Oregon Department of Consumer and Business Services

2014 Report on the Oregon Workers' Compensation System

Workers' Compensation
CELEBRATING
100
YEARS OF SERVICE

Twelfth Edition
January 2015

2014 Report on the Oregon Workers' Compensation System

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You may find more information relevant to the Oregon workers' compensation system at the following sites:

DCBS main page: dcbs.oregon.gov

Office of the Director: oregon.gov/DCBS/DIR/

Workers' Compensation Division: wcd.oregon.gov

Occupational Safety and Health Division: osha.oregon.gov

Workers' Compensation Board: wcb.oregon.gov

Insurance Division: insurance.oregon.gov

Ombudsman for Injured Workers: oregon.gov/DCBS/OIW/

Ombudsman for Small Business: oregon.gov/DCBS/SBO/

Information Technology and Research Section: www4.cbs.state.or.us/ex/imd/external/

Management-Labor Advisory Committee: www.oregon.gov/DCBS/MLAC/

Introduction

July 1, 2014, marked the 100th anniversary of the Oregon workers' compensation system. The 1913 Oregon Legislative Assembly passed the state's 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.

This report describes Oregon's workers' compensation system and documents the effects of the Legislature's more recent legislative changes. This report updates the previous report released in September 2012, adding statutory changes adopted during the 2013 and 2014 legislative sessions, 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.

As measured by the Bureau of Labor Statistics' employer survey, the Oregon total-cases incidence rate was 4.1 cases per 100 full-time workers in 2013 – a 63 percent drop from the 1988 rate. The safety and health chapter contains more safety data and discussion of the ways Oregon OSHA helps keep claims rates low.

The medical chapter includes a discussion of research studies about the role of various care providers in the workers' compensation system. A number of new medical fee schedules are aimed at holding costs down and simplifying the way costs are determined. Fee schedules now cover ambulatory surgery centers; durable medical equipment, prosthetics, orthotics, and supplies; and interpreter services.

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. Return-to-work programs are currently used at a higher rate, 23 percent of accepted disabling claims, than in any previously studied period.

Finally, as discussed in the insurance chapter, Oregon has one of the nation's least expensive workers' compensation systems. The Department of Consumer and Business Services conducts a study every two years comparing the premium rates for its major industries to the premium rates in other states. Based on this methodology, Oregon's rates in 2014 were 26 percent below the national median, and ranked 43rd out of 51 jurisdictions. This means Oregon's premium rates are the ninth lowest in the nation. Because of the system's successes, such as declining injury rates and workers getting back to work earlier, cumulative rate decreases have lowered workers' compensation pure premium rates by more than 66 percent since 1990. The 2015 pure premium rate is about 34 percent of the 1990 rate.

Department of Consumer and Business Services

OUR MISSION

The Department of Consumer and Business Services' mission is to protect and serve Oregon's consumers and workers while supporting a positive business climate in the state.

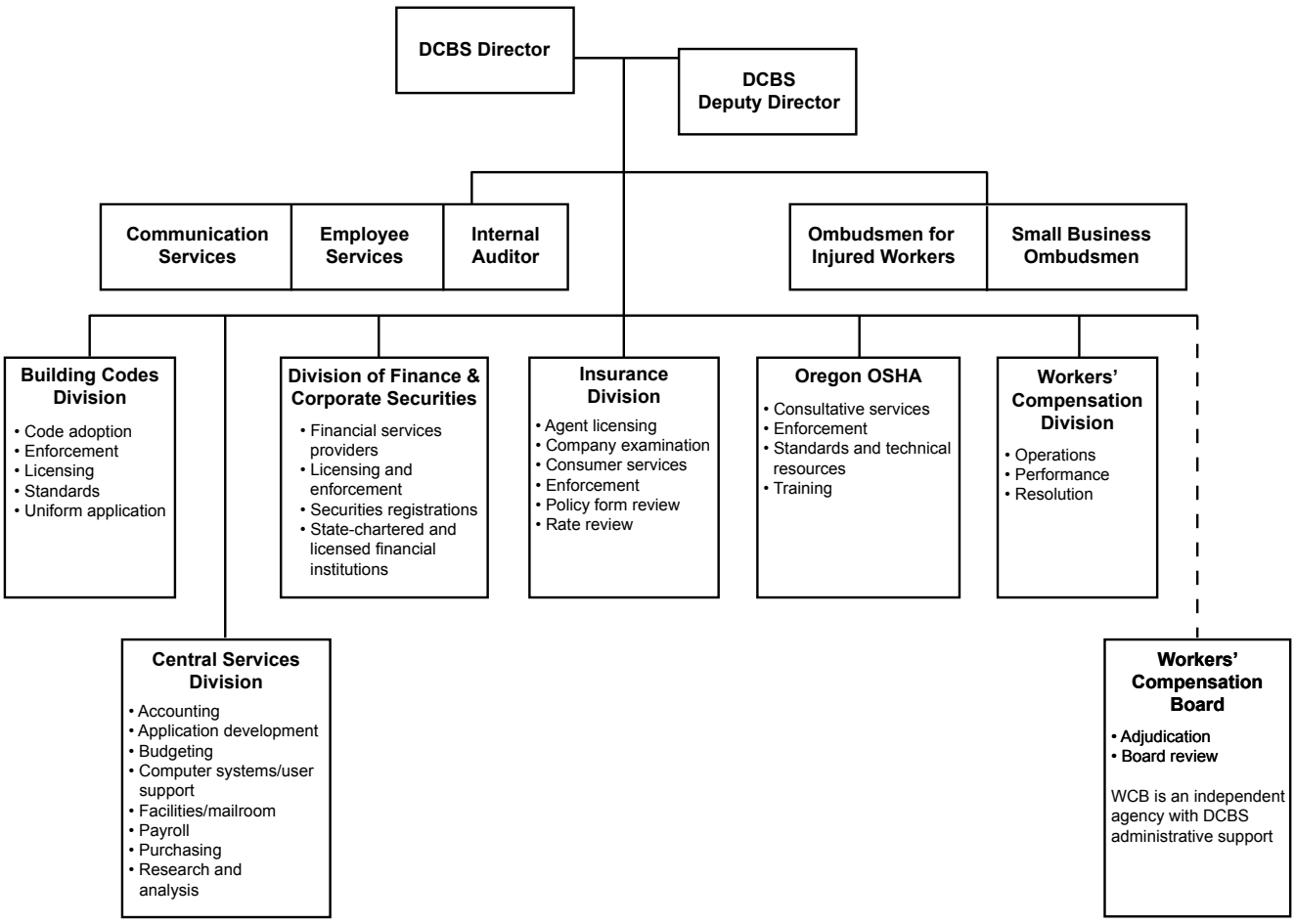
WHAT WE DO

DCBS is Oregon's largest business regulatory and consumer protection agency. The department administers state laws and rules and protects consumers and workers in the areas of workers' compensation; occupational safety and health; financial products, services, and institutions; insurance; and building codes.

OUR GOALS

- ✓ Protect consumers and workers in Oregon
- ✓ Regulate in a manner that supports a positive business climate
- ✓ 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 nonhazardous 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.

Period of major reform: 1987-1995

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, created 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 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 only to 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.

Several years later, the 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 reforms affected the costs of the workers' compensation system and the benefits paid to injured workers. A team of leading workers' compensation researchers conducted the study and released their 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.

Reform since 1995

The most significant changes to Oregon's workers' compensation system since 1995 were the reforms to the permanent partial disability (PPD) award system in 2003-2007. Although there have been many other important court decisions and legislative changes, the effect has been one of overall system stability. The major legislation and court decisions, including the PPD reform bills, are described below.

The changes made by the 1997 and 1999 legislatures limited the department's functions and expanded 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.

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 bill was created partly in response to another Oregon Supreme 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. Although the Legislature was concerned that the Smothers decision would have a significant effect on the costs of the system, the effect of the Smothers decision has been negligible. There have no known cases in which workers have prevailed at trial.

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 significantly changed the permanent partial disability award structure for workers injured after Jan. 1, 2005. The new structure in SB 757 simplified the rating system and provided larger awards to injured workers who are unable to return to work. The benefit award structure was designed to avoid increased total costs to the workers' compensation system; this resulted in lowering the benefits to some workers who do return to work.

The Legislature revised SB 757 by enacting HB 2408 in 2005. This bill provided that when a worker is ready to return to regular work, the worker receives only impairment benefits, not work disability benefits. The law applies to claims with dates of injury on or after Jan. 1, 2006. These changes were made permanent in 2007.

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 benefits; 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.

The 2007 Legislature passed HB 2756, which expanded the authority of chiropractors, podiatrists, naturopaths, and physician assistants to act as attending physicians and authorize temporary disability and manage the worker's return to work for up to 30 days.

A streamlining measure, SB 559 (effective July 1, 2009) simplified proof of coverage for insurers and employers. It removed the requirement for guaranty contract filing, instead requiring the insurer to provide policy information to the department as proof of coverage.

Also in 2007, 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. The result of that report was SB110 – passed in 2009 – expanded death benefits in the workers' compensation system.

Several bills that affected health and safety also passed through the 2007 Legislature. HB 2022 mandated data collection on assaults to health care employees. HB 2222 removed specific safety committee requirements from statute that exempted certain employers and gave 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.

The 2009 Legislature passed HB 2420, which added 12 conditions, including a variety of cancers, to the existing presumption for employment-caused occupational diseases of non-volunteer firefighters who have completed five or more years of employment. Denial of the claim for any condition or impairment must be on the basis of clear and convincing medical evidence that the condition was not caused or contributed to by the firefighter's employment. The first diagnosis by a physician must occur after July 1, 2009.

HB 2815 created the Interagency Compliance Network, charging state agencies with working to establish consistency in agency determinations relating to the classification of workers, including the classification of workers as independent contractors. Agencies sharing information should ensure that workers and employers comply with laws relating to taxation or employment, including workers' compensation law. HB 2197 clarified the period that the medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker, and restored chiropractors' ability to make impairment findings if they are serving as the attending physician at the time of claim closure.

SB 110 improved the benefits to beneficiaries when a worker is killed on the job or dies while permanently and totally disabled from a work injury. If a worker dies before his or her permanent partial disability award is fully paid, the insurer must pay the full remainder of the permanent disability benefit to the worker's estate.

The 2009 Legislature also passed bills that affected return-to-work assistance. HB 2195 replaced certification with a registry for vocational assistance provider organizations; allowed insurers or self-insured employers to voluntarily extend the payment of temporary disability compensation to 21 months; and modified the vocational assistance dispute resolution process. HB 2705 allowed insurers and self-insured employers to forego a vocational evaluation if the worker is released for regular work but has not returned to work. HB 2197 clarified the duration of premium assessment exemption for preferred workers.

Two bills passed the 2009 Legislature that affected disputes. HB 2197 allowed the parties to resolve medical fee disputes informally without requesting an administrative review by the director. HB 3345 provided attorney fees in circumstances in which workers' attorneys were not compensated for services; increased statutory caps on claimant attorney fees and tied an annual increase in the caps to changes in the state average weekly wage; and allowed for penalties when an insurer or self-insured employer does not respond within 14 days to a claimant request for a claim reclassification.

During the 2011 legislative session, the Legislature passed two bills affecting the medical system. HB 2093 gave DCBS the ability to take administrative action against a person or company that is actively managing the care of workers when that person or company is not certified as a managed care organization. The department can address these violations by imposing civil penalties and issuing cease-and-desist orders. The bill also provides a process for the person or company to appeal the department's action. The second bill, HB 2743, gave podiatric physicians and surgeons the ability to serve as attending physicians without limitation.

The Legislature also passed two bills affecting the dispute process. HB 2094 allows a delay of the reconsideration process for up to 45 days when both parties are actively engaged in settlement negotiations and agree to delay the process. This gives the parties more time to reach an agreement, without limiting the department's time to complete the reconsideration process if the negotiations are not successful. SB 173 allows a worker to agree to settle unpaid medical bills related to the claimed condition as part of the disputed claim settlement process. The worker can pay a higher reimbursement rate for unpaid medical bills directly out of the settlement. If the worker does this, SB 173 requires medical providers to accept this as payment in full; providers cannot bill the worker for any charges that exceed the workers' compensation medical fee schedule.

The 2011 Legislature passed HB 3490. This bill clarified coverage responsibility in situations when a county requests the services of another county's volunteers or the volunteers themselves offer their services in an emergency. The bill maintained the requirement for mandatory election of coverage for the otherwise nonsubject volunteers, but clarified which county must provide the coverage.

In 2013, the Legislature extended to 180 days the authority for authorized nurse practitioners to treat and authorize time-loss (wage replacement) benefits. It also allowed an injured worker enrolled in a managed care organization (MCO) to be treated by a non-MCO-paneled chiropractor under specified circumstances that focus on a current patient-provider relationship.

The 2013 Legislature also clarified that workers' compensation exclusive remedy protections, which generally prohibit an employer from being sued for work-related injuries or illnesses, did not apply to limited liability corporation members that employed an injured worker because the statute did not explicitly include those entities. It also clarified that exclusive remedy can be negated when an employer's negligence is a substantial factor in causing the injury or illness and occurs outside of the employer's capacity.

In 2014, the Legislature provided a means for employers to make an orderly exit from group self-insurance by requiring a one-time vote to exit such coverage and, in doing so, limiting the future joint and several liabilities of group members. The measure also imposes higher standards for self-insured groups that choose to continue to operate and also expands regulatory authority over groups that have decertified or will do so in the future to ensure that workers receive benefits to which they are entitled.

2014 Report Highlights

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

- The U.S. Bureau of Labor Statistics uses an employer survey to estimate injury and illness frequencies. In 2013, the Oregon total-cases incidence rate was 4.1 cases per 100 full-time workers. In general, incidence rates have been declining. The 2013 total-cases rate is 32 percent lower than the 2002 rate.
- In 2013, the accepted disabling claims rate (the number of compensable disabling claims per 100 workers) was 1.1, 30 percent below the 2000 figure.

Oregon OSHA provides workplace consultations and inspections.

- Oregon OSHA staff provided 2,546 consultations in 2013. These consultations help employers identify hazards that could lead to workplace injuries or illnesses.
- There were 4,192 Oregon OSHA inspections in federal fiscal year 2013. No violations were found in 31.5 percent of the inspections.
- 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 2013, 168 Oregon companies from diverse industries had been certified as SHARP employers

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

- The denial rate of disabling claims was 14 percent in fiscal year 2014; this figure has been nearly constant over the past nine years. The denial rate of disabling occupational disease claims was 36 percent.
- Insurers made timely compensability decisions 94 percent of the time, and timely first benefit payments 90 percent of the time in 2013.

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 8,500 inquiries to the office in 2013. 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 had 792 inquiries in 2013.
- The Workers' Compensation Division has a telephone information line for workers, employers, insurers, medical providers, attorneys, legislators, and others. In 2013, there were more than 6,600 calls to the information line.

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

- During federal fiscal year 2013, Oregon OSHA issued 2,873 citations against employers with $1.8 million in penalties for workplace violations.
- In 2013, WCD issued 1,290 citations against insurers for failing to meet requirements for payment of compensation, claim acceptance or denial, and claim closure. The penalties totaled about $756,000.

Injured workers with disabling claims receive indemnity benefits, such as temporary disability payments and permanent disability awards, and medical services.

- The total amount paid for indemnity benefits peaked in 2009. With the recession, there were fewer injured workers, so the indemnity amounts fell in the years 2010 to 2012.
- About 46 percent of paid benefits in 2013 were indemnity benefits; in contrast, in 1995, 58 percent of benefits were indemnity benefits.
- In 2013, 40 percent of indemnity benefits for accepted disabling claims were temporary disability benefits, 18 percent were permanent partial disability benefits, and 31 percent were settlements.

- In 2013, the average duration of temporary disability was 73 days. Over the past five years, the average has fluctuated between 70 and 77 days.
- In 2013, an estimated $317 million was paid for workers' compensation medical services. The three largest service categories were physical medicine, evaluation and management, and inpatient facility fees.
- Injured workers are not usually enrolled in managed care organizations until their claims are accepted. In 2013, 45 percent of injured workers with accepted disabling claims were enrolled in MCOs. SAIF enrolled 67 percent of its injured workers, private insurers enrolled 7 percent of their injured workers, and self-insured employers enrolled 43 percent.

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 June 2014, 21 percent of the workers issued cards in 2011 had used them to gain employment. Workers who used Preferred Worker benefits have employment rates that are up to 42 percentage points higher than those who did not use their benefits.
- Use of the Employer-at-Injury Program, which provides benefits to employers who quickly return their injured employees to work, has had strong growth. More than 9,000 workers used the program in 2013.
- Oregon's traditional vocational assistance program was scaled back in 1987. In 2013, 63 workers returned to work after completing vocational assistance. 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 2013, the Workers' Compensation Division and the Workers' Compensation Board (WCB) resolved nearly 14,000 disputes through orders, stipulations, agreements, and mediation. WCD resolves disputes involving claims closure and awards, medical issues and payment, vocational disputes, and similar issues. WCB has jurisdiction on insurer claim denials and certain claims-processing issues. It also hears appeals of WCD's administrative review cases.

- In 2013, 15 percent of claim closures were appealed for reconsideration. More than 2,800 reconsideration orders were written; 18 percent of these orders were appealed to the WCB Hearings Division.
- WCD resolved 2,227 medical disputes in 2013; 66 percent were medical disputes between practitioners and insurers.
- WCD resolved 178 vocational disputes in 2013. Of these cases, 26 percent were resolved through agreements. Another 48 percent of the disputes were dismissed, often because vocational assistance benefits were released in claim disposition agreements.
- In 2013, there were 7,581 hearing requests to the WCB Hearings Division. There were an additional 426 requests for WCB board review. The number of requests has been falling as the number of claims has declined.
- WCB approved 3,025 claims disposition agreements in 2013. The amount paid to workers and their attorneys totaled $61.4 million. WCB also approved 3,578 disputed claims settlements in the amount of $34.4 million. Insurers paid their attorneys about $34.2 million in 2013 to defend their actions before WCB and WCD. Another $20.7 million was paid to claimant attorneys from workers' compensation disputes. Seventy percent of the money paid to claimant attorneys came from claim disposition agreements and disputed claim settlements.

The Oregon workers' compensation insurance market has been growing in recent years.

- Workers' compensation total system written premiums in Oregon totaled $880.1 million for 2013, up 21 percent from 2010.
- The insurance commissioner approved overall pure premium rate changes of minus 5.3 percent for 2015.
- SAIF Corporation's share of the market in 2013 was almost 50 percent. Private insurers' market share was 35 percent. Self-insured employer and employer groups had the remainder of the market, 16 percent.
- Oregon's assigned risk pool was 6.8 percent of the market in 2013. About 8,800 employers were in the pool.

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 has used an employer survey based on OSHA recordkeeping requirements to estimate occupational injury and illness frequencies. This survey provides valuable information about trends in workplace injuries. In Oregon, the total-cases incidence rate in the private sector, a measure of all workplace injuries and illnesses, was 11.1 cases per 100 full-time workers in 1988. It has fallen steadily since then and was 4.1 cases per 100 full-time workers in 2013.

Within the workers' compensation system, the accepted disabling claims rate is a measure similar to the incidence rate. Like the incidence rate, the accepted disabling claims rate has fallen significantly in the past two decades. It has declined from 3.8 accepted disabling claims per 100 workers in 1988 to 1.1 per 100 workers in 2013, a decrease of more than 70 percent.

The number of accepted disabling claims (ADCs) has fallen most years in most of the past two decades. An exception to the trend was the period between 2003 and 2007. Employment grew by 11 percent during this four-year period, and the number of ADCs increased by 7 percent. During the recent recession, however, workers' compensation covered employment fell by 8 percent between 2007 and 2010, and the number of ADCs declined more than 20 percent. Compensable

Figure 1. Accepted disabling claims and employment, 1987-2013

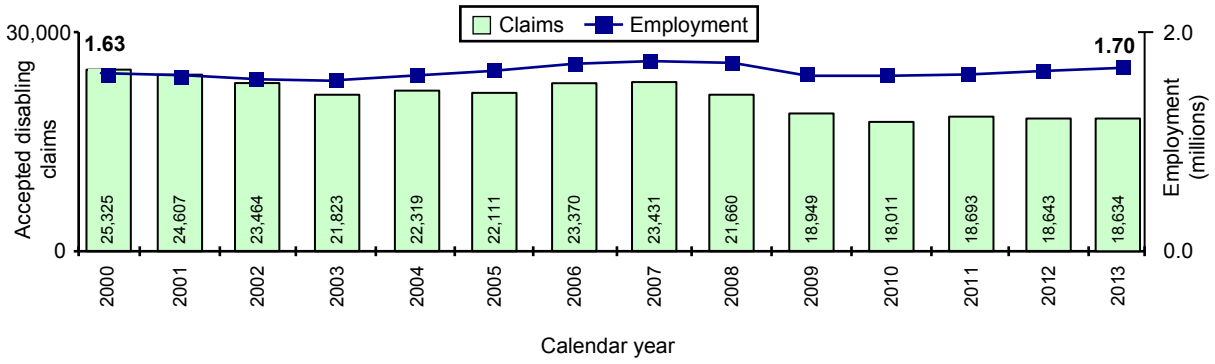
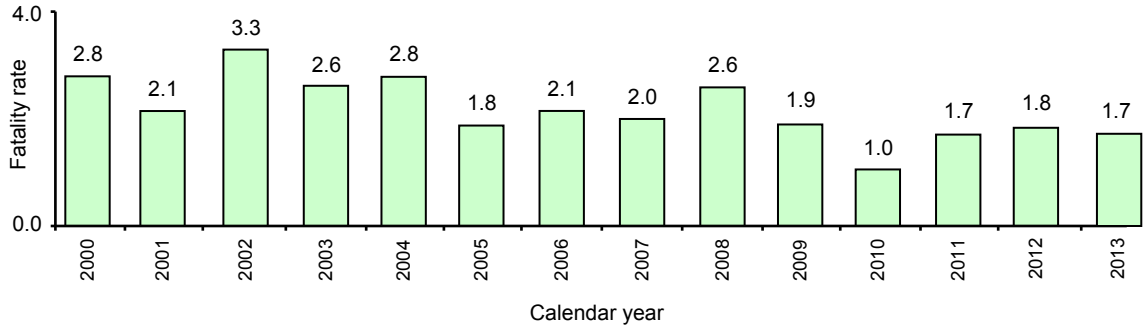


Figure 2. Compensable fatality rates per 100,000 workers, 2000-2013



fatalities have also declined over the years as well; the 29 deaths occurring in 2013 are the third fewest recorded.

Oregon's emphasis on workplace safety and health, legislative changes in the definition of compensability, changes in insurer claims-management practices, and the evolution of Oregon's economy during the past two decades have affected both claims volume and claims 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 center.

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 House Bill (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 Oregon OSHA uses 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, Senate Bill (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 and 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. Before 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 non-registration of farmworker camps be put into the account.

Voluntary Services/Outreach

Consultative services

Oregon OSHA staff members provided 2,546 consultations in 2013. 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.

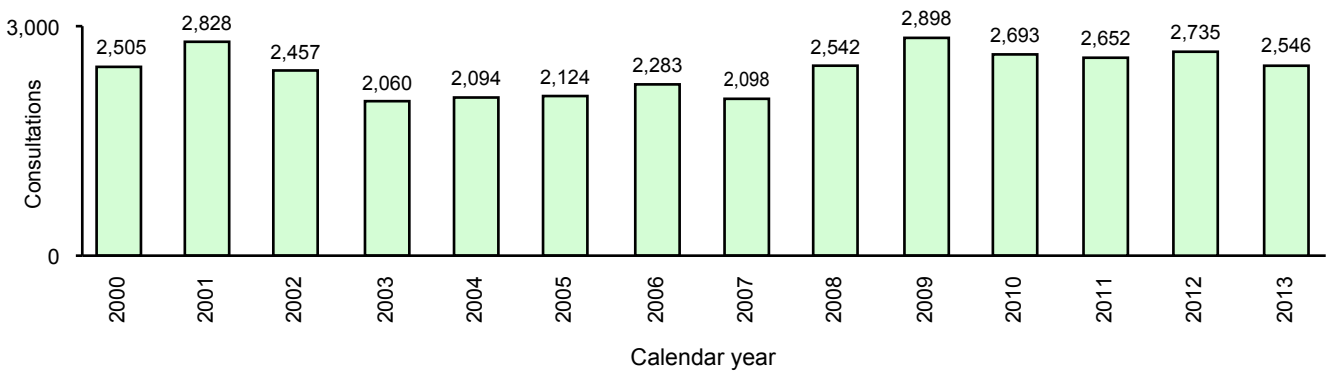
Safety and Health Achievement Recognition Program

The Safety and Health Achievement Recognition Program recognizes employers who reach specific benchmarks in managing their occupational safety and health program. SHARP provides employers assistance and tools for effectively 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 2013, the program had grown to 168 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 2013, there were 22 Oregon worksites participating in VPP.

Figure 3. Oregon OSHA consultations opened, 2000-2013



Oregon OSHA grants

Since 1990, Oregon OSHA has awarded nearly $2.9 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 English, Russian, and Spanish; 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.

In 2010, due to the severe revenue shortfall, the director of the Department of Consumer and Business Services accepted the recommendation of the Safe Employment Education and Training Advisory Committee (SEETAC) to suspend the training grants program for the remainder of that current biennium (through June 2011). The grant program remained suspended until it was recently reinstated in 2014.

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 2013 has reached nearly 385,000. 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 2013, in addition to the GOSH conference, there were six other conferences held around Oregon that addressed a variety of safety and health issues.

Oregon OSHA Resource Center: A one-stop source for workplace safety and health information

The Oregon OSHA Resource Center is the only library in Oregon that specializes in health and safety in the workplace. It is a public service The Oregon Department of Consumer and Business Services provides to Oregon employers and workers.

Videos and DVDs about workplace safety and health are available in the free lending library maintained by the Resource Center. Any employer or worker in Oregon may use the **video library**. The user's only cost will be for sending the item back to the Resource Center via a "trackable" carrier (USPS, etc.). This is a popular service with about 400 videos and DVDs going out each month.

The Resource Center carries a **full** selection of Oregon OSHA publications at its Labor and Industries Building location in Salem at 350 Winter St. NE. If you are not in the neighborhood, you can read or order copies **online** at http://www.orosha.org/standards/publications.html.

Books, journals, and consensus standards (NIOSH, ANSI, etc.) are available for use or review in the Resource Center.

Library topics include safety and health management, industrial hygiene, hazardous chemicals, occupational medicine, and ergonomics.

A skilled research librarian is available via **email** at osha.resource@state.or.us or by calling 800-922-2689 (toll-free) or 503-378-3272.

Partnerships with stakeholders

Oregon OSHA collaborates with groups, including business organizations and labor unions, to design better safety and health programs for workers. Many of the partnerships take the form of stakeholder advisory committees that help develop 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.

Oregon OSHA also participates as a member of O[yes] Oregon Young Employee Safety Coalition. The mission of O[yes] is to prevent young worker injuries and fatalities. O[yes] educates its constituency of young workers, educators, employers, parents, and labor and trade associations through outreach, advocacy, and sharing of resources.

Enforcement

Oregon OSHA inspections

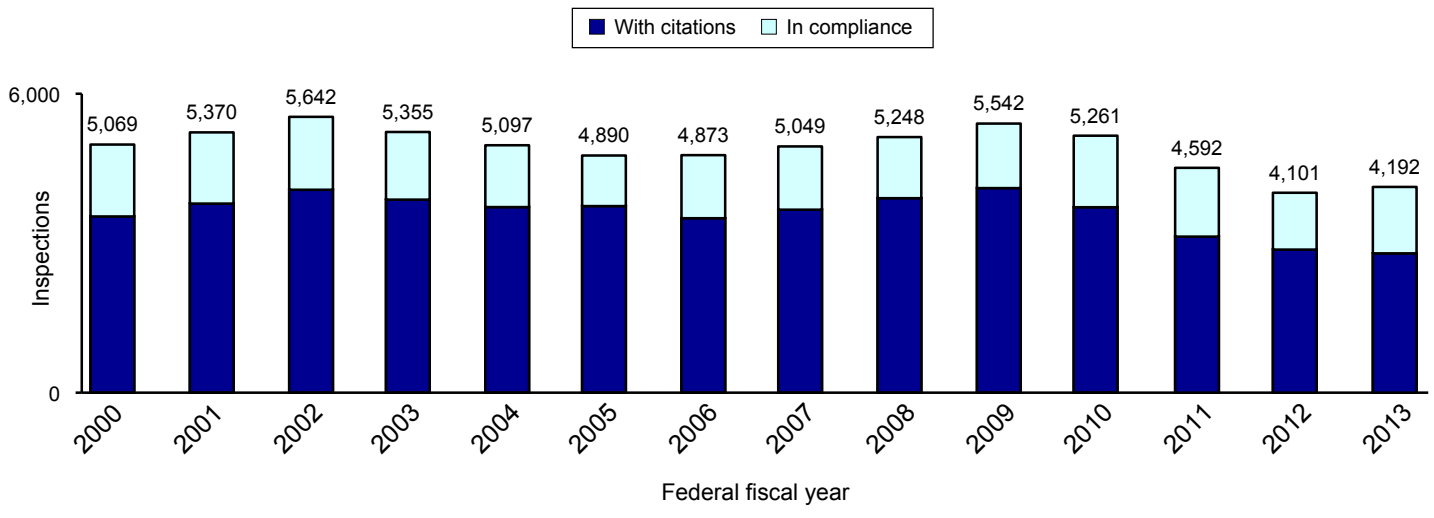
Oregon OSHA conducted 4,192 inspections in federal fiscal year 2013. More than 7,300 violations of safety and health standards were cited on 2,873 citations. Penalties assessed for these employer violations in federal fiscal year 2013 were $1.8 million, which is higher than the previous year.

Inspections at employer worksites in Oregon are based primarily on inspection targeting lists, complaints, accidents (including fatalities), and referrals. Sixty-two percent, about 2,600 inspections were initiated from several program-planned lists. Complaints received by Oregon OSHA about the safety or health conditions at Oregon worksites resulted in 873 inspections, 21 percent of the total. Accidents and fatalities at Oregon worksites resulted in 162 inspections, 4 percent of the total inspections, and approximately 13 percent were related to referrals, monitoring, follow-ups, and program-related activities.

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

Figure 4. Oregon OSHA inspections, 2000-2013



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.

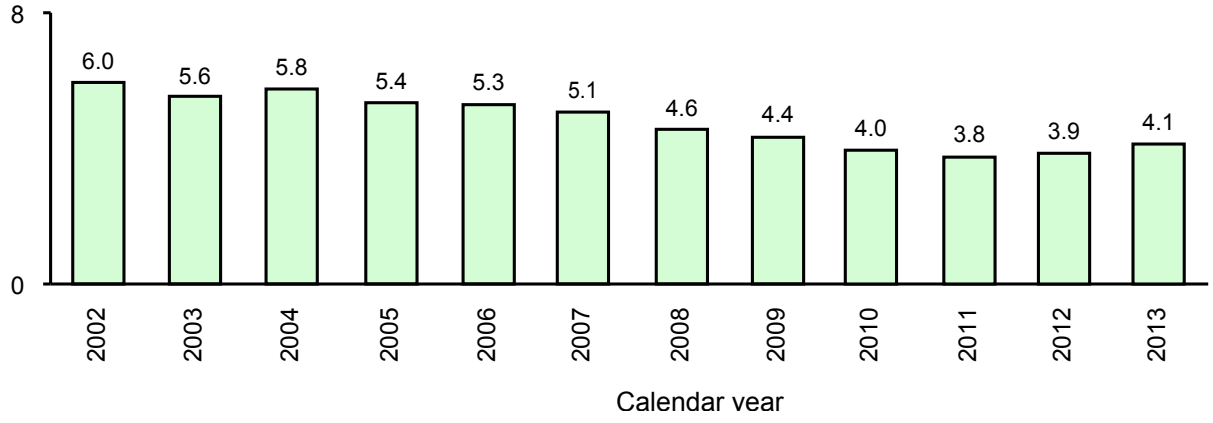
Customer service

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, 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 2013, nearly all (95 percent) rated their consultant as "good" or "excellent" in regard to helpfulness, expertise, timeliness, accuracy, availability of information, and overall service.

Figure 5. Total cases incidence rate per 100 workers (private sector)



Accepted disabling claims, employment, and claims rates, 1987-2013

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	25,325	1,627,600	1.6
2001	24,607	1,616,400	1.5
2002	23,464	1,596,100	1.5
2003	21,823	1,585,800	1.4
2004	22,319	1,630,500	1.4
2005	22,111	1,677,500	1.3
2006	23,370	1,734,400	1.3
2007	23,431	1,762,700	1.3
2008	21,660	1,746,200	1.2
2009	18,949	1,637,400	1.2
2010	18,011	1,623,300	1.1
2011	18,693	1,641,300	1.1
2012	18,643	1,664,000	1.1
2013	18,634	1,701,000	1.1

With the recession, employment declined by 7.9 percent and the number of ADCs declined by 23.1 percent between 2007 and 2010. With the recent slow employment growth, 4.8 percent between 2010 and 2013, the number of accepted disabling claims has been fairly constant.

The claims rate is the number of accepted disabling claims per 100 covered employees. The claims rate has fallen over time. The rate has been at record lows over the past four years, with 1.1 accepted disabling claim per 100 workers.

Note: Workers' compensation covered employment figures are based on data from the Employment Department.

Calendar Year 2013 figures are subject to revision.

Compensable fatalities, 1987-2013

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	2.8
2005	31	1.8
2006	37	2.1
2007	35	2.0
2008	45	2.6
2009	31	1.9
2010	17	1.0
2011	28	1.7
2012	30	1.8
2013	29	1.7

There were 29 compensable fatalities reported in 2013.

A large rise in yearly fatality counts can occur because of multiple-fatality incidents. For example, in 2008, one incident resulted in the deaths of eight Oregon workers.

Compensable fatalities are counted in the year they are reported, which will not necessarily correspond to the year of occurrence.

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

Occupational injuries and illnesses incidence rates, Oregon private sector, 1987-2013

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
2008	4.6	1.5	2.5
2009	4.4	1.4	2.3
2010	3.9	1.5	2.2
2011	3.8	1.3	2.1
2012	3.9	1.5	2.2
2013	4.1	1.4	2.2

These incidence rates are compiled from the Bureau of Labor Statistics' Occupational Injury and Illness Survey, and the data come from the employers' OSHA 300 Log. 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 for every 100 full-time employees. The cases-with-days-away-from-work incidence rate shows the cases that resulted in absences from work.

The DART rate is a broader measure that includes days away from work, restriction, or job transfer. The DART rate fell about 31 percent between 2002 and 2013.

Oregon OSHA inspections, federal fiscal years 1988-2013

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	163,807	18.8%
1992	5,739	206,170	17.7%
1993	5,613	245,929	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%
2008	5,248	221,994	23.7%
2009	5,542	212,372	24.0%
2010	5,261	132,245	27.3%
2011	4,592	105,395	29.5%
2012	4,101	127,109	28.6%
2013	4,192	101,955	31.5%

Inspections are classified in several ways. The broadest category identifies each inspection as either a safety inspection or a health inspection. In FFY 2013, 77.8 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 worksite is called "in compliance." The percentage of in-compliance inspections was 31.5 percent in FFY 2013.

Oregon OSHA citations, violations, and proposed penalties, federal fiscal years 1988-2013

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	11,805	2.4
2005	3,805	11,376	2.0
2006	3,595	10,020	2.4
2007	3,759	10,495	2.4
2008	4,004	10,623	2.5
2009	4,214	11,582	3.1
2010	3,825	10,311	1.7
2011	3,238	8,605	2.0
2012	2,928	7,676	1.7
2013	2,873	7,310	1.8

Oregon OSHA issues a citation to an employer when one or more violations of Oregon or federal standards are found during an inspection. The penalties listed here 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.

In recent years, there have been about 2.6 violations per citation. There has been an average of about one serious violation per citation.

Oregon OSHA consultations, 1988-2013

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	2,491	342,683	-	-
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	233,665	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	203,369	126	16
2008	2,542	209,525	142	23
2009	2,898	268,631	161	24
2010	2,693	159,280	196	27
2011	2,652	158,535	174	28
2012	2,739	160,727	163	27
2013	2,546	112,835	168	22

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. There have been more than 2,500 consultations each year since 2008.

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 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, 1998-2013

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	27,129
2006	22,751
2007	30,054
2008	19,754
2009	30,874
2010	18,580
2011	29,064
2012	23,212
2013	32,216

Oregon OSHA has provided education and training to thousands of workers and employers each year. These educational forums provide an opportunity to share ideas on occupational safety and health with national experts. The increases in attendance in odd-numbered years are due to the Governor's Occupational Safety and Health Conference. These conferences are coordinated and presented in partnership with businesses, associations, labor unions, etc.

In 2013, there were seven conferences held around Oregon. They addressed a variety of safety and health issues.

Oregon OSHA safety and health grant programs, 1989-2015

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
2007-2009	8	266,260
2009-2011	0	0
2011-2013	0	0
2013-2015	See the note.	

In existence since 1989, Oregon OSHA's Training and Education Grants program awarded 91 grants totaling nearly $2.9 million 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 was $40,000.

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.

Note: No funds were disbursed for several years when DCBS followed the Safe Employment Education and Training Advisory Committee (SEETAC) recommendation to suspend the program. The program was recently reinstated with the first round of funding closing in October 2014.

Compensability and Claims Processing

The Oregon workers' compensation system is a no-fault system. In other words, the compensability of a claim is not dependent upon demonstrating that the employer or worker was negligent. One purpose of a no-fault system is to promptly and fairly compensate injured workers for work-related claims.

Definition of compensability

When an injury or illness occurs and a claim is filed, the insurer's compensability decision controls whether the claim is covered within the system. An accepted disabling claim entitles the worker to medical services and disability or death benefits. An accepted nondisabling claim entitles the worker only to medical services.

The workers' compensation law governs the standards of compensability. The definition of a compensable claim was revised several times between 1987 and 1995. These revisions were partly responsible for the decrease in the number of accepted claims in the early 1990s. Details of the law changes can be found in the Compensability section of Appendix 1, Workers' Compensation Reform Legislation.

The 1999 Legislature allocated funds to study the effects of the compensability language changes on workers' compensation costs and worker benefits. The department contracted for a major study by leading academic researchers, which was completed in 2000. More detail on this study can be found in previous editions of this report (http://www4.cbs.state.or.us/ex/imd/external/reports/index.cfm?fuseaction=dir&ItemID=2000) or the study report itself (http://dcbs-reports.cbs.state.or.us/rpt/index.cfm?fuseaction=version_view&version_tk=175934&ProgID=CCRA024).

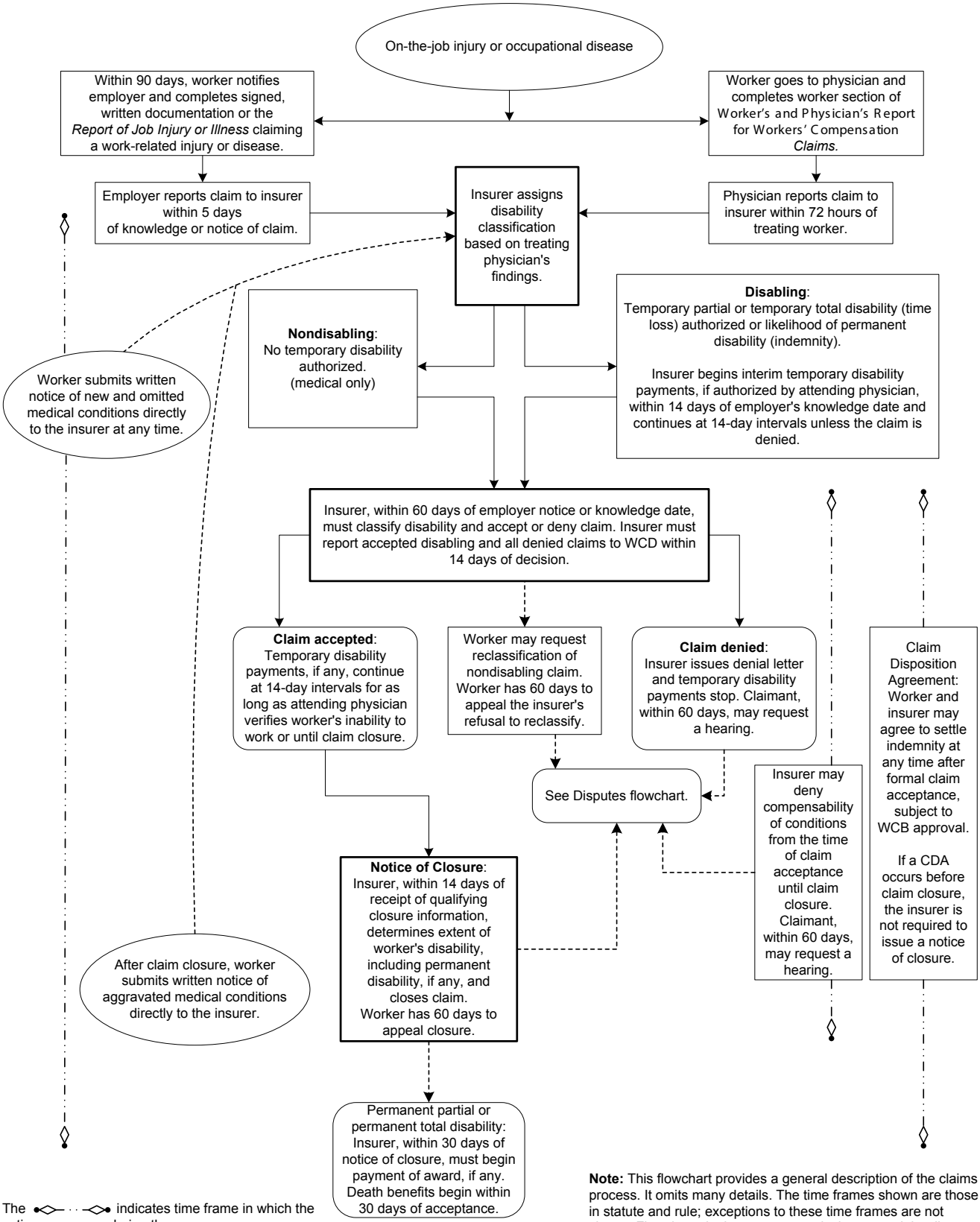
In May 2001, during the legislative session, the Oregon Supreme Court issued its opinion for the *Smothers v. Gresham Transfer, Inc.* case. The court ruled that when a workers' compensation claim is denied for failure to prove that the work-related incident was the major contributing cause of the injury or condition, then the exclusive-remedy provisions implemented by Senate Bill 369 of 1995 are unconstitutional. The 2001 Legislature addressed this decision by passing SB 485, which created a process for worker 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. Although it was estimated that the *Smothers* decision

Recent significant court decisions

In December 2013, the Oregon Supreme Court issued its opinion for *Schleiss v. SAIF Corporation*. The issue was whether an injured worker's permanent impairment can be apportioned to exclude that portion of the impairment that is due to conditions that have not previously been formally acknowledged or identified, either as part of the claim processing or resulting litigation. The court concluded that no portion of permanent impairment can be attributed to any condition the worker may suffer from that is not formally part of a combined condition or has not been established as a pre-existing condition.

In May 2014, the Oregon Court of Appeals issued its opinion for *Brown v. SAIF Corporation*. The issue was whether an insurer, to deny a combined condition, must prove it is the accepted condition or the accidental work-related injurious incident that is no longer the major contributing cause. The court ruled that the compensable injury is the work injury resulting from the work action, not the condition the insurer accepts. The burden, therefore, on an employer or insurer seeking to deny a previously accepted combined condition is to prove the work-related injury is no longer the major contributing cause of the disability or need for treatment.

Figure 6. Claims process flowchart



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.

could affect as many as 1,300 cases per year and cost up to $50 million per year, there have been no known cases in which workers have prevailed at trial; in a few cases workers have received settlements.

Modified acceptance decisions

The 1997 Legislature passed House Bill 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 also must issue an updated notice of acceptance that specifies the compensable conditions. If a medical condition, whether omitted from the notice of acceptance or new, is later found to be compensable, then 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 an omitted or new condition. In SB 485, the 2001 Legislature refined the process. 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 a new compensable condition arises during this period, the insurer pays the claim costs. If the new condition arises after the aggravation period and the insurer does not voluntarily accept the claim, the worker must pursue the claim through the Workers' Compensation Board's own-motion process. If the insurer or the board finds the condition compensable, then benefits are paid from the Workers' Benefit Fund, Reopened Claims Program.

Claim resolution

Before 1987, only the department could close claims and rate permanent disability. That year, the Legislature passed HB 2900, allowing insurers to close permanent disability claims if the worker had returned to work. Passage of SB 1197 in 1990 allowed insurers to close claims upon the attending physician's release of the worker to return to work, and thereby terminate temporary disability payments earlier in the life of a claim. The 1999 passage of SB 220 shifted responsibility for all claim closures from the department to insurers. The transition was completed in January 2001. The department continues to promulgate disability standards that insurers must use. Following passage of SB 757 in 2001, the standards for claims with dates of injury since Jan. 1, 2005, were changed to implement the new law. Permanent impairment is now expressed as a percent of the whole person.

Since July 1990, a worker with an accepted claim can resolve a claim by agreeing to release rights to workers' compensation benefits, except for medical services and the Preferred Worker Program, by means of a Claim Disposition Agreement (CDA). Since 1990, the percentage of initial claims resolved by CDA rather than claim closure has been trending upwards. See the chapter on indemnity for statistics about claim resolutions.

Claim compensability decisions

The prompt determination of compensability is also an aspect of insurers' claim processing performance, which is an important part of the workers' compensation system. To enable insurers to make better decisions and reduce the number of appealed denials, SB 1197 in 1990 changed the statutory time limit for the acceptance or denial of claim compensability from 60 days to 90 days. 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 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 2002, the median time to accept a disabling claim has ranged from 39 days to 44 days. In 2013, about 94 percent of the compensability decisions were made within the 60-day period.

Workers' compensation information line

Workers' Compensation Division benefit consultants answer workers' questions about their claims, describe workers' rights and responsibilities, and help people understand the workers' compensation system. In 2013, there were 6,614 calls to the line, 3,617 from workers and 2,997 from insurers, medical providers, attorneys, employers, legislators, and others. Cases requiring translation or advocacy are referred to the Office of the Ombudsman for Injured Workers.

Civil penalties

The department issues civil penalties to insurers and self-insured employers that do not meet acceptable performance standards. In 2013, the department issued 1,290 citations with penalty amounts of more than $750,000 – record high figures. Stipulated agreements, which may encompass various violations of rules and statutes under ORS Chapters 656 and 731 (workers' compensation and insurance law, respectively), and set up various performance expectations, are not included in these statistics.

Reported claims (thousands of claims), FY 1989-2014

Fiscal year	Accepted disabling	Denied disabling	Percent denied disabling	Denied non-disabling
1989	40.5	6.6	14.1%	8.0
1990	35.9	9.5	21.0%	10.6
1991	31.2	8.0	20.5%	12.4
1992	28.6	7.5	20.8%	12.9
1993	29.1	6.0	17.1%	13.4
1994	29.7	6.2	17.3%	13.3
1995	29.7	6.5	18.0%	13.4
1996	27.4	6.0	17.9%	14.1
1997	26.9	5.5	17.0%	14.8
1998	26.0	5.4	17.1%	15.0
1999	24.9	5.2	17.4%	14.7
2000	24.4	4.9	16.7%	13.7
2001	23.9	4.7	16.5%	13.9
2002	22.1	4.7	17.5%	13.0
2003	21.0	4.4	17.1%	11.7
2004	20.0	4.1	17.1%	10.2
2005	21.0	4.0	16.1%	9.5
2006	21.4	3.5	14.1%	9.5
2007	22.4	3.9	14.7%	9.1
2008	21.7	3.5	14.0%	8.3
2009	18.9	3.4	15.3%	7.2
2010	17.2	3.1	15.5%	6.5
2011	17.2	2.8	14.1%	5.9
2012	15.9	2.6	13.8%	5.4
2013	19.2	3.2	14.4%	6.7
2014	16.5	2.7	13.8%	5.2

The department requires insurers to report accepted disabling and denied claims within 14 days of the compensability decision. These counts reflect the initial decisions on those claims, as well as data entry patterns for the reports. The number of disabling claims has declined by an average of 3.2 percent per year since FY 1989, although there has been considerable year-to-year variability. The FY 2014 counts of accepted and denied are typical of recent years' compensability decisions.

The denial rate of disabling claims has generally declined since FY 1992, although with some variability. Counts of denied nondisabling claims have also declined, again with some variability.

Accepted nondisabling claims are not included in this report because insurers are not required to report them to the department.

Disabling occupational disease claims (thousands of claims), FY 1989-2014

Fiscal year	Accepted	Denied	Percent denied
1989	4.0	2.0	33.9%
1990	3.5	2.8	44.1%
1991	3.1	2.1	40.8%
1992	3.1	2.3	42.5%
1993	3.2	1.9	37.6%
1994	3.3	2.0	38.1%
1995	3.4	2.1	37.7%
1996	3.4	2.0	36.3%
1997	3.6	2.0	35.7%
1998	3.3	1.8	34.7%
1999	2.9	1.7	36.5%
2000	3.1	1.5	33.2%
2001	3.3	1.6	32.9%
2002	3.2	1.8	35.8%
2003	3.3	1.6	33.0%
2004	3.2	1.8	35.6%
2005	3.4	1.7	33.0%
2006	3.7	1.6	29.7%
2007	3.7	1.6	29.9%
2008	3.4	1.4	29.5%
2009	3.2	1.4	30.9%
2010	2.7	1.3	32.7%
2011	2.5	1.1	30.3%
2012	2.3	1.0	30.1%
Jul-Dec 2012	1.2	0.6	34.0%
----------> series break			
Jan-Jun 2013	1.0	0.4	34.1%
2014	1.4	0.8	35.9%

The total number of disabling occupational disease claims reported to the department has generally declined since 1990, although with considerable variability. Starting January 1, 2013, the department began using the Bureau of Labor Statistics' Occupational Injury and Illness Classification System, 2nd Edition. Data prior to 2013 use the 1st Edition. The coding structures for the two editions are not comparable, and so counts of occupational illnesses prior to 2013 should not be compared to subsequent data.

The denial rate of occupational disease claims has been generally declining since 1990, with considerable variation, but most recently has increased, reaching 36 percent in 2014.

Historical data are subject to small changes.

Disabling aggravation claims, CY 1991-2013

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%
2008	506	566	52.8%
2009	447	554	55.3%
2010	438	533	54.9%
2011	340	510	60.0%
2012	361	476	56.9%
2013	285	434	60.4%

After a claim has been closed, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. The number of these aggravation claims has generally declined during the past two decades. However, the number of these claims that have been denied has not declined as rapidly. As a result, the denial rate is now 60.4 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, which can be made after the five-year aggravation period expires.

Insurer claim acceptance and denial, median time lag days, 1988-2013

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	40	47
2008	41	48
2009	41	46
2010	42	49
2011	42	48
2012	41	47
2013	44	48

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

Between 2001 and 2002, there were significant drops in the median number of days taken to accept and deny claims. Since then, the median has remained at or below 44 days for claim acceptance and at or below 51 days for claim denial.

Lag days are measured from employer knowledge date to original date of acceptance or denial for disabling claims.

Insurer timeliness of acceptance or denial and of first payments, 1990-2013

Year	Acceptance/ denial timely	First payment timely
1990	85.4%	80.1%
1991	91.5%	85.0%
1992	94.2%	87.2%
1993	96.0%	89.0%
1994	96.1%	88.3%
1995	95.1%	88.4%
1996	94.5%	88.2%
1997	93.2%	87.9%
1998	92.6%	87.4%
1999	92.8%	87.2%
2000	92.9%	88.3%
2001	92.3%	88.2%
2002	93.1%	89.5%
2003	90.2%	90.3%
2004	90.1%	91.5%
2005	89.5%	90.1%
2006	90.9%	88.3%
2007	91.2%	90.0%
2008	92.8%	89.9%
2009	93.6%	91.1%
2010	93.3%	91.5%
2011	94.2%	91.8%
2012	93.5%	90.5%
2013	93.9%	89.8%

Insurer timeliness is measured by the rates at which claims are accepted or denied, and indemnity payments are made, in accordance with rules and statutes.

Insurer performance on timeliness of acceptance or denial of claims improved between 1990 and 1994, to 96.1 percent, after which it generally declined to a low of 89.5 percent in 2005. Recent performance has been in the 93 to 94 percent range.

Timeliness of first payments has also improved since 1990. Since 2007, performance has been in the 90 to 92 percent range.

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

Civil penalties issued, 1990-2013

Year	Number of Citations	Total Penalties Assessed	Average penalty per citation
1990	407	$158,325	$389.00
1991	420	156,775	$373.27
1992	506	163,101	$322.33
1993	621	166,650	$268.36
1994	679	197,025	$290.17
1995	525	139,325	$265.38
1996	491	140,850	$286.86
1997	629	244,175	$388.20
1998	813	254,925	$313.56
1999	789	243,375	$308.46
2000	844	248,875	$294.88
2001	738	204,400	$276.96
2002	947	301,900	$318.80
2003	1,241	343,875	$277.10
2004	677	206,675	$305.28
2005	745	360,600	$484.03
2006	951	588,150	$618.45
2007	915	575,800	$629.29
2008	1,140	596,775	$523.49
2009	739	404,525	$547.40
2010	526	286,525	$544.72
2011	661	369,500	$559.00
2012	744	398,700	$535.89
2013	1,290	755,600	$585.74

In 2011 the number of citations against insurers, and total penalties assessed, began to increase. In 2013 there were 1,290 citations and $755,600 in penalties, both of which are historic peaks. The average penalty per citation has been at least $500 every year since 2006.

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.

Calls to the workers' compensation information line, 1990-2013

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
2008	6,713	4,715	11,428
2009	5,446	4,214	9,660
2010	4,717	3,750	8,467
2011	2,714	1,918	4,632
2012	3,177	2,086	5,263
2013	3,617	2,997	6,614

WCD has an information line to assist workers and others (800-452-0288).

Although calls for assistance have steadily declined along with claims, recently there has been a, increase in calls. In 2013, there were more than 3,600 from workers with questions about their claims, the claims process, or the workers' compensation system.

The line also received almost 3,000 calls from insurers, medical providers, attorneys, employers, legislators, and others in 2013.

Cases requiring language translation or worker advocacy are referred to the Office of the Ombudsman for Injured Workers.

Advocates and Advisory Groups

Injured workers and employers may 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, assisting workers by accepting, investigating, and attempting to resolve complaints concerning matters related to workers' compensation. 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 seven staff members.

In 2013, the office recorded about 8,500 inquiries; the number of inquiries has decreased about 11 percent over the past two years. About 88 percent of these inquiries were from injured workers. Inquiries also came from attorneys, insurance companies, employers, and others. 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 Small Business Ombudsman is the resource center for employers needing information about the workers' compensation system. It helps resolve disputes between employers and insurers, provides educational seminars and trade shows, and assists all parties. The office had nearly 800 inquiries, and more than 1,100 subsequent contacts, in 2013.

Medical Advisory Committee

The members advise the director on matters relating to medical care for workers. In 1999, Senate Bill 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.

Recent Medical Advisory Committee Projects

- In conjunction with WCD, the Medical Advisory Committee approved a set of opioid prescriptions guidelines to assist doctors in prescribing, maintaining and withdrawing opioids in the treatment of injured workers.

Management-Labor Advisory Committee

In recognition of the success of the governor's labor-management committee in crafting the 1990 reforms, the Legislature created the Management-Labor Advisory Committee (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 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.

Recent Management-Labor Advisory Committee Activities

- The committee recommended improvements to the e-billing system to encourage provider participation.
- Studied issues affecting access to and continuity of care for injured workers in the system. The committee recommended legislation to improve access to treatment by extended the authority of authorized nurse practitioners and chiropractors who want to continue treating workers after enrollment in a managed care organization.

The Workers' Compensation Research Institute (WCRI) has recognized Oregon's workers' compensation system as a model that could provide lessons for other states. The study "Lessons from the Oregon Workers' Compensation System" provided four key lessons. One of these lessons is the cooperation between management and labor that is embodied in the Management-Labor Advisory Committee.

WCRI listed six factors in the design and operation of MLAC that are associated with its effectiveness in bringing about orderly and lasting change in the Oregon system.

- *Labor and management, not other interest groups, influence but do not control the system through MLAC.* MLAC is composed of five voting representatives from business and five from labor; the DCBS director is an ex-officio member.
- *The governor vows to veto any workers' compensation bill that does not gain advisory committee (i.e., labor and management) endorsement.* This feature has been the cornerstone of Oregon's advisory-committee process. In making such a vow, the governor has effectively said no to other interest groups unless management and labor have approved.
- *The Legislature usually defers to MLAC.* The advisory committee enjoys the support of legislators. Legislative caucus leaders and committee chairs generally understand that workers' compensation bills should first be vetted by MLAC.
- *The state agency actively supports* MLAC *by conducting studies and drafting legislative proposals.* Most MLAC members said it is critical that the state agency conduct special studies to provide input to their deliberations.
- *Public input is encouraged through testimony at MLAC meetings and other mechanisms.* This enables all parties to express concern, advocate, raise questions, and voice opposition.
- *Subcommittees are often used to hear testimony, narrow issues, and consider changes to legislative proposals.* This enables the advisory committee to draw on technical experts on technical issues, and it allows for the division of labor among MLAC members, who are volunteers.

Ombudsman for Injured Workers inquiries, 1999-2013

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	11,512
2008	11,404
2009	11,624
2010	10,817
2011	9,496
2012	8,664
2013	8,480

The Office of 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 8480 inquiries in 2013, an average of about 34 per working day.

Small Business Ombudsman inquiries, 1991-2013

Year	Total contacts
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
2008	3,258
2009	2,678
2010	2,179
2011	1,819
2012	2,313
2013	1,973

The Office of the Ombudsman for Small Business was created in 1990. The number of contacts peaked in 1999 and 2002. There were 1,973 contacts in 2013.

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 31 percent since 2002. In 2013, payments for medical services accounted for 54 percent of workers' compensation system costs in Oregon.

Early cost-containment measures

In 1990, Senate Bill 1197 eliminated most palliative care for medically stationary injured workers. Palliative care is treatment to relieve symptoms rather than to improve the worker's underlying condition. These restrictions had an immediate effect on workers who had been receiving palliative treatment. SAIF Corporation'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 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 must provide or prescribe care. Under SB 1197, for example, a chiropractor outside of a managed care organization could not continue to be a worker's attending physician beyond 12 visits or 30 days after the first service date. Data from SAIF showed that the proportion of payments to chiropractors dropped from 16 percent before 1990 to 3 percent after 1990. House Bill 2756 (enacted in 2007) relaxed the limitation to 18 visits or 60 days from the first service date. 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 a claim is accepted or denied, however, there is uncertainty about who will be responsible for medical bills. This uncertainty may lead some medical providers to delay treatment until after insurers make compensability decisions or make them reluctant to treat injured workers at all.

In 2001, the Legislature addressed this problem in two ways. First, SB 485 reduced the time allowed for insurers to accept or deny a claim from 90 days to 60 days. Second, it amended the law to require payment for some services performed before acceptance or denial. Included among these services are pain medicine, some diagnostic services, and services to stabilize the worker's condition and prevent further disability. However, the law excludes services provided to workers enrolled in managed care organizations.

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 first fee schedules for medical services in Oregon were implemented in 1982. Fee schedules now exist for nine physician service categories: pharmacy services; ambulatory surgery centers; durable medical equipment, prosthetics, orthotics, and medical supplies; transportation; interpreter services; dental services; multi-disciplinary services; and other Oregon-specific

service codes. Insurers pay for medical services at the lesser of the fee schedule or the billed amounts. Currently, nearly all payments for medical services to injured workers are subject to a fee schedule. The department is currently looking at new fee schedules for other service areas.

In 1997, the department adopted the Federal Resource-Based Relative Value Schedule (RBRVS) method for determining the maximum payment for the physician service categories. Since then, enhancements improved the usability of the physician fee schedule. A maximum allowable payment (MAP) for each service is published annually in OAR 436-009 according to its Current Procedural Terminology (CPT) code.

A new fee schedule methodology was adopted July 1, 2011, for durable medical equipment, prosthetics, orthotics, and medical supplies. The maximum is 110 percent of the Centers for Medicare and Medicaid Services (CMS) MAP or 80 percent of the billed amount for most products not covered by CMS. Hearing aids, however, are paid at 100 percent of charges.

Also on July 1, 2011, the department implemented a fee schedule based on the CMS Ambulatory Payment Classification (APC) system for payment of services performed in ambulatory surgery centers. The department publishes the MAPs according to the services' Healthcare Common Procedure Coding System (HCPCS) codes. Medical implants are paid at 110 percent of the APC's actual cost for the implant. Facility services that are not covered by CMS (and therefore not part of the APC system) are paid at 80 percent of the billed amount.

Before Jan. 1, 2011, all services that did not fall under one of the currently applicable fee schedules were to be paid as billed, that is, 100 percent of the amount charged. New rules took effect on that date requiring a maximum payment of 80 percent of the amount charged. Subsequently, fee schedules have been adopted in several categories to replace the 80 percent rule. Dental services are now paid at 90 percent of charges. Seven services relating to transportation (ambulance services) are paid at 100 percent of charges.

The maximum allowable fee for pharmaceuticals is 83.5 percent of the Average Wholesale Price, plus a $2 dispensing fee.

The interpreter services fee schedule was first implemented in April 2011 covering the interpreters' services, as well as travel to and from appointments.

The Workers' Compensation Division implemented a hospital payment system using adjusted cost-to-charge ratios (CCR) in 1991. Since July 1992, the department has published revised CCRs semi-annually for all general, acute-care hospitals in the state. The CCR is the proportion of the hospital bill that insurers reimburse Oregon hospitals for treating injured workers. The CCR calculation is based on information from hospitals' audited financial statements and Medicare cost reports. The CCR allows 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.

Rural hospitals 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 need as determined from financial reports. Currently, 25 of the 58 hospitals in Oregon are designated as critical-access hospitals. Three additional rural hospitals qualify for the exclusion based on their financial conditions. Exempt hospitals are paid 100 percent of charges.

Managed care organizations

SB 1197 (1990) established regulations regarding workers' compensation insurers' contracts with department-certified managed care organizations (MCOs), and it set the rules under which covered workers must obtain treatment within MCOs. MCOs contract with medical providers and, in return, MCO-covered workers are directed to those providers for treatment. 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.

In 2005, SB 670 made revisions to the statute regarding MCOs. The bill clarified that in order for an MCO to become certified, the DCBS director must review and approve the standards contained in the MCO's plan. 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 2013, four certified MCOs had 114 active contracts with workers' compensation insurers and self-insured employers. Forty-five percent of workers with accepted disabling claims were enrolled in MCOs. SAIF has used MCOs more than most other insurers. In 2013, SAIF enrolled 67 percent of its claimants with accepted disabling claims. For comparison, self-insured employers enrolled 43 percent of their claimants with accepted disabling claims, and private insurers enrolled 7 percent of their claimants.

Medical payments

The Workers' Compensation Division requires that insurers with a three-year average of 100 or more accepted disabling claims report their medical payment data. In 2013, approximately 85 percent of total medical payments were reported under the administrative rules. Total medical payments in 2013 are estimated to be $317.3 million.

Physician services made up the largest category of medical services in the WC system. Nearly 60 percent of the medical dollars spent went to physician services. Physical medicine, which includes physical therapy, wound care management, and osteopathic manipulation, was the largest sub-category, in terms of dollars, within physician services. Facility services made up the second largest service category at 23 percent of total payments.

Among physician services, therapeutic exercises were 10 percent of costs. Four of the top 15 physician services were physical medicine services. Narcotic analgesics (pain relievers) ranked as the top category of drugs prescribed to injured workers; 39 percent of drug costs were for this class of drugs. Anti-convulsants (anti-seizure medications, 12 percent) and anti-depressants (7.5 percent) round out the top three classes. The use of generic drugs increased in 2013 to 82 percent of dispenses and 45 percent of payments.

Independent medical exams account for a significant portion of medical payments. IME services, grouped together to include basic exams, reports, and specialized IME services (panel exams and exams by specialists), totaled 2.6 percent of total medical 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 the claim, authorize the payment of temporary disability benefits for 60 days, and release workers to their jobs.

In 2005, the department studied 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 that there were 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 (MLAC), completed a study of care providers. The department and MLAC focused on chiropractors, naturopaths, podiatrists, and physician assistants. The study tried to determine if rules regarding who may treat workers and authorize disability benefits facilitated 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 maxillofacial surgery can act as attending physician.

Medical payments by fee schedule category, 2013

Group	Fee schedule category	Payments ($ millions)	Percent of total
Physician Services	Physical Medicine	$55.87	17.6%
	Evaluation & Management	53.53	16.9%
	Radiology	26.62	8.4%
	Major Surgery[1]	21.84	6.9%
	Medicine	14.34	4.5%
	Minor Surgery[2]	9.07	2.9%
	Chiropractic	3.43	1.1%
	Laboratory	2.62	0.8%
	Unknown Professional Services	0.12	0.04%
Total Physician Services		187.44	59.1%
Facility Services	Inpatient Facility Fees	33.92	10.7%
	Outpatient Facility Fees	32.12	10.1%
	ASC Facility Fees	6.50	2.0%
	Other Facility Services	0.01	0.003%
Total Hospital Services		72.55	22.9%
OSCs, IMEs and IME-Related Services	IMEs	8.22	2.6%
	Oregon Specific Codes	4.18	1.3%
	IME-Related services	0.43	0.1%
Total OSCs, IMEs and IME-Related Services		12.84	4.0%
Pharmaceuticals	Pharmacy NDCs	12.26	3.9%
	Hospital Outpatient Dispenses	2.71	0.9%
	Other NDCs	1.36	0.4%
Total Pharmaceuticals		16.33	5.1%
Other Services	Non-hospital HCPCS[3]	15.57	4.9%
	DME & Supplies	5.73	1.8%
	Anesthesiology	5.09	1.6%
	Dental	1.75	0.6%
	Other/Unknown[3]	0.031	0.01%
Total Other Services		28.17	8.9%
Total		$317.33	100.0%

As set forth in Oregon Administrative Rule (OAR) 436-009-0040, the insurer pays for medical services at the provider's usual fee or in accordance with the fee schedule, whichever is less. Medical services not covered by a fee schedule are reimbursed at 80 percent of the provider's usual fees. New rules in effect in 2012 created fee schedules for several categories of previously non-fee-schedule services.

This table shows total payments and percent of total for fee-schedule-regulated service categories and non-fee-schedule categories. Physician services are those covered by the physician fee schedule (OAR 436-009-0050). Facility Services are paid according to the hospital cost-to-charge ratio (Bulletin 290) or the ASC fee schedule (OAR 436-009 Appendix C-D). Oregon-specific services accounted for $12.84 million, about two-thirds of which was for independent medical examinations (IMEs) and related services.

1: Major surgery includes all services with a 90-day global period

2: Minor surgery includes all services with a global period of less than 90 days

3: Non-fee-schedule services

Top 15 workers' compensation physician services, 2013

Service code	Description of service	Payments ($ millions)	Percent of total payments
97110	Therapeutic exercises	$19.24	10.3%
99213	Office/outpatient visit established patient	16.65	8.9%
97140	Manual therapy of 1 or more regions	10.89	5.8%
99214	Office/outpatient visit established patient	6.85	3.7%
97530	Therapeutic activities	5.24	2.8%
99203	Office/outpatient visit new patient	5.16	2.8%
99283	Emergency department visit	4.20	2.2%
99204	Office/outpatient visit new patient	3.10	1.7%
73721	MRI joint of lower extremity without dye	2.74	1.5%
99199	Special service/procedure/report	2.69	1.4%
73221	MRI joint upper extremity without dye	2.46	1.3%
29881	Knee arthroscopy/surgery	2.30	1.2%
97001	PT evaluation	2.18	1.2%
72148	MRI lumbar spine without dye	2.14	1.1%
29827	Arthroscopic rotator cuff repair	2.05	1.1%
	Subtotal:	87.89	46.9%
	Remaining services:	99.55	53.1%
	Total:	$187.44	100%

This table shows the top 15 physician service codes ranked according to total payments.

In 2013, the single medical service with the largest volume of payments, $19.24 million, was therapeutic exercises. The top 15 services combined accounted for more than one-fourth of all workers' compensation medical payments and approximately half of all physician services.

Four of the top 15 services are categorized as physical medicine, commonly performed by physical therapists. Five are evaluation and management services, either office or emergency room visits. Three are MRI services, two are surgeries, and one is for independent medical examinations.

Top 15 workers' compensation non-physician services, 2013

Service code	Description of service	Payments ($ millions)	Percent of total payments
S9122	Home health aide or certified nurse assistant	$1.76	2.4%
A0427	Ambulance Services: ALS1-emergency	1.08	1.5%
L8699	Prosthetic implant	0.98	1.3%
V5261	Hearing aid, digital, binaural, behind the ear	0.89	1.2%
A0431	Rotary wing air transport	0.77	1.1%
C1713	Anchor/screw bone-to-bone,tissue-to-bone	0.72	1.0%
A0436	Rotary wing air mileage	0.41	0.6%
L7499	Upper extremity prosthesis	0.39	0.5%
E1399	Durable medical equipment misc.	0.36	0.5%
A4556	Electrodes, pair	0.33	0.5%
A0425	Ground mileage	0.33	0.5%
L5999	Lower extremity prosthesis	0.31	0.4%
V5257	Hearing aid, digital, monaural, behind the ear	0.25	0.3%
C1820	Generator, neurostimulator, with rechargeable battery	0.20	0.3%
E0676	Intermittent limb compression device	0.19	0.3%
	Subtotal:	8.99	12.3%
	Remaining services:	63.89	87.7%
	Total:	$72.88	100%

This table shows the top 15 non-physician service codes ranked according to total payments. Non-physician services, designated by HCPCS Level II codes, include transportation services (e.g., ambulances), medical and surgical supplies, durable medical equipment, and orthotics and prosthetics.

Home health aids and certified nurse assistants accounted for the largest category of non-physician services in 2013. Transportation services were four of the 15 top services, three were prosthetic and orthotic procedures, two are for hearing aids, and the remainder are for durable medical equipment and surgical medical supplies.

Top 15 workers' compensation revenue codes, 2013

Service code	Description of service	Payments ($ millions)	Percent of total payments
360	Operating Room Services	$6.04	9.2%
278	Medical/Surgical Supplies: Other implants	4.64	7.0%
120	Room & Board (Semi-Private 2 beds)	2.83	4.3%
250	Pharmacy	2.58	3.9%
370	Anesthesia	2.34	3.5%
710	Recovery Room	2.07	3.1%
450	Emergency Room	1.72	2.6%
272	Medical/Surgical Supplies: Sterile supplies	1.61	2.4%
636	Drugs Require Specific ID: Drugs requiring detail coding	1.57	2.4%
121	Medical/Surgical/Gyn	1.48	2.2%
200	Intensive care	0.93	1.4%
270	Medical/Surgical Supplies	0.86	1.3%
320	Radiology - Diagnostic	0.53	0.8%
420	Physical Therapy	0.46	0.7%
300	Laboratory - Clinical Diagnostic	0.39	0.6%
	Subtotal:	30.04	45.5%
	Remaining services:	36.00	54.5%
	Total:	$66.04	100%

This table shows the top 15 revenue codes ranked according to total payments. Revenue codes are used on hospital bills to indicate the which department performed a service.

Top 15 workers' compensation pharmaceuticals, 2013

Drug name	Drug type	Therapeutic class	Payments ($ millions)	Percent of total payments
Oxycontin	Brand	Analgesics - opioid	$2.56	15.7%
Lyrica	Brand	Anticonvulsants	0.84	5.2%
Cymbalta	Brand	Antidepressants	0.84	5.1%
Hydrocodone with Acetaminophen	Generic	Analgesics - opioid	0.81	5.0%
Gabapentin	Generic	Anticonvulsants	0.80	4.9%
Celebrex	Brand	Analgesics - antiinflammatory	0.63	3.9%
Oxycodone HCL	Brand	Analgesics - opioid	0.55	3.4%
Modafinil	Generic	ADHD, anti-narcolepsy, anti-obesity, anorexiants	0.48	2.9%
Morphine Sulphate ER	Generic	Analgesics - opioid	0.48	2.9%
Lidoderm	Brand	Dermatologicals	0.42	2.6%
Oxycodone with Acetaminophen	Generic	Analgesics - opioid	0.35	2.1%
Metaxalone	Generic	Musculoskeletal therapy agents	0.24	1.5%
Opana ER (Crush Resistant)	Brand	Analgesics - opioid	0.24	1.5%
Lunesta	Brand	Hypnotics	0.23	1.4%
Subtotal:			9.74	59.7%
Remaining Pharmacy Payments:			6.59	40.3%
Total:			$16.33	100.0%

In 2013, the top 15 pharmaceuticals accounted for 59.7 percent of total pharmacy payments.

Generic drugs made up 82 percent of the prescriptions dispensed to injured workers and 45 percent of pharmacy payments for prescription medications. Prescription medications accounted for 99.4 percent of total pharmacy payments. Medical supplies and other non-drug services provided by pharmacies made up for the remaining 0.5 percent of total pharmacy payments.

MCO contracts with insurers and self-insured employers, CY 1995-2013

Calendar year	Insurers	Self-insured employers	Total
1995	31	46	77
1996	39	46	85
1997	42	52	94
1998	41	55	96
1999	36	50	86
2000	40	52	92
2001	45	56	101
2002	41	61	102
2003	41	64	105
2004	36	62	98
2005	39	70	109
2006	37	67	104
2007	33	59	92
2008	33	64	97
2009	33	72	105
2010	32	76	108
2011	32	81	113
2012	31	81	112
2013	30	84	114

At the end of 2013, there were four active certified managed care organizations. These four MCOs had 114 active contracts with insurers and self-insured employers at some point during 2013. In November 2010, a fifth MCO was activated but never began business with workers' compensation insurers or self-insured employers and has subsequently been inactivated.

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

Employees with accepted disabling claims enrolled in MCOs, 1998-2013

Year	SAIF	Private insurers	Self-insured employers	Total
1998	76.8%	24.5%	23.2%	39.8%
1999	72.4%	20.9%	21.8%	37.1%
2000	76.3%	20.1%	27.9%	40.1%
2001	70.3%	12.3%	26.8%	35.6%
2002	67.5%	11.7%	27.8%	36.5%
2003	70.3%	8.2%	30.1%	39.1%
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%
2008	64.1%	8.4%	33.3%	38.7%
2009	63.3%	8.9%	39.1%	39.5%
2010	62.6%	7.5%	42.6%	39.7%
2011	63.0%	7.7%	42.6%	40.2%
2012	67.5%	7.8%	49.2%	45.7%
2013	67.1%	7.3%	42.6%	44.6%

The percentage of claimants with accepted disabling claims (ADCs) who have been enrolled in MCOs has varied between 36 percent and 46 percent. It had been stable at around 40 percent for the period 2006-2011. During those same six years, SAIF's percentage of ADCs enrolled has gone down while the share of private insurers and self-insured employers has increased. In 2012, SAIF's share of enrolled claims increased, as did self-insured employers. In 2013, the percentage of ADCs enrolled dropped slightly again, perhaps indicating a leveling off of the recent trends.

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

Indemnity Benefits

Workers' compensation indemnity benefits are cash benefits paid to injured workers that vary with the severity of the worker's disability. These can include benefits for temporary disability (time loss), permanent partial disability, permanent total disability, and death. Statute sets eligibility criteria and the rate at which insurers pay these benefits. In the case of death from work-related causes, indemnity benefits are paid to survivors. Indemnity benefits also include vocational assistance benefits paid on behalf of severely disabled workers to get them back to work. There are two types of settlements typically paid as lump sums: claim disposition agreements and disputed claim settlements, which are negotiated amounts paid to the worker. For more details about vocational assistance, see the chapter on return to work. For agreements and settlements, see the chapter on disputes.

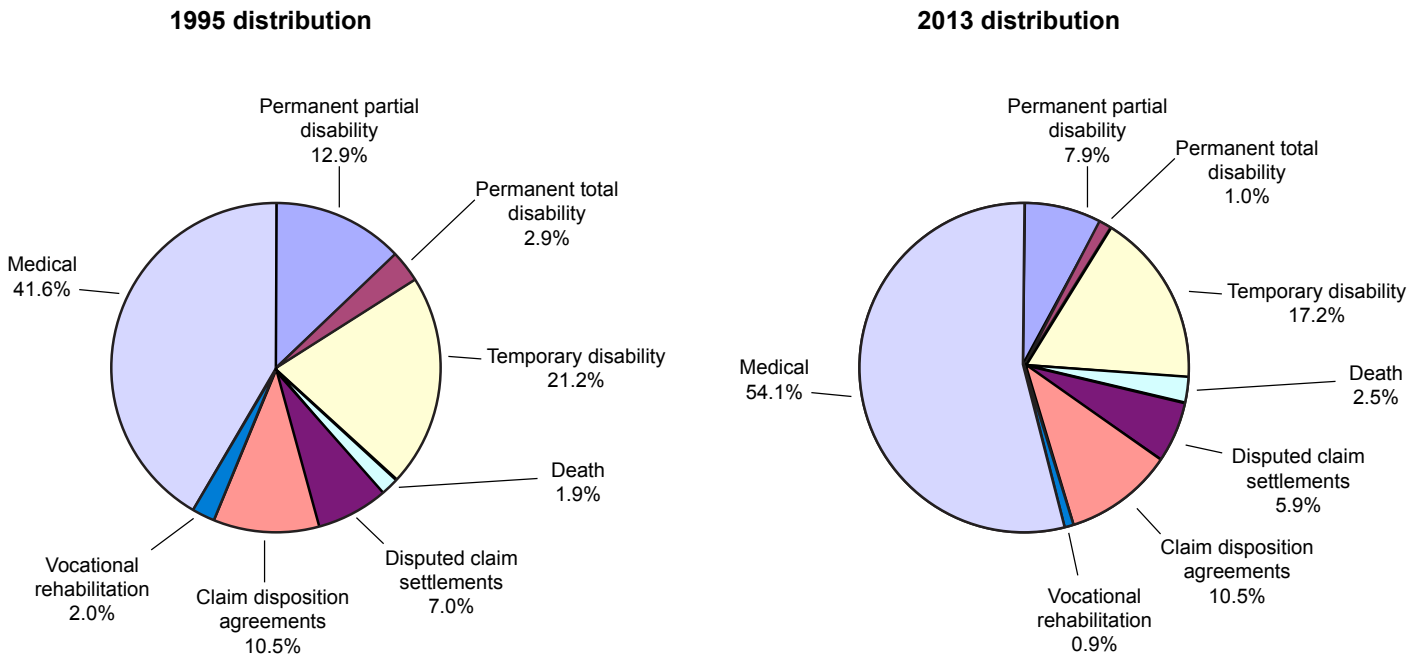
In 2013, about $586.3 million in total benefits were paid by insurers from premiums. Indemnity was 45.9 percent of total benefits, a percentage that reflects a gradual decline relative to medical costs, although both medical and indemnity have risen in absolute terms. Accepted disabling claims typically account for 93 percent to 95 percent of indemnity: $250.8 million paid in 2013 for accepted disabling claims. The average for those claims was almost $13,000.

In addition to indemnity benefits paid from premiums, several programs that assist employers and injured workers are paid from the Workers' Benefit Fund. The WBF is financed by assessments; its two major programs are the Retroactive Program, which pays cost-of-living increases for permanent total disability and death benefits; and the Re-employment Assistance Program, which provides incentives for injured workers to return to work through the Employer-at-Injury Program and the Preferred Worker Program (see the chapter on return to work). Payments in 2013 for those programs came to $73.8 million.

Temporary disability

Temporary disability benefits compensate injured workers for time lost from work, whether that loss is total or partial, while the injured worker recovers from medical restrictions. Most accepted disabling claims have temporary disability, which may be paid

Figure 7. Benefits paid by insurers and self-insured employers, calendar years 1995 and 2013



for multiple claim openings: the initial claim, new or omitted medical condition, aggravation of an accepted condition, and active engagement in training under vocational assistance. Temporary disability benefits were 40 percent of indemnity paid in 2013 for accepted disabling claims, an estimated $100.71 million. The average paid for accepted disabling claims resolved in 2013 was $5,658, compensating an average 73 days with lost wages.

The last major legislation affecting temporary disability benefits was SB 485 of 2001, which raised the ceiling on the rate of temporary disability benefits from 100 percent to 133 percent of the statewide average weekly wage. It also established supplemental disability, paid from the Workers' Benefit Fund in addition to temporary disability when the worker has an accepted disabling claim and is unable to work in other jobs held as well. In 2013, $968,000 million in supplemental disability was paid.

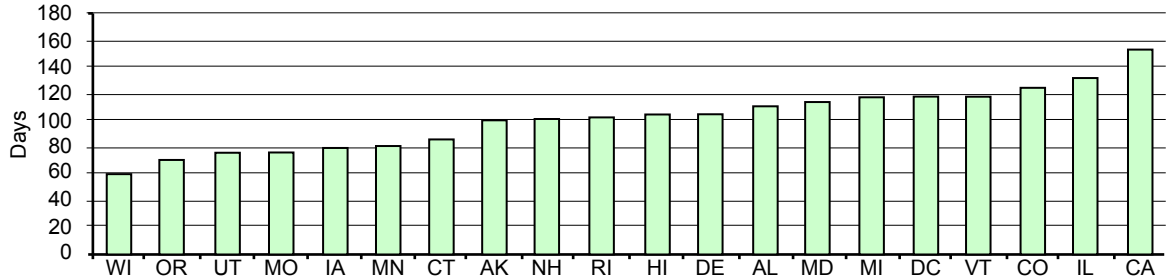
The number of temporary disability days paid is a measure of claim duration, which is a dimension of severity. One goal of Oregon's system has been to reduce the severity of disabling claims along with their incidence. Duration of temporary disability is influenced by the impairment and restrictions from the injury or illness, but also by the behavior of the worker, medical provider, employer, and insurer, and the interaction of those parties – as well as economic factors. A recent publication by National Council on Compensation Insurance, Inc. (NCCI) has provided comparative duration statistics for insured employers (excluding self-insurers) across several states for which NCCI provides insurance rate and loss cost recommendations. For 20 states with a similar three-day waiting period for temporary disability benefits, Oregon had the second lowest average duration.

Permanent partial disability

In 2003, SB 757 created a new structure for permanent partial disability (PPD) benefits. The changes, which were made permanent by HB 2244 (2007), apply to claims for injuries and illnesses occurring since January 2005. Since 2005, permanent impairment of all body parts and systems is rated in relation to the whole person. Workers receive an impairment benefit based on the statewide 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. By HB 2408 (2005), workers injured since January 2006 who are released to regular work are specifically excluded from work disability benefits.

HB 2244 (2007) 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. One of those goals is to allocate PPD award dollars equitably to claims with greater economic loss. Maximum PPD benefits, for claims with dates of injury between July 2014 and June

Figure 8. Temporary Disabilty Duration, mean days compensated
for states with 3-day wait period
Accident Year 2009 claims as of 36 months, NCCI TTD Duration Research Brief (8/2013)



2015, are $340,508 per claim. Oregon's maximum indemnity benefit levels are among the more generous nationally, exceeding the median values for comparable states. The average PPD benefit paid for PPD claims resolved in 2013 was $11,112, continuing the generally upward trend since 1995. The trend is arguably mostly attributable to statutory increases in benefits.

Permanent partial disability benefits paid in 2013 were $46.3 million, continuing the declining trend that began in 2008. One contributing factor is the increase in initial claims that are resolved by claim disposition agreements (CDA). Between 6 percent and 7 percent of claims resolved since 2009 have been resolved by a CDA. Those claims receive no PPD benefits, instead releasing rights to potential future benefits in exchange for cash, typically in a lump sum. Also, just over 26 percent of claims that resolved by claim closure in 2013 received PPD benefits, continuing a downward trend that began in 2009, compared to about 30 percent historically.

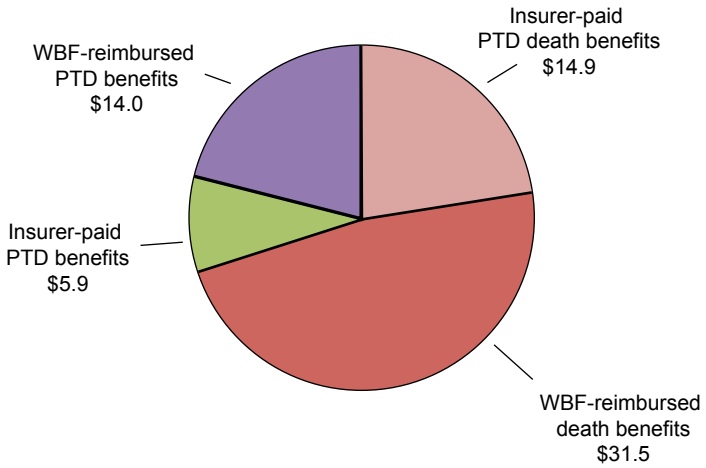
Permanent total disability and death

Permanent total disability (PTD) benefits are paid when a worker is totally and permanently disabled due to a work injury. The number of claims receiving these benefits declined dramatically between 1988 and 1990, when disability rating standards were adopted. The creation of CDAs in 1990 led to further decline. By 2001, there were 13 grants of PTD and 14 rescissions of the benefits, for a net of negative one award. The passage of SB 386 in 2005 provided increased access to permanent total disability benefits and protections for severely injured workers. There has been only one rescission since 2009, and, in 2013, there were 14 grants of PTD.

Death benefits are provided to surviving family members of a worker who dies on the job or while permanently and totally disabled. Passage of SB 110 in 2009 doubled burial benefits, established new benefits for orphans aged 18 to 23 who are attending school, and provided for payment of remaining benefits to the deceased worker's estate in the absence of legally defined beneficiaries.

In 2013, insurers paid an estimated $5.86 million for PTD and $14.94 million for death benefits. Together, these benefits accounted for 8 percent of indemnity paid from premium for accepted disabling claims. However, the majority of PTD and death benefits are paid from the Workers' Benefit Fund. The WBF reimburses insurers for payments that cover cost-of-living increases, $13.99 million for PTD and $31.53 million for death benefits in 2013. These reimbursements have declined from a peak of $66 million in 2000 to less than $50 million in 2013.

Figure 9. Insurer-paid and WBF-reimbursed death and PTD benefits, 2013 ($ millions)



Indemnity and medical benefits paid, CY 1995-2013

Year paid	Total paid ($ millions)	Indemnity percent of total	Medical percent of total
1995	$464.31	58.4%	41.6%
1996	441.45	56.3%	43.7%
1997	430.45	54.1%	45.9%
1998	436.44	52.1%	47.9%
1999	430.98	52.5%	47.5%
2000	450.50	51.0%	49.0%
2001	476.28	50.6%	49.4%
2002	489.85	50.7%	49.3%
2003	477.98	49.3%	50.7%
2004	505.61	48.7%	51.3%
2005	538.94	46.8%	53.2%
2006	562.55	47.5%	52.5%
2007	574.46	48.3%	51.7%
2008	579.82	50.4%	49.6%
2009	617.31	48.4%	51.6%
2010	597.54	48.1%	51.9%
2011	599.83	46.5%	53.5%
2012	580.01	44.7%	55.3%
2013	586.30	45.9%	54.1%

Total benefits paid peaked in 2009. Beginning in 2003, indemnity benefits paid have generally been less than 50 percent of total benefits paid. The overall declining trend in the ratio of indemnity to medical benefit payments has been driven by medical costs rising faster than indemnity.

Total benefits paid is indemnity benefits plus medical benefits for accepted and denied disabling and nondisabling claims. Most of this is paid by insurers from premium. A small amount is reimbursement from the Workers' Benefit Fund. Total paid does not include cost-of-living adjustments from the Retroactive Program or most payments under the Re-employment Assistance Program.

Indemnity benefits are temporary disability, permanent partial disability, permanent total disability, vocational assistance, and death benefits, plus agreements and settlements. Temporary disability excludes most payments before compensability denial or after a department or court order; this applies to all the tables. Medical benefits paid are extrapolated from reported paid bills.

Some indemnity data are also estimated. Historical data are subject to small changes.

Indemnity paid for accepted disabling claims by benefit type, CY 1995-2013

Year	Temporary disability ($ millions)	PPD ($ millions)	PTD ($ millions)	Death ($ millions)	Claim disposition agreements ($ millions)	Disputed claim settlements ($ millions)	Vocational assistance ($ millions)	Total ($ millions)
1995	$98.49	$59.87	$13.64	$9.00	$47.58	$15.01	$9.31	%252.88
1996	88.11	59.65	13.12	9.61	43.98	9.14	9.41	233.03
1997	82.33	55.20	12.61	10.33	42.89	8.19	7.81	219.36
1998	82.60	55.20	11.97	10.85	36.28	9.07	7.05	213.02
1999	83.67	53.40	11.45	11.09	38.59	8.74	6.39	213.33
2000	82.45	54.94	11.03	11.81	38.50	10.32	6.11	215.16
2001	92.06	58.99	10.51	12.04	37.75	9.53	6.10	226.98
2002	92.83	57.85	9.98	12.30	43.14	11.94	6.55	234.60
2003	84.64	57.98	9.54	13.12	39.45	10.57	6.04	221.35
2004	91.44	60.23	9.11	13.05	41.99	10.91	6.53	233.25
2005	92.02	63.67	8.95	13.66	42.11	11.02	6.49	237.91
2006	98.15	64.07	8.54	13.68	49.91	10.31	6.99	251.65
2007	104.93	64.96	8.38	14.38	50.75	11.94	7.30	262.63
2008	110.46	62.29	7.86	14.10	60.91	13.65	6.92	276.18
2009	111.75	61.06	737	14.55	61.94	16.93	7.42	281.02
2010	104.79	54.35	6.94	14.01	64.10	18.70	6.71	269.59
2011	101.04	50.37	6.54	14.70	64.32	18.76	6.51	262.24
2012	96.24	47.16	6.13	14.30	57.48	16.14	5.59	243.04
2013	100.71	46.30	5.86	14.94	59.92	17.97	5.13	250.83

In 2013, 40 percent of indemnity benefits for accepted disabling claims were temporary disability payments, 18 percent were permanent partial disability (PPD) awards, 31 percent were agreements and settlements, and the remainder were paid for permanent total disability (PTD), death, and vocational assistance benefits. Agreements and settlements have accounted for at least 30 percent of indemnity since 2010.

Categories of indemnity payments have all generally followed the same trend as accepted disabling claims of falling in the late 1990s, rising throughout the early 2000s, and falling again in recent years.

Data are reported by the year of closure by the insurer or order by the department or court. Temporary disability includes reports by insurers at claim closure and following a vocational assistance training plan, and estimates of unreported data such as for initial claims resolved by claim disposition agreement. Some death and PTD benefits are estimated and neither includes cost-of-living adjustments paid from the Workers' Benefit Fund. Benefits paid on PTD claims after the worker has died are included in death benefits. Historical data are subject to small changes.

Indemnity benefits paid for accepted disabling claims, CY 1995-2013

Year	Benefits paid ($ millions)	Average benefits
1995	$252.88	$7,601
1996	233.03	7,629
1997	219.36	7,515
1998	213.02	7,495
1999	213.33	7,906
2000	215.16	8,256
2001	226.98	8,791
2002	234.60	9,621
2003	221.35	9,632
2004	233.25	10,120
2005	237.91	10,577
2006	251.65	10,648
2007	262.63	10,798
2008	276.18	11,894
2009	281.02	13,447
2010	269.59	14,041
2011	262.24	13,668
2012	243.04	12,596
2013	250.83	12,983

Total indemnity benefits paid by insurers for accepted disabling claims also peaked in 2009, then declined the next three years, increasing about 3 percent in 2013.

After peaking in 2010, average indemnity paid declined the next two years, increasing about 3 percent in 2013. This average is indemnity paid divided by the number of claim resolutions in the year. The remaining tables provide details about types of benefits paid, claim resolutions, and resolved accepted disabling claims.

Some payment data are estimated. Historical data are subject to small changes.

Workers' Benefit Fund payments by benefit type, CY 1995-2013

Year	PTD ($ millions)	Death ($ millions)	EAIP disabling claims ($ millions)	EAIP non-disabling claims ($ millions)	PWP worker initiated ($ millions)	PWP employer initiated ($ millions)	PWP claim costs reimbursed ($ millions)	Total ($ millions)
1995	$29.39	$31.96	$4.95	$0.01	$6.19		$3.13	$75.63
1996	28.30	32.95	6.28	1.29	7.91		3.03	79.75
1997	28.19	34.72	6.62	3.21	8.87		3.01	84.62
1998	27.99	35.88	7.61	4.05	8.46		3.45	87.44
1999	27.61	36.79	6.78	3.82	7.23		3.71	85.94
2000	27.60	38.42	5.82	3.69	5.86		3.01	84.39
2001	26.28	38.82	7.01	4.00	5.86		3.19	85.08
2002	24.97	39.21	5.72	3.26	4.99		2.56	80.71
2003	23.35	38.22	5.75	3.01	4.41		2.27	77.02
2004	21.94	37.53	6.36	3.34	5.72		2.31	77.21
2005	21.49	36.95	6.74	3.29	5.03	$0.01	2.19	75.70
2006	20.57	36.92	7.92	3.96	4.57	1.05	2.04	77.02
2007	19.85	35.66	9.50	4.35	4.13	1.61	2.28	77.40
2008	19.42	35.80	12.64	5.53	4.56	1.88	2.34	82.16
2009	18.83	36.14	13.03	5.63	3.73	1.86	2.67	81.89
2010	17.70	35.24	11.68	4.81	3.05	1.71	2.68	76.88
2011	16.26	34.30	13.21	6.01	3.17	1.50	2.73	77.18
2012	14.85	32.62	14.26	6.43	2.86	1.62	2.18	74.82
2013	13.99	31.53	15.53	6.53	2.04	1.77	2.37	73.76

The Workers' Benefit Fund provides funds for several programs that assist employers and injured workers. Assessment revenues, not insurance premiums, finance these programs. Employers and workers each pay half the assessment. The two major programs are the Retroactive Program and the Re-employment Assistance Program.

The Retroactive Program pays cost-of-living increases to workers or their beneficiaries based on changes in average wages. The two major benefits paid are for permanent total disability and death. In 2013, the Retroactive Program provided an estimated $45.51 million for PTD and death benefits. Since at least 1995, the majority of PTD and death benefits have been paid from this program.

The Re-employment Assistance Program provides incentives for injured workers to return to work, through the Employer-at-Injury Program (EAIP) and the Preferred Worker Program (PWP). Benefits common to both are wage subsidies, worksite modifications, and employment purchases. Total payments for EAIP first exceeded PWP in 2000, and, in 2013, total EAIP was nearly 4 times total PWP payments.

Workers who have not been released to regular work but can return to transitional jobs are eligible for the EAIP. Use of this program allows many claims to remain nondisabling even though the workers have medical restrictions. (For more details, see the return-to-work tables.) Generally, EAIP payments for nondisabling claims have been about half that for disabling claims.

Workers who have a permanent disability and are unable to return to regular work are eligible for the PWP benefits, which may be initiated by either the worker or the employer. In addition, claim cost reimbursement is paid for preferred workers who suffer new injuries. PWP claim cost reimbursements are included in all tables that have statistics about indemnity or medical benefits paid.

Historical data are subject to small changes.

Claim resolutions, CY 1995-2013

Year	Initial claim, CDA	Initial claim, closure	Aggravation and medical condition, closure	Vocational training closure	Total claim resolutions
1995	714	30,490	1,822	242	33,268
1996	785	28,111	1,375	273	30,544
1997	854	26,794	1,252	288	29,188
1998	829	26,107	1,242	242	28,420
1999	947	24,618	1,212	207	26,984
2000	892	23,914	1,059	197	26,062
2001	954	23,559	1,104	203	25,820
2002	925	22,260	1,010	188	24,383
2003	927	20,888	962	205	22,982
2004	906	20,944	1,009	189	23,048
2005	953	20,404	938	199	22,494
2006	1,045	21,481	914	194	23,634
2007	1,159	22,083	860	220	24,322
2008	1,238	20,905	882	195	23,220
2009	1,390	18,484	826	199	20,899
2010	1,257	16,989	768	186	19,200
2011	1,269	16,980	757	180	19,186
2012	1,241	17,226	701	128	19,296
2013	1,289	17,276	631	124	19,320

Accepted disabling claims may be resolved multiple times. The trend for total claim resolutions has been down, from roughly 33,000 in 1995 to 19,000 currently, following the trend in claims.

Claim types are initial claims, aggravation, new or omitted medical condition, and vocational training. Resolutions are by claim closure or full-release claim disposition agreement (CDA) on an initial claim. Most claim resolutions are closures on initial claims.

For each of the past eight years, more than 1,000 claims have had a CDA rather than an initial claim closure. These counts exclude CDAs for nondisabling claims and for closed disabling claims.

Historical data are subject to small changes.

Average temporary disability days paid by type of claim resolution, CY 1995-2013

Year	Initial claim, CDA	Initial claim, closure	Aggravation and medical condition, closure	Vocational training closure	All claim resolutions
1995	264	50	117	205	60
1996	249	48	107	208	57
1997	222	45	97	222	54
1998	212	46	86	221	54
1999	213	46	84	208	55
2000	212	45	80	214	53
2001	223	48	92	213	57
2002	254	49	86	243	60
2003	229	49	73	221	58
2004	243	50	79	230	60
2005	259	51	86	209	63
2006	256	50	70	218	61
2007	246	50	96	215	63
2008	264	52	84	213	66
2009	236	60	69	237	74
2010	245	58	91	219	73
2011	239	54	89	260	70
2012	215	53	66	248	66
2013	212	55	86	262	68

The average duration of temporary disability for initial claim closures was 55 days in 2013, down from the recent peak of 60 days in 2009.

Temporary disability payments are not reported for initial claims that resolve by claim disposition agreement. However, a data call completed in March 2012 provided sample results that helped to improve our estimated averages. For 2013, the estimated average was 212 days, equal to the historic low.

Since 2008, the average number of paid days it takes for all claim resolutions has been 66 or more days. As the number of new claims was decreasing, older and longer-duration claims increased in proportion. That trend has now moderated.

The data are reported for each claim resolution by the year of claim closure or claim disposition agreement. The average days are calculated per resolution rather than per claim.

Historical data are subject to small changes.

Temporary disability for resolved accepted disabling claims, CY 1995-2013

Year	Resolved claims	Average days	Average dollars	Median days
1995	31,555	65	3,215	19
1996	29,081	62	3,101	17
1997	27,833	58	3,026	17
1998	27,087	58	3,087	18
1999	25,630	58	3,259	19
2000	24,814	56	3,288	18
2001	24,608	60	3,718	18
2002	23,107	63	3,958	18
2003	21,804	62	3,846	19
2004	21,883	63	4,124	19
2005	21,389	66	4,311	20
2006	22,557	64	4,289	19
2007	23,248	65	4,474	19
2008	22,191	69	4,913	20
2009	19,980	77	5,565	24
2010	18,417	77	5,698	23
2011	18,372	74	5,563	23
2012	18,657	70	5,380	23
2013	18,950	73	5,658	25

The trend for resolved accepted disabling claim counts follows the trend for new ADCs. An accepted disabling claim is resolved if it has had a claim closure or a claim disposition agreement on the initial opening and if it is not currently in an open or reopened status.

For claims resolved in 2013, the average number of temporary disability days paid per accepted disabling claim, counting all resolutions for a claim, was 73 days, down from the recent peak of 77, but still historically high. The average temporary disability payment was $5,658, a figure that reflects the historically long duration of temporary disability. The smaller figure for median days of temporary disability indicates that there was a relatively large number of ADCs which resolved fairly quickly, as well as a smaller number that took much longer to resolve.

The data are reported by the year of the latest claim resolution. Historical data will show small changes as claims are reopened and closed.

Permanent partial disability, CY 1995-2013

Year	Claims resolved by closure, with PPD	Percentage of closed claims with PPD	Average PPD award
1995	9,479	30.7%	$6,371
1996	8,911	31.5%	$6,602
1997	8,046	29.8%	$7,017
1998	7,737	29.5%	$7,118
1999	7,301	29.6%	$7,329
2000	6,937	29.0%	$7,767
2001	7,004	29.6%	$8,291
2002	6,712	30.3%	$8,554
2003	6,223	29.8%	$9,081
2004	6,285	30.0%	$9,567
2005	6,272	30.7%	$9,976
2006	6,347	29.5%	$9,563
2007	6,336	28.7%	$9,769
2008	6,021	28.7%	$10,157
2009	5,726	30.8%	$10,515
2010	5,001	29.1%	$10,743
2011	4,774	27.9%	$10,847
2012	4,704	27.0%	$10,454
2013	4,647	26.3%	$11,112

About 26 percent of claims that resolved by closure in 2013 received permanent partial disability awards, a historical low that continues the recent declining trend. Annual counts of closed claims with PPD have decreased from almost 9,500 in 1995 to fewer than 5,000 currently.

In 2013, the average award for those claims was $11,112, continuing the generally upward trend since 1995. which is mostly due to statutory increases. The effects of a 2003 law change that instituted a formula for benefit level changes began to account for most PPD awards in 2006.

Closed claims do not include initial claims resolved by claim disposition agreement, none of which receive a PPD award but all of which release future PPD liability. The upward trend for claims resolved by initial-claim CDA accounts for some of the decline in the number of PPD claims.

These data are reported by the year of the last claim closure. The average awards include the initial awards made by insurers and the net amounts that were awarded during the appeal process, summed over all claim closures. Data will change as claims are opened and closed.

Permanent total disability awards, CY 1987-2013

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
2008	10	1	9
2009	13	0	13
2010	23	0	23
2011	10	1	9
2012	9	0	9
2013	14	0	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 claim disposition agreements 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.

Following passage of legislation in 2005, PTD rescissions have become rare. Only one PTD award has been rescinded in the past five years.

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
July 2009 - June 2010	-	-	306,862
July 2010 - June 2011	-	-	314,061
July 2011 - June 2012	-	-	322,929
July 2012 - June 2013			322,447
July 2013 - June 2014			330,500
July 2014 - June 2015			340,508

In 2003, SB 757 revised the permanent partial disability award structure, effective January 2005. It eliminated the distinction between scheduled and unscheduled PPD. The new structure reallocated 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 has been no increased cost to the workers' compensation system.

Benefit levels are now associated by formula with the change in the state average weekly wage. The small decline in benefits beginning July 2012 reflects a recession-related decline in the average weekly wage. Maximum PPD benefit levels in the two most recent years are more than double the pre-2005 unscheduled maximum.

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 through benefit structures, discrimination protections, and re-employment programs.

The first of these is the structure of disability benefits. Temporary partial disability is used as an alternative to temporary total disability, keeping workers on the job; also, the possibility of payment of work disability benefits for permanent impairment acts as incentive for employers and insurers 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 laws. Third, the workers' compensation system assists injured workers with three re-employment programs.

The Employer-at-Injury Program (EAIP) and the Preferred Worker Program (PWP) provide incentives to employers who re-employ injured workers. The Employer-at-Injury Program focuses on workers who have medical releases to temporary, restricted work. The Preferred Worker Program is for workers who have known permanent work restrictions. Both programs attempt to provide early diagnosis and accommodation of medical restrictions. The insurer plays an active role in both programs.

Costs of EAIP and PWP benefits and insurer administration are paid from the Re-employment Assistance Program within the Workers' Benefit Fund. In 2013, benefit costs paid came to $22.06 million for the Employer-at-Injury Program and $6.18 million for the Preferred Worker Program. Costs for EAIP benefits first exceeded PWP in 2000, and since then, EAIP's share of Re-employment Assistance Programs benefits has been increasing rapidly. Also, the PWP benefit costs do not include placement services that were created by Senate Bill 119 (2005). Revenue for the Workers' Benefit Fund is mostly assessments paid equally by workers and their employers on hours worked.

The vocational assistance program is available for only the most severe disabilities. Insurers and rehabilitation professionals provide formal plans and needed purchases, usually for retraining, to return disabled workers to suitable jobs. For injuries after 1985, vocational assistance is funded through employers' insurance premiums. For more information about the costs of vocational assistance since 1995, see the indemnity chapter of this report.

Figure 10. Percent of accepted disabling claims with use of return-to-work programs by fourth year post-injury, 2006-2014

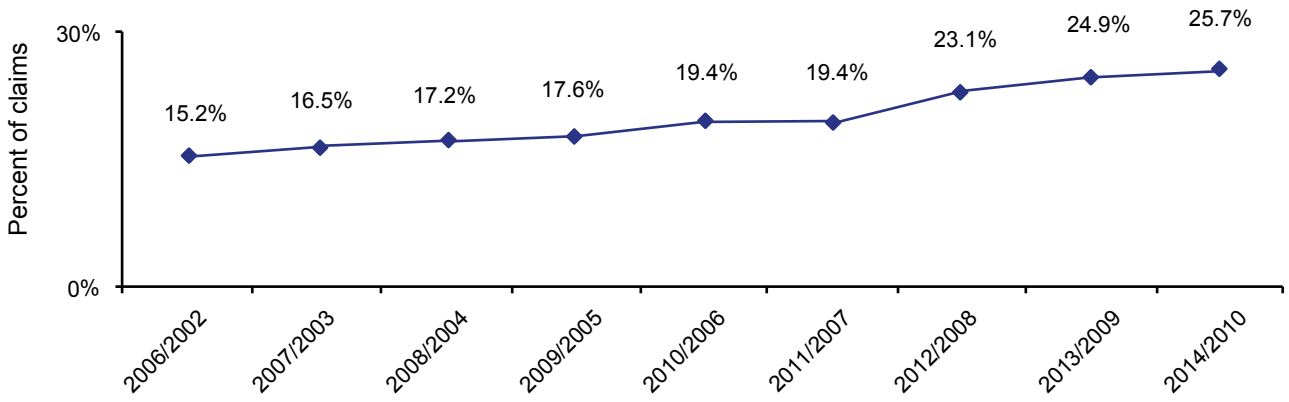
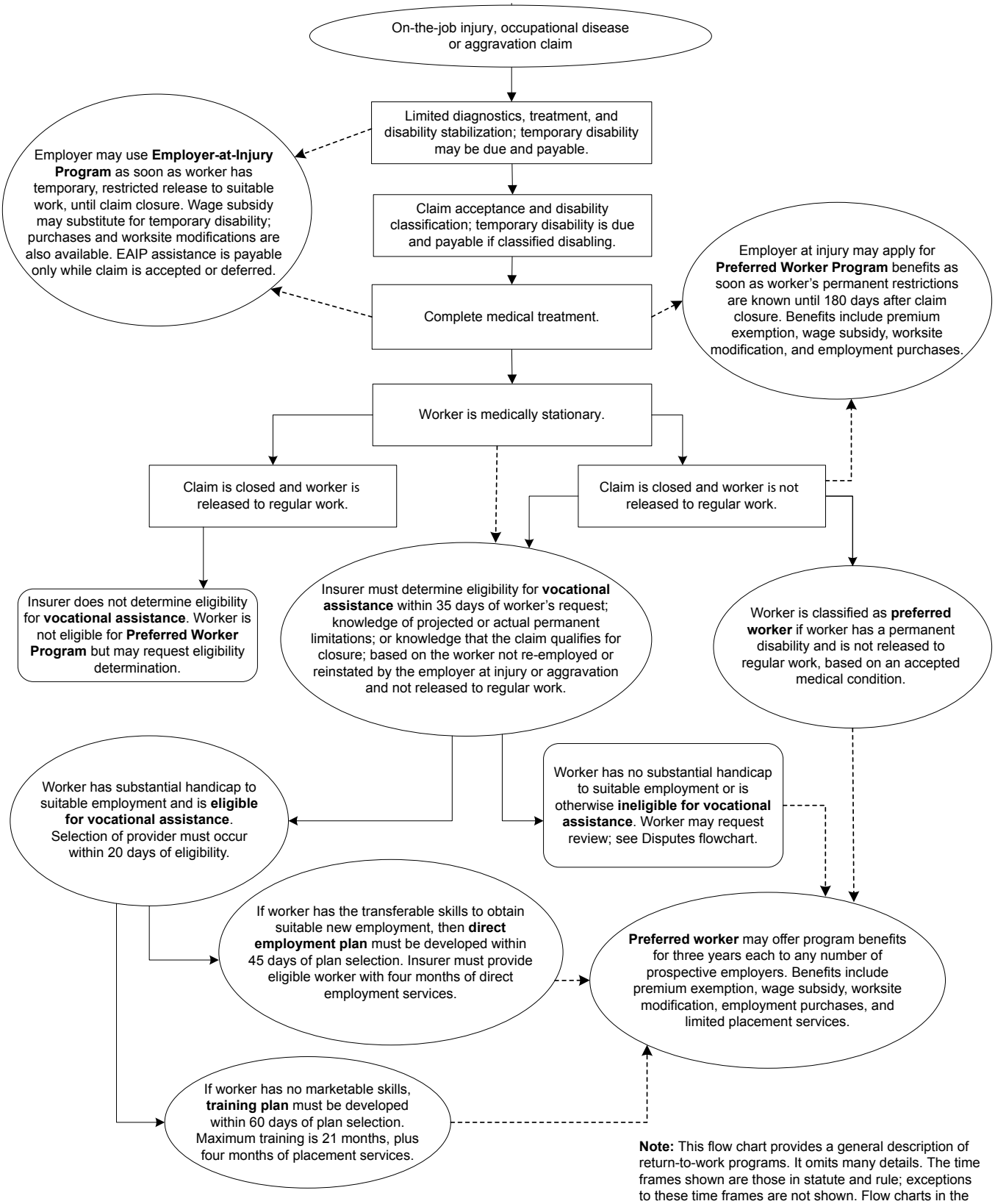


Figure 11. Return-to-work flowchart



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

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.

Measuring the effectiveness of return-to-work programs

The International Association of Industrial Accident Boards and Commissions and the Workers' Compensation Research Institute have recognized the department's performance measures for innovative use of employment and wage data. The measures are percentage point differences in employment and wage-recovery rates between workers with accepted disabling claims who used return-to-work programs and similar workers who did not. Data come from the Oregon Employment Department: Wages reported in the 13th quarter after the disabling injury or exposure compared to wages reported in the injury quarter and the quarter before injury.

In 2014, for workers with accepted disabling claims for 2010 injuries and illnesses, the employment rate advantage for use of return-to-work programs was 8 percentage points. Since 1997, through periods of both high and low unemployment, the employment rate for program users has been 8 percentage points to 13 percentage points higher compared to workers with no use of return-to-work programs. The wage-recovery advantage was 14 percentage points. On average, program users recovered 100 percent of their pre-injury wages, adjusted for statewide trends in employment and wages.

Results of a recent study featuring a more in-depth use of performance measurement data show that preferred workers are more likely to use their benefits if they had a transitional work placement under the Employer-at-Injury Program and that workers who complete their vocational assistance plans have better employment and wage-recovery outcomes if they use preferred worker benefits.

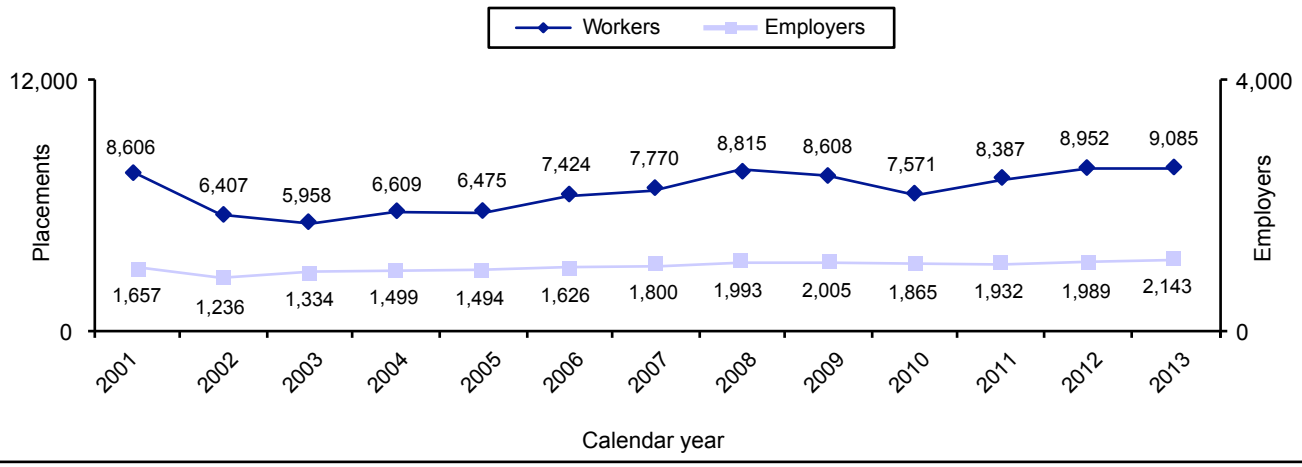
Return-to-work program use

By the first quarter of 2014, about 26 percent of accepted disabling claims for injuries and illnesses during 2010 had use of return-work-programs: an Employer-at-Injury Program placement, Preferred Worker Program benefits, completion of a vocational assistance plan, or any combination thereof. This is the highest rate of program use for the nine years of measurement.

The Employer-at-Injury Program

The Employer-at-Injury Program, created in 1993, is for Oregon employers and their injured workers who have temporary medical releases for return to light-duty, transitional jobs. Insurers arrange job placements for which they receive a flat fee of $120 each. Assistance to employers consisted of a 50 percent wage subsidy for a period of up to three months; effective

Figure 12. Employer-at-Injury Program, placements approved, 2001-2013



July 2013, the rate was reduced to 45 percent to help make up for a revenue shortfall. Worksite modifications and early return-to-work purchases are also available and have been made easier to use.

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 prevented many accepted nondisabling claims from becoming disabling claims, because no temporary disability benefits are due and payable. An administrative law change in December 2007 extends benefits 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 temporary disability benefits if a worker refuses modified work, including an EAIP placement. Effective in 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.

In 2013, the department approved payment for 9,085 placements, up slightly from 8,952 placements the previous year. There were 2,143 employers with at least one worker placement approved for payment. This was the highest figure on record. Statutory and administrative law changes have succeeded in improving access and participation. However, as with other return-to-work programs, economic conditions have an effect on these programs, too. For example, since the start of the recession in 2008 the number of claims declined through 2010 and has been relatively flat since. The same trends have affected worker placements.

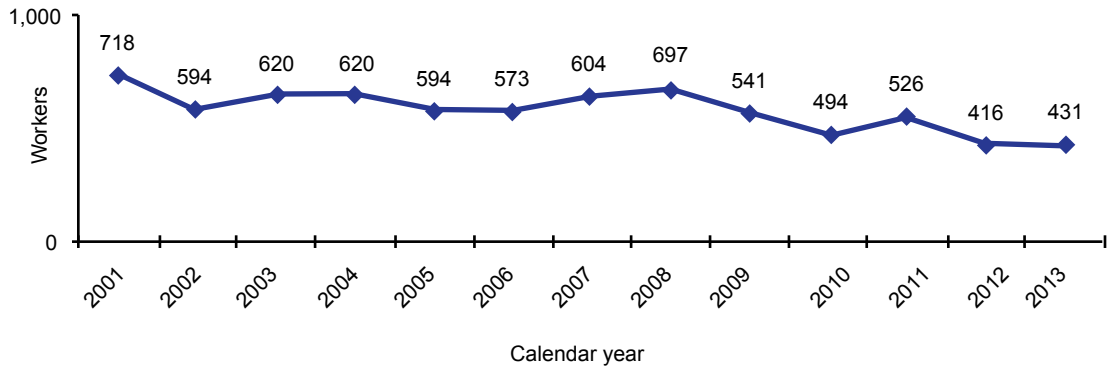
Measured at the 13th quarter after injury, employment and wage recovery rates have been consistently higher for workers with accepted disabling claims in which employers and insurers accessed Employer-at-Injury Program benefits. In fiscal years 2013 and 2014, the employment rates were 2 percent and 1 percent higher, and the wage recovery rates were 5 percent and 6 percent higher, respectively, among workers in the Employer-at-Injury Program than among others. These statistics are based on a comparison of workers released to regular work, but with significant severity indicators for temporary and permanent impairment. Recent research showed that a wage recovery and employment advantage is sustained over a period of at least five years after injury.

Preferred Worker Program

The current version of the program is a result of SB 1197 (1990). Clarifications were added in 1995 through SB 369; notably, workers may not release these benefits through a claim disposition agreement. SB 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 employment as soon as permanent medical restrictions are known. A worker automatically receives

Figure 13. Preferred workers starting contracts, 2001-2013



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 job, 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, payable by contract, 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 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 in July 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 in December 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 soon after becoming eligible, while others wait for years. Benefit use remained between 600 and 700 workers between 2002 to 2007, before sliding to about 430 in 2013. Measured at the 13th quarter after injury, employment and wage recovery rates have been substantially higher for preferred workers who used the program's benefits compared to preferred workers who did not. In 2014, the employment rate was 42 percentage points higher, and wage recovery was better by 44 percentage points. These statistics offer a relatively short-term perspective on the efficacy of the program. However, larger differences in wage recovery in favor of benefit users since 2005 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, the Legislature passed House Bill 2900, which significantly restricted eligibility for vocational assistance by introducing a new test. The substantial handicap test 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. In 1995, SB 369 further restricted eligibility for vocational assistance for aggravation claims. Because of these changes, as well as the declining number of claims, far fewer workers have been eligible for vocational assistance. The count for 2013 was 377, a near-record low. Effective January 2010, HB 2705 clarified that insurers no longer need to determine eligibility for workers released to regular work. Since 2009, the number eligible dropped 42 percent to 374 in 2012, with a slight increase in 2013.

Benefits available under vocational assistance include professional rehabilitation services such as plan development, counseling and guidance, and placement; purchases of goods and services such as tuition; and temporary disability while the worker is actively engaged in training. Under current law, the typical eligible worker is entitled to a training plan followed by placement (direct employment) services.

Eligible workers are not required to use vocational assistance benefits. Since at least 1987, less than one-half of eligible workers have begun a plan following their eligibility determinations. From 1995 to 2000, less than one-third of workers completed their plans – defined as placement in a job or receipt of maximum services. Since then, the percentage of those completing their plans has dropped and currently is about 21 percent. Maximum service is 16 months of training (21 months exceptionally), plus four months of placement.

In 1990, the claim disposition agreement (CDA) was first permitted. With CDAs, workers release their rights to vocational assistance and other indemnity benefits in exchange for lump-sum settlements. Since 2002, around 50 percent of eligibilities have ended with a CDA. In general, these workers do not use Preferred Worker Program benefits, and they have low post-injury employment rates and wages.

The statutory limitations on vocational assistance have resulted in fewer workers returning to work because of the program, just 63 in 2013. 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 19 percentage points to 39 percentage points higher for workers who completed plans. Wage-recovery rates have shown similar advantages for workers who completed their plans. Because the completion of a vocational assistance plan typically occurs in the third year after injury, these statistics are a relatively short-term perspective on the efficacy of the program.

Employer-at-Injury Program placements approved, CY 1995-2013

Year	Disabling claim placements	Nondisabling claim placements	Total worker placements	Employers	Mean cost per placement
1995	3,734	4	3,738	1,190	$1,326
1996	4,288	1,790	6,078	1,348	$1,245
1997	4,455	3,904	8,359	1,513	$1,180
1998	4,985	5,083	10,068	1,791	$1,167
1999	4,385	5,057	9,442	1,837	$1,132
2000	3,581	4,273	7,854	1,579	$1,215
2001	4,226	4,380	8,606	1,657	$1,292
2002	3,313	3,094	6,407	1,236	$1,411
2003	3,102	2,856	5,958	1,334	$1,477
2004	3,514	3,095	6,609	1,499	$1,472
2005	3,492	2,983	6,475	1,494	$1,553
2006	3,904	3,520	7,424	1,626	$1,604
2007	4,329	3,441	7,770	1,800	$1,787
2008	5,056	3,759	8,815	1,993	$2,066
2009	5,065	3,543	8,608	2,005	$2,168
2010	4,477	3,094	7,571	1,865	$2,182
2011	4,879	3,508	8,387	1,932	$2,292
2012	5,126	3,826	8,952	1,989	$2,311
2013	5,417	3,668	9,058	2,143	$2,398

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. SB 369 of 1995 allowed benefits to become available for nondisabling claims.

Higher counts of workers and employers with placements after 2005 are evidence that recent law changes are promoting use and access to the program, despite declining claim counts. Modifications and purchases are being used more often due to administrative law changes in late 2007.

Historical data are subject to small changes. Disabling and nondisabling placements are counted by current claim status.

Preferred workers, CY 1991-2013

Year	Eligibilities	Eligibilities with benefit use	Percent of eligibilities with benefit use
1991	4,189	1,523	36.4%
1992	3,548	1,116	31.5%
1993	3,104	990	31.9%
1994	3,351	981	29.3%
1995	4,459	1,334	29.9%
1996	3,708	1,107	29.9%
1997	3,120	912	29.2%
1998	2,946	738	25.1%
1999	2,549	645	25.3%
2000	2,267	586	25.8%
2001	2,375	565	23.8%
2002	1,858	501	27.0%
2003	1,821	499	27.4%
2004	1,779	482	27.1%
2005	1,794	476	26.5%
2006	1,756	467	26.6%
2007	2,014	553	27.5%
2008	1,943	389	20.0%
2009	1,617	322	19.9%
2010	1,346	255	18.9%
2011	1,156	244	21.1%
2012	1,186	Available August 2015	
2013	1,731	Available August 2016	

Preferred workers have permanent work restrictions that prevent return to unmodified regular work. Preferred worker eligibilities in 2007 and 2008 were at their highest number since 2001, but declined to a record low in 2011.

Eligibility entitles a preferred worker to many years - unlimited since December 2007 - in which to begin using benefits. Counts of eligibilities with benefit use do become relatively stable within about three years of the eligibility date. The percent of eligibilities with benefit use fell below 29 percent in 1998; it averaged 26 percent for more than a decade. The percent of eligibilities with use has averaged 20 percent over 2008-2011, the latest four years with available data.

The large jump in eligibilities in 2013 was due to a one-time event to find PWP-eligible claimants missed by the insurers' closing orders.

Historical data are subject to small changes.

Preferred Worker Program contracts started, CY 1988-2013

Year	Workers starting one or more contracts	Wage subsidies	Worksite modifications	Purchases
1988	312	1,272	293	0
1989	744	1,041	133	2
1990	833	1,000	135	35
1991	1,046	999	201	88
1992	1,043	957	379	215
1993	1,005	965	396	225
1994	979	1,040	513	317
1995	1,379	1,110	418	527
1996	1,448	1,111	515	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	604	495	218	237
2008	697	463	231	583
2009	541	342	187	415
2010	494	305	185	384
2011	526	350	162	411
2012	416	270	136	295
2013	431	312	164	293

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 law changes provided for use of program benefits at the injury employer's initiative beginning July 2005, and worksite creation purchases in December 2007. The number of workers starting contracts in 2013 was among the lowest on record.

Workers may start contracts in multiple years. Historical data are subject to small changes.

Vocational assistance determinations, CY 1987-2013

Year	Total determinations	Ineligible	Eligible
1987	13,037	3,177	9,860
1988	6,487	3,228	3,259
1989	6,406	3,575	2,831
1990	7,334	5,123	2,211
1991	6,921	5,231	1,690
1992	6,087	4,644	1,443
1993	5,847	4,414	1,433
1994	5,302	4,050	1,252
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	1,929	740
2006	2,439	1,749	690
2007	2,293	1,539	754
2008	2,665	1,960	705
2009	2,267	1,626	641
2010	1,138	566	572
2011	903	439	464
2012	725	351	374
2013	692	315	377

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 re-employment 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.

Although the total number of determinations in 2010 was the lowest on record to that time (about half the previous year), most of the change was among the ineligible workers. HB 2705 (2009) allows forgoing a determination when the worker has a regular work release.

Data may be reported by the insurer several months after the determination.

Vocational assistance eligibility closures, plans, and outcomes, CY 1995-2013

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	1,404	832	51	521	340	87	631	346
1996	1,243	698	39	506	337	58	582	266
1997	993	512	23	458	248	59	441	245
1998	874	455	6	413	208	50	424	192
1999	781	416	7	358	157	41	354	229
2000	725	395	4	326	171	46	323	185
2001	714	387	4	323	154	46	312	202
2002	787	453	7	327	140	70	390	187
2003	735	423	8	304	123	75	371	166
2004	779	449	5	325	128	60	375	216
2005	749	441	4	304	135	48	358	208
2006	743	410	7	326	143	48	368	184
2007	724	394	3	327	152	46	319	207
2008	714	412	5	297	109	45	351	209
2009	689	376	12	301	95	70	314	210
2010	635	336	10	289	81	62	325	167
2011	563	285	10	268	66	64	278	155
2012	455	231	2	222	68	46	223	118
2013	433	243	1	189	63	29	212	129

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 50 percent or more of eligibility closures. The claim disposition agreement continues to account for about 50 percent of eligibility closure outcomes.

Data may be reported by the insurer several months after the closure.

Employment and wage recovery advantage for return-to-work program users, FY 1997-2014

Fiscal year	Employer-at-Injury Program	Preferred Worker Program	Vocational Assistance	All return-to-work programs	Employer-at-Injury Program	Preferred Worker Program	Vocational Assistance	All return-to-work programs
1997	7	24	24	10	3	24	17	4
1998	5	23	28	11	2	22	27	9
1999	3	22	28	10	2	21	25	9
2000	6	24	30	12	6	22	26	12
2001	5	24	24	11	5	15	19	11
2002	4	21	21	9	8	18	28	14
2003	3	20	35	10	9	20	27	14
2004	4	23	35	11	8	14	33	14
2005	4	24	29	11	5	29	19	12
2006	6	29	34	13	9	33	26	16
2007	5	23	31	10	6	20	40	12
2008	4	27	39	11	4	27	30	11
2009	4	27	35	11	3	24	41	11
2010	6	26	21	12	6	28	28	14
2011	6	32	34	12	6	28	17	13
2012	3	44	19	11	3	51	8	12
2012	3	44	19	11	3	51	8	12
2013	2	39	27	10	5	43	10	13
2014	1	42	20	8	6	44	26	14

The department analyzes data from the Oregon Employment Department to calculate percentage-point differences in employment and wage-recovery rates between workers with accepted disabling claims who used return-to-work programs and similar workers who did not. The measures are based on wages reported in the 13th quarter after the disabling injury or exposure, when most workers have recuperated and used return-to-work programs. Since 2000, at least 87 percent of the program use at that point has been the Employer-at-Injury Program.

Disputes

The purpose of the Oregon workers' compensation system is to provide fair and timely benefits to injured workers. Impartial dispute resolution is an important part of the workers' compensation system.

The Oregon system provides two channels for dispute resolution. During resolution, workers, employers, insurers, and, in some instances, medical service providers have legal rights. Workers may contest denials and benefits, insurers and employers may defend against claims and benefits believed to be unwarranted, and medical providers may raise issues about medical services and fees.

The Oregon workers' compensation system has evolved into 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 claim denials and certain claims-processing issues, such as time loss and time-loss rate when the claim is open. It also hears appeals of cases decided by DCBS Workers' Compensation Division (WCD) 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.
- 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.

Lessons from the Oregon Workers' Compensation System: Dispute Resolution

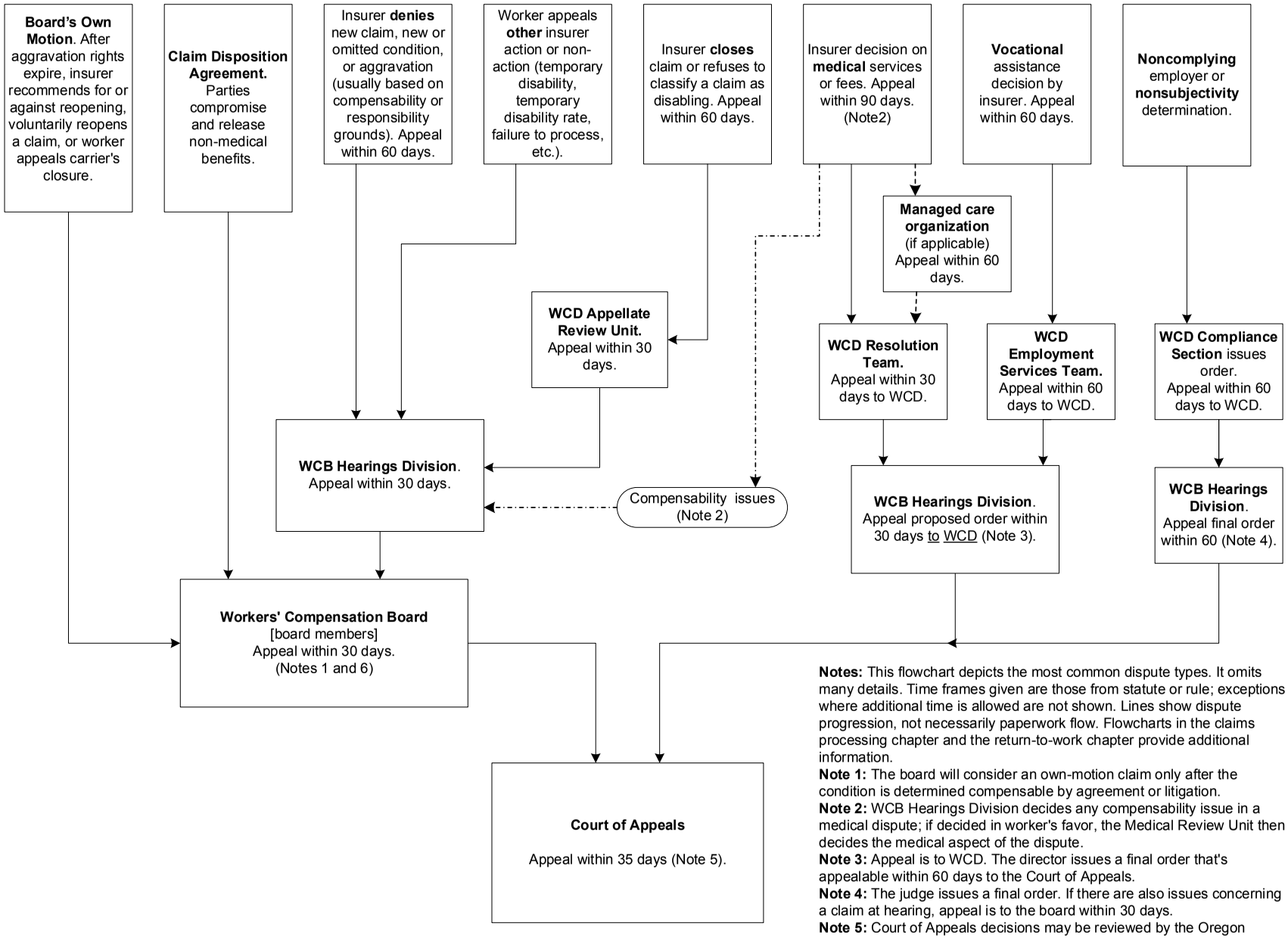
The Workers' Compensation Research Institute (WCRI) has recognized Oregon's workers' compensation system as a model that could provide lessons for other states. The study "Lessons from the Oregon Workers' Compensation System" provided four key lessons.

One of these lessons covers the system features that work together to increase certainty about the determination and payment of permanent partial disability (PPD) benefits and to reduce litigation over the benefit delivery. The goal is to resolve disputes swiftly, informally, and with a minimum of litigation. Following are the six key system features that increase certainty and reduce litigation:

- ***Reliance on the treating provider to offer the information needed to form the basis of an impairment rating*** when the worker reaches maximum medical improvement.
- ***Use of an Oregon-specific guide to rate permanent impairment***, thus allowing rating and compensation concepts to be consistent with Oregon statute and established case law.
- ***Use of objective criteria for assessing the factors affecting loss of earning capacity***, such as age, education, and occupation, in addition to permanent impairment, at all levels of decision-making.
- ***Active payer involvement in terminating TTD benefits and determining PPD benefits*** at initial claim closure.
- ***Use of a swift and mandatory mechanism for administrative dispute resolution (called reconsideration) to address objections to initial claim closure.*** The reconsideration process includes statutory time frames intended to avoid delays and is designed to minimize the need for attorney involvement on both sides.
- ***Use of a medical arbiter.*** Instead of parties spending resources on dueling experts, Oregon provides direct access to an impartial physician who is paid for by the insurer or self-insurer.

For more information about this report, see the "Lessons" press release at: **http://www.oregon.gov/DCBS/docs/news_releases/2008/nr_5_06_08.pdf?ga=t**.

Figure 14. 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 Review Unit then decides the medical aspect of the dispute.

Note 3: Appeal is to WCD. The director issues a final order that's 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.

Note 6: Alternatively, the mediating administrative law judge may approve a CDA. Only CDA disapprovals are appealable to the courts.

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 or propriety. As another example, disputes with a managed care organization (MCO) may begin with the MCO's review process and then go to WCD. Finally, the issue of insurer penalty for unreasonable conduct, and related attorney fees, may be heard by either WCD or WCB; WCD has original jurisdiction in proceedings involving *solely* these issues.

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 slow and inefficient.

In part to reduce litigation and speed up decisions, the Legislature enacted House Bill 2900 in 1987 and Senate Bill 1197 in 1990. HB 2900 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, which reduces litigation by resolving complaints.

SB 1197 created new administrative review processes and provided for claim disposition agreements. Before 1990, there were voluntary administrative review processes to resolve disputes over claim closure and disability classification (disabling or nondisabling), but 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. First, it restored to WCD jurisdiction over disputes involving proposed medical treatment. 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 frivolous appeals, those made in bad faith, and those intended to harass.

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 in which the worker's attending physician disagrees with the findings of an independent medical examiner, the worker can ask the WCD Benefit and Certifications Unit to select a physician to 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; and (5) appeal of the final order is made to WCD, but the Court of Appeals conducts the review (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 2013, 15 percent of closures were appealed.

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 2012 and 2013, insurers requested reconsideration on 123 and 107, respectively, of their notices of closure.

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 2013 for all review requests (including postponed reviews) and only 23 days for those review requests that did not experience a postponement.

Appellate review orders may be appealed to the WCB Hearings Division. Overall, the trend for appealed orders is downward. In 2013, the rate was 18 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.

Medical disputes

The medical disputes process has been affected by court decisions, legislative changes, and process changes. Following the Court of Appeals' 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 sharply. SB 369 (1995) restored this jurisdiction, and the number of requests rose again. SB 369 also required that disputes concerning the actions of a managed care organization, regarding the provision of medical services, peer review, or utilization review, be handled through the medical dispute resolution process. In 2013, 7 percent of the requests concerned MCO issues.

With SB 728, the 1999 Legislature specified that the Hearings Division had jurisdiction over disputes concerning the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service.

Compensability issues are resolved before other medical issues, such as medical services or the appropriateness of treatment, are considered. Once compensability or causality is determined, a case is sent to the Medical Review Unit for resolution of the medical service dispute. Compensability cases represented just 4 percent of all 2013 medical dispute resolution requests.

In 2008, the number of requests nearly doubled to more than 3,300. This increase was due primarily to the initiation of the medical disputes alternative dispute resolution, which has proven effective with medical fee disputes. Medical fee disputes jumped from 28 percent of all medical disputes issues in 2007 to 63 percent in 2008. Of the 2,189 dispute requests in 2013, 66 percent were medical fee disputes.

The medical dispute process differs from many of the other dispute processes; the injured worker may not be directly involved in the dispute. In 2013, 70 percent of the medical dispute requests were from medical providers; most requests 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 appealed to the WCB Hearings Division; 3 percent were appealed in 2013.

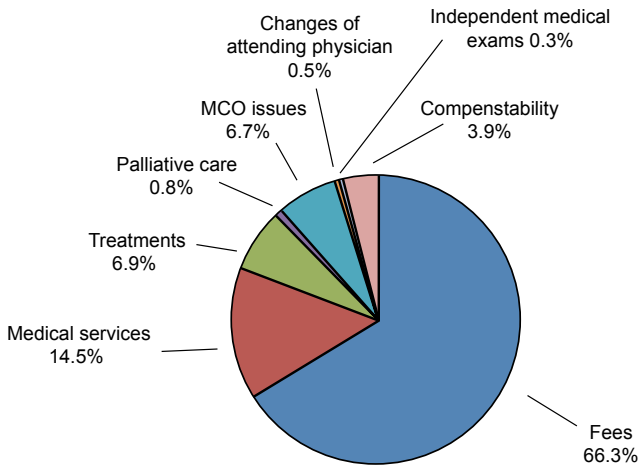
Vocational assistance disputes

The WCD Employment Services Team 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 had been stable during the four years from 2006 to 2009, before declining from roughly 450 to 175 in 2013. There have also been other periods of decline. Most of the long-term decline has resulted from the decline in the number of eligibility determinations for vocational assistance. About 25 percent of vocational eligibility determinations have had a vocational 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 2013, 26 percent of the vocational disputes were resolved through agreement. Another 48 percent were dismissed, often due to a claim disposition agreement; remaining resolutions required a formal administrative order. The insurer prevailed in about 41 percent of those orders. With HB 2091, jurisdiction for appeals of these orders was returned to the WCB Hearings Division. From 2007 to 2011, about 13 percent of vocational dispute review orders, including orders of dismissal, were appealed. In 2012, that number

Figure 15. Medical disputes by issue, CY 2013



dropped to 10 percent and in 2013, it dropped further to only 6 percent.

About 74 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 38 in 2013.

Disputes resolved at the Workers' Compensation Board

The Workers' Compensation Board's Hearings Division provides a forum for timely and impartial dispute resolution. In hearings conducted by administrative law judges (ALJs), 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 with background and understanding of employee concerns. Appeals are heard by at least one "worker" member and one "employer" member.

Hearing requests

The number of requests reached a high of 27,549 in 1989, then dropped substantially in the early 1990s; in recent years (through 2011), the number of requests has declined by about 3 percent per year. From 2011 to 2013, the number of requests has held steady at around 7,600 requests each year. The primary reasons for the decline are legislative changes and fewer disabling claims.

The creation of the reconsideration process by SB 1197 (1990) reduced hearing requests and resulted in a shift in the issues involved. Permanent disability dropped from being an issue in 32 percent of hearing orders in 1989 to 18 percent in 1991. This percentage has continued to drop, and was less than 2 percent in 2013.

SB 369 (1995) also reduced litigation by requiring that workers believing that a condition had been omitted from a notice of acceptance must notify the insurer and not allege a de facto denial in a hearing request.

In 2013, the most common issue at hearings was partial denial, which was at issue in more than 41 percent of hearing orders. Most post-acceptance compensability disputes that don't involve aggravation of the accepted condition are classified as "partial denial." The Legislature specifically provided for major-contributing-cause denials in SB 369.

The median request-to-order time lag for hearings was 121 days in 2013, while the median request-to-order lag for board review was 167 days. The median lag for 2013 Court of Appeals decisions was a record-high 654 days (1.8 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. Since 2008, roughly 400 mediations have been completed; this number was 425 for 2013. 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 90 percent of 2013 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 18 percent in 2013. The appeal rate of hearings orders has been declining slowly, from 12 percent in 1997 to less than 6 percent in 2013. The appeal rate of board-review orders dropped from 30 percent in 1987 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." In the past seven years, board appeal rates have ranged between 12 percent and 18 percent.

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 (CDAs). In 1995, SB 369 prohibited the release of preferred worker benefits. Since 1991, the board has approved an average of about 3,200 CDAs per year. There were 3,025 CDAs in 2013, and the average agreement was more than $20,300. CDAs significantly reduce subsequent litigation because workers relinquish rights for most benefits. Return-to-work studies show that workers who negotiate CDAs often have lower rates of returning to work.

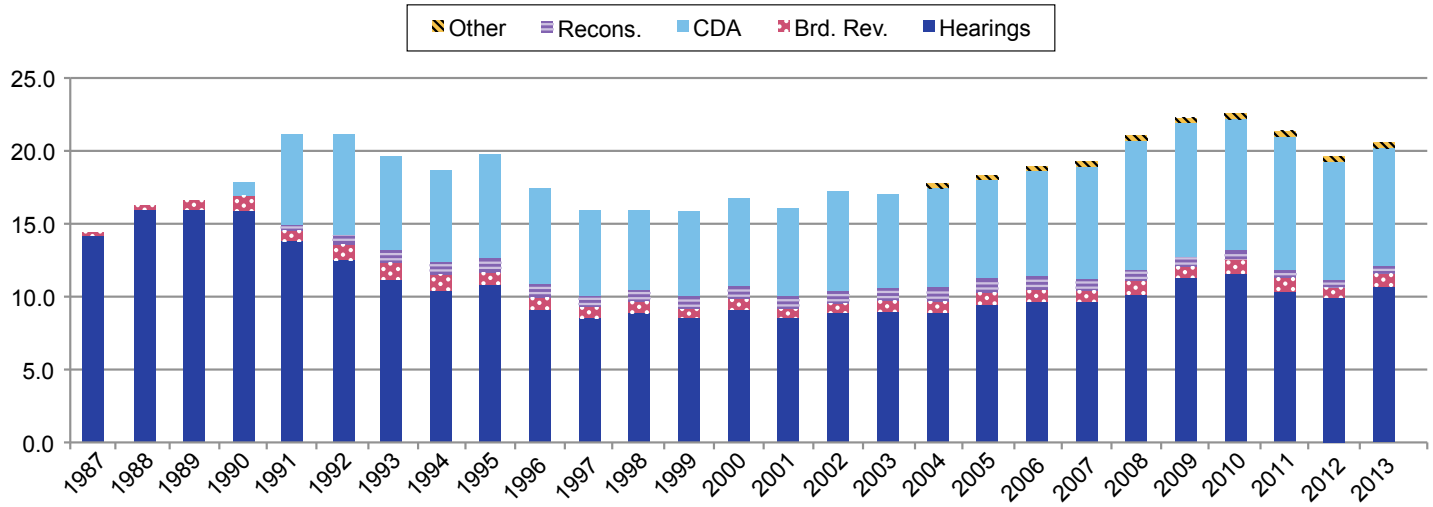
Claimant attorney fees

Fees are awarded to claimant attorneys for (1) getting a reversal of a claim or benefits denial, (2) getting an increase in indemnity benefits, (3) preventing a decrease in indemnity benefits, (4) getting a penalty 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 the others come out of award increases 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,

Figure 16. Claimant attorney fees, 1987-2013



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, except in extraordinary circumstances, to $2,000. It also required a fee when a dispute is settled prior to a contested-case hearing.

Total claimant attorney fees reached a high of $22.6 million in 2010. Fees in 2013 totaled $20.7 million, including $430,000 at reconsideration, $10.8 million at hearing, $886,000 at board review, and $8.3 million for CDAs. Lump-sum settlements (CDAs and disputed claim settlements) have accounted for a growing share of total claimant attorney fees, rising to just less than 70 percent of all claimant attorney fees in 2013.

In 2007, SB 404 made two additions to help claimants and their attorneys recover costs and fees. First, it allows an administrative law judge 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, the administrative law judge may grant the attorney a lien on additional compensation or proceeds from a settlement.

HB 3345, effective January 2010, increased maximum attorney fees allowed in disputes about insurer penalty, responsibility, and medical and vocational services. It also allowed attorney fees in areas for which they weren't provided for earlier (late-paid disputed claim settlement, affirming closure rescission, preventing a reduction of reconsideration awards, and appeal of classification orders), but these provisions were not expected to greatly increase total claimant attorney fees.

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 re-openings for treatment provided in lieu of hospitalization to enable return to work, permitting claims for new or omitted medical conditions after aggravation rights have expired, and allowing permanent disability awards in new or omitted medical condition cases.

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

Appellate review requests and orders, 1991-2013

Year	Requests on closures	Percent of closures appealed	Requests on disabling classifications	Total orders issued	Percent of orders appealed to hearings
1991	6,014	16.5%	26	5,896	49.0%
1992	6,535	20.0%	73	6,463	53.4%
1993	5,937	18.5%	87	5,954	48.1%
1994	5,839	18.0%	99	5,953	47.8%
1995	6,543	20.1%	152	6,420	44.6%
1996	5,352	18.1%	128	5,857	41.2%
1997	4,306	15.2%	100	4,452	38.8%
1998	4,228	15.3%	123	4,282	38.9%
1999	4,025	15.5%	126	4,263	38.7%
2000	3,833	15.3%	132	3,988	33.7%
2001	3,979	16.0%	142	4,021	30.7%
2002	3,906	16.7%	188	4,122	29.6%
2003	3,749	17.1%	205	4,037	28.2%
2004	3,800	17.2%	186	3,950	29.1%
2005	3,531	16.4%	182	3,824	25.3%
2006	3,424	15.2%	198	3,637	24.1%
2007	3,788	16.4%	186	3,941	23.1%
2008	3,527	16.1%	149	3,743	19.2%
2009	3,409	17.5%	147	3,598	21.6%
2010	2,978	16.6%	167	3,215	22.0%
2011	2,714	15.1%	135	2,844	19.1%
2012	2,669	14.8%	135	2,823	18.8%
2013	2,704	15.0%	148	2,852	17.6%

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 2004, insurers may also appeal claim closures when they disagree with findings on impairment by attending physicians.

Since 1995, the number of requests for reconsideration of claim closures has generally been declining; it is currently near its lowest level. This is largely due to the decline in the number of closures.

Requests are a count of the disputed closures, regardless of the number of amending closures that are disputed.

Medical dispute requests and orders, 1990-2013

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	1,049	918	81
2003	1,362	1,293	88
2004	1,350	1,264	87
2005	1,456	1,548	75
2006	1,651	1,745	41
2007	1,823	1,803	28
2008	3,319	2,740	24
2009	3,047	3,822	16
2010	2,950	2,665	11
2011	2,214	2,255	13
2012	2,076	2,104	13
2013	2,189	2,227	10

Medical dispute resolution requests have fluctuated with court decisions and legislative changes. They declined sharply after a court decision limited the department's jurisdiction. SB 369 (1995) reversed this decision and the numbers increased.

In 1999, SB 728 gave authority to the Hearings Division to determine the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service. All other medical disputes are handled by the WCD Medical Resolution Team.

In 2008, the number of requests nearly doubled; this was due primarily to the initiation of alternative dispute resolution, which has quickly resolved medical fee disputes. Since then, the number of requests has fallen, mainly due to the decline in the number of claims.

In 2013, there were 2,227 medical dispute orders. The median time from request to order was 10 days.

Vocational dispute requests and resolutions, 1991-2013

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
2008	469	504	36
2009	451	432	34
2010	306	323	35
2011	200	223	36
2012	176	177	34
2013	174	178	38

The WCD Rehabilitation Review Unit provides administrative review of vocational disputes brought by workers. The number of requests has fallen since 1991, chiefly because of the decrease in the number of vocational assistance cases.

The median time to resolve a dispute was 38 days in 2013; 74 percent were done within the standard of less than 60 days.

Vocational dispute resolutions, by outcome, 2009-2013

Year	Agree-ments	Insurer prevail orders	Worker prevail orders	Other orders	Dismissals
2009	25.9%	22.5%	8.8%	3.9%	38.9%
2010	21.1%	21.7%	9.0%	3.1%	45.2%
2011	22.0%	22.4%	12.6%	3.6%	39.5%
2012	24.9%	19.8%	7.9%	2.3%	45.2%
2013	25.8%	10.7%	10.7%	4.5%	48.3%

The department strives to resolve vocational disputes through agreements. These have ranged from 21 percent to 26 percent of the resolutions.

Alternative Vocational dispute resolutions, by outcome, 2009-2013

	Percent of outcomes less dismissals				
Year	Agreements	Insurer prevail orders	Worker prevail orders	Other orders	Dismissals % of total outcomes
2009	42.4%	36.7%	14.4%	6.4%	38.9%
2010	38.4%	39.5%	16.4%	5.6%	45.2%
2011	36.3%	37.0%	20.7%	5.9%	39.5%
2012	45.4%	36.1%	14.4%	4.1%	45.2%
2013	50.0%	20.7%	20.7%	8.7%	48.3%

The department strives to resolve vocational disputes through agreements. These have ranged from 36 percent to 50 percent of the resolutions less dismissals.

Hearing requests, orders, time lags, and appeal rates, 1987-2013

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%
2008	9,173	9,084	133	7.9%
2009	8,568	9,044	141	7.8%
2010	8,183	8,580	134	8.0%
2011	7,631	7,759	127	7.7%
2012	7,638	7,523	123	7.5%
2013	7,581	7,670	121	5.6%

Hearing requests peaked in 1989. The 7,581 requests in 2013 was the lowest on record and about 28 percent 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. Since the mid-1990s, the decline in the number of claims has been the primary cause of the decline in hearing requests.

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 121 days in 2013.

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.

All data exclude safety cases. WCD contested cases are considered in only the Requests and Orders columns.

Percentage of hearing orders involving selected issues, 1987-2013

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%
2008	4.0%	36.3%	43.5%	7.8%
2009	3.9%	35.8%	44.8%	7.3%
2010	3.5%	34.3%	47.3%	6.9%
2011	2.8%	35.8%	47.3%	5.8%
2012	2.5%	36.6%	45.8%	6.7%
2013	1.7%	34.1%	41.1%	5.6%

Permanent disability was the most frequent hearing issue until 1989, when whole claim denial replaced it. Since 2008, permanent disability has been an issue in 4 percent or less of hearings. Since 1990, partial denial has risen from 9 percent to more than 40 percent of hearings orders.

The reasons for the relative frequency change of permanent disability were HB 2900 in 1987 (disability standards), 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, so these percentages are based on opinion and order cases and settlements.

Workers' Compensation Board mediations, 1996-2013

Year	Mediations completed	Percent settled	Percent of settlements resolved by DCS
1996	128	84%	81%
1997	250	92%	82%
1998	233	90%	87%
1999	216	90%	84%
2000	280	89%	87%
2001	248	85%	93%
2002	285	86%	85%
2003	241	86%	88%
2004	268	84%	81%
2005	270	87%	82%
2006	356	88%	77%
2007	346	89%	79%
2008	398	90%	76%
2009	487	89%	80%
2010	439	91%	81%
2011	406	90%	82%
2012	387	89%	85%
2013	425	91%	78%

The board's mediation program began in June 1996.

The 91 percent settlement rate of 2013 mediations nearly equals the highest rate on record.

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

Note: Data through 2005 are based on mediation worksheets; data for 2006 and after are based on mediation events in the board's data system.

Issues in WCB mediations, 1996-2013

Year	Disease	Compensability	Non-WCB issues
1996	50%	N/A	N/A
1997	50%	90%	40%
1998	44%	98%	47%
1999	63%	N/A	46%
2000	41%	97%	43%
2001	49%	99%	51%
2002	42%	95%	55%
2003	41%	99%	45%
2004	31%	97%	50%
2005	67%	94%	47%
----------> series break			
2006	47%	82%	31%
2007	27%	83%	38%
2008	28%	77%	31%
2009	27%	78%	30%
2010	33%	81%	26%
2011	30%	84%	30%
2012	30%	83%	33%
2013	26%	81%	24%

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

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

In 2008, the cases resolved by mediation that included compensability as an issue dropped to an all-time low of 77 percent. The percentage of mediations that included non-WCB issues has ranged from 2013's record-low 24 percent to 55 percent.

In 2006, the mediations went from a paper system to a computer system. The percentages from 2006 forward are different from those reported in previous reports due to a change in computation methods.

Board review requests, orders, time lags, and appeal rates, 1987-2013

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%
2008	625	721	196	14.6%
2009	601	582	172	12.9%
2010	588	614	187	12.4%
2011	517	551	189	14.0%
2012	492	493	185	17.8%
2013	426	473	167	13.3%

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 7,000 in 1988 to fewer than 900 in 2013.

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. One reason was that 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, 1987-2013

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
2008	198
2009	166
2010	213
2011	156
2012	139
2013	120

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 curative treatment is in lieu of hospitalization, new and omitted medical condition claims, and permanent disability. These actions may account for the increase in orders in 2003 to 2005 over 2002.

Lawmakers in 2005 (HB 2294) required that a condition must be compensable before an own-motion claim may be processed, reducing numbers of own-motion claims. The decline since 2010 has been driven largely by fewer claims form private insurers.

Court of Appeals requests, decisions, and time lags, 1987-2013

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
2008	105	47	476
2009	75	38	553
2010	76	48	573
2011	77	49	586
2012	88	34	482
2013	63	32	654

Appeals to the court peaked in 1992; in 2013, the number of appeals, 63, was just 9.0 percent of the peak value in 1992.

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 reached a record-high 654 days (1.8 years) in 2013.

Notes: Decisions exclude court dismissals and remands where the court did not rule on the primary issue nor 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, 1987-2013

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
2008	541	855	1,455
2009	564	890	1,790
2010	581	867	1,570
2011	539	902	1,681
2012	498	862	1,434
2013	650	857	1,997

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 2013 court lag of 1,997 days equates to nearly 5.5 years.

Disputed claim settlements, 1987-2013

Year	Cases	Amount ($ millions)	DCSs with CDAs
1987	3,778	$18.2	N/A
1988	4,139	21.6	N/A
1989	4,365	22.5	N/A
1990	5,374	29.1	90
1991	6,021	32.6	768
1992	5,006	26.7	944
1993	4,784	26.0	1,069
1994	4,164	21.6	1,057
1995	4,507	22.7	1,330
1996	4,056	19.7	1,313
1997	3,895	19.6	1,355
1998	3,956	20.7	1,364
1999	3,761	20.0	1,372
2000	4,074	23.5	1,599
2001	3,967	22.1	1,619
2002	3,999	24.0	1,765
2003	3,774	23.0	1,614
2004	3,281	21.8	1,479
2005	3,461	23.4	1,496
2006	3,221	23.2	1,392
2007	3,324	24.8	1,505
2008	3,379	27.8	1,622
2009	3,652	32.0	1,738
2010	3,394	33.9	1,718
2011	3,351	32.3	1,684
2012	3,253	29.9	1,590
2013	3,578	34.4	1,619

The number of DCSs has remained fairly steady over the past ten years, averaging just under 3,400 per year. In 2013, DCSs were 47 percent of all hearing orders.

The DCS settlement amounts exceeded $34 million in 2014; the amounts have been fairly constant over the past five years.

Insurers and claimants often negotiate DCSs and CDAs at the same time. Over the past decade, 47 percent of the DCSs have been accompanied by a CDA issued at approximately the same time.

Notes: While most DCSs are issued at the Hearings Division, about one percent are issued by the Board. The figures since 1992 include the DCSs issued by the Board. Since 2000, the figures include DCSs approved by the Board after a remand or dismissal by the Court of Appeals.

The settlement amounts include the claimant attorney fees.

The DCSs with CDA figures are the DCSs with a CDA issued within 60 days of the DCS order date. In some cases the two settlements may occur in different years.

Claim disposition agreements, 1990-2013

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	3,050	52.5
2008	3,182	62.6
2009	3,446	64.6
2010	3,304	65.7
2011	3,180	66.2
2012	2,956	58.5
2013	3,025	61.4

SB 1197 authorized claim disposition agreements in 1990. In 2004, 2,869 CDAs were approved, the fewest since 1991. Since that time, the numbers of CDAs approved and total dollar amounts have risen to a smaller peak in 2009. Amounts continued to rise through 2011, when a record $66.2 million was paid in CDAs. Both the numbers and dollar amounts approved have dropped slightly since 2011.

Total amounts include claimant attorney fees.

Claimant attorney fees and defense legal costs, 1987-2013

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
2006	19.0	29.7
----------->Series break #2		
2007	19.3	30.2
2008	21.1	32.4
2009	22.3	37.9
2010	22.6	38.3
2011	21.4	36.2
2012	19.7	36.0
2013	20.7	34.2

Claimant attorney fees peaked in 1991 and 1992 at about 49 percent above 1987 fees; they didn't reach that level again until 2009.

Defense legal costs peaked in 1992 and were rising again after 2002, reaching the highest level on record in 2010.

Both claimant fees and defense costs declined in 2012; in 2013, claimant fees rose while the defense costs continued to decline.

Defense legal costs differ from claimant attorney fees in several ways: They are the actual amounts paid rather than the amounts in rule; they are not reversible on appeal; and 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 percent to 1.9 percent of the total.

Break #2. For 2007, data on fees for WCD contested cases at hearing and board own motion were available. Added fees in 2007 were 0.4 percent of total fees. Own-motion fees are estimated.

Claimant attorney fees, 1987-2013

Year	Hearings ($ thousands)	Board ($ thousands)	CDA ($ thousands)	Reconsideration ($ thousands)	Other ($ 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	880	
1996	9,100	857	6,677	819	
1997	8,518	753	5,999	675	
1998	8,863	802	5,664	757	
1999	8,537	612	5,908	756	
2000	9,128	693	6,118	776	
2001	8,540	612	6,115	826	
2002	8,914	626	6,880	771	
2003	8,989	721	6,540	810	
	----------->Series break #1				
2004	8,886	790	6,787	893	334
2005	9,490	762	6,784	976	333
2006	9,681	757	7,294	938	288
	----------->Series break #2				
2007	9,647	746	7,692	814	393
2008	10,139	951	8,856	707	381
2009	11,295	778	9,129	670	314
2010	11,603	980	9,008	576	387
2011	10,382	900	9,200	494	393
2012	10,007	860	7,964	474	370
2013	10,771	886	8,277	430	381

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 in 2003 changed penalty fees from one-half of the penalty to fees proportional to the benefit. The maximum fee is $3,000.

HB 3345 increased maximum fees in responsibility and penalty disputes, as well as providing for fees in a few additional areas.

In 2013, 42 percent of all claimant attorney fees came from CDAs.

For information about series breaks, see comments in previous table.

Claimant attorney fees from lump-sum settlements, 1989-2013

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	63.6%
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	61.5%
2006	4,270	146	11,710	61.7%
2007	4,528	152	12,373	64.1%
2008	4,847	226	13,966	66.3%
2009	5,508	150	14,873	66.8%
2010	5,830	178	15,016	66.6%
2011	5,490	194	14,884	69.7%
2012	5,157	162	13,283	67.5%
2013	5,969	154	14,400	69.6%

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, a level reached again in 2008. In 2013, lump-sum fees were almost 70 percent of all claimant attorney fees and were the second highest recorded.

In 1989, DCSs accounted for 26 percent of all hearing fees. This percentage peaked in 2002 at 50 percent; it reached 50 percent again in 2010, and a record-high 55.4 percent in 2013.

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

Maximum out-of-compensation attorney fees, 1988 to present

Hearings	1/1988 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	**1/1988 to 2/1999**	**2/1999 to 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

PTD is permanent total disability. PPD is permanent partial disability. DCS is disputed claim settlement. CDA is claim disposition agreement.

For PTD, PPD, and time loss, attorney fees allowed are 25 percent of increased compensation award, subject to these limitations. Fees may exceed these limitations in extraordinary circumstances.

Insurance and Self-insurance

Oregon law requires that every employer 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 (WCD) 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 was 149 percent of the national median in 1990. After the initial reforms in 1994, it dropped to 85 percent of the national median. Since then, Oregon's rates have generally been between 79 percent and 85 percent of the national median. Oregon's average rate was 74 percent of the national median in 2014.

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 of the principal reasons for the Legislature's 1990 special session.

Before 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 claim 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 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 ratemaking 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 more than 500 rating classifications, based on expected losses. These rates are subject to the approval of the Oregon insurance commissioner. Pure premium only covers benefit costs; it is based on claims from recent injuries.

Oregon had a period of 21 years, from 1991 through 2011, without an increase in workers' compensation pure premium rates. Small pure premium increases were approved for 2012 and 2013 rates. Fairly large pure premium decreases were approved for the 2014 and 2015 rates. The cumulative effect of these pure premium rate changes is that 2015 pure premium rates are 81 percent of the 2007 rates.

Under Oregon's ratemaking system, each insurer develops a loss-cost multiplier, which covers the insurer's operating expenses, taxes, profit, and contingencies. This factor is multiplied by the pure premium rate for a rating classification to arrive at the manual rate. The manual rate is applied to the employer's payroll to determine gross premium. In 2013, the average expense-loading factor for SAIF and private insurers was 25.6 percent.

Workers' compensation total system written premiums totaled $880.1 million in 2013. Premiums exceeded

$1 billion in 2007. From 2007 to 2010, the premium dropped 30 percent to $729.1 million. With the economic recovery, premiums have begun growing again.

The department defines total system written premiums as:

- Premiums written by SAIF
- Premiums written by private insurers
- Credits from the large-deductible premium policies issued by private insurers, and
- Simulated premium that is calculated for each self-insured employer to set its workers' compensation assessment.

Total system written premiums can be used to determine workers' compensation market share. In 2013, SAIF's share of the market was 50 percent. This represents SAIF's largest market share since at least 1980.

Although 481 private insurers were authorized to write workers' compensation insurance in Oregon, only 213 reported positive premium written in 2013. Private insurers had 35 percent of the market.

One measure of an insurer's financial condition is its loss ratio. The loss ratio is defined as incurred losses divided by earned premiums. In 2013, SAIF's loss ratio was 55.0 percent, and private insurers' average loss ratio was 51.2 percent. These ratios are among the lowest loss ratios reported in the past 25 years.

Another measure of an insurer's financial condition is the dividends it pays to its policyholders. Dividends depend on premiums and insurers' profitability in previous years. SAIF paid about $630 million in dividends during the period from 2010 to 2013. Private insurers paid $3.4 million over the same period.

Large-deductible premium policies

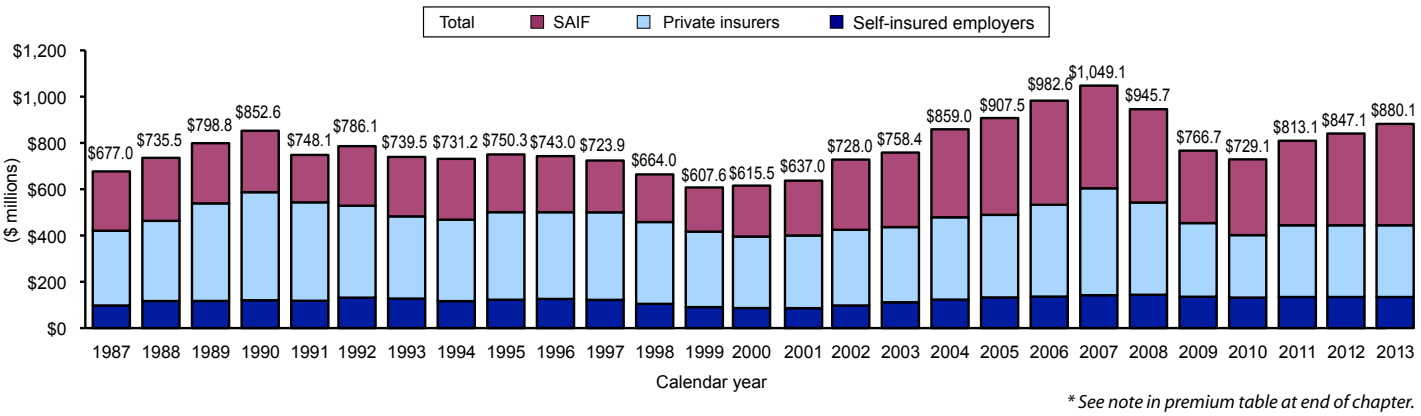
In 1996, large-deductible premium policies were added as an option for Oregon employers. Under these policies, insurers administer workers' compensation claims and pay the claims costs. Employers then reimburse insurers for claims costs up to the specified deductible amount. Employers pay lower premiums for these policies. However, insurers and employers are assessed on the premium before the deductions. Premium credits, a measure of the market share of this arrangement, represent the differences in premium with and without the reported deductions.

Few credits were applied in 1996, but the program grew rapidly to $96.9 million in credits in 2007. Although the number of credits fell during the recession, the number had returned to $97.0 million in 2013. These credits represented 32 percent of the private-sector portion of the workers' compensation market.

Self-insured employers and groups

To become self-insured, an employer 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. The self-insured

Figure 17. Total system written premiums, by insurer type, 1987-2013



** See note in premium table at end of chapter.*

employer must also have deposits with the Workers' Compensation Division. These deposits protect injured employees in the event of the employer's bankruptcy.

Employers can form into self-insured employer groups if all of the employers in the group are members of an organization; the employers in the group constitute at least 50 percent of the employers in the organization (unless the number of covered workers in the group exceeds 500, in which case the employers in the group must constitute at least 25 percent of the employers in the organization); and the grouping of employers is likely to improve accident prevention, claims handling for the employers, and reduce expenses. Employers who are members of the group are jointly liable for one another's workers' compensation claims. Self-insured groups must also provide surety bonds or letters of credit to the department to securitize their claim liabilities.

In 2010, there were seven self-insured employer groups. A self-insured employer group representing the contracting industry filed for bankruptcy in early 2011, the first time a group had become insolvent. Another group decertified in 2012, and the department came close to decertifying an additional group in 2013.

As a result of these issues, the Legislature enacted SB 1558 (2014). The legislation created a number of reforms. It required that the group members vote by July 1, 2014, to remain a group. Those groups that voted to dissolve or were already out of operation are allowed use of Workers' Benefit Fund monies to pay claim costs. The legislation also gave the director more authority over these decertified groups. The three groups in financial trouble were decertified under the provisions of this legislation.

SB 1558 also set additional requirements for the remaining four self-insured employer groups.

Oregon Workers' Compensation Insurance Plan (assigned risk plan)

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 such a plan. In 1980, the commissioner adopted rules constituting the Oregon Workers' Compensation Insurance Plan and establishing the state's assigned risk plan (ARP).

In 1991, a tiered rating plan was introduced for ARP employers too small to qualify for experience rating plans. Under the plan, small employers receive a premium discount. Most of the employers in the ARP 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 half a million dollars a year.

In 2007, the department released a report that it completed with technical expertise and guidance from the National Council on Compensation Insurance. The report found that the Oregon assigned risk plan was working well and did not need major changes. Recommendations were made in three areas:

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

HB 2250, effective Jan. 1, 2008, allows a surcharge to ARP members to help pay the costs of assigned risk plan losses when they exceed premiums. Before this, when losses exceeded premiums, the voluntary market had to make up the difference. The current plan is not to implement this surcharge but to carry on as before. This bill implements one of the recommendations from the ARP study.

Currently under Oregon's assigned risk plan, SAIF, LM Insurance Corp., and Travelers Property & Casualty Insurance Co. of America act as service providers. Premium rates paid by ARP 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 use of the assigned risk plan has risen and fallen over time. At the most recent peak in 2005 over 13,000 employers were in the plan. With an effort to encourage employers to enroll in the voluntary market and due to the effects of the recession, the number of employers in the plan fell to fewer than 8,000 in 2010. With the recent recovery, the number of employer is increasing again. In 2013, there were about 8,800 plan participants; the premiums paid by these employers were 6.8 percent of all written premium (per NCCI).

Oregon Insurance Guaranty Association

The Oregon Insurance Guaranty Association (OIGA) 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 premium assessment

An assessment on workers' compensation premium funds much of the regulation of the Oregon workers' compensation system. Insurers collect the assessment revenue 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 (PAOA). The PAOA also receives some fines and penalties, federal grant money, investment income, and other miscellaneous revenue. The account funds the department's programs related to workplace safety and workers' compensation. Senate Bill 592 in 1999 established the current rules for setting the assessment rate. Some funds are paid to the Oregon Institute of Occupational Health Sciences at the Oregon Health and Science University. At times, the Legislature has also used the account to fund other programs.

Workers' compensation premiums and rate changes, 1987-2015

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	744.0	-0.8%	-1.8%	-37.0%
1997	733.2	-1.5%	-10.5%	-43.6%
1998	675.3	-7.9%	-15.6%	-52.4%
1999	607.6	-10.0%	-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	6.8%	-2.1%	-58.3%
2008	945.7	-9.9%	-2.3%	-59.2%
2009	766.7	-18.9%	-5.9%	-61.6%
2010	729.1	-4.9%	-1.3%	-62.1%
2011	813.1	11.5%	-1.8%	-62.8%
2012	847.2	4.2%	1.9%	-62.1%
2013	880.1	3.9%	1.7%	-61.5%
2014	N/A	N/A	-7.5%	-64.4%
2015	N/A	N/A	-5.3%	-66.3%

Total system written premiums exceeded $1 billion in 2007. During the most recent recession and its aftermath, premiums fell sharply. The $729.1 million in CY 2010 was 31 percent below the CY 2007 high, and the CY 2013 figure is still 16 percent below the CY 2007 figure. Pure premium rate declines accounted for about half of the 16 percent decline in premium volume between 2007 and 2013; economic factors account for the rest of the decline.

Beginning in 1990, Oregon had a 21-year period without an increase in pure premium rates. Small increases were approved for 2012 and 2013, followed by fairly large decreases for 2014 and 2015. Through 2015, workers' compensation pure premium rates had declined over 66 percent since 1990.

Notes: Total system written premiums are defined as the premium written by SAIF and private insurers, plus the credits for large-deductible premium policies, and the simulated premium calculates for self-insured employers.

* SAIF Corporation reported that its 2007 written premium amount was artificially inflated due to a policy system conversion, which now recognizes annual written premium at policy inception. SAIF estimated that this one-time adjustment inflated 2007's written premium by $143.8 million. This inflated figure is included in the total system written premium. It has been removed, however, from the calculation of the annual change in written premium in 2007 and 2008. This was done to better show the real change in premium.

Workers' compensation average premium rate ranking, 1986-2014

Year	Rate ranking	% of study median rate
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%
2010	41st	83%
2012	39th	84%
2014	43rd	74%

Oregon's average premium rate ranking was the 43rd highest in the nation in 2014. The average premium index was 74 percent of the national study median (a record low). Oregon's average premium has been between 74 percent and 85 percent of the national median in almost every study since 1994.

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 may produce different rankings.

Workers' compensation market share, by insurer type, 1987-2013

Year	SAIF	Private insurers	Self-insured employers
1987	37.9%	47.7%	14.4%
1988	37.0%	47.1%	15.9%
1989	32.5%	52.8%	14.7%
1990	31.1%	54.8%	14.1%
1991	27.3%	56.9%	15.8%
1992	32.7%	50.5%	16.7%
1993	34.7%	48.0%	17.2%
1994	36.0%	48.1%	15.9%
1995	33.2%	50.4%	16.3%
1996	32.6%	50.4%	17.0%
1997	30.9%	52.3%	16.8%
1998	31.0%	53.2%	15.8%
1999	31.4%	53.7%	14.9%
2000	35.7%	50.2%	14.0%
2001	37.2%	49.3%	13.5%
2002	41.7%	44.9%	13.4%
2003	42.5%	42.8%	14.7%
2004	44.3%	41.4%	14.3%
2005	46.1%	39.3%	14.6%
2006	45.8%	40.4%	13.9%
2007 *	42.4%	44.0%	13.6%
2008	42.6%	42.1%	15.2%
2009	40.8%	41.5%	17.7%
2010	44.9%	37.0%	18.1%
2011	44.9%	38.6%	16.5%
2012	47.2%	36.6%	16.2%
2013	49.6%	34.7%	15.7%

In 2013, SAIF had 49.6 percent of the market, as measured by total system written premiums, its highest recorded value. Private insurers' share was 34.7 percent, its lowest share since 1981.

* Note: SAIF Corporation reported that its 2007 written premiums were artificially inflated due to a policy system conversion, which now recognizes annual written premiums at policy inception. SAIF estimated that this one-time adjustment has inflated 2007's written premiums by $143.8 million. This amount was removed from SAIF's premiums in the computation of the 2007 market shares.

Earned large-deductible premium credits, 1996-2013

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%
2008	87.8	22.0%
2009	75.7	23.8%
2010	63.6	23.6%
2011	82.3	26.2%
2012	79.5	25.7%
2013	97.0	31.7%

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 reached a peak in dollar volume of $96.8 million in 2007. The amount of these credits dropped by 34 percent from 2007 to 2010. The drop was completely recovered by 2013, when the credits totaled $97.0 million.

The use of these premium credits continued to grow as a percentage of private insurer premium, even through the recession.

SAIF Corporation financial characteristics, 1987-2013

Year	Total system written premiums ($ millions)	Loss ratio	Loss cost multipliers	Dividends ($ millions)
1987	$256.3	114.4	1.190	$0.5
1988	272.2	134.8	1.251	0.6
1989	259.8	104.8	1.270	0.0
1990	265.4	69.3	1.229	20.4
1991	204.6	72.6	1.200	17.7
1992	257.4	3.7	1.211	22.6
1993	256.8	121.0	1.209	32.6
1994	262.9	69.2	1.178	29.7
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
2008	403.1	87.5	1.204	0.0
2009	312.9	88.6	1.201	0.0
2010	327.4	98.6	1.195	200.5
2011	365.2	65.5	1.197	150.0
2012	399.8	66.1	1.209	149.9
2013	436.2	55.0	1.213	129.2

SAIF's written premium has grown significantly during two recent periods: between 1999 and 2006, written premium grew by about 13 percent per year; and between 2009 and 2013, growth was 8.7 percent per year.

SAIF's loss ratio (incurred losses divided by earned premiums) was 55.0 percent in 2013.

SAIF's loss cost multiplier covers operating expenses, taxes, profit, and contingencies. This factor is multiplied by the pure premium rate and applied to the employer's payroll to determine gross premium.

SAIF has paid almost $630 million in dividends in the past four years. (The negative dividend figure in 2002 represented uncashed dividend checks credited back to SAIF.)

* Note: SAIF Corporation reported that its 2007 written premium amount was artificially inflated due to a policy system conversion, which now recognizes annual written premium at policy inception. SAIF estimated that this one-time adjustment has inflated 2007's written premium by $143.8 million. Therefore, a more representative figure for SAIF's 2007 premium is $445.1 million.

Private insurers' financial characteristics, 1987-2013

Year	Total system written premiums ($ millions)	Loss ratio	Loss cost multipliers	Dividends ($ millions)
1987	$323.1	84.6	1.262	$3.0
1988	346.5	80.0	1.264	7.1
1989	421.8	83.3	1.266	8.4
1990	467.0	69.0	1.279	7.6
1991	425.5	61.9	1.308	10.0
1992	397.2	65.6	1.300	14.3
1993	355.2	66.1	1.301	10.1
1994	351.6	72.8	1.289	12.5
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	1.415	1.9
2008	398.5	71.0	1.397	1.1
2009	318.3	66.2	1.362	2.9
2010	269.9	109.1	1.363	1.1
2011	313.7	66.0	1.344	1.2
2012	310.1	50.1	1.339	0.6
2013	305.8	51.2	1.342	0.5

Private insurers' written premium (including large-deductible premiums) grew at a rate of 5.9 percent per year between 2000 and 2007. After falling during the recession, it has been in the range of $305.8 million to $318.3 million for four of the past five years. During this leveling period for private insurers (2009 - 2013) SAIF's written premium has climbed rapidly. One factor in this different recovery between SAIF and the private insurers is that Liberty NW has gone from a high of $122.5 million in 2006 down to $26.5 million in 2013. Excluding Liberty NW, the private market has been growing by 34 percent since 2010.

The loss ratio for all private insurers (incurred losses divided by earned premiums) was 109.1 percent in 2010. This was the first time the loss ratio had been above 100 since 1984. It has now dropped to a level of 50.8.

Each private insurer develops a loss cost multiplier to cover operating expenses, taxes, profit, and contingencies. These factors are multiplied by the pure premium rate and applied to the employer's payroll to determine gross premium. The average 2013 factor was 1.342.

WC Insurance Plan (Assigned Risk Pool) characteristics, 1987-2013

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%
2008	10,617	38.2	5.4%
2009	9,242	24.3	4.5%
2010	7,853	21.9	4.2%
2011	7,875	22.3	3.7%
2012	7,956	31.4	5.0%
2013	8,794	43.6	6.8%

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. It has again cycled, down to 4 percent of written premium in 2010 and 2011 and climbed back up in 2012 and 2013.

Although the number of employers in the pool stayed roughly constant from 2004 through 2007, the pool premium declined as a percentage of written premium. From 2008 to 2010, the number of covered employers decreased markedly. Fewer than 8,000 employers were in the pool during 2010-2012. 2013 saw a marked increase in covered employers, but still less than the 2002-2009 range of values.

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 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) (In 2007, HB 3400 rescinded this change.)

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 length 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 a civil penalty can be recorded as a judgment from 10 days 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 and Claims Processing

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)

656.268 (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))

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)

656.160 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) (SB 485 reduced the time to 60 days in 2001.)

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)

656.268 (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))

656.273 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)

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

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)

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

656.005 (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)

656.012 (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 the 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 (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)

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)

656.726 (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

656.027 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)

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 January 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)

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 (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)

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

656.017 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)

656.210 (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)

656.266 (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)

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 he or she 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)

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)

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 the Management-Labor Advisory Committee. (SB 914)

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)

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)

656.273 (3) and (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)

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)

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)

2009
656.802 (5) Presumes that the death, disability or impairment of nonvolunteer firefighters who have completed five or more years of employment is an occupational disease when the condition is caused by certain cancers. Denial of the claim for any condition or impairment must be on the basis of clear and convincing medical evidence that the condition was not caused or contributed to by the firefighter's employment. The first diagnoses by a physician must occur after July 1, 2009. (HB 2420)

The Legislature created the Interagency Compliance Network. State agencies, including the Department of Consumer and Business Services, were charged with working to establish consistency in agency determinations relating to the classification of workers, including but not limited to classification of workers as independent contractors. The agencies will share information to better ensure that workers and employers comply with laws relating to taxation or employment, including workers' compensation law. (HB 2815)

2011
656.268 (7) and 656.325 When both parties agree, provides for a delay of up to 45 days in order to reach a settlement agreement. Also provides that the worker's permanent disability payments continue throughout the settlement negotiations.

2013
656.018 Extended the exclusive remedy protection to include an employer's partners, LLC members, and similar corporate entities. The measure also clarified that exclusive remedy can be negated when an employer's negligence is a substantial factor in causing the injury or illness and occurs outside of the employer's capacity. (SB 678)

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 (MLAC). (SB 1197)

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

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))

1995
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
656.790 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' compensations 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; the report to the 75th Oregon Legislative Assembly was 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 in 1995 changed the maximum from 20 percent to 40 percent.)

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 (IME) 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 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) (SB 563 revised this section in 2007, 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)

2009

656.245 (2)(a) Clarified that the medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker for a period of 30 days from the date of the first visit on the initial claim or for 12 visits, whichever occurs first. (HB 2197))

656.245 (2)(b)(C) Restored chiropractors' ability to make impairment findings if they are serving as the attending physician at the time of claim closure. (HB 2197)

2011

656.260(20) Authorizes the DCBS director to impose civil penalties and issue cease-and-desist orders against a person or company that actively manages the care of injured workers but is not certified as a managed care organization. (HB2093)

656.005 (12)(A) Allows podiatric physicians and surgeons to serve as attending physicians without limitations. (HB 2743)

656.313 Allows a worker to pay unpaid medical bills out of a settlement agreement, but limits the amount to the workers' compensation fee schedule amount and requires that providers accept that amount. Previously, workers were only allowed to authorize 50 percent of the fee schedule amount to be paid from the settlement agreement and the provider could bill the worker for the balance of usual and customary charges, which are often substantially more than the fee schedule amount. (SB 173)

2013

656.245 and 656.260 Extends authority of authorized nurse practitioners to treat and authorize time-loss from 120 to 180 days and allows an injured worker enrolled in a managed care organization (MCO) to be treated by a non-MCO chiropractor under specified circumstances that focus on a current patient-provider relationship. (SB 533)

2014

656.247 Modifies interim medical benefits when an injured worker has a health benefit plan (HBP) and will ensure that injured workers will not have to wait for treatment while the approval or denial of their workers' compensation claim is pending. (HB 4014)

Indemnity Benefits

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)

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)

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)

2007

656.790 (2) Required the 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. (HB 2244)

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

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)

2009

656.204 (1) and (8)(b) Improved the benefits to beneficiaries when a worker is killed on the job or dies while permanently and totally disabled from a work injury. If a worker dies before his or her permanent partial disability award is fully paid, the insurer must pay the full remainder of the permanent disability benefit to the worker's estate. (SB 110)

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 Re-employment 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)

1999

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

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)

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)

2009

656.340 (9) Moved from the certification of vocational assistance provider organizations to their registration. (HB 2195)

656.340 (1)(b) (B) Allowed insurers and self-insured employers to forego a vocational evaluation if the worker is released for regular work but has not returned to work. (HB 2705)

656.340 (12) and (16) For workers actively engaged in vocational training, allowed insurers or self-insured employers to voluntarily extend the payment of temporary disability compensation to a maximum of 21 months; the former length was 16 months. Also modified the vocational assistance dispute resolution process. (HB 2195)

656.622 (10) Clarified that neither insurance premiums nor premium assessments under this chapter are payable for preferred workers during the first three years from the date they were hired. (HB 2197)

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 the 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 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 a 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 cases 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 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 cost 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 nonsubjectivity 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 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 the 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 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)

2009

656.248 (12) Allowed the parties to resolve medical fee disputes informally without requesting an administrative review by the director. (HB 2197)

656.262(11), 656.308(2), and 656.385(1) Increases maximum claimant attorney fees as follows: for succeeding on an issue of insurer penalty, from $2,000 to $3,000; for prevailing against a responsibility denial, from $1,000 to $2,500; and for prevailing on medical or vocational services denial, from $2,000 to $3,000. Provides for annual adjustment of maximum fees based on the average weekly wage. (HB 3345)

656.262(12), 656.382(2), and 656.386(3) Adds provisions for claimant attorney fees as follows: for a penalty for late-paid disputed claim settlements; for affirming closure rescissions or preventing a reduction of reconsideration awards; and for insurer nontimely response to reclassification requests and when insurers appeal classification orders and the claim is finally found to be disabling. (HB 3345)

656.386 (3) Allowed for penalties when an insurer or self-insured employer does not respond within 14 days to a claimant request for a claim reclassification. (HB 3345)

Note: Authorizes the Management-Labor Advisory Committee to study the effects of changes to attorney fees.

2013

656.726 Provides authority to the Workers' Compensation Board to adopt new rules and revise existing rules that allow the electronic transmission and signature of filings, notices, and other documents. (SB190)

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) (In 2005, HB 3018 increased this to $1,500; in 2007, SB 762 indexed this to medical inflation.)

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 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 that portion of the Insurance Code governing unfair claims settlement practices and undefined trade practices. (SB 24)

1993

656.018, 656.403, 656.850, 656.855, and 737.270 Established 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 will 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)

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 money advanced. (SB 977)

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)

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

656.430 (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, if necessary, on assigned risk plan members 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 in requiring the employer 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 the effect 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)

2014

ORS 656.407, 656.430, 656.434, 656.443, 656.506 and 656.614 Provides an orderly exit for self-insured employer groups who choose to stop operating as a group, if their members vote to do so. Groups that continue would need to meet higher standards. The bill helps keep some Oregon employers in business and ensure there are adequate funds to pay their injured workers' claims, while increasing the department's ability to regulate self-insured groups. (SB 1558)

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 Workers' Compensation Board 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 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 reversed 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 director's 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 for the need for treatment.

Stockdale v. SAIF Corporation, 192 Or App 289 (2004) The Court of Appeals ruled that an insurer could both accept and deny parts of a combined condition in the same document as long as the denial 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 of Appeals 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 nonmember 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. Terrien, 221 Or App 671 (2008) The court ruled that claimant's attorney was not entitled to an assessed fee for prevailing against SAIF's challenge to a finding of premature closure in an order on reconsideration. The court found that the intent of the Legislature was to allow such a fee when compensation actually awarded is not disallowed or reduced, not just when the attorney's efforts create the potential for benefits. HB 3345, passed in 2009, effectively "reversed" this case by specifically allowing assessed fees when attorney efforts result in the affirmation of an order rescinding a notice of closure.

Murdock v. SAIF, 223 Or App 144 (2008) The court ruled that the worker's diabetic condition was not a cause of his toe infection, but merely rendered him more susceptible to infection. Susceptibility cannot be considered a cause for the purpose of determining major contributing cause, so the denial must be reversed.

2009

SAIF v. Sprague, 346 Or 661 (2009) The Court of Appeals had ruled that, for the gastric bypass surgery to be compensable, the need for the surgery for weight loss must be caused by the accepted knee condition. The Oregon Supreme Court agreed that the surgery is compensable, but based on different reasoning. To establish compensability of the surgery, two requirements must be met: (1) the current condition (knee) must be caused in major part by the compensable knee injury and (2) the bypass surgery must be "directed to" that current condition.

2010

Liberty Northwest Insurance Corp. v. Watkins 347 Or 687 (2010) The Oregon Supreme Court, after careful analysis of the statute text, found that an assessed fee in a medical dispute may be awarded, despite a CDA that had released all allowable benefits. Further, the high court found this interpretation to be consistent with the Legislature's intent to provide medical services for the life of a worker.

Pilgrim v. Delta Airlines, 234 Or APP 80 (2010) The court found that when the pre-existing condition and the combined condition are both work related, compensability requires only that the worker establish that "employment conditions" are the major contributing case of the combined condition.

Merten v. PGE Company, 234 Or App 407 (2010) A worker's civil action alleged that the employer's fraudulent inducement not to appeal a denial effectively denied him the opportunity for remedy within the workers' compensation system. The trial court granted summary judgment, reasoning that the Board had exclusive jurisdiction. The Court of Appeals reversed (allowed the action to proceed), finding that the fraud claim was not for a "compensable injury" and was not within workers' compensation law. The fraud didn't occur in a workers' compensation hearing.

Hopkins v. SAIF, 349 Or 348 (2010) The Supreme Court held that, for the purpose of defining "pre-existing condition," the Legislature intended the statutory term "arthritis" to mean the inflammation of one or more joints, due to infectious, metabolic, or constitutional causes, and resulting in breakdown, degeneration, or structural change. The court found that the Legislature had intentionally left "arthritis" undefined. Further, it determined that the term should not be limited to inflammation of moveable joints. See Karjalainen (2006), above.

2011

Basin Tire Service/Argonaut v. Minyard, 240 Or App 715 (2011) The Court of Appeals found that, when a worker must file an aggravation claim in order to receive medical benefits, the worker is entitled to pursue the aggravation claim, despite the earlier approval of a claim disposition agreement.

Sandberg v. JC Penney Co, 243 Or App 342 (2011) The Court of Appeals determined that the injury to a worker, who was required to work at home, arose out of (was caused by) her employment. The court reasoned that home hazards (risks) are also employment hazards in this situation, despite the lack of employer control over the premises. (The court remanded for the determination of the other prong of the compensability issue, whether the injury happened in the course of employment.)

2012

SAIF v. DeLeon, 352 Or 130 (2012) The Oregon Supreme Court held that under ORS 656.382(2), when a claimant obtains an award of attorney fees and the insurer initiates a review, the tribunal has the final decision as to whether the award should be disallowed or reduced.

2013

Estacada Rural Fire District #69 v. Hull, 256 Or App 729 (2013) The court held that, when a worker who would ordinarily qualify for the "firefighter's presumption" has a mental disorder claim, the compensability standard for mental disorders under ORS 56.802(3) would apply. Determining that the Board had erred in applying the "firefighter's presumption," the court remanded for application of the mental disorder standard prescribed in ORS 656.802(3).

Schleiss v. SAIF Corporation, 354 Or 637 (2013) The Oregon Supreme Court concluded that no portion of permanent impairment can be attributed to any condition the worker may suffer from that is not formally part of a combined condition or has not been established as a pre-existing condition.

2014

Brown v. SAIF Corporation, 262 Or App 640 (2014) The Court of Appeals ruled that, to deny a combined condition, an insurer must prove it is the accepted condition or the accidental work-related injurious incident that is no longer the major contributing cause. The court ruled that the compensable injury is the work injury resulting from the work action, not the condition the insurer accepts. The burden, therefore, on an employer or insurer seeking to deny a previously accepted combined condition, is to prove the work-related injury is no longer the major contributing cause of the disability or need for treatment.

Note: This case has been accepted for review by the Oregon Supreme Court as of this writing. It is expected to be heard in 2015.

SAIF v. Carlos-Macias, 262 Or App 629 (2014) The Court of Appeals ruled that diagnostic services related to discovery of the cause of complaints of pain can be reasonable and necessary expenses, even if the results of the testing reveal that the condition was unrelated to the compensable condition.

Francisco Vargas, 66 Van Natta 1777 (2014) The Workers' Compensation Board ruled that, once enrolled in an MCO, a worker remains subject to the MCO contract as long as the claim remains in accepted status. However, where a new/omitted medical condition claim is in denied status, the MCO requirements do not apply to the claim for those particular conditions.

Moreover, when a denial of the new/omitted medical condition claim is subsequently set aside, the carrier becomes obligated to pay temporary disability benefits for that particular claim during the period that the claim was in denied status, provided that there was an attending physician's authorization during that period (regardless of that physician's affiliation with an MCO).

Spurger v. SAIF, 266 Or App 183 (2014)
Under OAR 436-035-0019, a worker is entitled to chronic condition impairment value if the worker is "significantly limited" in the repetitive use of certain body parts. The Court of Appeals held the board erred in failing to provide an adequate explanation of what it considered "significantly limited" to mean. The court remanded the decision to the board to correct that deficiency. Subsequently, the Workers' Compensation Division issued an industry notice clarifying its interpretation of the term "significantly limited" as applied in the context of its rule.

Notes

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