowledge of such consumption, then it may be compensable. SB 1197 also allowed insurers to deny an accepted claim during the two-year period following the date of original claim acceptance. Insurers may deny a claim at any time if acceptance was due to fraud, misrepresentation, or other illegal activity by the worker.

SB 1197 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.

Major contributing cause study

The 1999 Legislature allocated funds to study the effects of the compensability language changes. The primary focus was the major contributing cause language in SB 1197 and SB 369. 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. It issued the report in October 2000. Copies are available from the department.

The researchers examined more than 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. They concluded that many of the claims denied due to major contributing cause language would have been denied for other reasons prior to SB 1197. 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 sought to determine how much of the decline in Oregon's costs was due to legislative changes and how much would have occurred as a result of the national trends. They concluded that SB 1197 (the entire bill, not just the major contributing cause language) resulted in a reduction in benefits of at least 6.4 percent and that SB 369 resulted in a reduction of at least another 6.7 percent. This savings was due to a drop in the number of claims; the average cost per claim remained about the same.

The researchers also conducted a survey of physicians. 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 reviewed comparable statutes and legal decisions in other states. The review showed that the major contributing cause standard was used in three other states. The Oregon 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, it would find portions of Oregon's workers' compensation law unconstitutional; such a ruling was handed down the next year.

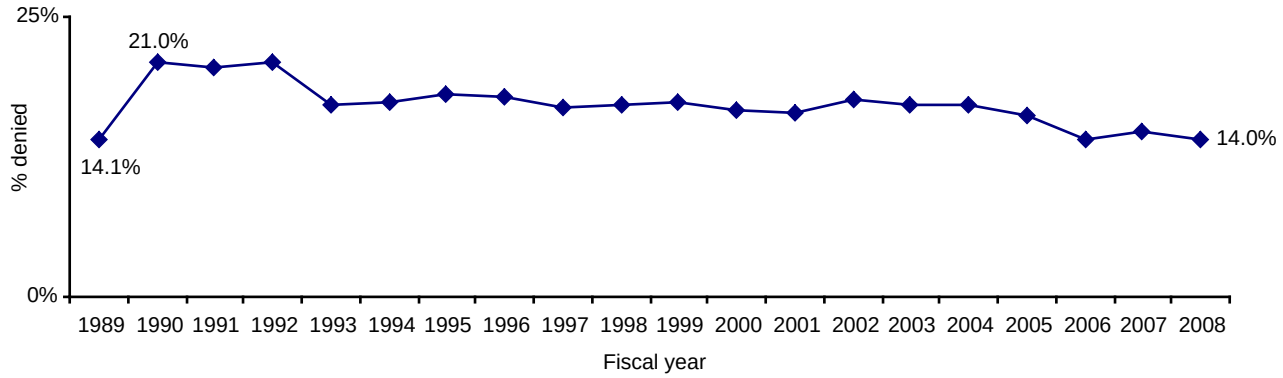
Smothers v. Gresham Transfer, Inc.

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 court ruled that 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 the 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 pre-existing 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. Early estimates were that the decision could affect as many as 1,300 cases per year and cost up to $50 million per year. In fact, there have been no known cases in which workers have prevailed at trial and only a few cases in which workers have received settlements.

Figure 6. Disabling claims denial rate, FY 1989-2008



Claim denial rates

The denial rate of disabling claims has been fairly constant for more than a decade, with the fiscal year 2008 denial rate of 14 percent maintaining this trend and keeping consistent with the previous two years (14.1 and 14.7 percent, respectively). This period of stability follows a short period of higher denial rates. Largely as a result of a major change in SAIF's claims-management practices, the denial rate of disabling claims jumped from 14 percent in fiscal year 1989 to 21 percent in fiscal year 1990; the denial rate for disabling occupational disease claims jumped from 34 percent to 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.

Oregon Population Survey

The Oregon Population Survey includes questions about workplace injuries and workers' compensation claims. Survey results show that just over 5 percent of Oregonians employed in 2005 were injured on the job and required the attention of a medical provider. Almost 80 percent of injured workers reported missing at least one day of work, while 40 percent reported missing at least a month.

The survey also found that 46 percent of workers injured on the job do not file a workers' compensation claim. Those not filing included workers employed in positions not covered by workers' compensation insurance and therefore not eligible to file a claim, as well as those with workers' compensation coverage. The most common reasons given by covered workers for not filing a claim included the belief that their medical insurance would cover the costs, feeling that they were to blame for the injury, or that their recovery was quick.

Total reported claims, FY 1989-2008

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	4,420	17.1%	11,715
2004	20,004	4,117	17.1%	10,176
2005	21,020	4,030	16.1%	9,578
2006	21,445	3,516	14.1%	9,672
2007	22,449	3,873	14.7%	9,165
2008	21,734	3,533	14.0%	8,391

The denial rate of disabling claims remained fairly constant over the period 1993-2005, varying between 16 percent and 18 percent. The denial rate in FY 2006-2008 was slightly lower, varying between 14 percent and 15 percent.

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

Disabling occupational disease claims, FY 1989-2008

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	3,275	1,636	33.3%
2004	3,074	1,727	36.0%
2005	3,247	1,670	34.0%
2006	3,182	1,431	31.0%
2007	3,480	1,523	30.4%
2008	2,926	1,339	31.4%

The denial rate of occupational disease claims was fairly constant over the period FY 1996-2005, varying between 33 percent and 37 percent. The denial rate in FY 2006-2008 was slightly lower, varying between 30 percent and 31 percent.

While the denial rate was relatively unchanged, the total number of disabling occupational disease claims reported to the department in FY 2008 was 14.8 percent lower than the previous year.

Over the last five fiscal years, nearly half of disabling occupational disease claims were due to diseases and disorders of the musculoskeletal, connective tissue, and peripheral nervous systems. These claims include rheumatisms, carpal tunnel syndrome, tendonitis, various back or spinal conditions (dorsopathies), and arthritic conditions.

Disabling aggravation claims, 1991-2007

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%
2004	563	416	42.5%
2005	549	340	38.2%
2006	523	432	45.2%
2007	518	534	50.8%

The number of aggravation claims has increased since 2005. The denial rate is now above 50 percent.

Note: The counts are aggravation claims reported to the department by insurers. These exclude claims made under Board Own Motion authority for worsened conditions.

Claims Processing

Insurer performance is an important part of the workers' compensation system. The department monitors insurer performance issues, such as the first payment of temporary disability benefits, claim compensability decisions, and claim closures.

The department issues civil penalties to insurers and self-insured employers who do not meet acceptable performance standards. In both 2006 and 2007, the department issued more than 900 citations, with penalty amounts of more than $575,000. Not included in these statistics are stipulated agreements. These may encompass various violations of rules and statutes under ORS Chapters 656 and 731 and set up various performance expectations. One recent stipulation, issued under an Insurance Division order, set a penalty at $5 million, with $4 million suspended pending the insurer group meeting certain conditions.

Claim acceptance or denial

Several legislative changes have affected time frames for insurers' action to accept or deny a claim. To enable insurers to make better decisions, the statutory time limit for the acceptance or denial of a claim was changed from 60 days to 90 days by SB 1197 in 1990. It was hoped that this would lessen the number of appealed denials. The median number of days to accept a disabling claim increased after 1990, peaking at 52 days in 1998, but this resulted in longer periods of uncertainty for workers and

Figure 7. Median calendar days from employer knowledge to claim acceptance or denial, 1988-2007

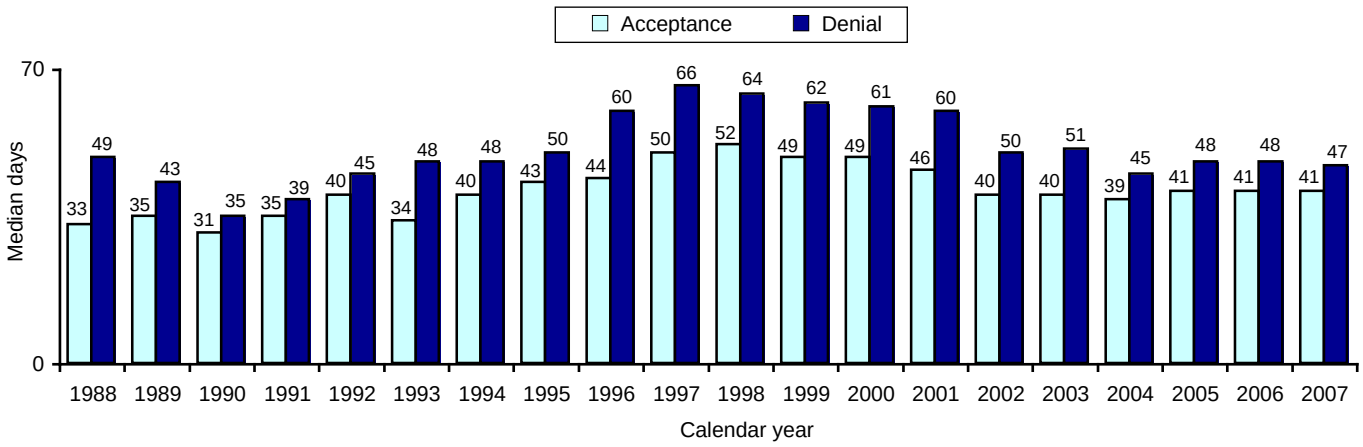


Figure 8. Insurer timeliness of acceptance or denial and of first payments, 1990-2007

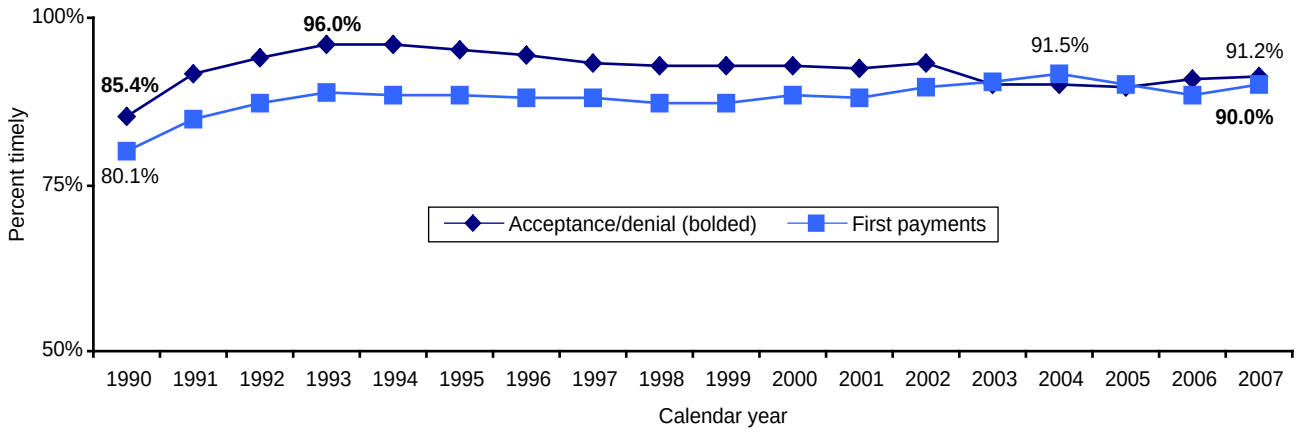
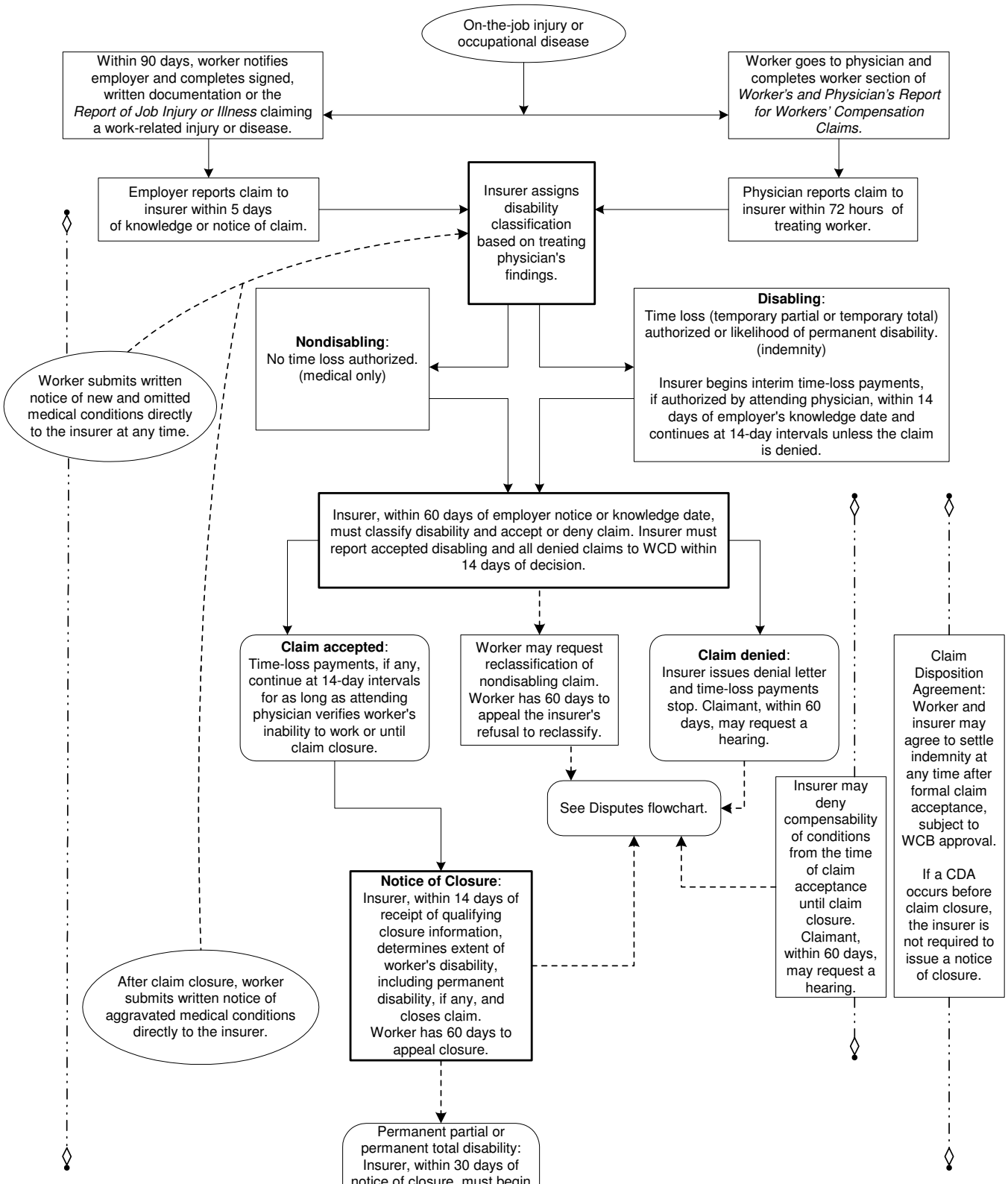


Figure 9. Claims process flowchart



The ●◇— · · —◇● indicates time frame in which the action may occur during the process.
The – – – – – indicates potential path of process.

Note: This flowchart provides a general description of the claims process. It omits many details. The time frames shown are those in statute and rule; exceptions to these time frames are not shown. Flowcharts in the return-to-work chapter and the disputes chapter provide additional information.

medical providers. In 2001, as part of SB 485, the Legislature reduced the statutory time limit back to 60 days. This affected the processing time for compensability decisions. Since 2005, the median time to accept a disabling claim has been 41 days. Just over 90 percent of the compensability decisions in 2007 were made within the 60-day period.

In an effort to streamline reporting, the requirement for insurers to notify the department within 21 days of receiving a claim was changed. Since 2003 with the passing of SB 914, the insurer must notify the department within 14 days of the decision to accept or deny the claim. It was hoped this would speed up compensability decisions, but this has not occurred.

Modified acceptances

The 1997 Legislature passed HB 2971, which 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, insurers are also required to issue an updated notice of acceptance that specifies the compensable conditions. In addition, if a condition is later found to be compensable, the insurer must reopen the claim for that condition.

The Court of Appeals, in the 1999 Johansen v. SAIF Corporation decision, ruled that there are no time limits for liability on a new condition. In SB 485, the 2001 Legislature refined the process for new conditions. A worker must request formal written acceptance of a new or omitted medical condition, which the insurer has 60 days to accept or deny. The period for disabling claims aggravation rights extends five years after the first closure. If new compensable 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.

Claim closures

Prior to 1987, only the department could close a claim and rate permanent disability. HB 2900 (1987) 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 that the insurers had to use. 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. In 1992, insurers completed 58 percent of the claim closures.

In SB 220, the 1999 Legislature shifted responsibility for all claim closures from the department to insurers and self-insured employers. The transition was completed Jan. 1, 2001.

The median number of days from injury to first closure was 150 calendar days for claims first closed in 2007. The median has been between 154 and 157 days in eight of the past 10 years.

System abuse

The department works to eliminate abuse of the workers' compensation system. The WCD investigates allegations of inappropriate actions by employers, medical providers, insurers, workers, and other parties. (Insurers also conduct investigations; the department does not have a count of the number of these investigations.) In fiscal year 2008, eight investigations of fraud or abuse complaints were opened. Historically, the most frequent complaints received have been employers pressuring employees not to file claims; improper claims processing by insurers or medical providers; employers improperly directing the medical treatment of workers; and failure to report or improper reporting of claims-related documents by employers, insurers, and medical providers.

Workers' compensation information line

The Workers' Compensation Division has a workers' compensation information line to answer workers' questions about their claims, describe workers' rights and responsibilities, and help them understand the workers' compensation system. In 2007, there were more than 12,300 calls to the line. Of the callers, about 7,300 were workers and about 5,000 were insurers, medical providers, attorneys, employers, legislators, and others.

Insurer claim acceptance and denial, median time lag days, 1988-2007

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
2004	39	45
2005	41	48
2006	41	48
2007	41	47

In 1990, SB 1197 extended the time allowed for insurers to accept or deny a claim from 60 to 90 days. SB 485 (2001) reduced the allowed time back to 60 days.

Since 2002, the median time taken to accept a disabling claim has been about 40 calendar days; the median time to deny a disabling claim has been about 48 days.

Insurer timeliness of acceptance or denial and of first payments, 1990-2007

Year	Acceptance/ denial timely	First temporary disability 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%
2004	90.1%	91.5%
2005	89.5%	90.1%
2006	90.9%	88.3%
2007	91.2%	90.0%

Insurer performance on timeliness of acceptance or denial of claims improved between 1990 and 1994, to 96.1 percent. It has generally declined since, standing at 91.2 percent in 2007.

Timeliness of first payments has improved since 1990, also. In 2007, 90.0 percent of the first payments of temporary disability benefits were made timely.

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

Claim closures, with insurer closures, 1987-2007

Year	Claim closures	Insurer closures	Percent insurer closures
1987	50,587	18,153	35.9%
1988	50,223	14,194	28.3%
1989	48,732	14,053	28.8%
1990	46,488	14,884	32.0%
1991	38,351	18,483	48.2%
1992	34,506	19,876	57.6%
1993	33,823	19,256	56.9%
1994	34,631	20,192	58.3%
1995	35,657	20,742	58.2%
1996	33,838	20,676	61.1%
1997	31,671	20,949	66.1%
1998	30,810	22,071	71.6%
1999	28,894	22,191	76.8%
2000	27,675	26,287	95.0%
2001	27,020	27,016	100%
2002	25,423	25,413	100%
2003	23,877	23,877	100%
2004	23,908	23,908	100%
2005	23,173	23,173	100%
2006	24,081	24,081	100%
2007	25,095	25,095	100%

The number of total closures, which includes insurers' disabling status reclassifications, has shown a steady downward trend since 1995. The decline has averaged 3 percent per year.

SB 220, passed in 1999, phased out the department's former role in closing claims. Since Jan. 1, 2001, insurers, self-insured employers, and third-party administrators have handled all claim closures.

Time lag from injury date to first closure, 1987-2007

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	156
2003	241	155
2004	260	155
2005	240	157
2006	241	154
2007	231	150

For claims first closed in 2007, the average calendar days from injury to first closure was 231 days. For 2007, the average was the lowest since 2000.

The median number of days from injury to first closure was 150 days in 2007. There has been almost no change in the median number of days over the past decade.

Civil penalties issued, 1990-2007

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
2004	677	206,675
2005	745	360,600
2006	951	588,150
2007	915	575,800

Citations and penalties against insurers have been trending upward since 2004.

Not included in these statistics are stipulated agreements. These may encompass various violations of rules and statutes under ORS Chapters 656 and 731 and set up various performance expectations. One recent stipulation, issued under an Insurance Division order number, set a penalty at $5 million, with $4 million suspended pending certain conditions.

Abuse complaint investigations, FY 2002-2008

Fiscal year	Opened	Closed
2002	110	93
2003	87	94
2004	63	76
2005	62	70
2006	20	21
2007	7	7
2008	8	8

In FY 2008, eight investigations were opened concerning complaints of inappropriate actions by employers, providers, insurers, workers, and other parties.

The counts exclude inquiries that did not require issuing a director's order or warning notice. In FY 2008, there were 92 such inquiries. These inquiries were usually resolved with educational counseling, referred to other agencies, or dropped after callers withdrew their complaints.

Workers' compensation information line calls for assistance, 1990-2007

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
2004	10,129	7,703	17,832
2005	9,463	6,270	15,733
2006	7,898	6,056	13,954
2007	7,359	4,947	12,306

WCD has an information line to assist workers and others. In 2007, there were more than 7,300 calls from workers with questions about their claims, the claims process, or the workers' compensation system. Ten percent of these calls were fielded by bilingual benefit consultants.

The line also received almost 5,000 calls from insurers, medical providers, attorneys, employers, legislators, and others in 2007.

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. The office consists of the ombudsman and eight staff members.

In 2007, the office recorded more than 11,500 inquiries, down about 6 percent from 2006. About 89 percent of these inquiries were from injured workers. The issues that prompted the most inquiries were claims processing, medical benefits, and accurate and timely benefits.

Small Business Ombudsman

The Office of the Small Business Ombudsman for Workers' Compensation was created during the 1990 special session to serve as an advocate for and educator of small businesses. The SBO is the resource center for employers needing information about the workers' compensation system. It helps resolve disputes between employers and insurers, provides educational seminars, participates in trade shows, and assists all parties. The office had 3,785 inquiries in 2007, up more than 15 percent from the previous two years.

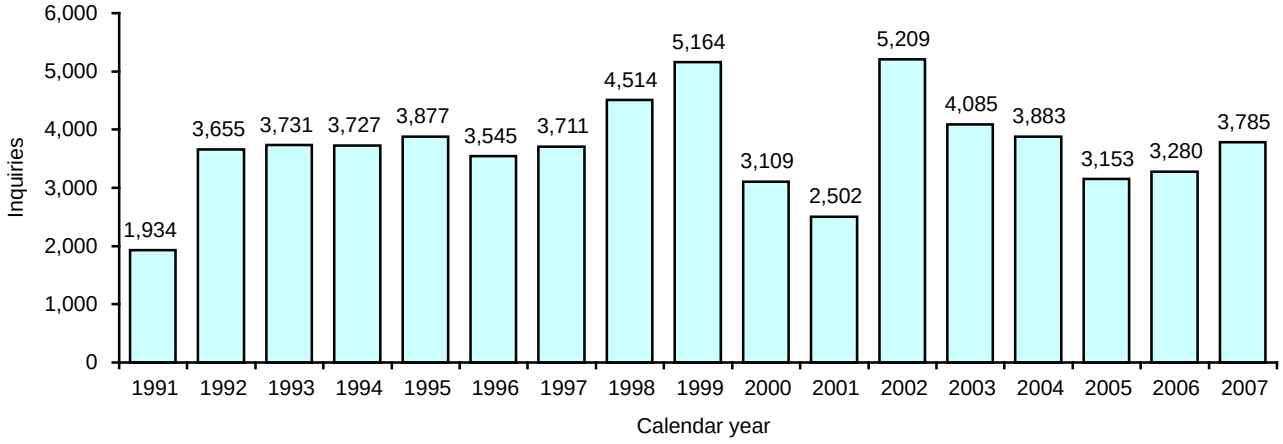
Medical Advisory Committee

The members advise the director on matters relating to medical care for workers. In 1999, SB 222 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, which may include representatives of insurers, employers, and managed care organizations.

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-

Figure 10. Small Business Ombudsman inquiries, 1991-2007



Labor Advisory Committee (MLAC). 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 its 2008 study, "Lessons from the Oregon Workers' Compensation System," the Workers' Compensation Research Institute described MLAC as "unusually effective as a force for orderly system improvement." The study further concluded, "On the whole the Oregon system (through MLAC and other system features) has succeeded in balancing the values of stability and flexibility remarkably well, resulting in a system stable enough to be predictable yet flexible enough to change when necessary. In many states the two values are not compatible."

In 1995, SB 369 reduced the membership of MLAC from 14 members 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.

In 2007, SB 835 directed MLAC to study death benefits, and a subcommittee was formed to study the topic. The study will include a review of the method of calculating benefits, burial amounts, categories of beneficiaries, and feasibility of providing lump-sum benefit payments. A written report to the 75th Oregon Legislative Assembly is required by Jan. 31, 2009. In addition, MLAC formed subcommittees to review several other areas in detail: significant court cases, supplemental disability benefits for multiple job holders, the claim reconsideration process, and claimant attorney fees.

Ombudsman for Injured Workers inquiries, 1999-2007

Year	Inquiries
1999	9,492
2000	10,581
2001	10,944
2002	12,685
2003	14,730
2004	12,752
2005	12,809
2006	12,257
2007	11,505

The Ombudsman for Injured Workers was created in 1987. Inquiries to the ombudsman come primarily from injured workers, but they are also initiated by attorneys, insurance companies, employers, and others. There were 11,505 inquiries in 2007.

Small Business Ombudsman inquiries, 1991-2007

Year	Inquiries
1991	1,934
1992	3,655
1993	3,731
1994	3,727
1995	3,877
1996	3,545
1997	3,711
1998	4,514
1999	5,164
2000	3,109
2001	2,502
2002	5,209
2003	4,085
2004	3,883
2005	3,153
2006	3,280
2007	3,785

The office of Small Business Ombudsman was created in 1990. The number of inquiries peaked in 1999 and 2002. There were 3,785 inquiries in 2007.

Medical Care and Benefits

In recent years, the cost of health care has risen more rapidly than overall inflation. In Oregon's workers' compensation system, the cost of medical services has increased more than 38 percent since 2000. Payments for medical services account for approximately half of workers' compensation system costs in Oregon. There have been recent initiatives to contain medical costs; these are discussed later in this section.

Early cost-containment measures

In 1990, Senate Bill 1197 eliminated most palliative care after the worker becomes medically stationary, when no further improvement in the worker's condition is expected. 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 implementation of SB 1197. 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 now receive palliative care if they have a permanent total disability or a prosthetic device, when they need services to monitor prescription medicine, or when the attending physician believes the palliative care is necessary for continued employment.

SB 1197 also placed limits on who could 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. Under SB 1197, for example, a chiropractor outside of a managed care organization, could not be the worker's attending physician after 12 visits or 30 days from the first service date, whichever came first. Data from SAIF showed that the proportion of total payments received by chiropractors dropped from 16 percent before 1990 to 3 percent after 1990. In 2008, House Bill 2756 relaxed that limitation to 18 visits or 60 days from the first service date, whichever comes first. HB 2756 also changed limits for other provider types acting as attending physicians. These changes are discussed in more detail later in the report.

Medical benefits

Insurers and self-insured employers must pay the cost of medical services for compensable claims. During the period before claim acceptance or denial, however, there is uncertainty about who will be responsible for medical bills. This uncertainty may make some medical providers reluctant to treat injured workers, and some treatments may be delayed until after insurers' compensability decisions.

In 2001, SB 485 tried to address this concern in two ways. First, the bill reduced the time allowed for insurers to accept or deny a claim from 90 days 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. The law covers certain services: pain medicine, diagnostic services required to identify appropriate treatment or to prevent disability, and services required to stabilize the worker's condition and to prevent further disability. However, it excludes any services provided to workers enrolled in managed care organizations (MCOs). For denied claims, medical costs are paid as follows:

- 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.
- 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.
- If the insurer denies the claim and the worker has no health insurance, the worker pays the entire bill.

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 exist for anesthesiology, surgery, radiology, laboratory and pathology services, medicine, physical medicine and rehabilitation, evaluation and management, multi-disciplinary services and other Oregon-specific service codes, durable medical equipment and medical supplies, and pharmacy services. Insurers must pay for medical services at the lesser of the providers' usual fees or according to the fee schedule. This rule also applies to claims enrolled in MCOs unless terms are otherwise dictated by the MCO contract.

The medical fee schedules establish the maximum allowable reimbursement for services. In 1997, the department also adopted the Federal Resource Based Relative Value Schedule, which is used to determine the ceiling for most medical services. For durable medical equipment and medical supplies, the ceiling is 85 percent of the manufacturer's suggested retail price or 140 percent of the actual cost, whichever is greater. In July 2008, a reduction in the pharmacy fee schedule took place. The maximum allowable fee for pharmaceuticals is now set at 83.5 percent of the Average Wholesale Price plus a $2.00 dispensing fee. Previously it was 88 percent of Average Wholesale Price and an $8.70 dispensing fee.

WCD implemented a hospital payment system using adjusted cost-to-charge ratios (CCR) in 1991. In July 1992, the department began publishing revised CCRs semi-annually for all general, acute-care hospitals in the state. The CCR is the percentage of the hospital bill that insurers reimburse Oregon hospitals for treating injured workers. The computation of the CCR uses data from each hospital's audited financial statement and Medicare cost report. The CCR allows all hospitals to recover the cost of providing facility-related services to injured workers, a reasonable rate of return on their capital assets, and an allowance for losses due to bad debt and charity care. 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 designation as a critical-access hospital under the Medicare Rural Hospital Flexibility Program, or on economic necessity as determined from financial reports. Currently, 25 of the 58 general, acute-care hospitals in Oregon are designated as critical-access hospitals, thereby qualifying for an exclusion from the hospital fee schedule. Five additional rural hospitals qualify for the exclusion based on their financial condition.

In 2007, 88 percent of medical payments reported to the department were for services subject to fee schedules other than the hospital CCR. On average, these payments were 29 percent lower than the charged amounts. Reimbursements for hospital charges subject to the CCR averaged 47 percent less than the charged amounts.

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 it 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 have the option to enroll injured workers covered by MCO contracts in managed care. When this happens, the insurer notifies the injured worker that he or she must seek any future treatment from providers who are on the MCO's panel. Since 1995, insurers are allowed to require that injured workers receive medical treatment in the MCO before the determination of claim acceptance or denial. However, if the insurer denies the claim it must pay the medical costs until the worker

receives notice of the denial or until three days after the denial notice is mailed. Insurers that do not enroll workers in an MCO are not required to pay medical services if the claim is eventually denied.

In 2005, SB 670 made minor revisions to the statute (ORS 656.260) regarding managed care organizations. The bill clarified that in order for an MCO to become certified, the quality, continuity, and treatment standards contained in its plan must be reviewed and approved by the director. The bill also provided that the managed care plan cannot prohibit an injured worker's attending physician from advocating for medical services and temporary disability benefits supported by the medical record. This provision addressed concerns that some managed care contracts contained provisions limiting the attending physician's role.

As of Dec. 31, 2007, four certified MCOs had 69 active contracts with workers' compensation insurers and self-insured employers. Contracts in effect on Oct. 31, 2007, covered 58,684 Oregon employers, or 64 percent of Oregon workers' compensation covered employers. The percent of Oregon workers covered by managed care has increased from 64 percent in October 2005 to 65 percent in October 2007. In October 2007, an estimated 1,144,700 Oregon workers were covered by a managed care contract.

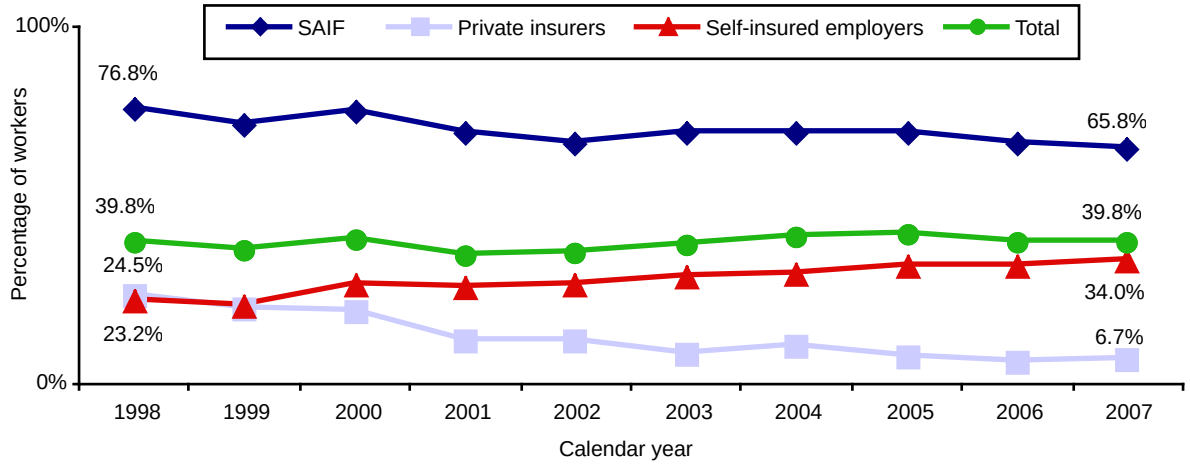
The percentage of workers with accepted disabling claims who were enrolled in MCOs has ranged from 36 percent to 42 percent since 1998. In 2007, it was 40 percent. SAIF insured 79 percent of those enrolled. Self-insured employers enrolled 34 percent of accepted disabling claims. The percentage of workers with accepted disabling claims enrolled by private insurers has dropped more than 16 percent since 1998, reaching a low of 7 percent in 2007.

Medical payments

In 1991, the Workers' Compensation Division began requiring that insurers with 100 or more accepted disabling claims report their medical payment data under Bulletin 220. In 2007, more than 83 percent of total medical payments were reported. Department research analysts developed a model that adjusts reported payments to account for payments that are not reported in Bulletin 220. Using this model, the estimated total medical payments in 2007 were $319.4 million.

In 2007, insurers paid about $92 million for medical doctor services which accounted for 29 percent of all medical payments. This was followed by hospital outpatient services at 22 percent, hospital inpatient services at 12 percent, "other medical" providers at 10 percent, and physical therapy services at 8 percent. These five provider types accounted for 81 percent of all medical payments. A substantial number of the payments classified under the "other medical" provider type were for independent medical exams and ambulance services. Six percent of medical payments went to pharmacies. Radiologists received 3 percent of total payments,

Figure 11. Percentages of workers with accepted disabling claims enrolled in MCOs, by insurer type, 1998-2007



mostly for providing magnetic resonance imaging, computed tomography, and X-ray services. Chiropractors received 2 percent of payments for providing chiropractic manipulative treatments and other therapeutic services.

Physical medicine and rehabilitation services, evaluation and management services (such as office visits, emergency visits, etc.), and surgery are the top three service categories in terms of payments. Physical medicine and rehabilitation services accounted for 15 percent of total 2007 medical payments, nearly $47 million. Evaluation and management accounted for 14 percent of total medical payments, or about $46 million, and surgical services accounted for 13 percent of 2007 total medical payments, approximately $42 million.

Independent medical exams also generated 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), accounted for 3.2 percent of total medical payments.

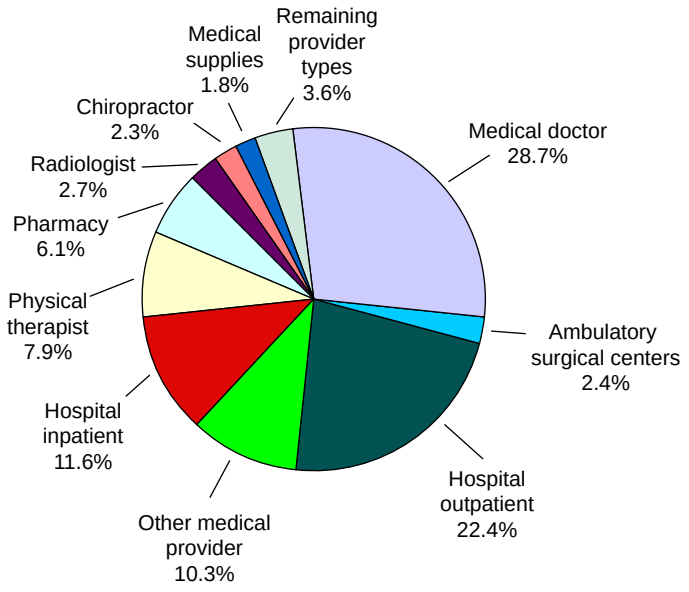
Reported pharmacy data shows that narcotic analgesics (pain relievers) ranked as the top category of drugs prescribed to injured workers and accounted for 37 percent of total pharmacy payments in 2007, followed by anti-convulsants (anti-seizure medications) at 11 percent, and anti-arthritics (anti-inflammatories) at 8 percent. Some of the widely used narcotic analgesics in workers' compensation are Hydrocodone/Acetaminophen, Oxycodone HCL, Fentanyl, Oxycodone/Acetaminophen, and Morphine Sulfate. There is evidence of higher use of generic drugs in workers' compensation than in the general health care system. In 2007, generic drugs made up about 79 percent of the prescriptions dispensed to injured workers and 49 percent of pharmacy payments.

Recent initiatives and studies

Nurse practitioners

In 2003, HB 3669 relaxed restrictions regarding who can be an attending physician by allowing nurse practitioners to perform some of these functions. The bill requires nurse practitioners to become authorized by the department to provide any compensable medical services as attending physicians. It allows authorized nurse practitioners to give expanded treatment in three significant ways. They may provide compensable medical services for 90 days from the date of the first visit on

Figure 12. Top 10 medical payments by provider type, 2007



Note: "Other medical provider" payments are chiefly for independent medical exams and ambulance services. The "Remaining provider types" are acupunturist, dentist, home health care, laboratory, naturopath, nursing home care, occupational therapist, optometrist, osteopath, physician assistant, podiatrist, psychologist, and registered nurse practitioner.

the claim, to authorize the payment of temporary disability benefits for 60 days, and to release workers to their jobs.

In 2005, the department began a study to measure the effects of HB 3669. The study provided the results of a review of the department's medical billing data, claims information provided by SAIF, and a survey of board-certified nurse practitioners. The results found no system cost increases related to the expanded authority for nurse practitioners. In the survey, nurse practitioners reported providing more services to injured workers after the bill went into effect.

Care providers

In 2006, the department, at the request of the Governor and in conjunction with the Management- Labor Advisory Committee, completed a study of care providers. The department and MLAC focused on chiropractors, naturopaths, podiatrists, and physician assistants. The study tried to determine if current rules regarding who may treat workers and authorize disability benefits facilitates accessible, timely, efficient, and effective medical treatment. The study included a literature review; an analysis of chiropractic, naturopathic, podiatric, and physician assistant care providers in Oregon's workers' compensation system; employer focus groups; and an injured worker survey.

The literature review found little data about the role of chiropractors, naturopaths, podiatrists, and physician assistants within the workers' compensation system. The available data did not provide sufficient evidence to either support or oppose a change in Oregon's limitations on who can treat workers.

Employers and injured workers indicated that they were generally satisfied with access to quality health care, the choice of available health care providers, and the quality of care received. Both groups requested that additional restrictions not be added to the current system.

The 2007 Legislature passed HB 2756, which expanded the roles and responsibilities of certain provider types. The new law increased the role of chiropractors, nurse practitioners, podiatrists, naturopaths, and physician assistants to act as attending physician. The new time limit for these providers to act as attending physician was established at 18 visits or 60 days from the first date of service, whichever comes first. These providers were also allowed to authorize temporary disability for up to 30 days from the first service date.

The new law also allowed a medical provider who did not qualify to be an attending physician to provide compensable services for the first 30 days or up to 12 visits, whichever comes first. Beyond the 60 days or 18 visits for chiropractors, nurse practitioners, podiatrists, naturopaths, and physician assistants, and 30 days or 12 visits for providers not authorized to be attending physicians, only a doctor of medicine, osteopathy, or maxillo-facial surgery can act as attending.

Independent medical examinations

SB 311 (2005) introduced changes to how independent medical examinations may be conducted. Much of the bill was based on findings from a study of IMEs the department completed at the request of the Management-Labor Advisory Committee. The study was designed to acquire information about Oregon's IME system, especially in areas where there were concerns regarding:

- Bias of IME physicians toward insurers
- Rude and rough behavior by IME doctors with injured-worker patients
- IME physicians not receiving actual diagnostic studies for review at the exam
- The distance injured workers had to travel for an IME
- The lack of information given an injured worker about what to expect at an IME
- The use of leading questions in letters from insurers to IME physicians prior to an exam

SB 311 required that IMEs be conducted by physicians who insurers select from a list developed by the Workers' Compensation Division, and that WCD develop the training requirements and educational materials necessary for qualification. Physicians must agree to abide by a standard of professional conduct for performing these exams. The bill also included a requirement to establish a process for the removal of a physician from the list and a process for investigating complaints about exams. In addition to physician training, the bill charged the department with approving specific training for claims examiners regarding communications with physicians conducting IMEs.

Other changes the bill made to the existing IME process included provisions for injured workers to challenge the location of an exam, imposing penalties against workers who fail to attend an exam without prior notification or justification, and imposing penalties against medical service providers who unreasonably fail to provide diagnostic records for an exam in a timely manner.

MCO contracts with insurers and self-insured employers, FY 1995-2007

Fiscal year	Insurers	Self-insured employers	Total
1995	30	41	71
1996	35	39	74
1997	39	44	83
1998	33	46	79
1999	33	46	79
2000	36	48	84
2001	35	48	83
2002	35	49	84
2003	30	51	81
2004	30	50	80
2005	28	49	77
2006	25	43	68
2007	27	42	69

At the end of calendar year 2007, four certified managed care organizations had 69 active 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, 1996-2007

Date	Employers		Employees	
Oct 1996	39,868	51.8%	648,500	43.6%
Oct 1997	46,846	59.3%	902,400	58.3%
Oct 1998	51,995	64.7%	969,300	61.5%
Oct 1999	51,786	63.7%	993,700	62.0%
Oct 2000	56,225	68.3%	1,121,400	68.9%
Oct 2001	58,084	69.3%	1,116,900	69.1%
Oct 2002	60,200	71.3%	1,163,600	72.9%
Oct 2003	50,333	59.0%	913,400	57.6%
Oct 2004	51,066	59.3%	965,300	59.2%
Oct 2005	52,639	60.4%	1,073,100	63.8%
Oct 2006	53,273	59.4%	1,092,700	63.0%
Oct 2007	58,684	64.1%	1,144,700	64.9%

As of October 2005, 60 percent of Oregon employers and 64 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 12 percentage points, and the percent of employees dropped by 15 points.

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

Employees with accepted disabling claims enrolled in MCOs, 1998-2007

Year	SAIF	Private insurers	Self-insured employers	Overall
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%
2004	69.7%	10.4%	30.7%	40.9%
2005	70.5%	7.8%	32.9%	42.1%
2006	67.0%	5.7%	33.2%	39.6%
2007	65.8%	6.7%	34.0%	39.8%

The percentage of claimants with accepted disabling claims who have been enrolled in MCOs has varied between 36 percent and 42 percent.

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

Medical payments by provider type, 2007

Provider type	Payments ($ millions)	Percent of total
Medical doctor	$91.78	28.7%
Hospital outpatient	71.69	22.4%
Hospital inpatient	37.20	11.6%
Other medical provider	33.02	10.3%
Physical therapist	25.39	7.9%
Pharmacy	19.47	6.1%
Radiologist	8.54	2.7%
Chiropractor	7.48	2.3%
Ambulatory surgical center	7.51	2.4%
Medical supplies	5.74	1.8%
Subtotal	307.81	96.4%
Remaining provider types	11.57	3.6%
Total	$319.38	100.0%

In 2007, an estimated $319.38 million were paid for workers' compensation medical services. Of this, 28.7 percent was paid to medical doctors.

Note: Other Medical Provider payments are chiefly for independent medical exams and ambulance services. The remaining provider types are osteopath, home health care, occupational therapist, dentist, nursing home care, acupuncturist, physician assistant, podiatrist, laboratory, optometrist, registered nurse practitioner, psychologist, and naturopath.

Medical payments by service category, 2007

Service category	Payments ($ millions)	Percent of total
Physical medicine	$46.72	14.6%
Evaluation & management	$45.51	14.2%
Surgery	41.97	13.1%
Procedural services (ICD-9-CM codes)	33.34	10.4%
Revenue services	31.82	10.0%
Radiology	26.18	8.2%
Healthcare common procedural services (HCPCS codes)	21.21	6.6%
Pharmaceuticals (NDC codes)	20.50	6.4%
Oregon specific services (OSC codes)	13.66	4.3%
Medicine	12.66	4.0%
Durable medical equipments & supplies	5.98	1.9%
Anesthesia	5.87	1.8%
Laboratory & pathology	1.89	0.6%
Other Services	12.08	3.8%
Total	$319.38	100%

As set forth in Oregon Administrative Rule (OAR) 436-009-0040, the insurer shall pay for medical services at the provider's usual fee or in accordance with the fee schedule, whichever is less. Medical services that have no fee schedule are reimbursed at the provider's usual fees.

This table shows total payments and market shares for 10 fee-schedule-regulated service categories and three non-fee-schedule categories. Examples of non-fee schedule service categories include revenue services, HCPCS (Medicare's national level II codes, detailing supplies and materials), and procedural services (Hospital ICD-9-CM; international classification of diseases 9th revision clinical modification). However, all non-fee-schedule services, if performed in the hospital setting, are subject to the hospital's cost-to-charge ratio. In 2007, the total share of non-fee-schedule service categories was about 27 percent of total medical payments. Oregon specific services accounted for about $13.7 million, 75 percent of which was spent on reimbursements for Independent Medical Examinations (IMEs) and related services.

Top 15 workers' compensation medical services, 2007

Service code	Description of service	Payments ($ millions)	Percent of total
97110	Therapeutic exercises	$19.41	6.1%
99213	Office/outpatient visit (established patient, 15 min)	14.50	4.6%
97140	Manual therapy	10.42	3.3%
360	Operating room services	8.18	2.5%
450	Emergency room	7.40	2.5%
D0003	Independent Medical Examination	6.66	2.1%
99214	Office/outpatient visit (established patient, 25 min)	5.83	1.9%
ASC	Ambulatory Surgical Center services	5.31	1.3%
99203	Office/outpatient visit (new patient, 30 min)	4.29	1.2%
72148	Magnetic resonance image (MRI), lumbar & spine; w/o dye	3.96	1.2%
73721	Magnetic resonance image (MRI), joint of lower extremity; w/o dye	3.73	1.2%
97530	Therapeutic activities	3.70	1.2%
99283	Emergency department visit	3.62	1.1%
73221	Magnetic resonance image (MRI), joint of upper extremity; w/o dye	3.34	0.9%
97001	Physical therapy evaluation	2.97	0.9%
	Subtotal	103.31	32.0%
	Remaining services	216.07	68.0%
	Total	$319.38	100%

In 2007, the single medical service code with the most payments, $19.4 million, was therapeutic exercises.

Top 15 pharmacy payments by drug name, 2007

Drug name	Drug type	Drug class	Payments ($ millions)	Percent of total
Oxycodone Hcl Cr, Er	Generic	Narcotic analgesics	$1.37	7.0%
Hydrocodone/Acetaminophen	Generic	Narcotic analgesics	1.19	6.1%
Oxycontin	Brand	Narcotic analgesics	1.12	5.7%
Celebrex	Brand	Anti-arthritic	0.58	3.0%
Lyrica	Brand	Anticonvulsants	0.56	2.9%
Lidoderm	Brand	Anaesthetic	0.49	2.5%
Oxycodone/Acetaminophen	Generic	Narcotic analgesics	0.48	2.5%
Gabapentin	Generic	Anticonvulsants	0.82	4.2%
Skelaxin	Brand	Muscle relaxants	0.44	2.3%
Fentanyl	Generic	Narcotic analgesics	0.42	2.2%
Morphine Sulfate Cr, Er	Generic	Narcotic analgesics	0.42	2.1%
Cymbalta	Brand	Antidepressants	0.40	2.1%
Cyclobenzaprine Hcl	Generic	Muscle relaxants	0.32	1.6%
Duragesic	Brand	Narcotic analgesics	0.29	1.5%
Endocet, Percocet, Roxicet	Brand	Narcotic analgesics	0.25	1.3%
Subtotal			9.14	46.9%
Remaining pharmacy payments			10.34	53.1%
Total			$19.47	100%

In 2007, the top 15 pharmaceuticals accounted for 47 percent of total pharmacy payments.

Generic drugs made up about 79 percent of the prescriptions dispensed to injured workers and 49 percent of pharmacy payments for prescription medications. Precription medications accounted for 92 percent of total pharmacy payments. Medical supplies and other non-drug services provided by pharmacy made up the remaining 8 percent of total pharmacy payments.

Indemnity Benefits

In 2003, SB 757 created a new structure for permanent partial disability (PPD) awards. The changes apply to claims for injuries occurring since Jan. 1, 2005:

- Injuries to all body parts are rated in relation to the whole person. There is no longer a distinction between scheduled and unscheduled awards, and awards are no longer measured in degrees.
- Workers with permanent disability receive an impairment benefit based on the state average weekly wage multiplied by the percentage of impairment. Benefits are adjusted annually in accordance with the change in the state average weekly wage.
- Workers unable to return to work 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 are limited to a range between 50 percent and 133 percent of the state average weekly wage.

In 2005, HB 2408 modified this new structure. Workers injured since Jan. 1, 2006, who are released to regular work are specifically excluded from work disability benefits. HB 2408 also mandated a study by the department of the impact of the PPD benefit changes.

Also in 2005, SB 386 provided increased access to permanent total disability benefits and protections for severely injured workers.

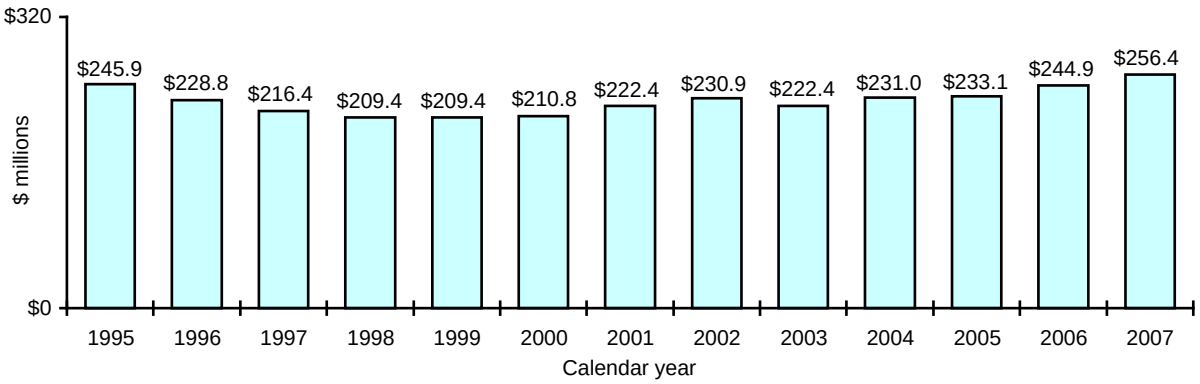
In 2007, HB 2244 removed the sunset in the 2003 bill and made the permanent partial disability changes permanent. The bill also required the Workers' Compensation Management-Labor Advisory Committee (MLAC) to review permanent partial disability benefit amounts on a biennial basis and make recommendations to ensure the original policy goals continue to be met over time.

Indemnity benefits

Indemnity benefits for workers with accepted disabling claims include temporary total and partial disability (time-loss) payments during recovery from the injury, permanent partial and permanent total disability awards for permanent impairment and wage loss, fatality benefits, disputed claim settlements and claim disposition agreements, and professional services and purchases under vocational assistance. (Benefits for the two other return-to-work programs, the Employer-at-Injury Program and the Preferred Worker Program, are paid from the Workers' Benefit Fund rather than by insurers; they are not included here.)

In 2001, SB 485 included several changes to temporary disability benefits. The bill raised the ceiling on benefits for temporary total disability (TTD) to

Figure 13. Indemnity benefits paid for accepted disabling claims, 1995-2007



133 percent of the statewide average weekly wage. Also, for the first time, workers could 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 for 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 for the job at injury.

SB 485 did 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 benefits directly to the worker, also from the Workers' Benefit Fund.

Indemnity benefits paid on accepted disabling claims increased moderately during the current decade; in 2007, an estimated $256.4 million was paid. Of this amount, 42 percent were temporary disability payments, 28 percent were permanent partial disability awards, and 21 percent were settlements (disputed claim settlements and claim disposition agreements). Almost all accepted disabling claims have time-loss benefits; about 30 percent have PPD benefits granted. Settlements on accepted disabling claims occur more often as claim disposition agreements (CDAs), which release rights to all indemnity benefits, rather than disputed claim settlements on denied medical conditions; CDAs accounted for 81 percent of settlement dollars paid in 2007.

The average indemnity benefit for 2007 was $10,565. Average indemnity benefits have increased by an average of 4 percent per year since 1998. Over the same period, the average weekly wage used to set most benefit levels increased by an average of 2.8 percent per year.

Average time-loss dollars increased slightly in 2007, to $4,519, continuing a trend of annual increases from the low of $2,931 in 1997. The average days of time loss paid, a measure of claim duration, declined from a high of 92 days in 1990 to 53 days in 2000, after which the trend turned upward, to 67 days for claims last closed or settled in 2007. For claims with permanent partial disability awards, the average PPD award had been increasing at a rate of 4.5 percent per year; the average award for claims last closed in 2007 was $10,579.

In the 1980s, permanent total disability (PTD) claims accounted for a significant portion of indemnity dollars. By 1993, however, the number of net PTD claims had declined to 13 from the peak of 195 in 1988. Permanent total disability benefits were affected by law amendments that standardized permanent disability rating and redefined gainful employment. The creation of CDAs in 1990 and changes in claims management practices also reduced the number of net PTD awards. The number for 2007 was 14, not much different from the net PTD award counts in preceding years. Senate Bill 386 (2005), which modified criteria for eligibility and rescission of PTD benefits, went into effect in 2006; the early effects of this change can be seen in the reduction in rescissions: one each in 2006 and 2007.

National rankings and comparisons

Along with the costs of indemnity benefits, national rankings that address adequacy of benefits have been important to Oregon's policymakers. States can be ranked using seven categories of maximum indemnity (statutory) benefits. Oregon's ranking for temporary total disability benefits has been above the 86th percentile since 2002, in large 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 time-loss payments, while only about 2 percent have TTD benefits reduced by the higher maximum.

In 2006, Oregon's maximum benefits continued to be above the national median for PTD awards, survivor's benefits for spouses with children, and burial allowances. For the first time, permanent partial disability benefits for both scheduled and unscheduled body parts or systems were also above the national medians. This is attributable to SB 757 in 2003, which went into effect in 2005. The only benefit below the median was survivor's benefits for spouses without children.

Although the national median for maximum benefits has been useful in comparing PPD and other benefits among states, it is insufficient to measure the generosity of benefits. The most recent study to address this issue came in 2001, when the RAND Institute for Civil Justice conducted a multi-state evaluation of the adequacy and equity of cash benefits, especially PPD, for New Mexico. Oregon was included in a group of four comparison states, using Oregon claims and benefit data from 1992 and 1993 injuries. The study 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 (two-thirds) replacement of wage losses by PPD benefits. 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 most of the four other states. The researchers concluded that this was largely a product of Oregon's emphasis on return-to-work incentives. These programs reduce the length of occupational disability.

House Bill 2408 study of PPD benefit structure

A section of HB 2408 in 2005 mandated that the department report to the 2007 Legislature on the impact to permanent partial disability awards from the SB 757 and HB 2408 changes to the benefit structure. The department's study was based on a random sample of PPD awards made in the last nine months of calendar year 2005, and compared three sets of laws and associated administrative rules:

- PPD benefits and rules for dates of injury immediately prior to Jan. 1, 2005
- PPD benefits and rules for dates of injury in 2005 (effects of SB 757)
- PPD benefits and rules for dates of injury in 2006 (effects of HB 2408)

This method was chosen because claims with dates of injury under the more recent laws were not sufficiently mature to provide an accurate reflection of the law within the study's time frame. Thus, the study results reflect the potential effects of SB 757 and HB 2408 on the PPD benefit structure. While the sample study results did show increased average PPD awards under SB 757 and small decreases under HB 2408, the differences were not statistically significant.

The study data showed that 26 percent of SB 757 cases and 24 percent of HB 2408 cases received work disability awards. The study confirmed one of the expected effects of SB 757, which was to reallocate PPD award dollars to claims with greater economic loss. The assumption was that claimants who returned to regular work (generally shorter-duration claims) would receive lower awards under SB 757. Experience for short-duration claims rated under SB 757 supported the assumed effect. Average awards for 2005 claims that were closed within three quarters of the date of injury were more than 25 percent lower than comparable claims in 2004.

SB 835 Study of Fatality Benefits

In SB 835, the 2007 Legislature required a study and report by the Workers' Compensation Management-Labor Advisory Committee (MLAC) on adequacy of death benefits in the workers' compensation system. The bill required the study include review of:

- The current method of calculating burial benefits in relation to the actual cost of burial
- Current formulas for determining benefits
- The categories of beneficiaries who are entitled to benefits
- The feasibility of providing lump-sum benefit payments

MLAC appointed a subcommittee to conduct the study, which met seven times in 2007 and 2008, and included opportunity for public testimony. The subcommittee found that the current fatality benefit structure is generally working well, with a few areas for improvement.

The subcommittee approved a set of recommendations based on its study, which included some administrative process enhancements. The Governor and MLAC requested a draft bill to include the major statutory recommendations contained in the report:

- Broadening the statutory term "burial" to the more encompassing term "final disposition of body and funeral services." This ensures that the benefit covers the wide range of options available to the worker's family.
- Doubling the amount of the burial benefit, from 10 times to 20 times the state average weekly wage.
- Allow the family, employer, or other parties to submit burial and funeral bills to the insurer for 60 days after the claim is accepted. At that point, the insurer would pay the unused amount of the benefit to the worker's estate to address any remaining expenses. MLAC bases this recommendation on public input about the number of issues that a family must take care of right after the worker's death, as well as other expenses that arise long after the burial and funeral.
- Create a category of benefits for children aged 18-23, who are attending school, but have no surviving parents. Set the benefit amount at 4.35 x 66 2/3 percent of the state average weekly wage.
- Clarify ORS 656.218 so that when a worker without statutory dependents dies before his or her permanent partial disability award is paid in full, the insurer must pay the full amount of the remaining award to the worker's estate.

Indemnity and medical benefits paid, 1995-2007

Year paid	Total paid ($ millions)	Indemnity percent of total	Medical percent of total
1995	$458.2	56.6%	43.4%
1996	435.5	55.2%	44.8%
1997	430.8	53.2%	46.8%
1998	427.5	51.8%	48.2%
1999	428.3	51.6%	48.4%
2000	448.1	50.1%	49.9%
2001	471.3	50.2%	49.8%
2002	487.4	50.2%	49.8%
2003	476.9	49.6%	50.4%
2004	503.0	48.4%	51.6%
2005	533.5	46.2%	53.8%
2006	557.6	46.6%	53.4%
2007	590.5	45.9%	54.1%

Indemnity benefits have been a decreasing percentage of all payments.

Note: The data include paid amounts for all claims, not just accepted disabling claims. The total paid excludes payments for the Employer-at-Injury Program, the Preferred Worker Program, and fatal and PTD benefits that are reimbursed from the Workers' Benefit Fund. Some data are estimated, and historical data are subject to small changes.

Indemnity benefits paid for accepted disabling claims, 1995-2007

Year	Benefits paid ($ millions)	Average benefits
1995	$245.9	$7,411
1996	228.8	7,506
1997	216.4	7,419
1998	209.4	7,367
1999	209.4	7,767
2000	210.8	8,128
2001	222.4	8,609
2002	230.9	9,482
2003	222.4	9,689
2004	231.0	10,028
2005	233.1	10,357
2006	244.9	10,374
2007	256.4	10,565

Indemnity benefits include temporary disability payments, permanent partial disability awards, permanent total and fatality indemnity benefits, settlements (claim disposition agreements and disputed claim settlements), and vocational assistance.

Total indemnity benefits remained fairly constant between 1995 and 2007. At the same time, the number of claims has fallen, so the average indemnity benefit has increased by an average of 4 percent per year since 1998.

Note: Some data are estimated, and historical data are subject to small changes.

Indemnity benefits for accepted disabling claims by type, 1995-2007

Year	Time loss ($ millions)	PPD ($ millions)	PTD ($ millions)	Fatal ($ millions)	Claim disposition agreements ($ millions)	Disputed claim settlements ($ millions)	Vocational assistance ($ millions)
1995	$97.14	$60.69	$13.65	$8.98	$47.62	$9.52	$8.28
1996	85.99	59.96	13.12	9.61	43.97	8.11	8.09
1997	80.99	55.61	12.61	10.28	42.68	7.85	6.43
1998	81.38	55.49	11.97	10.85	36.30	7.87	5.50
1999	81.75	53.74	11.45	11.07	38.44	8.10	4.83
2000	79.30	55.19	11.03	11.81	38.51	10.06	4.90
2001	88.90	59.38	10.42	12.01	37.72	9.28	4.72
2002	90.83	58.36	9.80	12.30	43.21	11.64	4.80
2003	87.52	57.94	9.45	13.14	39.40	10.35	4.59
2004	89.89	61.13	9.11	13.05	42.00	10.78	5.08
2005	88.92	64.05	8.93	13.62	42.06	10.27	5.22
2006	92.66	64.84	8.51	13.68	50.00	9.79	5.47
2007	100.68	67.13	8.26	14.45	50.24	11.61	4.04

The table provides indemnity payment data by type. In 2007, 42 percent of the indemnity benefits were temporary disability payments, 28 percent were PPD payments, and 21 percent were awarded in settlements.

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, and vocational assistance data (purchases and professional services), which are reported by the date vocational assistance is completed. Time loss paid during vocational training is included with the other time-loss payments. Fatal and PTD benefits shown are benefits that are not reimbursed from the WBF. The fatal benefits include the benefits paid on PTD claims after the claimant has died. Some data are estimated, and historical data are subject to small changes.

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.

Temporary disability days paid per accepted disabling claim, 1995-2007

Claim closure year	Average days	Average time loss paid	Median days
1995	61	$3,117	15
1996	57	2,988	14
1997	55	2,931	14
1998	55	3,015	15
1999	55	3,171	15
2000	53	3,179	15
2001	57	3,556	16
2002	60	3,853	17
2003	60	3,993	17
2004	62	4,061	17
2005	65	4,183	19
2006	63	4,152	19
2007	67	4,519	19

The average number of temporary disability days per accepted disabling claim was 67 days in 2007. The average has been increasing 3 percent per year since 2000. Statutory time-loss benefits increase each year with changes in the statewide average weekly wage, so average benefits have increased faster than the average days. Average time-loss benefits have increased 5 percent per year.

Note: The data are reported by the year of the latest claim closure. Claims that are resolved with claim disposition agreements rather than notices of closure are included in these series; the time loss paid for these claims is estimated. Data will change as claims are reopened and closed. The changes are fairly consistent, and recent data have been adjusted for expected changes.

Average temporary disability days, by type of claim resolution, 1995-2007

Year	Initial closure	Subse-quent clsoure	Vocational training closure	Resolved with a CDA	Any resolution
1995	47	98	208	211	57
1996	45	98	190	205	54
1997	42	91	200	197	51
1998	44	84	218	186	52
1999	44	80	203	192	52
2000	42	77	211	194	51
2001	46	89	218	186	55
2002	48	80	244	208	57
2003	47	72	226	198	56
2004	49	79	236	208	59
2005	52	85	219	210	62
2006	51	72	216	198	60
2007	51	99	212	202	62

Accepted disabling claims may be closed multiple times. In 2007, 90 percent of claim resolutions were initial claim closures. The average time-loss days paid was 51 days. Five percent of resolutions were subsequent closures of reopened claims. The average time-loss days for these reopenings was 99 days. One percent of the resolutions were closures after the completion of vocational training. The average time-loss days during this period was 212 days. Finally, about 5 percent of the resolutions involved claims that ended with a claim disposition agreement rather than closure. The department estimates that insurers paid time-loss benefits for an average of 202 days on these claims.

Permanent partial disability cases and average dollars, 1995-2007

Year	PPD claims	Percentage of closed claims	Average PPD award
1995	9,476	30.8%	$6,375
1996	8,904	31.6%	6,618
1997	8,049	29.9%	7,028
1998	7,759	29.5%	7,161
1999	7,342	29.7%	7,360
2000	6,954	29.2%	7,766
2001	7,015	29.6%	8,320
2002	6,730	30.4%	8,569
2003	6,266	30.0%	9,069
2004	6,369	30.2%	9,684
2005	6,386	31.0%	10,060
2006	6,580	30.1%	10,096
2007	6,844	30.1%	10,579

In general, 30 percent to 31 percent of claims that have been closed have received permanent partial disability awards. The average PPD award has increased at a rate of about 4.5 percent per year.

Note: These data are reported by the year of the last claim closure; data will changes as claims are opened and closed. The average awards include the initial awards made by insurers and the net amounts that were awarded during the appeal process. About 95 percent of claim resolutions are claim closures.

Permanent total disability awards, 1987-2007

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
2004	20	7	13
2005	20	4	16
2006	18	1	17
2007	15	1	14

The number of permanent total disability awards declined dramatically between 1988 and 1990, when disability rating standards were adopted system-wide. The creation of CDAs in 1990 led to further 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 15 grants in 2007, 13 were by insurer closure and the other two grants were by department reconsideration.

Oregon percentile ranking for maximum temporary disability and permanent disability benefits, 1988-2006

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
2006	86	82	70	66

Temporary total disability benefits are set at two-thirds of workers' weekly wages, between maximum and minimum limits. For injuries since Jan. 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 percentile.

Restructuring of permanent partial disability benefits in 2005 by SB 757 (2003) brought the maximums for both scheduled and unscheduled parts of the body above the national median.

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 U.S. Department of Labor. Publication of this comparative data series ended in 2006; a similar data series is expected to become available in 2009.

Oregon percentile ranking for survivors' benefits, 1988-2006

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
2006	16	90	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, except for death benefits without children.

Note: National data are from the U.S. Department of Labor. Publication of this comparative data series ended in 2006; a similar data series is expected to become available in 2009.

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 - June 2005	-	-	$263,917
July 2005 - June 2006	-	-	273,271
July 2006 - June 2007	-	-	276,517
July 2007 - June 2008	-	-	290,073
July 2008 - June 2009	-	-	302,946

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 was no initial increased cost to the workers' compensation system.

The increase in PPD maximum amounts since 2005 is due to benefit levels now being escalated by the change in the AWW under the new law.

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 close to their pre-injury wages. Oregon statute does this in three ways. First, the disability benefits structure has incentives to get injured workers back to work. Second, statute prohibits employment discrimination and provides re-employment 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.

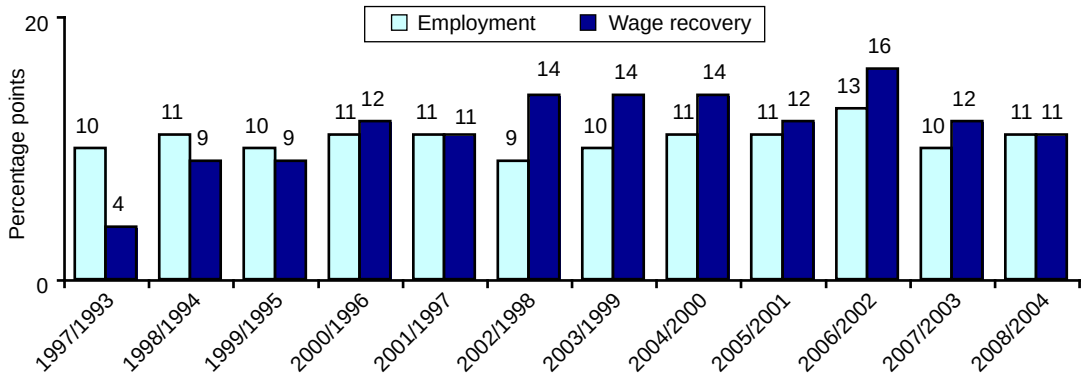
The Management-Labor Advisory Committee has been studying the three return-to-work programs since the end of the 2003 legislative session. Recommendations to improve access to the programs, increase participation, and streamline processes have been enacted into law through Senate Bill 119, effective Jan. 1, 2006, and by July 1, 2005, and Dec. 1, 2007, amendments to Oregon Administrative Rules: 436-105, Employer-at-Injury Program; 436-110, Preferred Worker Program; and 436-120, Vocational Assistance.

Oregon's return-to-work programs

The Employer-at-Injury and the Preferred Worker programs provide incentives to employers who choose to hire injured workers. The Employer-at-Injury Program focuses on early return to transitional work while workers have medical release to restricted work and the claim is still open. The Preferred Worker Program targets workers who have known permanent work restrictions. The essence of both programs is to help workers return to work as quickly as possible in jobs that accommodate their restrictions. Costs are paid from the Reemployment Assistance Program within the Workers' Benefit Fund (WBF). The WBF is funded by assessments paid equally by workers and their employers. The vocational assistance program is available for only the most severe disabilities; insurers provide formal plans for returning disabled workers to suitable jobs. For injuries after 1985, the program is funded through employers' insurance premiums.

The department measures the effectiveness of return-to-work programs, in part, by examining employment and wage data reported to the Oregon Employment Department. The wages are reported in the 13th quarter after the disabling injury or exposure — a point at which most workers have recuperated and used return-to-work programs.

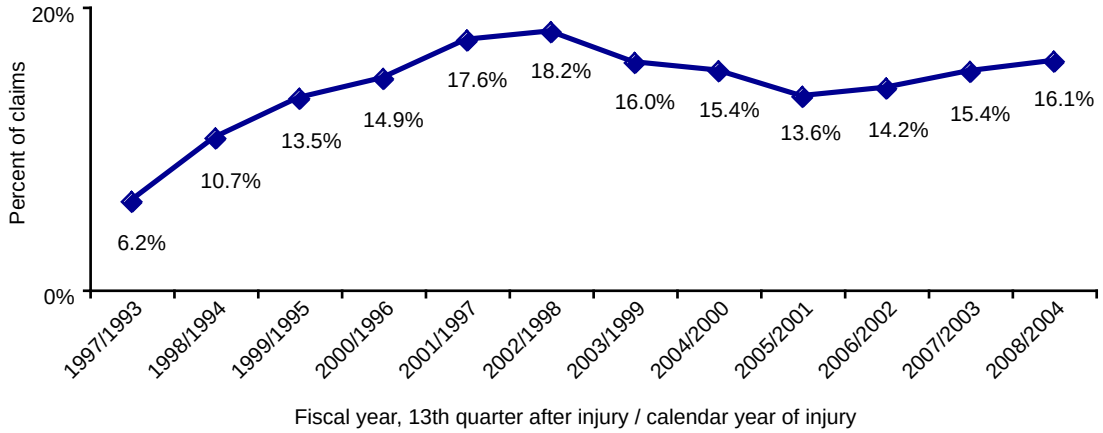
Figure 14. Employment and wage advantage for return-to-work program users, FY 1997-2008



Fiscal year, 13th quarter after injury / calendar year of injury

Note: The data are the percentage point differences in employment and wage-recovery rates between workers who used return-to-work programs and similar workers who did not. The measures are based on a snapshot of wages reported in the 13th quarter after the disabling injury or exposure. This is a point at which most workers have recuperated and used return-to-work programs.

Figure 15. Percent of closed disabling claims with use of return-to-work programs by fourth year post-injury, FY 1997-2008



The department compares employment and wage-recovery rates between workers who used return-to-work programs and similar workers who did not. In fiscal year 2008, the employment rate of workers injured in 2004 was 11 percentage points higher for workers using return-to-work programs compared to similar workers who did not use these programs. Wage recovery for workers who used these programs was 11 percentage points higher.

The department also monitors use of the programs for disabling claims that close within 13 quarters of injury. The use rate rose rapidly after the introduction of the Employer-at-Injury Program in 1993. For disabling injuries that occurred in 1993, the use rate was measured in 1997; it was more than 6 percent. Peak use came in 2002, when slightly more than 18 percent of workers with closed disabling claims from 1998 injuries used return-to-work programs. Program use has trended upward beginning in 2006. One inference is that statutory and administrative law changes have succeeded to some extent in improving access and participation. However, economic conditions probably have an effect on all these indicators, whether of use or effectiveness.

Profiles of each return-to-work program follow.

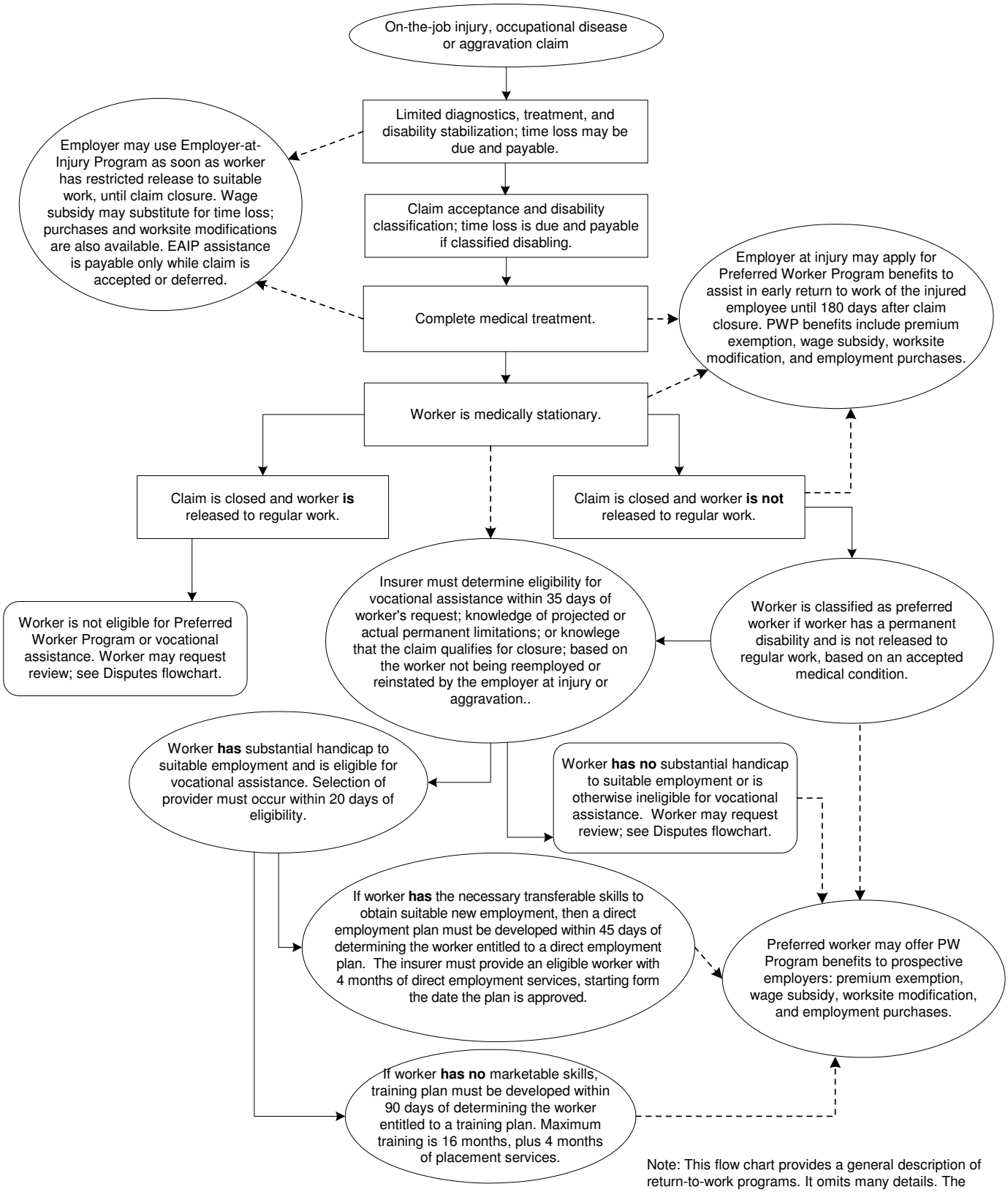
The Employer-at-Injury Program

The Employer-at-Injury Program (EAIP), created in 1993, is available to Oregon employers who obtain temporary medical releases specifying their injured workers may return to light-duty, transitional jobs. Insurers arrange job placements for which they receive a flat fee of $120 each. 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. Financial and management information for the first half of 2008 indicate that these benefits are being used more often than in the past.

A statutory change in 1995 permitted extension of the program to include workers with claims classified as nondisabling even though the workers have medical restrictions on the kinds of work they can perform. By getting workers back to a job shortly after injury, the EAIP has precluded many accepted nondisabling claims from becoming classified as disabling, because no temporary disability benefits are due and payable. An administrative rule change in December 2007 permits extension of the program to workers with claims where compensability ultimately was denied, but temporary disability benefits were due and payable while compensability was investigated.

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

Figure 16. Return-to-work flowchart



Note: This flow chart provides a general description of return-to-work programs. It omits many details. The time frames shown are those in statute and rule; exceptions to these time frames are not shown. Flow charts in the claims processing chapter and the disputes chapter provide additional information.

The- - - - - - - indicates potential path of process.

The peaks for EAIP use came in 1998, when the department approved 10,066 placements with 1,775 employers; and in 1999, during which 1,837 employers used the program for 9,440 workers. Program use has trended upward beginning in 2006. One inference is that statutory and administrative law changes have succeeded to some extent in improving access and participation. However, as with other return-to-work program indicators, economic conditions probably have an effect on these measures, too.

Measured at the 13th quarter after injury, employment and wage recovery rates have been consistently higher for workers with disabling claims where employers and insurers accessed Employer-at-Injury Program benefits. In 2008, the employment and wage recovery rates were both four points higher. These statistics are based on a comparison of workers released to regular work, but with significant severity indicators for temporary and permanent impairment.

While these outcomes are low compared to other programs, 12 years of consistently higher indicators for EAIP use at 3.25 years post-injury is remarkable in that EAIP use typically takes place in the quarter of or the first quarter after injury — about three years before the measurement. Research in progress provides more evidence that a wage recovery and employment advantage is sustained over a period of at least five years after injury.

Figure 17. Employer-at-Injury Program, placements approved, 1993-2007

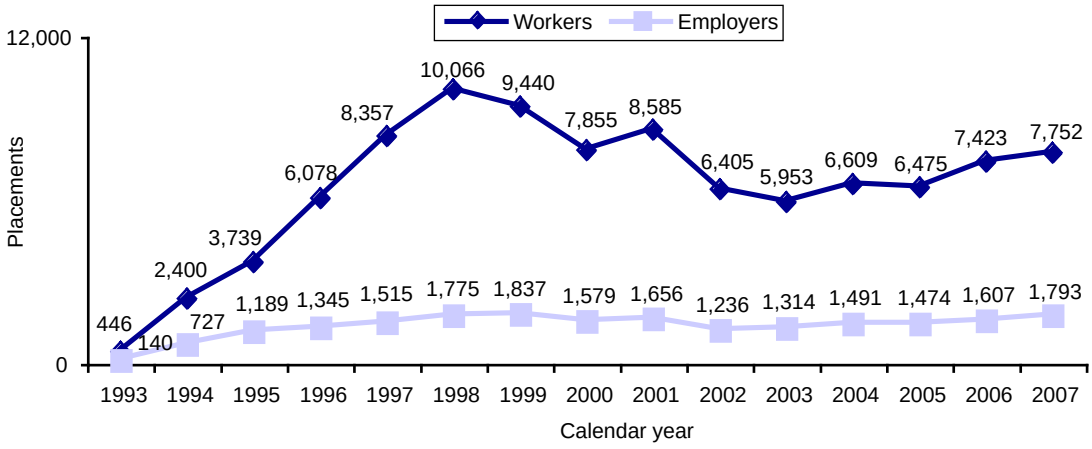
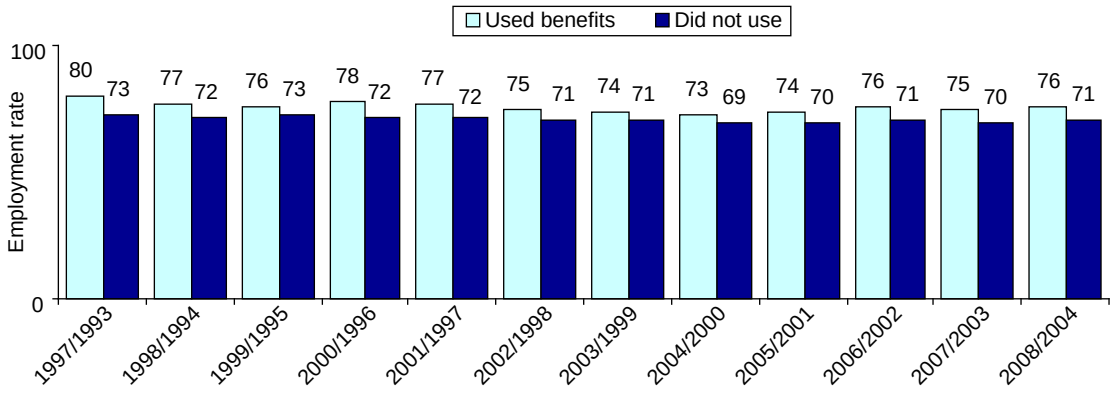


Figure 18. Employment rates for the Employer-at-Injury Program, FY 1997-2008



Preferred Worker Program

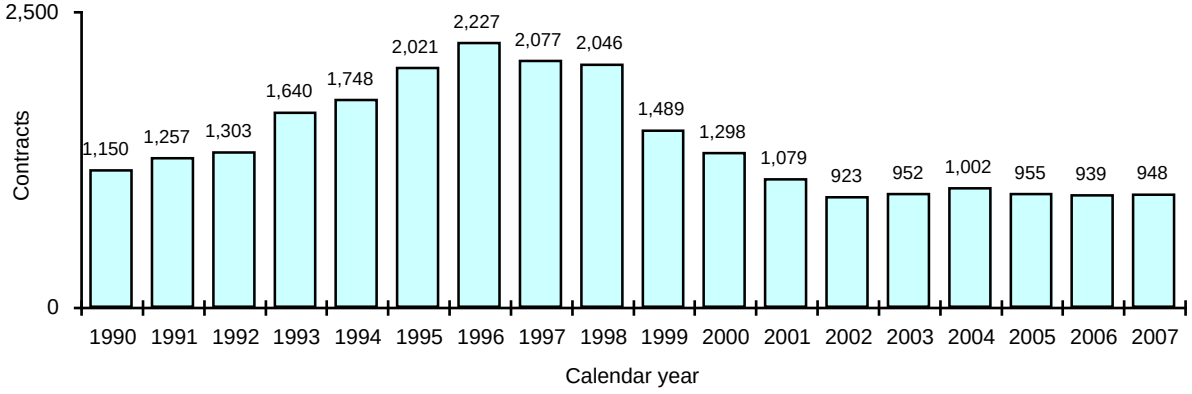
Although incentives such as wage subsidies and worksite modifications have been available for many years, the current version of the Preferred Worker Program was formed during the 1990 special session. Clarifications were added in 1995 through SB 369; notably, workers may not release these benefits through a claim disposition agreement. Senate Bill 119 (2005) expanded the program's options by enabling the payment for limited placement services contracted for on behalf of preferred workers.

The program's objective is to sustain disabled workers in modified regular or new employment as soon as permanent medical restrictions are known. A worker automatically receives a preferred worker identification card when the insurer reports that the worker has a work-related permanent disability preventing return to regular work. The card informs prospective employers that the worker may be eligible for the program's benefits. A worker may also request qualification as a preferred worker from the department. The department, not insurers, delivers benefits under the Preferred Worker Program.

An eligible employer who chooses to hire a preferred worker is exempt from workers' compensation premiums on the worker for three years. If the worker moves to another employer, premium exemption is transferred to the new employer for an additional three years. The department reimburses insurers for all claim costs, including administrative expenses, for any claims preferred workers file during the premium-exemption period.

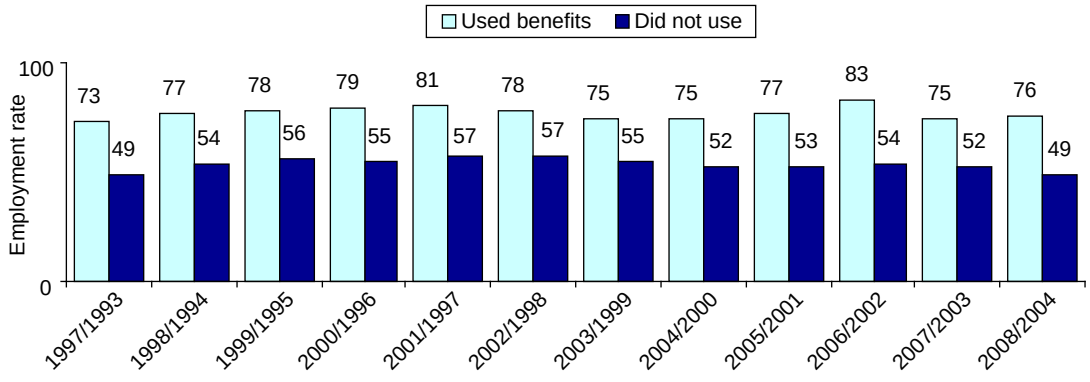
Three other benefits are available for preferred workers and employers. Wage subsidies provide 50 percent reimbursement for six months; higher benefits are available for exceptional levels of disability. Worksite modifications alter worksites within Oregon to accommodate the workers' restrictions. Employment purchases provide

Figure 19. Preferred worker contracts started, 1990-2007



Note: Premium exemption contracts and substantial modifications are no longer tracked and have been excluded from this series

Figure 20. Employment rates for preferred workers, FY 1997-2008



Fiscal year, 13th quarter after injury / calendar year of injury

uniforms, licenses, tools, worksite creation, and other benefits required to set up the preferred worker for employment. These benefits may be used more than once.

Administrative rule changes effective July 1, 2005, permit use of the program at the initiative of the employer at injury. A worker's entitlement to future program benefits is not affected if the worker accepts this option. Otherwise, use of the Preferred Worker Program is at the initiative of the injured worker and at the option of the prospective employer. Administrative rule changes effective Dec. 1, 2007, clarified that a preferred worker has no time limit on when to start using the program's benefits.

Benefit use among preferred workers is difficult to measure because some workers use benefits as soon as possible after becoming eligible, while others may wait for years. The statistical indicators point to peak use in 1996, falling drastically thereafter until stabilizing early in the current decade. Financial and management information for the first half of 2008 indicate that further rule changes effective in 2007 may be increasing benefit use.

Measured at the 13th quarter after injury, employment and wage recovery rates have been consistently higher for preferred workers who used the program's benefits, compared to preferred workers who did not. These statistics are based on a comparison of workers who were released to modified work at claim closure, excluding workers who were also eligible for vocational assistance. They offer a relatively short-term perspective on the efficacy of the program. However, large differences in wage recovery since 2005, in favor of benefit users, may be due in part to changes in administrative rules and statute.

Vocational assistance

Insurers provide vocational assistance, usually through professional rehabilitation organizations, to overcome limitations that prevent injured workers' return to suitable work. In 1987, more than 8,500 workers became newly eligible for vocational assistance plans to return to work, and more than 1,300 had their eligibility restored. Total reported benefits stood at $36.5 million, excluding the costs of eligibility determinations. The average cost of vocational assistance benefits was more than $4,000.

In 1987, the Legislature passed HB 2900, which significantly restricted eligibility for the vocational assistance program by introducing a new test, substantial handicap. In general, substantial handicap means that injured workers are eligible for vocational assistance only if a permanent disability prevents re-employment in any job paying 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 excluded from eligibility 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 eligibilities for vocational assistance. The average has been around 740 each year since 1999. Total costs of benefits have also declined. 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 direct employment plans because they did not need retraining. Now, few workers receive only placement services under vocational assistance. As a result, the cost reduction 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 2007, reported as of May 2008, time-loss payments were an estimated $4.5 million, and insurers' reported expenditures for purchases were $1.7 million and for professional services, $2.3 million.

Eligible workers are not required to use vocational assistance benefits. Since at least 1987, less than one-half of eligible workers have received a plan following their eligibility determinations. Since 1995, less than one-third of workers have completed their plans — completion is defined as placement in a job or receipt of maximum services. The maximum service is 16 months of training (21 months for exceptional cases), plus four months of direct employment services.

In 1990, the claim disposition agreement (CDA) was legalized. With CDAs, workers release their rights to vocational assistance and most other disability benefits in exchange for lump-sum settlements. Since 1995, at least 50 percent of cases have ended with a CDA. In general, workers with permanent work restrictions 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 132 cases in 2007.

However, workers who completed a vocational assistance plan have had better employment outcomes than eligible workers who did not complete their plans. Measured at 13 quarters after injury, employment rates have been at least 20 percent higher for workers who completed plans. Wage-recovery rates have shown similar advantages for workers who completed their plans. Note that the completion of a vocational assistance plan typically occurs in the third year after injury. These statistics, then, represent a relatively short-term perspective on the efficacy of the program.

Figure 21. Vocational assistance eligibilites, 1987-2007

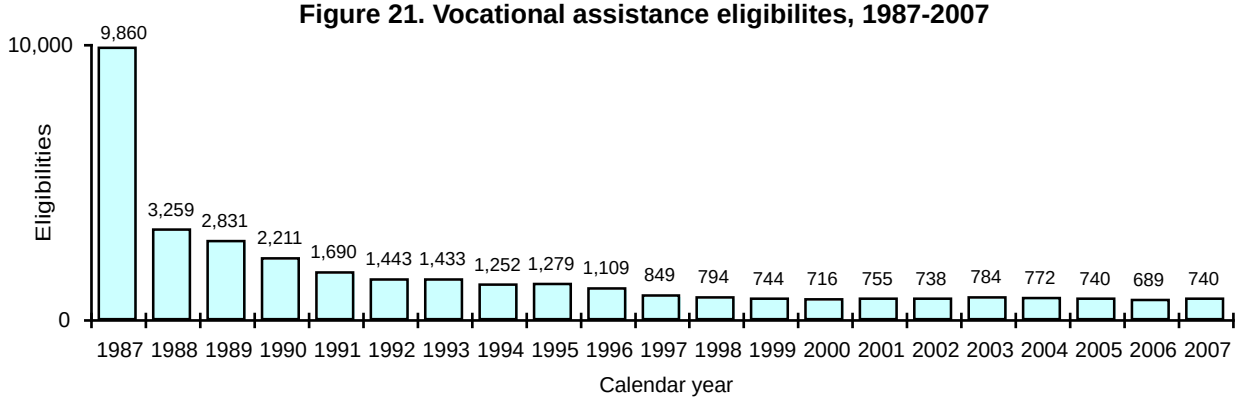
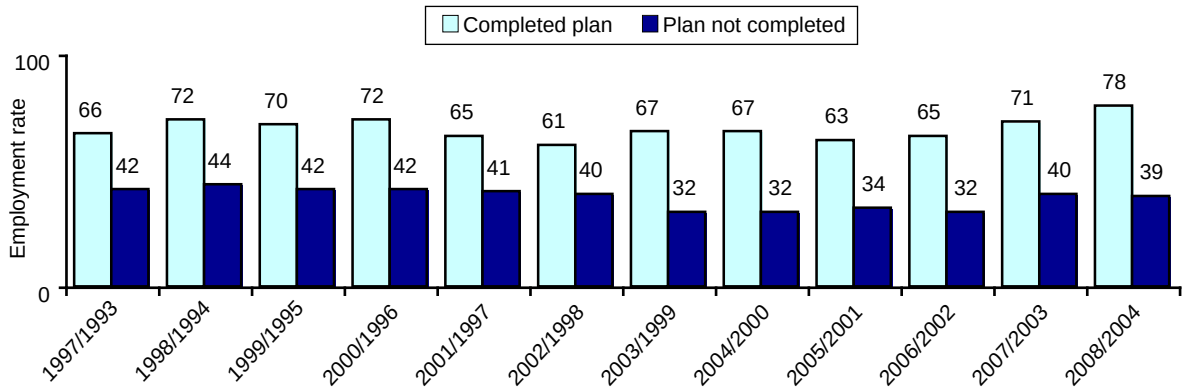


Figure 22. Employment rates for vocational assistance cases, FY 1997-2008



Fiscal year, 13th quarter after injury / calendar year

Employer-at-Injury Program placements approved, 1995-2007

Year	Workers	Employers	Average cost per placement
1995	3,739	1,189	$1,326
1996	6,078	1,345	$1,245
1997	8,357	1,515	$1,182
1998	10,066	1,775	$1,168
1999	9,440	1,837	$1,132
2000	7,855	1,579	$1,216
2001	8,585	1,656	$1,290
2002	6,405	1,236	$1,414
2003	5,953	1,314	$1,481
2004	6,609	1,491	$1,473
2005	6,475	1,474	$1,553
2006	7,423	1,607	$1,605
2007	7,752	1,793	$1,768

The Employer-at-Injury Program was created to encourage placement of injured workers into transitional work while they recover from their injuries. Benefits available to employers and their workers include wage subsidy, worksite modification, and purchases. Financial and management information for the first half of 2008 indicate that modifications and purchases are being used more often.

Increasing counts of workers and employers with placements approved since 2005 are evidence that recent administrative rule changes are promoting use and access to the program.

Preferred workers, CY 1995-2007

Calendar year	Eligibilities	Workers using benefits	Percent of eligibilities with benefit use
1995	4,459	1,334	30%
1996	3,708	1,104	30%
1997	3,120	912	29%
1998	2,946	738	25%
1999	2,549	643	25%
2000	2,267	584	26%
2001	2,375	562	24%
2002	1,858	492	26%
2003	1,821	496	27%
2004	1,779	469	26%
2005	1,806	456	25%
2006	1,770	Available Dec. 2009	
2007	2,022	Available Dec. 2010	

Preferred workers have permanent work restrictions that prevent return to unmodified regular work. In 2007, there were 2,022 preferred worker eligibilities, the highest number since 2001.

Benefit use among preferred workers is difficult to measure because some workers use benefits as soon as possible after eligibility while others may wait for years. There is no time limit on when use may begin. Current statistics exclude some workers using benefits at the injury employer's initiative.

Preferred worker statistical data were revised following system updates to reflect administrative rule changes.

Preferred Worker Program contracts started, CY 1995-2007

Calendar year	Workers starting contracts	Wage subsidies	Worksite modifi-cations	Purchases
1995	1,379	1,110	418	527
1996	1,448	1,111	519	638
1997	1,380	1,063	448	602
1998	1,273	957	448	668
1999	979	734	293	462
2000	871	673	282	344
2001	718	539	232	310
2002	594	473	200	250
2003	620	517	200	235
2004	620	488	265	249
2005	594	458	245	252
2006	573	482	232	225
2007	602	493	218	237

Preferred Worker Program benefits include premium exemption and claim cost reimbursement, plus wage subsidy, worksite modification, and employment purchase contracts or agreements. Workers may use all these benefits, more than one time.

Administrative rule changes provided for use of program benefits at the injury employer's initiative beginning July 2005. However, use of benefits, as measured by contracts started, has not increased through 2007. Financial and management information for the first half of 2008 indicate that further rule changes effective in 2007 may be increasing benefit use.

Vocational assistance determinations, 1995-2007

Year	Total determinations	Ineligible	Eligible
1995	4,447	3,168	1,279
1996	4,084	2,975	1,109
1997	3,547	2,698	849
1998	3,441	2,647	794
1999	3,299	2,555	744
2000	2,421	1,705	716
2001	2,046	1,291	755
2002	2,046	1,308	738
2003	2,108	1,324	784
2004	2,495	1,723	772
2005	2,668	1,928	740
2006	2,438	1,749	689
2007	2,274	1,534	740

Insurers determine eligibility or ineligibility for vocational assistance for workers with permanent partial disability who do not return to permanent work with the employer at injury. The department audits claim closures to assure that insurers determine eligibility.

In general, workers are eligible for vocational assistance if they have a substantial handicap that prevents reemployment in any job that pays at least 80 percent of the job-at-injury wages.

Eligible determinations include insurer letters, eligibility orders, and eligibility restorations.

Vocational assistance eligibility closures, plans, and outcomes, 1995-2007

Year	Total eligibility closures	Closed, no plan	Closed, direct employment plan	Closed, training plan	Outcome: return to work	Outcome: maximum services or job ended	Outcome: CDA	Outcome: other
1995	1,403	840	52	511	340	87	631	345
1996	1,242	701	39	502	337	58	582	265
1997	993	515	23	455	248	59	441	245
1998	870	455	6	409	208	50	424	188
1999	777	415	7	355	157	41	354	225
2000	723	396	4	323	171	46	324	182
2001	708	382	4	322	154	46	313	195
2002	782	454	7	321	140	70	394	178
2003	717	418	7	292	123	75	380	139
2004	760	440	5	315	128	60	391	181
2005	728	432	4	292	135	58	370	165
2006	733	409	7	317	143	48	391	151
2007	653	377	2	274	132	35	347	139

Eligibility closures include insurer eligibility closures and eligibilities where there is a claim disposition agreement in full but no eligibility closure. No-plan closures continue to account for more than 50 percent of eligibility closures. The claim disposition agreement continues to account for more than 50 percent of eligibility closure outcomes.

Disputes

The purpose of the Oregon workers' compensation system is to provide fair and timely benefits to injured workers. An impartial forum for the resolution of disputes is an important part of this system.

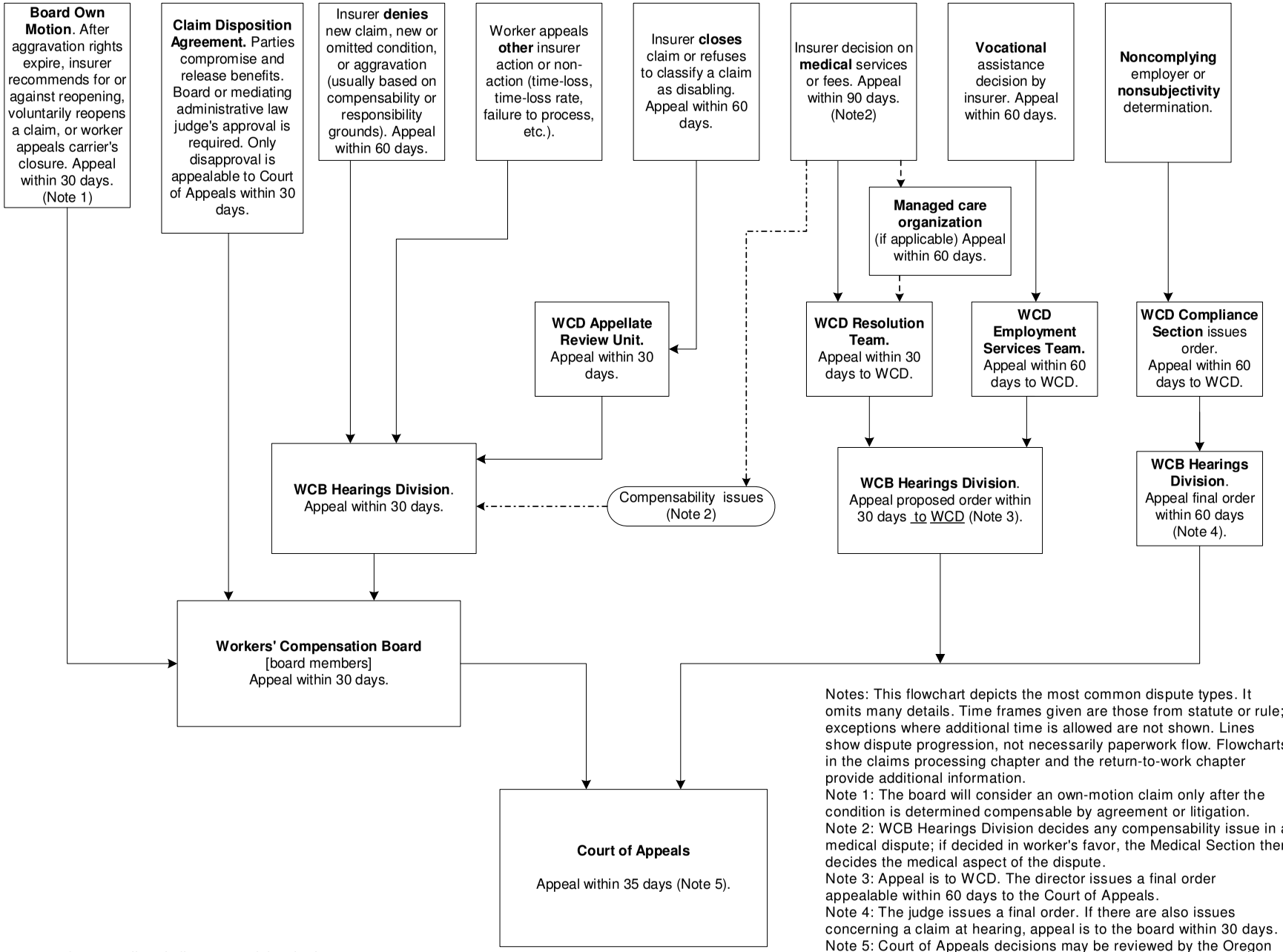
The Oregon system provides several methods through which disputes may be resolved. In these processes, workers, employers, insurers, and, in some instances, medical service providers have legal rights. Workers may contest denials and benefits, and insurers and employers may defend against claims and benefits believed to be unwarranted. Medical providers may raise issues about medical services and fees.

The Oregon workers' compensation system has evolved to include a two-part dispute resolution system:

- The Workers' Compensation Board is an independent agency that receives administrative support from the Department of Consumer and Business Services. It has original jurisdiction on insurer denials and certain claims-processing issues — time loss and time-loss rate when the claim is open, insurer penalty for unreasonable conduct, etc. It also hears appeals of cases decided by DCBS Workers' Compensation Division administrative review — primarily the reconsideration of claims closures, medical services and vocational assistance disputes, and nonsubjectivity and noncomplying employer determinations. Hearings decisions can be appealed to board review, and then to the Court of Appeals. Court of Appeals decisions can be appealed to the Oregon Supreme Court, whose review is discretionary. Exceptions are disputes about medical services, vocational assistance, non-complying status, subjectivity, and safety citations; orders for these disputes are not appealable to board review but instead are reviewed by the Court of Appeals.
- The Workers' Compensation Division provides administrative review for many types of disputes. Within the Benefit Services Section, the Appellate Review Unit resolves disputes involving claim closures and classifications, and the Employment Services Team resolves vocational disputes. The Medical Section resolves medical disputes.

The system, however, is more complex than the description above suggests. For instance, workers may have disputes in different venues at the same time; they may be disputing vocational assistance decisions while appealing PPD awards. In other cases, medical disputes may have two issues: whether the proposed treatment is related to the accepted conditions, and whether it is reasonable and necessary. In such cases, after the WCB decides treatment is related to the accepted condition, the WCD Medical Review Unit decides on necessity. As a final example, disputes with a managed care organization (MCO) may begin with the MCO's review process and then go to WCD.

Figure 23. Disputes flowchart



The - - - - - and -·-·-·- lines indicate potential path of process.

Notes: This flowchart depicts the most common dispute types. It omits many details. Time frames given are those from statute or rule; exceptions where additional time is allowed are not shown. Lines show dispute progression, not necessarily paperwork flow. Flowcharts in the claims processing chapter and the return-to-work chapter provide additional information.
Note 1: The board will consider an own-motion claim only after the condition is determined compensable by agreement or litigation.
Note 2: WCB Hearings Division decides any compensability issue in a medical dispute; if decided in worker's favor, the Medical Section then decides the medical aspect of the dispute.
Note 3: Appeal is to WCD. The director issues a final order appealable within 60 days to the Court of Appeals.
Note 4: The judge issues a final order. If there are also issues concerning a claim at hearing, appeal is to the board within 30 days.
Note 5: Court of Appeals decisions may be reviewed by the Oregon Supreme Court, but the high court's review is discretionary.

Reforming the dispute-resolution 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 hearing and at further review by the Workers' Compensation Board and the courts. Dispute resolution was neither swift nor efficient.

In part to reduce litigation, the Legislature enacted HB 2900 in 1987 and SB 1197 in 1990. HB 2900 included provisions to speed up litigation. It reduced the time to request a hearing on a claim closure from one year to 180 days, required hearings to be scheduled for a date within 90 days of the request, required that orders be issued within 30 days of the hearing, and required that hearings be postponed only in extraordinary circumstances. It also required that the Hearings Division create an expedited claim service to informally resolve small claims for which compensability was not at issue. It required fact-finding about disability, emphasizing objective medical evidence, with the idea that uniform standards for permanent disability would reduce litigation. The bill also created the Office of the Ombudsman for Injured Workers; the ombudsman reduces litigation by resolving complaints.

SB 1197 created new administrative review processes and provided for claim disposition agreements. Prior to 1990, there were voluntary administrative review processes to resolve disputes over claim closure and disability classification (disabling or nondisabling). These processes were used infrequently. SB 1197 made the reconsideration processes mandatory. It also made the medical dispute process mandatory. Claim disposition agreements allowed workers to compromise and release claim benefits other than medical services, reducing litigation.

In 1995, SB 369 produced further changes. Following the Court of Appeals' decision in Jefferson v. Sam's Café in 1993, WCD lost jurisdiction over disputes involving proposed medical treatment; SB 369 restored it. The Legislature also tightened the timelines in the reconsideration process, limited hearing issues to those that were raised at, or arose out of, the reconsideration, and limited evidence at hearings to that provided at reconsideration. For WCB, 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.

With SB 485, the 2001 Legislature addressed evidentiary concerns by providing for a worker deposition to be included as part of the reconsideration process. The insurer-paid deposition is limited to testimony and cross-examination about a worker's condition at closure. The bill also provided for a medical exam as part of a hearing on a compensability denial. In a denial case where the worker's attending physician disagrees with the findings of an independent medical examiner, the worker can ask the WCD Medical Section to provide the name of a physician who will conduct a new independent exam. The insurer pays the costs of the exam and physician's report, which becomes part of the hearing record.

The appeal process has been changed frequently. With SB 369 in 1995, 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. Some reconsideration orders were also appealed to WCD. In 1998, however, a Court of Appeals decision, James Jordan v. Brazier Forest Products, determined that all Appellate Review Unit decisions were reconsideration orders and had to be appealed to the board. HB 2525 in 1999 created a centralized Hearing Officer Panel (later renamed the Office of Administrative Hearings) and transferred WCD appeals to this panel. HB 2091 in 2005 transferred jurisdiction from the Hearing Officer Panel back to the Hearings Division of WCB. This dispute resolution process is unique: (1) The hearing request is made to WCD; (2) WCD refers the dispute to WCB; (3) the WCB judge sends to WCD a proposed and final order; (4) WCD issues a final order; (5) review of the final order is by the Court of Appeals. There is no board review.

Disputes resolved by the Workers' Compensation Division

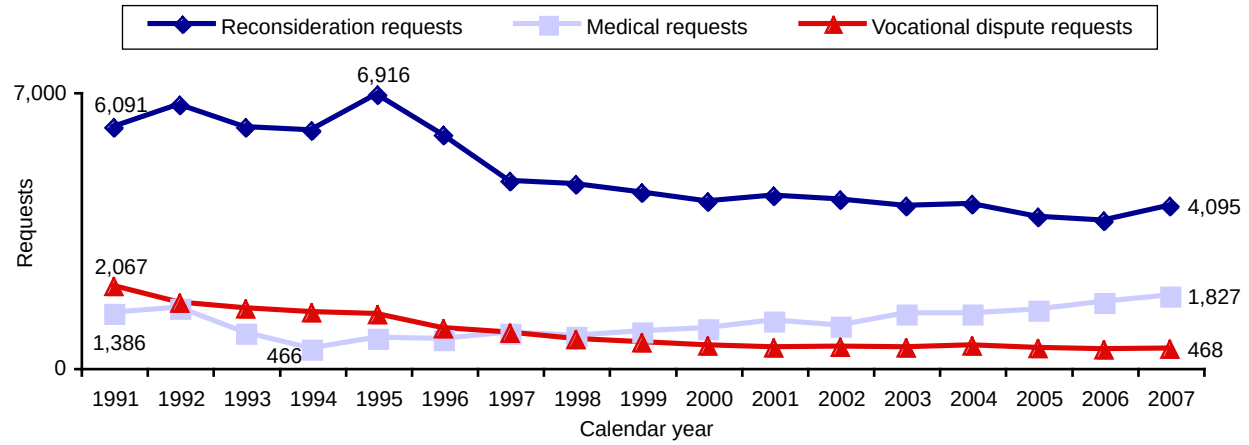
Appellate review of claim closures and disability classifications

For injuries that have occurred since mid-1990, 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 working days. When impairment is disputed or medical information is insufficient to determine impairment, a medical arbiter is appointed to examine the worker, and an additional 60 days is allowed. No additional medical evidence may be used in subsequent litigation.

Since 1995, requests for appellate review have fallen — reconsideration requests have fallen much more than classification requests. The long-term trend of decreasing numbers of claim closures has contributed to this decline.

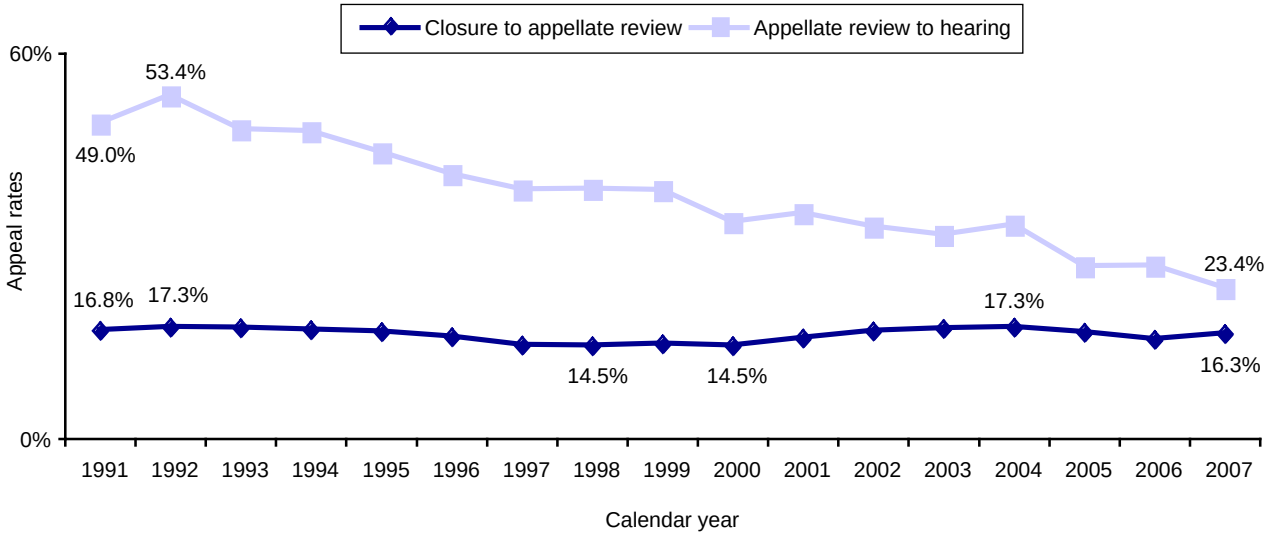
In 2001, insurers assumed total responsibility for claim closures, and the Legislature amended claims processing law. In 2003, SB 757 made changes in claim closure for workers injured in 2005, and HB 2408 in 2005 made changes in claim closure for workers injured in 2006. Despite the increased complexity of claim processing, disputes of closures and classifications have leveled off, as measured by the appellate review request rate. In 2007, 16.3 percent of closures were appealed.

Figure 24. Requests for reconsideration and medical and vocational dispute resolution, 1991-2007



Note: The reconsideration figures include requests on closures and requests on disabling classifications.

Figure 25. Appeal rates of claim closures and reconsideration orders, 1991-2007

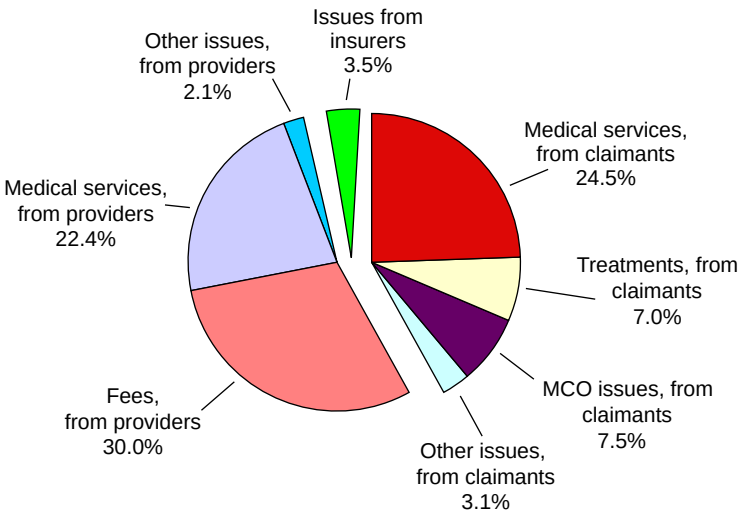


There has been other legislation concerning the reconsideration process. In 2000, the Oregon Supreme Court (Koskela v. Willamette Industries, Inc.), in an exception to the evidence limitation, ruled that in permanent total disability cases a worker must be allowed to testify about willingness to work and efforts to obtain employment. In response, SB 485 (2001) allowed for worker depositions to be included in the records of the reconsideration process. Through SB 285 in 2003, 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. In both 2006 and 2007, insurers requested reconsideration on more than 100 of their notices of closure (102 and 143, respectively).

Nearly all appellate review orders are issued timely. The median time from request for review of claim closure to date of order issue was 70 days in 2007.

Appellate review orders may be appealed to the WCB Hearings Division. Overall, the trend for appealed orders is downward. In 2007, the rate was 23 percent, a record low. This trend is down considerably from the 50 percent appeal rates registered in the first years of administrative review of claim closures and disability classifications.

Figure 26. Medical disputes, by issue and requester, CY 2007



Medical disputes

The number of medical-dispute-resolution requests previously 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; the 1,827 requests in 2007 mark a new high. 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, be handled through the medical-dispute-resolution process. In 2007, 8 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 normally resolved before other medical issues, such as medical services or the appropriateness of treatment, are considered. Once compensability or causality is determined a case is sent to the Medical Resolution Team for resolution of the medical service dispute. Compensability cases represented 12 percent of all 2007 medical dispute resolution requests.

The medical dispute process differs from many of the other dispute processes; the injured worker may not be directly involved in the dispute. In 2007, 54 percent of the medical dispute requests were from medical providers; most concerned fee disputes and disagreements between the provider and insurer about services to which the injured worker may have been entitled.

With the implementation of HB 2091 in 2005, medical dispute orders could be reviewed by the WCB Hearings Division; 5 percent were appealed in 2007.

Vocational assistance disputes

The Employment Services Team (EST) strives to resolve vocational disputes by mediating agreements between the parties. When agreement is not possible, EST issues an administrative review order.

The number of requests for vocational-dispute resolution fell by about 75 percent between 1991 and 2001 and has been relatively stable since. Most of the long-term decline resulted from the decline in the number of eligibility determinations for vocational assistance. Vocational disputes, however, have remained steady with about 20 percent of eligibility determinations having at least one dispute. Most disputes follow an insurer's denial of eligibility for vocational assistance; other disputes concern vocational training programs, the quality of professional services, or worker purchases.

In 2007, 28 percent of the vocational disputes were resolved through agreement. Another 43 percent were dismissed, often due to a claim disposition agreement; remaining resolutions required a formal administrative order. The insurer prevailed in about 70 percent of those orders. With HB 2091, responsibility for appeals of these orders was returned to the WCB Hearings Division. During the past five years, about 12 percent of vocational dispute review orders, including orders of dismissal, were appealed.

About 93 percent of vocational disputes were resolved timely, as measured by a nonstatutory standard of 60 days. The median number of days from request for review of vocational assistance to date of resolution was 28 in 2007.

Disputes resolved at the Workers' Compensation Board

The Workers' Compensation Board's Hearings Division provides a forum to achieve justice. In hearings conducted by administrative law judges, parties have an opportunity to present their case. They have the right to be represented by counsel, to have a qualified interpreter, to present evidence (lay and expert witnesses, personal testimony, medical and vocational reports, etc.), to compel testimony by subpoena and under oath, to receive pre-hearing disclosure of evidence, to present argument on issues of fact and of law, to provide cross-examination and impeachment evidence, to have the hearing postponed or continued, to have the hearing at a location not distant from the worker's home, and to request reconsideration of an order and appeal the order.

The Board Review Division hears appeals of ALJ orders, decides board own-motion cases (reopenings or additional benefits after aggravation rights have expired), approves claim disposition agreements, hears appeals of Department of Justice decisions in the crime victim assistance program, and resolves third-party disputes (distribution of proceeds from a liable third party, between insurer and worker). The board is composed of five governor-appointed members: the chair, two members selected because of their background and understanding of employer concerns, and two members selected because of their background and understanding of employee concerns. Appeals are heard by at least one "worker" member and one "employer" member.

Hearing requests

Hearing requests reached a peak in 1989 after increasing for more than 20 years. The number of requests dropped substantially in the early 1990s; the number in 1997 was just 41 percent of the 1989's peak. Since then, the number of requests has declined by about 2 percent per year. There were 9,355 requests in 2007.

The primary reason for declining hearing requests in the early 1990s was the creation of the reconsideration process, which cut the hearing request rate on initial disabling claim closures from 21 percent in 1989 to 6 percent since 1997. 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 composition of issues litigated has changed significantly over time. The 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 less than 5 percent in 2007. 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 9 percent of hearing cases in 1987 to nearly 41 percent in 2007, the highest since at least 1987 (most post-acceptance compensability disputes that don't involve aggravation of the accepted condition are classified as "partial denial").

Figure 27. Requests for hearing, 1987-2007

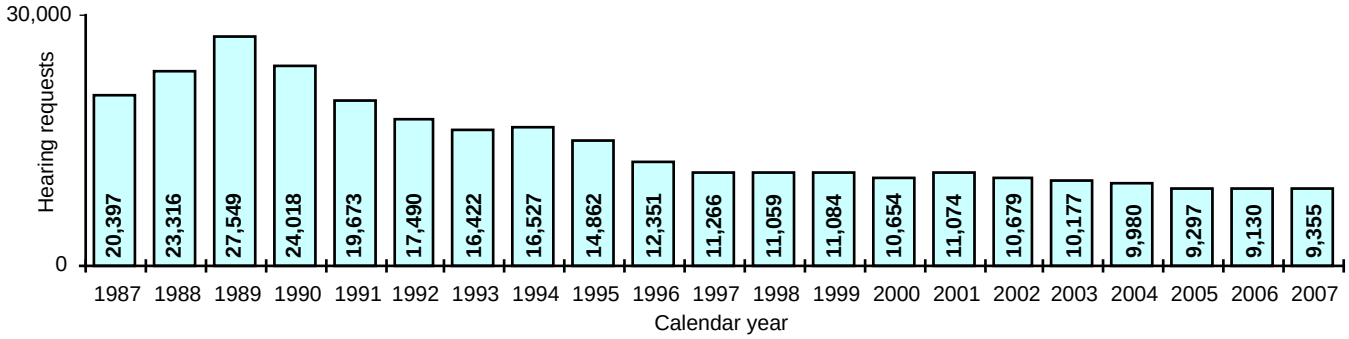
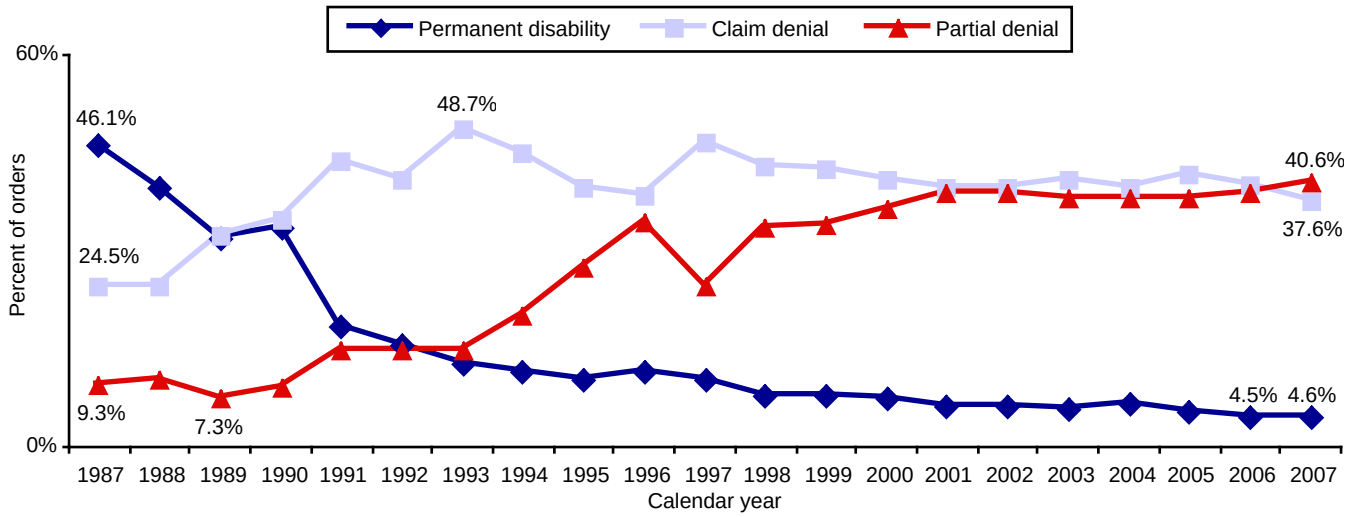


Figure 28. Hearing issue relative frequencies, 1987-2007



One reason for the increase is that the Legislature specifically provided for major-contributing-cause denials in SB 369.

The median request-to-order time lag for hearings was 138 days in 2007. The median request-to-order lag for board review was 170 days in 2007, higher than the average of 149 days during the previous 10 years. The median lag for 2007 Court of Appeals decisions was 453 days (1.2 years).

Mediation

Since 1996, the board has offered trained administrative law judge mediators and facilities, at no cost, to help settle disputes without formal litigation. Historically, the mediators completed about 250 mediations per year; this number increased to around 350 for 2006-07. This increase is in part due to a change in how mediations are counted. Most mediated cases deal with complex issues: 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.). Adding to that complexity, the average mediation deals with 1.2 hearing requests. More than 89 percent of 2007 mediations resulted in settlement.

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

Appeal rates

The appeal rate of reconsideration orders has dropped from 53 percent in 1992 to 23 percent in 2005. The appeal rate of hearings orders has been declining slowly, from 12 percent in 1997 to less than 9 percent in 2007. The appeal rate of board-review orders dropped from 1987's 30 percent to 13 percent the next year, mostly in response to HB 2900 (1987), which changed the

court review standard from de novo to "substantial evidence." For 1992-2004, board appeal rates have mostly ranged from 17 percent to 23 percent, but dropped to 14 percent in 2007.

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

Claim disposition agreements

In 1990, SB 1197 allowed workers to release their rights to claim benefits other than medical services in claim disposition agreements (CDA). In 1995, SB 369 prohibited the release of preferred worker benefits. Since 1991, the board has approved an average of nearly 3,200 CDAs per year. The numbers have declined recently; there were 3,025 CDAs in 2007. The average agreement in 2007 was more than $17,000. CDAs significantly reduce the subsequent litigation because workers relinquish rights for most benefits. Return-to-work studies show that workers who negotiate CDAs often have difficulty returning to work.

Claimant attorney fees

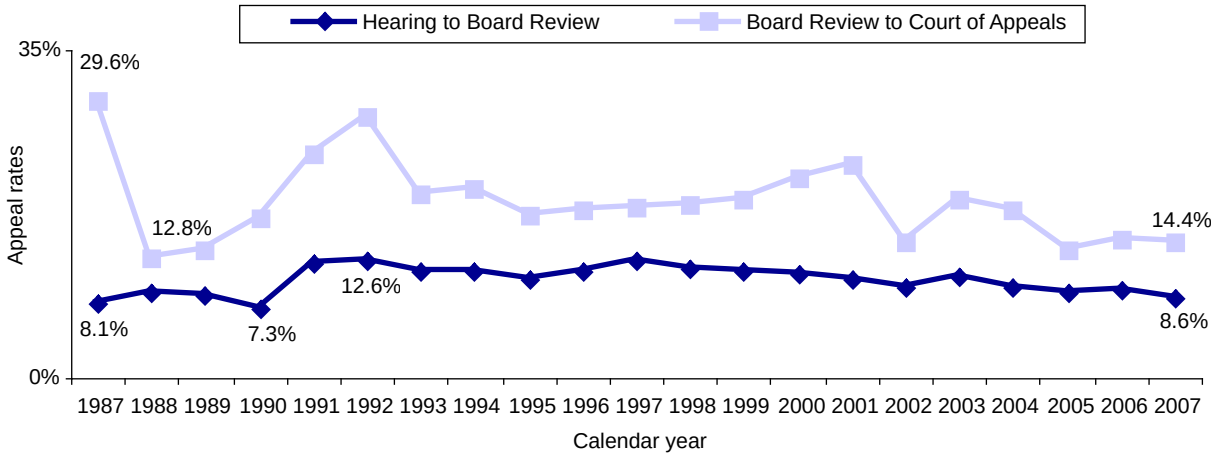
Fees are awarded to claimant attorneys for (1) getting a reversal of a denial of a claim or of services in an accepted claim; (2) getting an increase in indemnity benefits; (3) preventing a decrease in indemnity benefits; (4) getting a penalty assessed against the insurer; and (5) negotiating a disputed claim settlement or claim disposition agreement. Fees for (1), (3), and (4) are assessed against insurers, while fees for (2) and (5) are taken out of the award increase or settlement proceeds.

The 1990 law change limited penalty-related attorney fees to half of the penalty amount. Via SB 369, the 1995 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 to cases where the denial is based on the compensability of the underlying condition.

In 1999, for the first time in more than 11 years, the board changed its rules to increase fees allowed in disputed claim settlements, CDAs, and orders increasing disability awards.

With SB 620 in 2003, the Legislature reversed the 1990 law change by providing for penalty-related attorney fees proportional to the benefit, and limiting 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 29. Appeal rates of WCB hearing orders and board review orders, 1987-2007



The 2003 law change, for the first time, allowed attorney fees in medical services and vocational assistance disputes before the director.

Total claimant attorney fees jumped by almost 49 percent from 1987 to 1991. However, the total of $19.2 million in 2007 was about 90 percent of the total in 1991. Fees in 2007 included $841,000 at reconsideration, $9,647,000 at hearing, $746,000 at board review, and $7,621,000 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 more than 60 percent since 1996.

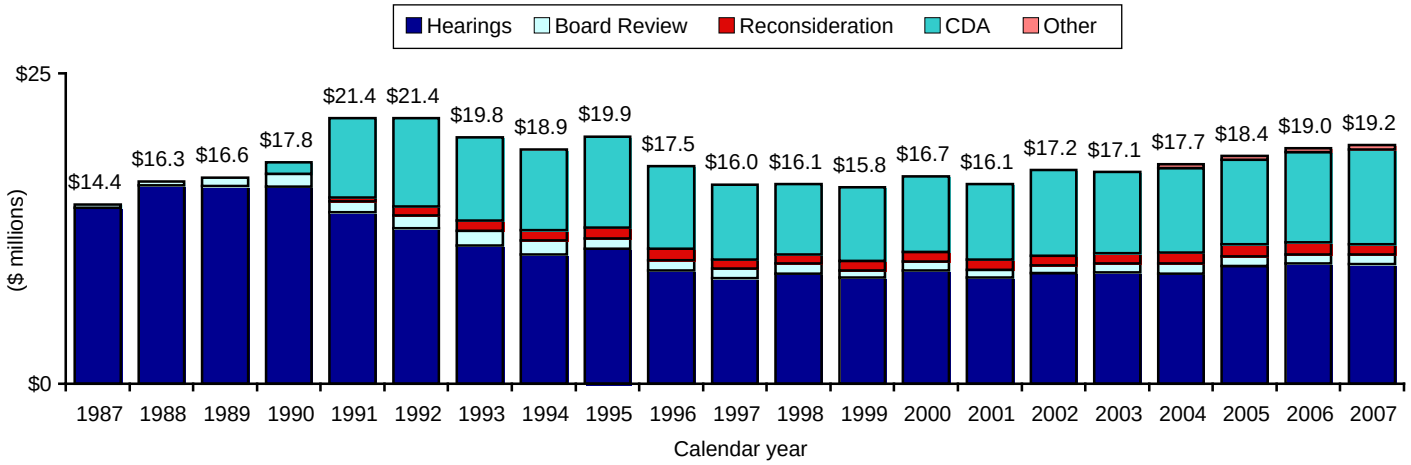
In 2007, SB 404 made two additions to assist claimants and their attorneys in recovering costs and fees. First, the legislation allows an administrative law judge, board, or court to order payment for a claimant's reasonable expenses and costs for records, expert opinions, and witness fees. Second, if an injured worker signs an attorney fee agreement, and the attorney was instrumental in obtaining additional compensation or settling a worker's claim, then the administrative law judge, board, or court may grant the attorney a lien on additional compensation or proceeds from a settlement.

Board own motion

Legislation in 1987 limited worker benefits under own-motion authority to time-loss and medical services. In SB 485, the 2001 Legislature expanded benefits by providing for reopenings for treatment provided in lieu of hospitalization to enable return to work, claims for new or omitted medical conditions after aggravation rights have expired, and permanent disability awards in new or omitted medical condition cases.

Total own-motion orders peaked in 1991, and decreased steadily afterward to 243 orders in 2002. SB 485, passed in 2001, led to an increase in the number of orders, causing them to double. The number of own-motion orders declined again after a 2005 law change (HB 2294).

Figure 30. Claimant attorney fees, 1987-2007



Note: "Other" category includes sources of fees where data was unavailable before 2004. See notes about series breaks in the tables on Page 75.

Appellate review requests and orders, 1991-2007

Year	Requests on closures	Requests on disabling classifications	Appellate review request rate	Total orders issued	Percent of orders appealed to hearings
1991	6,065	26	16.8%	5,953	49.0%
1992	6,590	73	17.3%	6,508	53.4%
1993	6,011	87	17.2%	6,029	48.1%
1994	5,915	99	16.9%	6,026	47.8%
1995	6,764	152	16.6%	6,563	44.6%
1996	5,773	128	15.8%	6,299	41.2%
1997	4,621	100	14.6%	4,790	38.8%
1998	4,527	123	14.5%	4,582	38.9%
1999	4,313	126	14.8%	4,544	38.7%
2000	4,078	132	14.5%	4,244	33.7%
2001	4,208	142	15.6%	4,253	35.1%
2002	4,072	188	16.8%	4,290	33.0%
2003	3,888	205	17.1%	4,187	31.7%
2004	3,955	186	17.3%	4,110	33.3%
2005	3,641	182	16.5%	3,935	26.8%
2006	3,514	198	15.4%	3,731	26.9%
2007	3,909	186	16.3%	4,057	23.4%

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

The appeal rate for appellate review orders reached a record low in 2007. While the number of requests on closures increased in 2007, the rate of requests for appellate review was below its peak of 2004.

Medical dispute requests and orders, 1990-2007

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	905	819	84
2000	991	948	114
2001	1,181	1,222	69
2002	1,054	918	81
2003	1,365	1,293	88
2004	1,360	1,264	87
2005	1,457	1,548	75
2006	1,651	1,745	41
2007	1,827	1,804	28

Medical dispute resolution requests and orders had a peak in 1992. They declined sharply after a court decision limited the department's jurisdiction. SB 369 reversed this decision and the numbers have since increased, with 2007 having the most requests and orders overall.

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. All other medical disputes are handled by the WCD Medical Resolution Team.

In 2007, the number of medical dispute requests rose by 11 percent to 1,827; the number of orders rose by 3 percent to 1,804.

Medical dispute issues, by year of request, 2001-2007

Year	Fees	Medical services	Treatments	Palliative care	MCO issues	Changes of attending physician	Insurer medical exams	Compensability	Interim medical benefits
2001	22.8%	39.7%	8.6%	3.0%	8.2%	2.4%	1.1%	14.1%	-
2002	15.7%	39.0%	11.7%	3.1%	9.3%	1.8%	1.0%	18.2%	0.1%
2003	13.0%	40.6%	10.7%	1.8%	12.7%	0.7%	0.5%	19.6%	0.4%
2004	13.5%	38.8%	9.6%	2.2%	16.8%	1.0%	0.5%	17.4%	0.2%
2005	11.5%	49.1%	7.8%	1.2%	17.2%	1.3%	0.7%	10.9%	0.3%
2006	25.6%	45.1%	7.3%	1.6%	9.0%	1.3%	0.3%	9.7%	0.1%
2007	27.8%	42.4%	8.0%	0.9%	7.9%	0.5%	0.4%	11.9%	0.2%

SB 728 (1999) gave responsibility for disputes in which the compensability of the underlying medical condition is at issue to the Hearings Division. These cases were 12 percent of all 2007 medical-dispute-resolution requests. SB 485 (2002) amended the law regarding payment for interim medical benefits (medical services provided before a claim's initial acceptance or denial). It added a process for these disputes.

Vocational dispute requests and resolutions, 1991-2007

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
2004	551	551	42
2005	492	485	47
2006	456	495	30
2007	468	446	28

The WCD Employment Services Team provides administrative review of vocational disputes brought by workers. The number of requests has fallen by about 77 percent since 1991. The decline has resulted chiefly from the decrease in the number of vocational assistance cases.

The median number of days to resolve a dispute was 28 days for disputes resolved in 2007, and 93 percent were resolved within the standard of less than 60 days.

Vocational dispute resolutions, by outcome, 2001-2007

Year	Agreements	Insurer prevail orders	Worker prevail orders	Other orders	Dismissals
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%	15.8%	0.8%	27.0%
2004	30.1%	26.0%	15.1%	2.0%	26.9%
2005	27.0%	22.9%	10.1%	1.2%	38.8%
2006	27.3%	27.9%	8.1%	0.8%	36.0%
2007	28.0%	21.5%	6.5%	0.9%	43.0%

The department strives to resolve vocational disputes through agreements, which generally have accounted for less than a third of resolutions.

Hearing requests, orders, time lags, and appeal rates, 1987-2007

Year	Requests	Orders	Request to order median days	Appeal rate
1987	20,397	23,680	224	8.1%
1988	23,316	26,386	114	9.0%
1989	27,549	24,890	116	8.7%
1990	24,018	25,073	147	7.3%
1991	19,673	21,368	133	12.2%
1992	17,490	19,580	125	12.6%
1993	16,422	16,888	119	11.3%
1994	16,527	15,751	121	11.3%
1995	14,862	16,798	124	10.6%
1996	12,351	13,341	120	11.5%
1997	11,266	11,596	122	12.5%
1998	11,059	11,271	121	11.7%
1999	11,084	10,846	124	11.5%
2000	10,654	10,935	128	11.0%
2001	11,074	10,269	126	10.6%
2002	10,679	10,830	128	9.8%
2003	10,177	10,429	136	10.9%
2004	9,980	9,531	127	9.6%
2005	9,297	10,006	146	9.0%
2006	9,130	9,442	143	9.4%
2007	9,355	9,261	138	8.6%

Hearing requests peaked in 1989. There were 9,130 requests in 2006, the lowest on record, and a third of the 1989 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, including the provision for claim disposition agreements.

HB 2900 (1987) required that a hearing be scheduled within 90 days and an order published within 30 days of the hearing. The median time between request and order was 138 days in 2007.

Notes: Counts include settlements that were received without a prior hearing request and cases generated in order to record a mediation result. Appeal rates are based on all hearing order types, not just appealable orders.

Percentage of hearing orders involving selected issues, 1987-2007

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	6.3%	39.7%	38.9%	6.6%
2003	5.6%	40.7%	38.0%	7.2%
2004	6.6%	39.7%	37.8%	7.5%
2005	5.3%	41.5%	38.1%	7.3%
2006	4.5%	39.8%	38.7%	7.7%
2007	4.6%	37.6%	40.6%	8.6%

Permanent disability was the most frequent hearing issue until 1989, when whole claim denial replaced it. For 2006-2007, permanent disability was an issue in less than 5 percent of hearings. Since the late 1980s, partial denial has become the most frequent hearing issue, rising from 9 percent of hearings to more than 40 percent.

The primary reasons for the relative 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 cases, and each case may have multiple issues. Issues are not recorded for cases that are dismissed or withdrawn.

Workers' Compensation Board mediations, 1996-2007

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%
2004	268	84.0%	80.9%
2005	270	87.0%	81.6%
2006	356	87.7%	76.9%
2007	346	89.4%	79.0%

The board's mediation program began in June 1996.

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

Data through 2005 are based on mediation worksheets; data for 2006-2007 are based on mediation events in the board's data system.

Issues in WCB mediations, 1996-2007

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%	55%
2003	41%	20%	99%	45%
2004	31%	16%	97%	50%
2005	67%	21%	94%	47%
2006	46%	10%	81%	42%
2007	64%	20%	81%	43%

"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, 1987-2007

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%
2004	802	912	162	17.9%
2005	796	770	140	13.8%
2006	782	738	167	14.9%
2007	705	701	170	14.4%

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 high of more than 7,000 in 1988 to fewer than 2,000 in recent years.

HB 2900 (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 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, 1987-2007

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
2004	496
2005	466
2006	183
2007	179

In 1987, the Legislature (HB 2900) limited worker benefits by own motion. The number of board own-motion 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 2003-2005 over 2002.

Lawmakers in 2005 (HB 2294) required that a condition must be compensable before an own-motion claim may be processed, reducing own-motion claims.

Court of Appeals requests, decisions, and time lags, 1987-2007

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
2004	163	114	441
2005	106	80	440
2006	110	60	482
2007	101	59	453

Appeals to the court peaked in 1992; in 2007, the number of appeals, 101, was just 15 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. Time lags peaked in 2006 at 482 days (1.3 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. The decision date is the date of the court's slip opinion.

Median time lag (days) from injury to order, 1987-2007

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
2004	535	806	1,481
2005	559	827	1,446
2006	537	831	1,447
2007	533	834	1,440

Times from injury to order have declined substantially since 1987, in large part due to the change in the mix of issues. 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 except Court of Appeals dismissals. The 2007 court lag of 1,440 days equates to 3.9 years.

Disputed claim settlements at hearing and board review, 1987-2007

	Hearing		Board	
Year	DCS cases	Amount ($ millions)	DCS orders	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
2004	3,219	20.7	62	1.065
2005	3,401	22.6	60	0.822
2006	3,176	22.5	45	0.735
2007	3,276	24.0	48	0.787

The number of DCSs at hearing has dropped significantly since the peak in 1991, but their relative significance has risen. Between 1987 and 2007, DCSs grew from 16 to 36 percent of all hearing orders and from 26 to 70 percent of all settlements. Attorney fees for DCSs have increased from 23 to 47 percent of all hearing claimant attorney fees.

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

Claim disposition agreements, 1990-2007

Year	CDAs approved	Total amount ($ millions)
1990	362	$6.9
1991	2,840	45.6
1992	3,229	47.0
1993	3,304	42.5
1994	3,260	41.8
1995	3,929	48.6
1996	3,564	45.0
1997	3,268	44.3
1998	3,074	37.7
1999	3,073	39.7
2000	3,144	39.9
2001	3,143	39.3
2002	3,207	44.9
2003	3,040	41.2
2004	2,869	43.8
2005	2,923	43.7
2006	2,954	52.2
2007	3,025	52.1

SB 1197 authorized claim disposition agreements in 1990. In 2004, 2,869 CDAs were approved, the fewest since 1991. This decline probably results from the decline in the number of claims. In 2007, more than $52 million was paid in for CDAs. This figure includes $7.6 million in claimant attorney fees.

Claimant attorney fees and defense legal costs, 1987-2007

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	27.0
1992	21.4	28.2
1993	19.8	27.2
1994	18.9	25.7
1995	19.9	27.4
1996	17.5	25.3
1997	16.0	24.3
1998	16.1	24.2
1999	15.8	24.2
2000	16.7	23.9
2001	16.1	25.7
2002	17.2	25.3
2003	17.1	27.1
----------->Series break #1		
2004	17.7	27.7
2005	18.4	29.4
----------->Series break #2		
2006	19.0	29.7
2007	19.2	29.7

Claimant attorney fees peaked in 1991 and 1992 at about 49 percent above 1987 fees.

Defense legal costs peaked in 1992 and were rising again in 2003-2006, reaching the highest level on record in 2006.

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.

Information about series breaks:

Break #1. Beginning with 2004, data on fees at the Court of Appeals and in department medical service and vocational assistance disputes were available. For 2004-2006, these added fees were 1.5 to 1.9 percent of the total.

Break #2. For 2007, data on fees for WCD contested cases at hearing ("Dept. Hrng.") and Board Own Motion were available. Added fees were 0.4 percent of total fees. Both fees are estimated.

Claimant attorney fees, 1987-2007

Year	Hearings ($ thousands)	Board ($ thousands)	CDA ($ thousands)	Reconsideration ($ thousands)
1987	$14,187	$226	-	-
1988	15,967	335	-	-
1989	15,953	656	-	-
1990	15,902	1,007	$900	$1
1991	13,796	905	6,429	277
1992	12,505	1,067	7,096	727
1993	11,145	1,165	6,658	858
1994	10,400	1,140	6,511	835
1995	10,859	826	7,315	890
1996	9,100	857	6,677	825
1997	8,518	753	5,999	683
1998	8,863	802	5,664	761
1999	8,537	612	5,908	764
2000	9,128	693	6,118	786
2001	8,540	612	6,115	833
2002	8,914	626	6,880	785
2003	8,989	721	6,540	810
----------->Series break #1				
2004	8,886	790	6,787	890
2005	9,490	762	6,784	994
2006	9,681	757	7,291	954
----------->Series break #2				
2007	9,647	746	7,621	841

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 2007, 40 percent of all fees came from CDAs.

For information about series breaks see comment in previous table.

"Dept. Hrng." refers to "WCD contested cases," usually medical or vocational disputes, that are appealed to hearing (previously to the Office of Administrative Hearings and, from 1/1/2006 to WCB hearings).

See table above for explanation of series breaks.

Claimant attorney fees from lump-sum settlements, 1989-2007

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	12,672	59.2%
1992	4,978	164	12,238	57.2%
1993	4,708	222	11,588	58.4%
1994	4,105	143	10,759	57.0%
1995	4,376	106	11,797	59.3%
1996	3,787	129	10,593	60.7%
1997	3,629	121	9,749	61.1%
1998	3,954	57	9,675	60.1%
1999	3,787	67	9,762	61.7%
2000	4,338	168	10,624	63.5%
2001	4,145	149	10,409	64.7%
2002	4,407	170	11,457	66.6%
2003	4,318	196	11,054	64.8%
2004	3,910	200	10,897	61.6%
2005	4,316	178	11,278	61.4%
2006	4,270	146	11,707	61.7%
2007	4,528	152	12,302	63.9%

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; it was 47 percent in 2007.

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
Time loss	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
Time loss	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. Maximum fees at Board review include fees at hearing, if any.

Insurance and Self-insurance

Oregon law requires every employer 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 Insurance Division provides financial, rate, and trade practices regulation of insurance companies including SAIF, while the Workers' Compensation Division regulates benefits, coverage, and claims practices. WCD also regulates self-insured employers.

Every two years, the department studies the workers' compensation insurance 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 sixth highest in the nation in 1986. After the early reforms, it dropped from eighth highest in 1990 to 32nd highest in 1994. Oregon's average ranking was 39th highest in 2008.

History of reform

In the late 1980s, the Oregon workers' compensation insurance market was under financial strain. Premiums and system losses were at all-time highs, and SAIF was losing $1 million 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 the of the principal reasons for the Legislature's 1990 special session.

Prior to 1990, HB 2900 (1987) allowed employers to exclude some claims costs from their loss experience. Employers were allowed to pay up to $500 in medical costs for nondisabling claims; these costs were excluded from their rating experience. HB 3318 (2005) increased the exclusionary amount from $500 to $1,500. SB 762 (2007) added an annual adjustment of this amount, based on the change in the medical services Consumer Price Index, rounded to the nearest $100.

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. HB 2900 excluded claim costs incurred as a result of an injury sustained by a preferred worker during the first two years of hire. SB 1197 (1990) extended this exemption from two to three years.

HB 2900 also restricted the eligibility for board's own motion relief (aggravation more than five years after the first claim closure) and directed that these costs be paid from the Workers' Benefit Fund and excluded from the employers' loss experience.

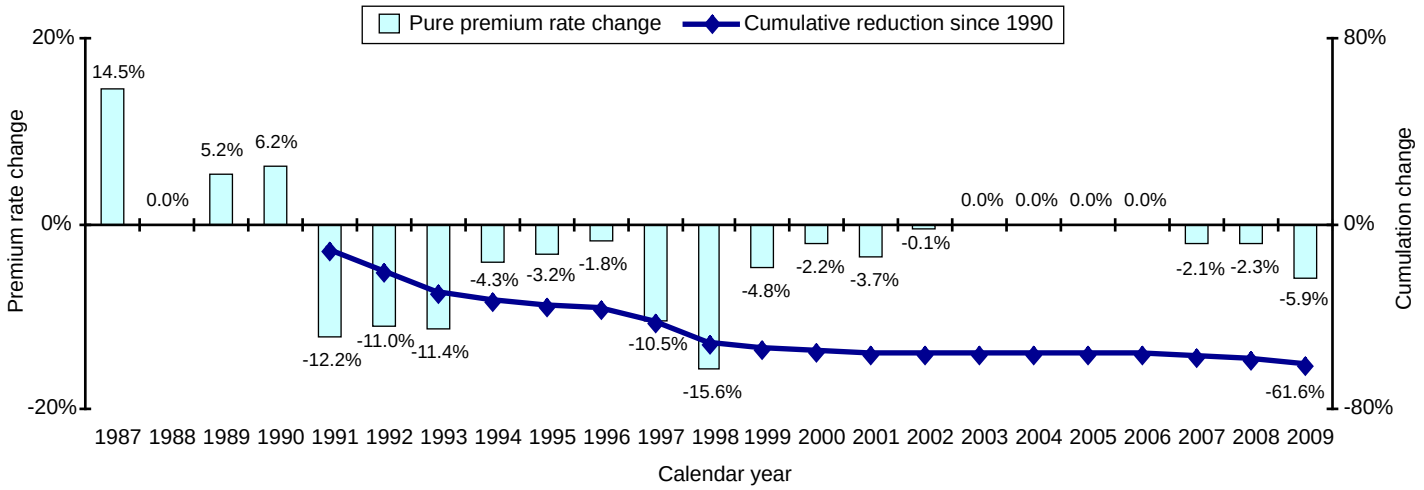
Workers' compensation premiums and rates

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 pure premium rates for each of the almost 600 rating classifications, based on expected losses. These rates are subject to the approval of the Oregon insurance commissioner. Pure premium covers benefit costs only; it is based on claims from recent injuries.

Overall pure premium rates were reduced 5.9 percent for CY 2009. Pure premium rates have been reduced or left unchanged in each of the past 19 years. There were reductions of more than 10 percent in 1991, 1992, 1993, 1997, and 1998. As a result of these reductions, the CY 2009 pure premium rate is 38.5 percent of the CY 1990 rate.

Under Oregon's rate-making system, each insurer develops an expense loading factor to cover operating expenses, taxes, profit, and contingencies. This factor is multiplied by the pure premium rate for a classification to arrive at the manual rate to be applied to the employer's payroll to determine gross premium. The average expense loading factor for SAIF and private insurers rose slightly in 2007 to 30 percent, the highest percentage on record.

Figure 31. Pure premium rate changes, 1987-2009

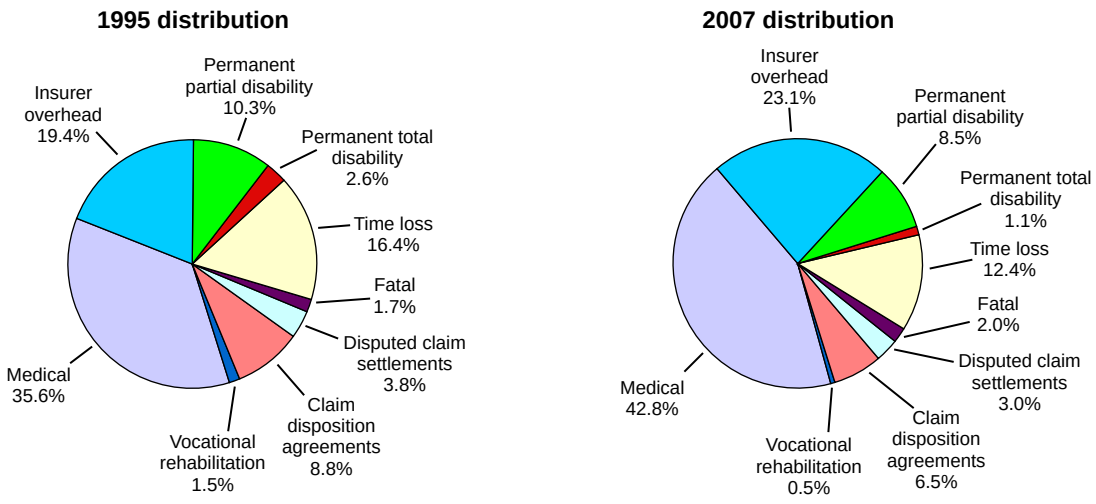


Workers' compensation total system written premiums totaled $1,192.9 million in 2007. (The department defines total system written premiums as the premium written by insurers, the simulated premium that the department calculates for each self-insured employer to set its workers' compensation assessment, and the estimated premium from large-deductible premium policies.) Premiums have grown steadily since 1999, when they were $607.6 million. The average annual growth rate since 1999 has exceeded 8 percent.

The loss ratio (defined as incurred losses divided by earned premiums) is one measure of an insurer's financial condition. SAIF's loss ratio was 86.4 percent in 2007. SAIF's loss ratio had been above 100 percent in five of the eight years prior to 2007. Its loss ratio has been volatile, due in part to substantial adjustments to its reserves. Private insurers' average loss ratio was 69.7 percent, below the average for the previous five years. The combined loss ratio for SAIF and private insurers in 2007 was 79.1 percent.

Insurers may pay dividends to their policy holders. Dividends depend on premiums and insurers' profitability in previous years. For the previous six years, little has been paid in dividends. But, 2007 saw a large increase in SAIF's dividend to $60.0 million. Private insurers continued their low dividend rate and paid $1.9 million in dividends in 2007.

Figure 32. Breakdown of workers' compensation premium, calendar years 1995 and 2007



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 36 percent in 1995 to 43 percent in 2007, while the percent paying for indemnity benefits decreased from 45 percent to 34 percent. Insurer overhead expenses were 23 percent of premiums in 2007.

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 premium prior to deductible credits.

Few credits were applied in 1996, but the program has grown rapidly since. An estimated $96.8 million were applied in 2007. This amount was 21 percent of private insurers' written premium. (The state's two largest insurers, SAIF and Liberty Northwest, do not write large-deductible premium credits.)

Self-insured employers and groups

There were 146 self-insured employers active in Oregon at the end of 2007. 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.

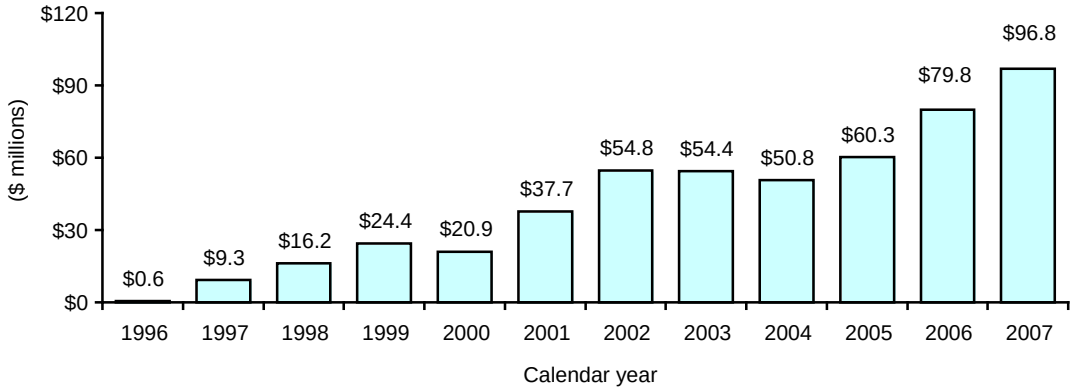
There are also six employer groups, combining more than 1,250 employers. Employers can form groups if the grouping of employers is likely to improve accident prevention and claims handling for the employers. Employers who are members of the group are jointly liable for one another's workers' compensation 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 2007, SAIF's share of the market was 49 percent, the highest percentage since 1978. Over the past several years, the market has been at its most concentrated level in more than 20 years.

Although 432 private insurers were authorized to write workers' compensation insurance in Oregon, only 178 reported positive premium written in 2007. Private insurers, including Liberty Northwest, had 39 percent of the market; Liberty Northwest's market share was 10 percent. Self-insured employers made up 12 percent of the market.

Figure 33. Earned large-deductible premium credits, 1996-2007



NOTE: SAIF Corporation reports that its 2007 written premium amount is artificially inflated due to a policy system conversion, which now recognizes annual written premium at policy inception. SAIF estimates that this one-time adjustment has inflated 2007's written premium by $143.8 million.

Oregon Workers' Compensation Insurance Plan (Assigned Risk Pool)

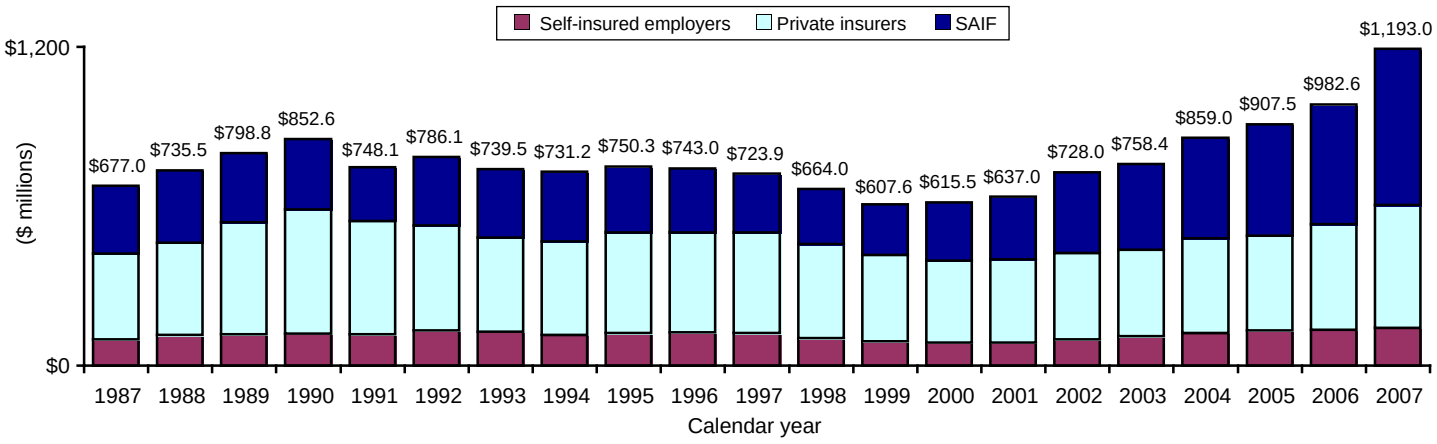
When the Legislature created SAIF in 1965 it provided that, if requested by either SAIF or the National Council on Compensation Insurance, the insurance commissioner had to promulgate an assigned risk plan to make workers' compensation insurance available to employers unable to obtain coverage in the 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. Currently 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 loading factor recommended by NCCI and subject to the commissioner's approval. The National Workers' Compensation Reinsurance Pool provides reinsurance with the cost borne by all insurers in proportion to their share of all Oregon workers' compensation premiums written.

The assigned risk pool premium was in the range of 3 percent to 4 percent of written premium between 1997 and 2000. The pool grew between 2000 and 2003, becoming more than 9 percent of premium in 2003. Since then, the pool has declined as a percentage of written premium. Although the number of employers in the pool grew from 2000 to 2005, it declined in 2006 and 2007. At the end of 2007, there were more than 12,000 employers in the pool; the pool premium was 6 percent of all written premium, the lowest share since 2001.

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.

A major study of the Oregon Assigned Risk Plan (ARP) was undertaken by the Workers' Compensation Division, Insurance Division, Information Management Division, and the Small Business Ombudsman for Workers' Compensation with technical expertise and guidance from the National Council of Compensation Insurance. The study

Figure 34. Total system written premiums, by insurer type, 1987-2007



report, released in 2007, found that the Oregon Assigned Risk Program is working well and does not need major changes. Recommendations were made in three areas:

1. Improve assigned risk plan operations and pricing.
2. Help assigned risk plan employers obtain voluntary market coverage where possible.
3. Improve incentives and programs that may keep employers from entering the plan.

HB 2250, effective Jan. 1, 2008, allows a surcharge to plan members to help pay the costs of assigned risk pool losses when they exceed premiums. Prior to this, when losses exceeded premiums the voluntary market had to make up the difference. This bill implements one of the recommendations from the ARP study. All other study recommendations must be implemented and evaluated before the plan will consider using a surcharge.

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 insurers 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 that is based on the policyholder's premium.

Workers' compensation premiums and rate changes, 1987-2009

Year	Total system written premiums ($ millions)	Annual change in written premium	Annual pure premium rate changes	Cumulative rate changes since 1990
1987	$677.0	-	14.5%	
1988	735.5	8.6%	0.0%	
1989	798.8	8.6%	5.2%	
1990	852.6	6.7%	6.2%	
1991	748.1	-12.3%	-12.2%	-12.2%
1992	786.1	5.1%	-11.0%	-21.9%
1993	739.5	-5.9%	-11.4%	-30.8%
1994	731.2	-1.1%	-4.3%	-33.7%
1995	750.3	2.6%	-3.2%	-35.9%
1996	743.0	-1.0%	-1.8%	-37.0%
1997	723.9	-2.6%	-10.5%	-43.6%
1998	664.0	-8.3%	-15.6%	-52.4%
1999	607.6	-8.5%	-4.8%	-54.7%
2000	615.5	1.3%	-2.2%	-55.7%
2001	637.0	3.5%	-3.7%	-57.3%
2002	728.0	14.3%	-0.1%	-57.4%
2003	758.4	4.2%	0.0%	-57.4%
2004	859.0	13.3%	0.0%	-57.4%
2005	907.5	5.6%	0.0%	-57.4%
2006	982.6	8.3%	0.0%	-57.4%
2007	1,192.9	21.4%	-2.1%	-58.3%
2008	N/A	N/A	-2.3%	-59.2%
2009	N/A	N/A	-5.9%	-61.6%

Workers' compensation pure premium rates have decreased 59 percent between 1991 and 2008. Total system written premiums decreased by $245.0 million between 1990 and 1999; they increased $585.3 million between 1999 and 2007, an annual growth rate of more than 8 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 premium rate ranking, 1986-2008

Year	Rate ranking	% study median
1986	6th	137%
1988	8th	142%
1990	8th	149%
1992	22nd	107%
1994	32nd	85%
1996	34th	89%
1998	38th	85%
2000	34th	85%
2002	35th	85%
2004	42nd	79%
2006	42nd	79%
2008	39th	83%

Oregon's average premium rate ranking improved from sixth highest in the nation with a 137 percent of study median in 1986 to 32nd highest with an 85 percent of study median in 1994. In 2008, the ranking was the 39th highest, 83 percent of the study median.

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.

Earned large-deductible premium credits, 1996-2007

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%
2005	60.3	16.9%
2006	79.8	20.1%
2007	96.8	21.0%

Earned large-deductible premium credits are credits on employers' workers' compensation premium. Participating employers repay insurers their claims costs up to the deductible amounts. The use of these credits grew rapidly through 2002, then stayed roughly the same through 2004, after which rapid growth started again. In 2007, these credits were equal to 21 percent of private insurers' written premium.

Workers' compensation market share, by insurer type, 1995-2007

Year	SAIF	Private insurers	Self-insured employers
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%
2005	46.1%	39.3%	14.6%
2006	45.8%	40.4%	13.9%
2007	49.4%	38.7%	11.9%

In 2007, as measured by total system written premiums, SAIF had 49 percent of the market. Private insurers' share was 39 percent. The largest private insurer, Liberty Northwest, had 10 percent of the market and 25 percent of the private insurer market.

Note: SAIF Corporation reports that its 2007 written premium amount is artificially inflated due to a policy system conversion, which now recognizes annual written premium at policy inception. SAIF estimates that this one-time adjustment has inflated 2007's written premium by $143.8 million.

SAIF Corporation financial characteristics, 1995-2007

Year	Total system written premiums ($ millions)	Loss ratio	Expense loading factors	Dividends ($ millions)
1995	249.3	82.4	1.206	80.2
1996	242.2	125.6	1.200	50.1
1997	223.6	66.6	1.193	69.8
1998	205.7	40.6	1.130	121.1
1999	191.0	140.4	1.097	211.5
2000	220.0	166.2	1.103	159.4
2001	237.0	94.5	1.108	0.1
2002	303.4	108.9	1.129	-0.6
2003	322.0	109.5	1.149	0.2
2004	380.2	123.3	1.203	2.0
2005	418.3	65.8	1.204	0.0
2006	449.8	92.9	1.208	0.0
2007	588.9	86.4	1.211	60.0

SAIF's written premium grew by about 13 percent per year between 1999 and 2006. Starting with 2007, SAIF changed its DPW calculation method from arrears based to total estimated at policy inception. This caused a large one-time jump in 2007.

SAIF's loss ratio (incurred losses divided by earned premiums) was 86.4 percent.

SAIF's expense loading factor covers operating expenses, taxes, profit, and contingencies. This factor is multiplied by the pure premium rate to the employer's payroll to determine gross premium. The 2007 factor was 1.211.

Between 1998 and 2000, SAIF paid $492 million in dividends. Little had been paid until the $60.0 million of 2007. The 2002 negative dividend figure represents uncashed dividend checks credited back to SAIF.

Private insurers' financial characteristics, 1995-2007

Year	Total system written premiums ($ millions)	Loss ratio	Expense loading factors	Dividends ($ millions)
1995	378.4	68.2	1.269	12.5
1996	374.8	66.8	1.207	10.3
1997	378.4	62.2	1.213	9.4
1998	353.6	71.3	1.232	10.3
1999	326.0	69.4	1.216	11.6
2000	309.1	78.4	1.238	10.3
2001	314.0	88.7	1.272	8.4
2002	327.0	66.7	1.349	6.0
2003	324.7	91.2	1.384	3.1
2004	355.7	88.0	1.382	2.6
2005	356.7	83.2	1.423	1.4
2006	396.7	81.1	1.413	2.2
2007	461.9	69.7	1.413	1.9

Private insurers' written premium jumped 16 percent in 2007. It had been growing by about 5 percent per year since 2000. The 2007 premium was $461.9 million.

The loss ratio for all private insurers was 69.7 percent in 2007, lower than the average of the six previous years.

Each private insurer develops an expense loading factor to cover operating expenses, taxes, profit, and contingencies. These factors are multiplied by the pure premium rate to the employer's payroll to determine gross premium. The average 2007 factor was 1.413, unchanged from 2006.

Over the past five years, private insurers have paid back less than 1 percent of written premium in dividends.

WC insurance plan (Assigned Risk Pool) characteristics, 1987-2007

Year	Covered employers	Pool premium ($ millions)	Percent of written 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%
2005	13,054	58.9	8.2%
2006	12,799	59.4	7.7%
2007	12,023	55.6	5.8%

After declining during the late 1990s, the Assigned Risk Pool grew rapidly between 2000 and 2003, from 3 percent to 9 percent of the total premium. Although the number of employers in the pool has stayed roughly constant for 2004 through 2007, pool premium as a percentage of written premium has declined.

Workers' Benefit Fund

The Workers' Benefit Fund provides funds for a number of programs that assist employers and injured workers. HB 2044 in 1995 created the WBF and altered the structure of the workers' compensation accounts. Effective Jan. 1, 1996, the WBF contains these former workers' compensation reserves that are now considered WBF programs: Re-employment Assistance, Workers with Disabilities, Reopened Claims, and Retroactive programs. WBF assessment revenue funds these programs with employers and workers each paying one-half the assessment. The WBF assessment rate is currently set at 2.8 cents per hour, unchanged since Jan. 1, 2007. The WBF also includes the Noncomplying Employer (NCE) and Rehabilitation programs. Formerly, these programs were included within the Workers' Compensation Premium Assessment Operating Account (PAOA), a major account of the DCBS Fund. Fund transfers are made quarterly from the PAOA to the WBF to cover the net expenditures for the NCE and Rehabilitation programs.

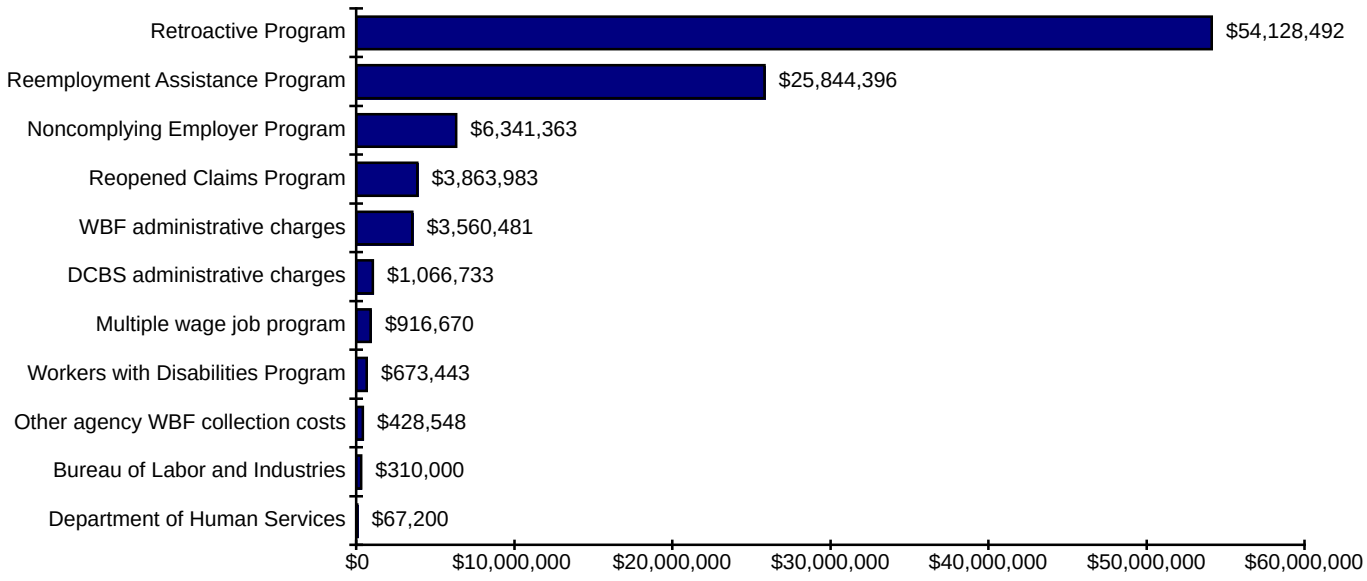
Before the passage of SB 484 during the 1997 legislative session, WBF assessment rates were set so that the fiscal-year ending fund balance would be approximately two quarters of expenditures and rate volatility would be minimized. SB 484 altered the minimum balance to four quarters of expenditures. The bill's language was set to expire at the end of calendar year 1999, but SB 213 in 1999 made the fund balance change permanent for the assessment-funded programs.

In 2001, Senate Bill 485 added a new component to the WBF; it allowed 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 Jan. 1, 2002. A new program was established within the WBF to report expenditures associated with SB 485 multiple jobs.

Beginning July 1, 2001, the WBF began funding a portion of the DCBS operating costs associated with the administration of WBF programs. The department's fiscal year 2008 budget includes a transfer of $3.6 million from the WBF to the PAOA for the reimbursement of administrative costs. This effectively reduced some of the cost burden on the PAOA for administering WBF programs.

The 2005 Legislature, in SB 386 and SB 119, provided that insurers pay vocational assistance benefits and permanent total disability benefits while

Figure 35. Workers' Benefit Fund expenditures and transfers, FY 2008



workers are appealing the denial of these benefits. In cases where insurers' denials are upheld, the WBF is now used to reimburse the insurers' costs.

Workers with Disabilities Program (formerly known as Handicapped Workers' Program)

Senate Bill 1197, passed during the 1990 special session, increased the level of incentives offered under the Re-employment Assistance Program and phased out the Handicapped Workers' Program (now known as Workers with Disabilities Program in accord with SB 183, passed during the 2007 legislative session). No new applications were accepted after May 1, 1990, and program expenditures have been slowly declining. Nevertheless, more than $673,000 was paid in fiscal year 2008, 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 Jan. 1, 1986. There were no expenditures from fiscal year 2000 through the third quarter of fiscal year 2004. However, SAIF submitted requests for reimbursement under this program for fiscal years 2004-2006. Some intermittent payments may occur from this program in the future.

Re-employment Assistance Program

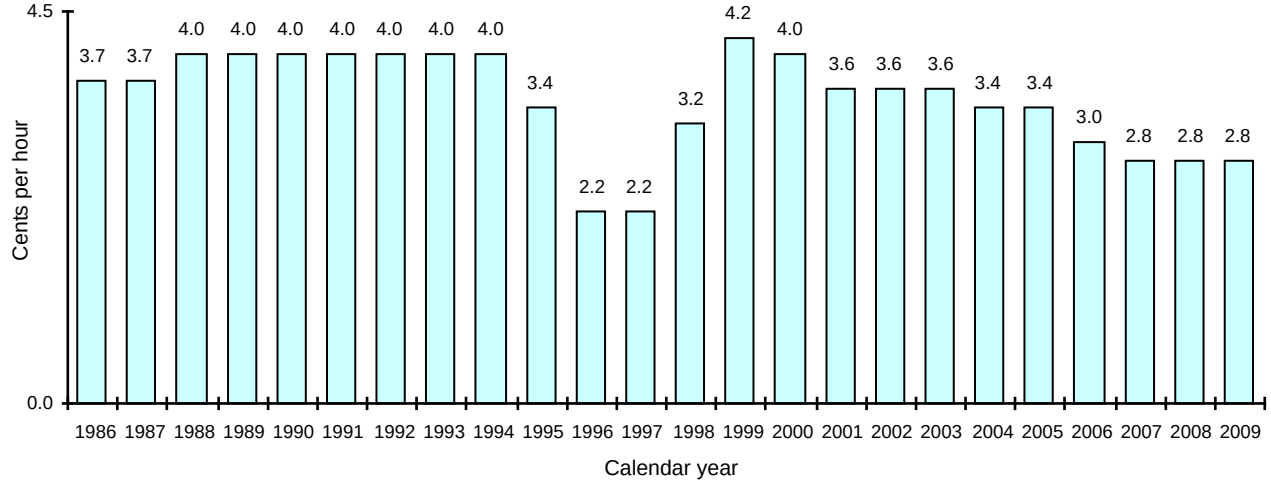
The Re-employment Assistance Program was developed to provide incentives for returning injured workers to jobs. The major incentive programs currently available are the Preferred Worker Program and the Employer-at-Injury Program. It also includes several other programs.

The Preferred Worker Program is designed to assist 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 Re-employment Assistance Program pays the claims costs, including the administrative costs. The program also pays wage subsidies, direct employment purchases, and worksite modifications. In fiscal year 2008, $8.7 million was spent on the Preferred Worker Program.

The Employer-at-Injury Program provides incentives for employers that 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 can return to light-duty, transitional jobs are eligible. Expenditures totaled $15.5 million in fiscal year 2008.

The Re-employment Assistance Program also provides money to the Oregon Health and Science University Center for Research on Occupational

Figure 36. Oregon WBF (Cents-Per-Hour) assessment rate, 1986-2009



and Environmental Toxicology. Of the 2.8 cents per hour assessment, 1/16 of a cent is paid to CROET, which totaled $1.7 million in fiscal year 2008.

SB 119, passed during the 2005 legislative session, provides payments from the WBF to the Department of Human Services, Office of Vocational Rehabilitation Services for the injured worker job placement program. Transfers to DHS totaled $67,200 in fiscal year 2008.

Retroactive Assistance Program

The Retroactive Assistance Program, the largest WBF program, pays benefit increases to workers or their beneficiaries to account for changes in average wages. In fiscal year 2008, the program had $54.1 million in expenditures.

Effective Oct. 1, 2008, the Retroactive Assistance Program benefits increased 4.9 percent for workers' injuries prior to July 1, 2007. 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, 2007, a cost-of-living adjustment. The benefit decisions also included the fatal benefit increase mandated by SB 369 (1995) for surviving spouses without children and the administrative decision to grant a similar increase to surviving spouses with children, effective Oct. 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 Jan. 1, 1966. Claimants with more recent injuries are reimbursed for temporary-disability costs. In addition, provisions in SB 485 (2001) permit the Workers' Compensation Board to grant permanent partial disability benefits for new or omitted medical conditions. In fiscal year 2008, the program had $3.9 million in expenditures.

Noncomplying Employer Program

The department is responsible 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. A transfer from the Premium Assessment Operating Account finances the remaining program expenditures. In fiscal year 2008, the program had $5.0 million in net expenditures.

Table 1 - Workers' Benefit Fund revenues and expenditures, FY 2008

Revenues	**FY 2008**
Assessments[1]	$75,593,938
Investment income	8,748,531
Fines and penalties	1,552,831
Other income	325,603
Noncomplying Employer Program[2]	5,081,721
Total	**$91,302,624**
Expenditures	
Workers with Disabilities Program	$673,443
Noncomplying Employer Program	6,341,363
Re-employment Assistance Program[3]	25,844,396
Rehabilitation Program	0
Reopened Claims Program	3,863,983
Retroactive Program	54,128,492
SB 485 Multiple Wage Jobs	916,670
Other agency WBF collection costs[4]	428,548
Shared services chargeback[5]	1,066,733
Total	**$93,263,628**
Transfers	
NCE/Rehabilitation[6]	$1,366,604
WBF administrative cost[7]	(3,560,481)
Bureau of Labor and Industries[8]	(310,000)
Department of Human Services[9]	(67,200)
Transfer out – other[10]	(124)
Total	**($2,571,201)**
Net cash flow	**($4,532,205)**
Ending fund balance	**$164,123,246**

1 The WBF assessment rate is 2.8 cents effective January 1, 2007.

2 Noncomplying 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 Re-employment expenditures.

4 Expenditures paid to other state agencies for collection of WBF assessment rate revenue.

5 This represents the indirect portion of the WBF Administrative Cost and is reflected as an expenditure.

6 Net NCE/Rehab expenditures are transferred from the Premium Assessment Operating Account.

7 Quarterly transfer from the WBF to the PAOA to cover direct costs associated with WBF programs.

8 In accord with the legislatively approved budget for 2007-2009, a transfer of $310,000 was made to the Bureau of Labor and Industries in FY 2008.

9 This represents the indirect portion of the WBF Administrative Cost and is reflected as an expenditure.

10 Transfers to the Department of Human Services for costs related to injured worker assistance programs in accord with SB 119.

Column detail may not add to totals due to rounding.

Workers with Disabilities and Rehabilitation Assistance Program expenditures, FY 1987-2008

Fiscal year	Workers with Disabilities 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
2005	0.5	0.0
2006	0.7	0.0
2007	0.6	0.0
2008	0.7	0.0

The Workers with Disabilities Program (SB 183, passed during the 2007 legislative session, changed the name of the Handicapped Workers' Program to the Workers with Disabilities Program) was created by the Legislature in 1981. It 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 $0.7 million in FY 2008.

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 Jan. 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. The program reimbursed SAIF $40,000 in FY 2005 and $4,556 in FY 2006. There were no payments in FY 2007 or FY 2008, but there may be additional small payments in the future.

Re-employment Assistance Program expenditures, FY 1991-2008

Fiscal year	Re-employment 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
2005	18.6
2006	20.2
2007	22.0
2008	25.9

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

Re-employment 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 Re-employment Assistance Program expenditures reflect certain programmatic costs that are not explicitly identified in the detailed Re-employment Assistance Program tables below. The expenditures shown are net Re-employment Assistance Program expenditures, which means they include transfers-in and transfers-out.

Expenditures for the Preferred Worker portion of the Re-employment Assistance Program, FY 1991-2008

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
2005	3.0	2.3	0.2	2.0
2006	2.7	2.4	0.3	2.2
2007	3.0	2.3	0.2	2.1
2008	3.5	2.3	0.4	2.5

The Preferred Worker Program was created by HB 2900 in 1987. It provides assistance opportunities for many injured workers with PPD awards who have not returned to regular work. Expenditures for the program were $8.7 million in FY 2008.

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 Re-employment Assistance Program, FY 1991-2008

Fiscal year	Employer-at-Injury Program ($ millions)	CROET ($ millions)	Vocational rehabilitation services ($ millions)
1994	$1.8	$1.3	-
1995	3.9	1.4	-
1996	5.3	2.2	-
1997	10.1	3.2	-
1998	9.9	1.7	-
1999	11.6	1.5	-
2000	10.4	1.4	-
2001	10.6	1.6	-
2002	10.4	1.6	-
2003	8.4	1.6	-
2004	9.6	1.6	-
2005	9.4	1.6	-
2006	10.9	1.6	$0.10
2007	12.5	1.7	0.05
2008	15.5	1.7	0.07

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.

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.

SB 119 (2005) provides payments to the Department of Human Services, Office of Vocational Rehabilitation Services from the WBF for the injured worker job placement program.

Noncomplying Employer, Reopened Claims, and Retroactive Assistance Program expenditures, FY 1991-2008

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	0.9	2.7	54.5
1997	4.8	3.6	60.1
1998	3.5	3.9	61.3
1999	3.5	3.4	66.3
2000	3.3	4.1	63.2
2001	2.7	3.6	64.6
2002	3.3	3.9	66.3
2003	2.8	4.0	64.0
2004	2.8	4.2	59.0
2005	3.7	5.0	56.3
2006	4.8	4.6	56.8
2007	5.9	4.7	57.0
2008	5.0	3.9	54.1

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. The expenditures shown since 1996 are net NCE Program expenditures, which means they include transfers-in and transfers-out from the Premium Assessment Operating Account. Over the past three years, net expenditures have averaged $5.2 million, which is a substantial increase from the average level of $3.5 million seen from 1998-2005. Johnston and Culbertson Inc. has handled NCE claims since Aug. 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 $5.0 million in FY 2005, the highest level in the history of the program. FY 2003-FY 2008 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, FY 2002-2008

Fiscal year	Multiple Wage Jobs Program ($ millions)
2002	$0.00
2003	0.28
2004	0.53
2005	0.66
2006	0.75
2007	0.95
2008	0.92

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

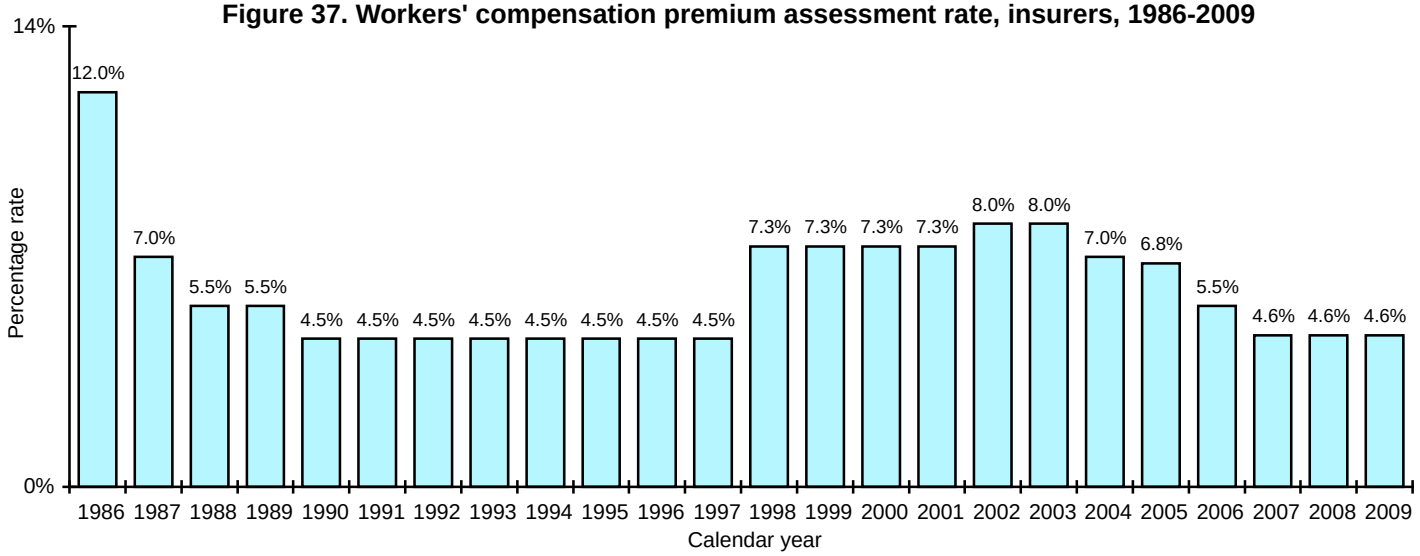
Much of the regulation of the Oregon workers' compensation system is funded by an assessment on workers' compensation premium. The assessment revenue is collected from insurers based on workers' compensation premiums earned in Oregon. (For self-insured employers and self-insured employer groups, the assessment is based on a simulated premium calculated by the department.) The revenue is deposited into the Premium Assessment Operating Account. The PAOA is also funded in part by some fines and penalties, federal grant monies, investment income, other miscellaneous revenue, 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, Oregon OSHA, some of the Insurance Division's duties, the Director's Office, and the department's support divisions. Senate Bill 592 in 1999 established the current rules for setting the assessment rate.

Since January 2007, the assessment rate for insurers is 4.6 percent of premium. For self-insured employers and self-insured employer groups, it is 4.8 percent. The rate for self-insured employers and self-insured employer groups is higher than that for insurers in order to fully fund the Self-Insured Employer Adjustment Reserve and the Self-Insured Employer Group Adjustment Reserve.

The 2007-2009 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, 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 approximates six to 12 months of expenditures.

In fiscal year 2008, there were $58.7 million in expenditures and transfers from the PAOA. $47.5 million was gathered through premium assessment. In addition, $3.6 million was earned in investment income, $1.7 million was collected in fines and penalties, $1.9 million in other revenue that includes a settlement payment of $1.2 million from American International Group (AIG), and $5.6 million was received in federal funds. The fund also received money transferred to the account from other accounts and transferred money

Figure 37. Workers' compensation premium assessment rate, insurers, 1986-2009



to the Workers' Benefit Fund to pay for the Non-complying Employer Program. Also, $1.7 million was paid to Oregon Health and Science University for its Center for Research on Occupational and Environmental Toxicology. The money paid from the PAOA essentially matches the money paid to OHSU from the WBF.

Three bills from the 2003 Legislature affected the PAOA in fiscal year 2004. 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 originally created, the program was to run during 2004-2007. However, SB 183, passed during the 2007 legislative session, extended the program through calendar year 2011. SAIF must pay the costs of the program, but it can reduce its assessments paid to the PAOA by $40 million over the duration of the program and cannot exceed an average of $5 million per year for the eight years of the program. SAIF's assessments were reduced by $5.6 million in fiscal 2008 and it has used $22.2 million of the $40 million allowable, with an average assessment credit of $4.4 million per fiscal year.

Table 2 - Premium Assessment Operating Account revenues and expenditures, FY 2008

Revenues	**FY 2008**
Assessments[1]	$47,538,717
Fines and penalties	$1,732,538
Investment income	$3,638,624
Federal funds	$5,552,742
Other[2]	$1,879,096
SAIF reinsurance pool credit[3]	($5,590,022)
Total	**$54,751,695**
Expenditures	
Administration[4]	$65,098,978
Self-insured employer reserve	$363,077
Chargeback[5]	($6,785,093)
Oregon Health Sciences University[6]	$1,678,823
Total	**$60,355,785**
Adjustments/transfers	
Noncomplying employer[7]	($1,366,604)
Insurance Division[8]	($159,090)
WBF administrative expenses[9]	$3,560,481
BOLI transfer[10]	($174,000)
Miscellaneous transfers/adjustments[11]	($211,355)
Total	**$1,649,432**
Net cash flow	**($3,954,658)**
Ending fund balance	**$74,706,132**

For the purposes of this analysis, self-insured employer reserves are included in the Premium Assessment Operating Account.

1 The premium assessment rate was 4.6 percent effective since 1/1/2007.

2 The category of "Other" includes a $1.2 million payment from AIG.

3 Annual premium assessment credit for SAIF in accordance with Section 781, Oregon Laws 2003 (HB 3630) and amended by Chapter 574, Oregon Laws 2007 (SB 183).

4 Includes Department and Board administrative costs, expenditures of Federal funds, capital outlay, and Shared Services costs.

5 Chargeback expenditures reflect Central Support chargeback recoveries, from non-PAOA account, DCBS entities. Chargeback expenditures also include indirect costs from the WBF.

6 OHSU/CROET transfers and/or expenditures are equal to 1/16 cent per worker per hour.

7 Net noncomplying employer expenditures are transferred to/from the Workers' Benefit Fund.

8 Transfer to the Insurance Division in the first quarter of each fiscal year to help fund workers' compensation activities.

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 Miscellaneous transfers and adjustments are from actual quarterly financial statements.

Column detail may not add to totals due to rounding.

Premium assessment rates, 1986-2009

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%
2006	5.5%	5.7%	5.7%
2007	4.6%	4.8%	4.8%
2008	4.6%	4.8%	4.8%
2009	4.6%	4.8%	4.8%

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 and again in 2007-2009 were set low in order to draw down the PAOA balance.

The 2006-2009 rate for self-insured employers and self-insured employer groups is 0.2 percent higher than for insurers to fully fund the Self-Insured Employer Adjustment Reserve and Self-Insured Employer Group Adjustment Reserve.

Premium Assessment Operating Account expenditures, with funding sources, FY 1986-2008

Fiscal year	Expenditures ($ millions)	Assessment revenue and other revenue ($ millions)	Investment income ($ millions)	Fund balance draw down ($ millions)
1986	$64.8	$61.7	$3.1	$0.0
1987	59.4	55.5	3.9	0.0
1988	53.2	48.9	4.3	0.0
1989	45.2	40.6	4.6	0.0
1990	42.0	35.0	7.0	0.0
1991	48.9	41.5	7.4	0.0
1992	48.6	43.1	5.5	0.0
1993	49.7	43.4	4.6	1.7
1994	51.0	42.2	5.0	3.9
1995	51.0	42.7	5.7	2.6
1996	54.7	41.2	7.2	6.3
1997	53.0	38.7	4.3	10.0
1998	48.9	39.7	2.4	6.8
1999	51.8	49.7	2.1	0.0
2000	56.6	49.7	2.3	4.6
2001	56.3	49.9	3.3	3.0
2002	52.6	51.0	1.6	0.0
2003	51.1	49.6	1.5	0.0
2004	53.2	47.2	1.8	4.1
2005	52.5	50.2	2.3	0.0
2006	52.4	49.3	3.2	0.0
2007	55.4	51.5	3.9	0.0
2008	58.7	51.1	3.6	4.0

In fiscal year 2008, $58.7 million was spent from the PAOA to regulate the workers' compensation system.

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. SB 183, passed during the 2007 legislative session, extended the program through calendar year 2011. 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 $5.6 million in FY 2008. The assessment revenue and other revenue shown is net of SAIF's assessment reductions.

Premium Assessment Operating Account year-end balance, FY 1986-2008

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
2005	59.5
2006	72.5
2007	78.7
2008	74.7

At the end of fiscal year 2008, the Premium Assessment Operating Account had a balance of $74.7 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, 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. A chronology of important legislative changes since then 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 training programs for employees in safe employment practices. (HB 2982)

1990

654.176 (1) Required that all employers with more than 10 employees establish a safety and health committee. The legislation 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 penalty increases 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) meeting certain criteria from scheduled inspections by Oregon OSHA. (HB 3019) (Now 654.172)

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

656.622 Established a Worksite Redesign Program, including engineering design work and occupational health consulting services, to prevent the recurrence of on-the-job injuries. (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 This section was repealed, and the State Advisory Council on Occupational Safety and Health was abolished. (SB 135)

658.790 Transferred enforcement authority of the law from the Bureau of Labor and Industries to the department. Required farmworker camp operators to provide seven days of housing in the event of camp closure by a government agency. (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 Oregon OSHA schedule inspections by predominantly focusing resources on the most unsafe places of employment. (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 nonregistration of farmworker camps be put in the account. The purpose of the account is to expand the state's supply of housing for low-income farmworkers. (HB 3573)

Chapter 625, 2001 laws Amended tax law to transfer the administration of the Farmworker Housing Tax Credit from Oregon OSHA to the Oregon Department of Housing and Community Services. (HB 3172)

Chapter 635, 2001 laws Amended tax law to make the Farmworker Housing Construction Tax Program permanent. Also amended the program. (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)

2005

654.035 (1)(d) Removed the accepted disabling claims rate as one of the criteria used by Oregon OSHA when identifying employers who will receive notification of the increased likelihood of having a workplace safety inspection. Provided the director with the authority to determine which industries and workplaces are most unsafe and should receive this notification. (HB 2093)

2007

654.176(2), 654.182, and 654.182 (1)(f) Eliminated the 10-employee threshold from statute and replaced the safety committee requirement with a requirement for all employers to have safety committees or use safety meetings under rules adopted by DCBS. The bill requires appropriate consideration for the unique circumstances of agriculture, small employers and employers with mobile worksites. (HB 2222)

654.005 (5) Expanded the definition of "employer" for the purposes of the Oregon Safe Employment Act (ORS 654). The bill enables DCBS/Oregon OSHA to adopt rules that will hold a successor employer (one that is essentially the same as a prior employer) responsible for the correction of hazards to protect workers, for determining "repeat" violations, and for the payment of civil penalties. (HB 2223)

ORS 654.414, 654.416, 654.418, 654.421, and 654.423 Required health care employers to address assaults of employees who work in ambulatory surgical centers and hospitals. These employers are required to conduct periodic security and safety assessments to identify assault hazards, develop an assault prevention and protection program, provide training, and maintain a record of assaults that result in injury to their employees. (HB 2022)

656.062 (6)(a) Increased the amount of time a worker has to file a retaliation (discrimination) complaint with the Oregon Bureau of Labor and Industries from 30 days to 90 days if the worker believes they have been discriminated against for raising workplace health or safety issues. (HB 2259)

654.035 (2) Eliminated existing statutory provisions that prevent Oregon OSHA from adopting rules requiring fall protection in steel erection below the federal OSHA trigger height. (HB 3400)

654.078 Extended the appeals deadline for workplace health and safety citations from 20 days to 30 days and expanded the period before civil penalty can be recorded as a judgment from 10 to 20 days after a final order. This statutory change applies to citations, notices and orders received by an employer on or after the effective date of the bill. (SB 556)

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) Required that a compensable injury be established by medical evidence supported by objective findings. The compensable injury must be the major contributing cause of a consequential condition. If the compensable injury combines with a pre-existing condition, the resulting 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 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 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 (7)(a)(B) Stated 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 from "clear and convincing evidence" to "preponderance of 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 is for fraud, misrepresentation, or other illegal activity, to be proved by a preponderance of evidence. Lowered 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 from "clear and convincing evidence" to "preponderance of evidence." (SB 369)

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

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

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

2001

656.005 (24) and 656.804 Revised the definition of pre-existing conditions. It provided separate definitions for injury claims and for occupational disease claims. (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 by either 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 disability and retirement systems. (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 part of the implementation of Ballot Measure 99 in 2000. (HB 3816)

2003

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

2005

656.027 (15)(d) Provided that owners or leaseholders of motor vehicles used in the transportation of property by a for-hire motor carrier are nonsubject workers for purposes of workers' compensation statutes. (SB 433)

2007

656.039 (5)(a) Required the Home Care Commission to elect workers' compensation coverage on behalf of Department of Human Services clients who employ home care workers if the worker is paid by the state on behalf of the client. Required the home care worker to accept appropriate modified employment with any client of the Department of Human Services who employs a home care worker or risk termination of his or her temporary disability benefits. (HB 3362)

656.027(28) Clarified that taxicab drivers are considered as nonsubject workers under workers' compensation insurance coverage requirements if they lease a taxicab by the shift or for a longer period or the taxicab used is under a contract to a third party for transporting designated passengers, to provide errand service, or to provide non-emergency medical transportation. (SB 688)

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 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 days to 90 days. (SB 1197) (In 2001, SB 485 reduced the time to 60 days.)

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

656.726 (3)(f) Mandated that impairment be established by a preponderance of medical evidence based on objective findings. Also required that the director 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))

656.780 Required the director to establish a workers' compensation claims examiner certification program. (SB 1197) (SB 211 repealed this 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)(b))

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. (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 that the Oregon compensation paid for an injury or illness be offset by the out-of-state compensation paid for the same injury or illness. (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) (SB 386 revised definition in 2005; now 656.206 (11)(a).)

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

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

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

656.262 (14) & (15) Required that injured workers cooperate with the insurer or self-insured employer in the investigation of claims for compensation. If a worker does not cooperate, the director is to suspend the compensation. (SB 369) (Now 656.262 (13) & (14))

656.265 (1) Increased the time for filing of a claim from 30 days 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 made in writing. (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)(E))

1997

656.262 (6)(b)(F) Required that the insurer or self-insured employer modify the notice of acceptance when medical or other information changed a previously issued notice of acceptance. (HB 2971)

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. (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 its own claim closure activities; insurers and self-insured employers were to assume responsibility, no later than June 30, 2001, for closing all claims. (SB 220) (This was accomplished by Jan. 1, 2001.)

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)

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's knowledge of the claim. The bill also reduced the time the insurer has to accept or deny a claim for aggravation or new or omitted conditions 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 originally classified as nondisabling and 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 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 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)

656.265 (4)(c) Added an exemption to the requirement for reporting claims within 90 days if the worker can establish that he or she 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 to conduct an evaluation of its claims reporting requirements. The results were to be presented to MLAC. (SB 914)

2005

656.273 (3) & (6) Expedited the processing of claims for aggravation, and clarified that insurers' and self-insured employers' responsibility for timely compensation payments does not begin until the physician's report is received. (HB 2405)

656.268 (6)(e) Authorized the director to issue civil penalties for violation of statutes regarding reports or other requirements needed to administer workers' compensation law. (SB 172)

2007

656.230 (5) Eliminated the requirement to adopt a rule and instead allowed the determination of impairment to be included in an order on reconsideration, which can be appealed to the Workers' Compensation Board. (HB 2218)

656.230 (7)(c)(J) Eliminated the requirement to consult a physician if requested when determining whether to approve a worker's additional change of attending physician. (HB 2218)

656.230 Consolidated the reason an insurer can deny a lump-sum payment for a permanent partial disability award into one section of the law and removed the director's review of a denied request. (HB 2218)

Advocates and Advisory Groups

1987

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

1990

656.709 (2) Established the Office of the Ombudsman for Small Business. (SB 1197)

656.790 Created the Workers' Compensation Management-Labor Advisory Committee. (SB 1197)

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

1995

656.790 Reduced the membership of the Management-Labor Advisory Committee from 14 members to 10 members (five representing subject workers, five representing subject employers). Mandated that MLAC report to the Legislature findings and recommendations the committee finds appropriate, including reports on 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. (SB 369)

1997

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

2001

192.530 (Note) Created the Advisory Committee on Privacy of Medical Information and Records. The committee had 17 members. The committee's purpose was to review state and federal laws concerning the privacy of medical information and to see if state laws conflicted 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) & (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. (SB 234)

2007

Oregon Legislative Note: Required the Management-Labor Advisory Committee to conduct an interim study of the adequacy of death benefits in the workers' compensation system; report to the 75th Oregon Legislative Assembly is required by Jan. 31, 2009. (SB 835)

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 independent 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) (Revised in 2007 to include podiatrists, naturopaths, chiropractors, and physician assistants to act as attending physician for up to 60 days or 18 visits, whichever comes first.) (HB 2756)

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 the 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) (SB 223 repealed this 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 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 nonwork-related illnesses or injuries. Exempted insurers that provide combined coverage in pilot programs from certain requirements for transacting health or workers' compensation insurance. (HB 2285) (This program was phased out in 1996.)

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) (SB 369 changed the maximum from 20 percent to 40 percent in 1995.)

1995

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

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

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

1997

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

1999

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

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

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 treatments and 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 injured workers only, rather than to workers and employers, unless the worker provides consent. (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, sections 29 & 30, 2003 laws Required that the department develop and make available to nurse practitioners informational materials about the workers' compensation system. Also required nurse practitioners to 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)

2005

656.325 (1), 656.328, and 656.780 Required the director to develop rules and training applicable to independent medical examinations for workers' compensation claims. Modified the process for insurer-requested IMEs; insurers must now select an IME provider from a department-developed list. Allowed workers to appeal the reasonableness of the location of exam, subject to an expedited review by the department. (SB 311)

656.260 (4)(a) & (4)(i) Required the director to review and approve medical treatment standards for care provided by managed care organizations. Required MCO plans to allow attending physicians to advocate for medical services and temporary disability benefits. (SB 670) (Revised in 2007 by SB 563, removing the requirement for the department to review and approve individual treatment standards.)

2007

656.245 Allowed authority to the department to issue civil penalties against managed care organizations that fail to comply with laws or rules. (HB 2218)

656.245 (2)(b)(C) Expanded the role of nurse practitioners to provide compensable medical services to injured workers for up to 90 days, authorize time loss for up to 60 days, release the worker to work, and manage the worker's return to work during that time period. (HB 2247)

656.005 (12)(b)(B) Allowed chiropractic physicians, podiatrists, naturopaths, and physician assistants to act as attending physicians for injured workers for 60 days or 18 visits, whichever comes first. The four provider groups can authorize time loss for 30 days and manage the worker's return to work during that period, and are to certify they have reviewed informational materials developed by the director. (HB 2756)

656.328 Required that the department adopt rules to outline the standard of conduct for providers that do not have conduct guidelines from their regulatory board. Removed the statutory reference to the American Board of Independent Medical Examiners guidelines relating to code of conduct for independent medical examination providers. The rules may be consistent with the code of conduct adopted by the Oregon Independent Medical Examination Association. (HB 2943)

656.005 (12)(b)(B) and 656.245 (2)(b)(B) Excludes an emergency room physician from the definition of an attending physician when the physician refers the worker to a primary care physician for follow-up care. Allowed the emergency room physician to authorize time-loss benefits for a maximum of 14 days. If a physician treats patients in an emergency room but also maintains an independent practice, the physician could act as the worker's attending physician if he or she otherwise qualifies to be an attending physician and also provides the follow-up care to the injured worker. (SB 504)

656.260 Removed the requirement for the department to review and approve all individual treatment standards adopted by managed care organizations. (SB 563)

Indemnity Benefits

1991

656.214 (Note) Established the value for a degree of scheduled disability as 71 percent of the state average weekly wage, thus providing annual adjustments to the value of a scheduled degree. Established a tiered structure for calculating the value of a degree of unscheduled disability as a function of the state average weekly wage, thus providing annual adjustments to the value of an unscheduled degree and providing a structure that compensates the more severely injured at higher rates per degree of disability. (SB 732) (SB 757 in 2003 and HB 2408 in 2005 revised the PPD structure.)

1995

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

656. 214 (2) & (6) 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. (SB 369) (SB 757 in 2003 and HB 2408 in 2005 revised the PPD structure.)

1999

656.202, 656.204, and 656.206 Changed workers' compensation benefits for spouses and some children of fatally injured workers: increased remarriage allowance to 36 times the monthly benefit; eliminated reduction in benefits for children of deceased workers who had remarried; equalized benefits for PTD and fatal claims for beneficiaries in full-time education; and eliminated $5 weekly beneficiary payment for PTD claims. (HB 2022)

2001

656.210 (1) Raised the maximum temporary total disability benefit to 133 percent of the average weekly wage. (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 of 50 percent to 133 percent of the average weekly wage. (SB 757)

656.214 (3) Defined PPD awards in terms of impairment percentages rather than degrees. (SB 757)

2005

656.726 (4)(f)(E) and 656.214 (2)(a) Modified the evaluation of a worker's permanent disability benefits and impairment for purposes of workers' compensation benefits. (HB 2408)

Chapter 653, section 7, 2005 laws Directed the department to collect data and report to the Legislature on the impact of the changes in law from SB 757 and HB 2408 on permanent partial disability awards. (HB 2408)

656.206 (1) & (5) - (11) and 656.268 (1)(d) Provided increased permanent total disability benefits and protections for severely injured workers. Authorized administrative law judges to request medical arbiter examinations. Expanded the description of "gainful occupation" to adjust the worker's wage rate at the lesser of the poverty level for a family of three or 66 percent of the worker's average weekly wages. (SB 386)

2007

656.790 (2) Required the Management-Labor Advisory Committee to review permanent partial disability benefit amounts on a biennial basis and make recommendations to ensure the original policy goals continue to be met over time. (HB 2244)

Chapter 656, section 2, 2007 laws made permanent the partial disability benefit changes made by SB 757 in 2003 and HB 2408 in 2005 permanent.

Oregon Legislative Note: Required the Management-Labor Advisory Committee to conduct an interim study of the adequacy of death benefits in the workers' compensation system; report to the 75th Oregon Legislative Assembly is required by Jan. 31, 2009. (SB 835)

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) (Now 659A.043)

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 implemented 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 that 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) (Now 659A.043 and 659.046)

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)

2005

656.206 (7) & (8) Established eligibility for vocational benefits when PTD benefits are terminated. Required workers who have PTD benefits to attend vocational evaluations. (SB 386)

656.262 (6)(b)(E) and 656.622 (3) & (12) Modified the statutory purpose of the Reemployment Assistance Act to allow the Workers' Compensation Division to provide direct services through the Preferred Worker and Employer-at-Injury programs. (SB 119)

Disputes

1987

656.268 (4)(f) Provided for penalties if insurer claim closure actions were unreasonable. (HB 2900) (Now 656.268 (5)(d))

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 claim costs from loss experience, provided funding for these costs from the Reopened Claims Reserve. (HB 2900)

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

656.291 Required the board to establish an expedited claim service to resolve claims where compensability is not the issue and other conditions are met. (HB 2900)

656.298 (6) Changed de novo review by the Court of Appeals to substantial evidence review. The court is limited to reviewing matters of law. (HB 2900) (Now 656.298 (7))

656.388 (3) Required the board to establish a fee schedule 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. (SB 1197) (Now 656.262 (11))

656.268 Required the mandatory reconsideration of a disputed insurer notice of closure, or department determination order. (SB 1197)

656.268 (4)(g) Provided for an insurer penalty if the department's determination of permanent disability on reconsideration of an insurer notice of closure is greater than the insurer's award by 25 percent or more. (SB 1197) (Now 656.268 (5)(e))

656.268 (7) Required claim referral to medical arbiter if impairment findings are disputed. 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 referees and the board to apply the same standards for evaluation of disability as used by the department and insurers, but allowed 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 the performance of hearings administrative law judges. (SB 1197)

1991

656.386 Provided for a reasonable attorney fee when an attorney is instrumental in obtaining compensation for a claimant prior to a judge's decision. (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 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. Also subjected the director's decision regarding additional changes of attending physician and the director's decision to exclude from compensability any medical treatment that is unscientific or experimental to a contested case review. (SB 369)

656.260 (14)-(19) 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. Subjected issues other than these to a contested case hearing. (SB 369)

656.268 (4) Changed the appeal 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) & (2) Removed vocational assistance disputes from jurisdiction of hearings. Provided for dispute resolution on vocational assistance through nonadversarial procedures to the greatest extent possible. Mediated agreements are subject to reconsideration by the director, but not reviewed by any other forum. Appeals of director's orders go to contested case hearing before the director and then to 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) Provided for resolution of responsibility disputes by a private mediator. (SB 369)

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

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

656.319 (6) Authorized hearing for failure to process, or correctly process, a claim if the request for hearing was made within two years. (SB 369)

656.327 (1) & (2) Gave exclusive jurisdiction over all medical treatment disputes to the director, including treatment that the injured worker has received, is receiving, or will receive. 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. (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)

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. (HB 2971)

656.268 (6) Allowed only one reconsideration per claim closure; time frames for conducting the reconsideration begin when all parties request or waive reconsideration rights. (SB 118) (This had the effect of undoing the Guardado v. J.R. Simplot Company decision.)

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 worker 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 using the administrative law judges of several agencies. Appeals of the department's administrative orders (contested case hearings) are sent to this panel. Board orders and nonsubjectivity determinations are excluded from this change. (HB 2525) (HB 2091 changed this in 2005.)

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

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)(A) Allowed for a deposition arranged by the worker to be included as 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 insurer pays the cost. (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 that the rules for the board's own-motion process apply to 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 independent medical exam with which the attending physician disagreed. The insurer pays the costs of the exam. (SB 485) (Now 656.325 (1)(e))

2003

656.262 (15) 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 employer or insurer. In such cases, penalties for untimely claim denial cannot be imposed. (SB 63)

656.268 (5) & (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 may be more than one responsible employer or insurer. 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)

656.726 (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 non-subjectivity determination from 30 days to 60 days. (SB 233)

2005

656.054 (4), 656.170 (3), 656.245 (1)-(3), 656.247 (3)(a), 656.248 (12), 656.254 (3), 656.260 (6) & (16)-(18), 656.262 (11)(a), 656.283 (1) & (2)(c),

656.327 (1)(a) & (2), 656.385 (1)-(5), 656.440 (1)-(3), 656.704 (1)-(5), 656.726 (4)(a), and 183.635 (3) Transferred the responsibility for appeals of director's administrative review cases (primarily on medical, vocational, and some penalty issues) from the Office of Administrative Hearings to the Hearings Division of the Workers' Compensation Board. (HB 2091)

656.267 (2)(b), 656.278 (4), and 656.298 (1) Clarified that regardless of when the worker makes a claim for an omitted or new medical condition, if the claim is denied, the worker may request a hearing on the denial. Clarified that if a worker's claim for a new or omitted condition is compensable, but was made more than five years after the first closure of the claim, the claim is to be processed under the jurisdiction of the board. Provided that any party can appeal an own-motion order from the board. Established hearing rights for orders issued under own-motion authority of Workers' Compensation Board. (HB 2294)

656.268 (5)(e) Eliminated penalties assessed against an insurer or self-insured employer if information used during the reconsideration of a closure was not reasonably known at the time of claim closure. (HB 2404)

656.283 (4) & (5) Required that the board give at least 60 days notice of a scheduled hearing, with some exceptions. Postponements are to be rescheduled within 120 days of the original hearing date, with the exception of multiple employer/insurer responsibility cases. (HB 2717)

656.319 (7) Required that the appeal of the rescission of PTD benefits be made within 60 days of the issuance of the notice of closure. (SB 386)

2007

656.236 Allowed the administrative law judge who mediates a workers' compensation claim disposition agreement to approve the agreement. (SB 253)

656.386 (2)(d) Allowed for payment of reasonable costs for records, expert opinions, and witness fees associated with appealing a workers' compensation claim if the claimant prevails. The bill caps reimbursement for reasonable costs at $1,500 unless the claimant demonstrates extraordinary circumstances justifying payment of a greater amount. (SB 404)

656.388 (3) Allowed an attorney who represents an injured worker a lien for recovery of fees out of additional awarded compensation or the proceeds of a claim settlement if the worker signs an attorney fee agreement for representation and the attorney was instrumental in obtaining the outcome of the claim. (SB 404)

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) (HB 3318 increased this to $1,500 in 2005, and SB 762 indexed it to medical inflation in 2007.)

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

656.622 (8) Extended from two years to three years from hire the exclusion from ratemaking for the preferred worker claim costs arising from injury or occupational disease; changed the program to a premium exemption program. (SB 1197) (Now 656.622 (10))

656.730 (1)(a) Mandated a tiered rating scheme for insured 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)

737.602 Allowed 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 the 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 the 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 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 would end Jan. 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)

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

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

2001

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

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

2003

656.407 (2) & (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)

2005

656.430 (13) Authorized public utilities with more than $500 million in assets to obtain workers' compensation excess insurance coverage from eligible surplus lines insurers. (HB 2718)

656.262 (5) Increased the amount an employer may pay for medical services for nondisabling workers' compensation claims from $500 to $1,500. (HB 3318)

2007

737.322 (1) Allowed a surcharge on assigned risk plan members, if necessary, to help pay the costs of assigned risk pool losses when the losses exceed premiums. (HB 2250)

656.427(2) Extended the notice requirement to an employer from 30 days to 45 days when an insurer terminates the employer's workers' compensation insurance. Notice was shortened to 10 days in the event of nonpayment of premiums. (HB 2783)

656.427(1) Removes the requirement that employers and insurers provide proof of workers' compensation coverage by filing a guaranty contract with DCBS and instead requires the insurer to provide insurance policy information to DCBS as the proof of workers' compensation coverage. The bill streamlines reporting requirements for insurers and eliminates an unnecessary duplicate filing with the state. (Operative July 1, 2009) (SB 559)

656.262(5) Required the department to annually set the amount of nondisabling medical costs that an employer can voluntarily pay to minimize impact on the employer's experience rating. The threshold amount is based on the change in the medical services consumer price index, rounded to the nearest $100. (SB 762)

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 the 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)

2005

656.605 (1)(g) Provided that insurers and self-insured employers be reimbursed from the Workers' Benefit Fund for permanent total benefits paid on appeal if the insurer's decision is upheld. (SB 386)

656.313 (1)(a)(D) and 656.605 (2)(g) Provided that insurers and self-insured employers be reimbursed from the Workers' Benefit Fund when a denial of vocational benefits is upheld by a final order. (SB 119)

Appendix 2 - Workers' Compensation Court Cases

A number of appellate decisions have modified the legislative reform of the workers' compensation system. Some of the major decisions since 1991 are as follows:

1991

Robertson, 43 Van Natta 1505 (1991) The Court of Appeals ruled that "objective findings" did 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. (In 1995, SB 369 reversed this decision by requiring that objective 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. (In 1995, SB 369 reversed the effect of the decision 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. (In 1995, SB 369 reversed the effect of the decision.)

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 statute to treatment the claimant is receiving; therefore, disputes over proposed treatments must be decided at the Hearings Division. (In 1995, SB 369 reverseed the effect of the decision 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. (In 1995, SB 369 reversed the effect of the decision.)

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. (In 1995, SB 369 reversed the effect of the decision.)

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

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. (In 1995, SB 369 reversed the effect of the decision.)

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

Messmer v. Delux Cabinet Works, 130 Or App 254 (1994) The Court of Appeals ruled that the failure to appeal a determination order barred 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 decision was issued (see below), and the 1997 Legislature passed new language in HB 2971.)

1995

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 found to be compensable under workers' compensation law. Employers' immunity from civil suits only extends to injuries compensated through the workers' compensation system. Thus, workers whose claims are work-related but not compensable are not precluded from pursuing civil actions. (In 1995, SB 369 reversed the effect of the decision. In 2001, the decision in Smothers v. Gresham Transfer, Inc. modified the effects of SB 369.)

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" included requests to reopen a previously closed claim; thus, there may be multiple 30-day periods for a single injury.

Welliver Welding Works v. Farmen, 133 Or App 203 (1995) The Court of Appeals held that the Legislature had intended vocational assistance eligibility decisions to 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. (HB 2971, passed by the 1997 Legislature, reversed the effect of the decision.)

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 Health 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 directors' review, not the board. Because there was 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 as well as 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 an independent 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) applied to all claims. The statute states that attending physicians cannot authorize the payment of temporary disability benefits more than 14 days retroactively. 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 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 were unconstitutional. When a workers' compensation claim is denied for failure to prove 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 2001 Legislature, in SB 485, set out the process for these actions.)

2002

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 the occupational illness had to be verified at some time, not necessarily at the time of the exam.

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 during the reconsideration process, the claimant had not exhausted his administrative remedies at reconsideration; therefore, he could not pursue the matter on appeal.

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 administrative law judge's 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

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 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 decision of the Court of Appeals.

Kahn v. Providence Health Plan, 335 Or 460 (2003) The Supreme Court stated that ORS 656.260(8) precludes an injured worker from bringing an action for damages arising out of a managed care organization's conclusion that a proposed medical treatment is unnecessary. The MCO's conclusion had come out of its utilization review process. The circuit court had not decided the case on that ground, so the high court remanded the case.

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.

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 no longer the major contributing cause for the need for treatment. The court agreed with the claimant that the insurer must first accept a combined condition claim before the combined condition could be denied.

2004

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 basic functional capacity at hearing. The functional capacity was used in part to determine his PPD award. The Supreme Court said 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 was 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 during the reconsideration process.

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 involved 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, but not while a contractor. This decision reversed the ruling by the Court of Appeals.

Vsetacka v. Safeway, 337 Or 502 (2004) The Supreme Court found that ORS 656.265 does not explicitly require a formalistic injury notice. Rather, it requires injured workers to include enough information so the employer knows there may be a compensable injury. In this case, the claimant's three written entries in the employer's injury log were sufficient.

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 pre-existing degenerative condition. Therefore, the degenerative condition was excluded from the determination of whether the accepted condition was the major contributing cause of 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 effective date was later than the acceptance effective date. It said this practice was consistent with ORS 656.262(6)(c), which contains the phrase "… later denying the combined … condition."

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.

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 within 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, which held that the claimant's occupational disease claim for hearing loss was not void because neither of the events (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.

2005

Lewis v. Cigna, 339 Or 342 (2005) The Supreme Court ruled that a claim could not be denied because the worker refused to submit to an insurer-requested independent medical exam. The justices determined that the Legislature intended to limit sanctions in such cases to the suspension of benefits.

Morales v. SAIF, 339 Or 574 (2005) The Supreme Court determined that SAIF could reduce the time-loss rate because the worker was released to modified work, even though he couldn't actually return because he'd been terminated for violating work rules. The court found that the employer had satisfied the requirements of ORS 656.325(5) by creating a modified job to accommodate the worker and by implementing a written policy of offering modified jobs.

Managed Healthcare Northwest v. DCBS, 338 Or 92 (2005) In this case, the issue was a rule prohibiting managed care organizations from using past practices as a basis to deny authorization of non-member physicians from treating subject workers. The Supreme Court found that the rule did not exceed agency authority, nor did it conflict with statute or policy.

SAIF v. Drury, 202 Or App 14 (2005) The Court of Appeals held that a worker's self-reported symptoms of cold intolerance constituted objective findings to support a permanent disability award. The court stated that the indications did not need to actually be verified, they only needed to be verifiable.

Dedera v. Raytheon Engineers & Constrs, 200 Or App 1 (2005) The Court of Appeals held that an ongoing time-loss authorization by a worker's prior attending physician continues when there is a change in attending physician. The insurer is not entitled to terminate time loss for that reason.

Ainsworth v. SAIF, 202 Or App 708 (2005) The Court of Appeals held that OAR 436-035-0390(12) exceeded the director's authority. It precluded an unscheduled disability for psychiatric disability because the claimant had also incurred brain damage from the injury. The court decided that the rule failed to provide compensation for all of the injury-caused disability.

Allied Waste Industries v. Crawford, 203 Or App 512 (2005) To determine the major contributing cause when an otherwise compensable injury combines with a pre-existing condition, the Court of Appeals ruled that the contributions of each cause, including the precipitating cause, must be weighed.

2006

Roberts v. SAIF, 341 Or 48 (2006) The Supreme Court held that a worker's injury, which occurred while he was riding a motorcycle on his employer's car lot, was not compensable because he was injured while performing a recreational or social activity primarily for personal pleasure. The worker had stipulated that motorcycle riding served no business purpose and that the employer gained no benefit from it.

Merle West Medical Center v. Parker, 207 Or App 24 (2006) The Court of Appeals set aside a carrier's denial of the claimant's aggravation claim for a bilateral wrist condition. The court reasoned that the claimant's attending physician's opinion, which was based on the claimant's reports of her symptoms and the physician's medical knowledge, was sufficient to establish that the worsening of her compensable wrist condition was supported by objective findings.

Multnomah County v. Obie, 207 Or App 482 (2006) The Court of Appeals affirmed the board's finding that a pre-existing chronic depression was not a "pre-existing condition" under ORS 656.005(24)(a). The insurer contended that the claimant's "vulnerability" was a pre-existing condition, and it was not excluded for disease claims. The court found that the 2001 Legislature's intent was to eliminate predisposition as a pre-existing condition in both injury and disease claims.

United Airlines v. Anderson, 207 Or App 493 (2006) The Court of Appeals agreed that the claimant's time-loss rate should be based on her "at-injury" wage, which was increased retroactively in a bargaining agreement that occurred after the injury.

Karjalainen v. Curtis Johnson & Pennywise, Inc., 208 Or App 674 (2006) The court held that, for the purpose of determining a pre-existing condition, "arthritis or an arthritic condition" refers to joint inflammation. The interpretation of the statutory phrase is a matter of law, so this inexact term must be given its common, ordinary meaning; it should not be based on case-by-case medical opinion. (ORS 656.005(24) requires pre-existing conditions, except arthritis, be previously diagnosed or treated if the combined condition is to be compensable.)

2008

Sisco v. Quicker-Recovery, 218 Or App 376 (2008) The court held that the claimant's injury, which occurred when he resisted a police officer's request to exit his employer's tow truck, was compensable. The court reasoned that the worker's interaction with the police officer related to the method of performing the ultimate work, so the injury occurred "in the course of" his employment. The "arising out of" prong of the compensability question was satisfied because his work environment exposed him to the risk of the interaction with police, and the motivation for his conduct originated, at least partly, from the workplace.

SAIF v. Sprague, 221 Or App 413 (2008) The court found that a compensable knee injury was a material cause of the need for weight-loss surgery. The board did not need to determine whether the compensable injury caused his obesity. Earlier, the court had ruled that a noncompensable condition is compensable if its treatment is necessary to the treatment of the compensable injury or any compensable consequential conditions.

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Information Management Division
350 Winter St. NE, Room 300
P.O. Box 14480
Salem, Oregon 97309-0405
503-378-8254