Mahonia Hall/SB 1197 (1990) Law Changes

Benefits are as listed in the April 30, 1990 Mahonia Hall recommendation report to Governor Goldschmidt.
Statutory references reflect 1990 laws (some laws have since been renumbered).
This document summarizes law changes made only to the specific statutes impacted by SB 1197 (1990).

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Worker safety and Oregon OSHA	Increased safety lowers costs	The requirement to have a safety committee was based on criteria set by the director. Oregon OSHA provided technical assistance to employers and insurers regarding safety programs.	Required safety committees for all public and private employers with more than 10 employees. 654.176 Required safety committees for small employers with a high lost workday incidence rate. Modified safety committee duties. 654.182 Added 73 Oregon-OSHA staff (consultants, enforcement, and support). This was not in the bill, but accomplished through budget process.	The director is required to set safety committee criteria by rule (HB 2222, 2007) OSHA staffing has changed many times since 1990. Currently there are 34 consultants and 70 inspectors, plus administrative and other support. Major changes: - 2001-2003 reduced 17 positions (consultation, enforcement, and support) - 2005-2007 reduced 5 support positions - 2007-2009 reduced 3 positions - 2009-2011 reduced 29.50 positions (consultation, enforcement, and support) - 2017-2019 added 6 enforcement and 3 consultation positions

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Managed care - high quality and consistent standard	Managed care - high quality, consistent standard, controls costs	No provisions for managed care	Established MCOs and certification process. (codified in 656.260) Required workers enrolled in managed care to get medical services subject to the contract. 656.245(5)	Added definitions for peer review, service utilization review, quality assurance, dispute resolution. Required MCOs to provide quality assurance and dispute resolution. Required peer review and quality assurance panels to be primarily physicians licensed by the Medical Board. Required disputes about MCO decisions be resolved by the director and established appeal process (SB 369, 1995). The 1995 bill placed a 2001 sunset on the changes. The sunset was repealed (1999, SB 460). Added requirement providers be provided a reason for being terminated from MCO panel (SB 484, 1997) Allowed "come along" to an MCO for nurse practitioners (HB 3369, 2003) and chiropractic physicians (SB 533, 2013) Minor adjustments to administrative appeal process and clarified attending physician could advocate for medical services supported by medical record (HB 2091 and SB 670, 2005)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Managed care - high quality and consistent standard	Managed care - high quality, consistent standard, controls costs			Clarified content of managed care plan elements (SB 563, 2007) Allowed only MCOs to direct worker care and set civil penalties for persons that violate the law (HB 2093, 2011)
Disability rating by attending physician		There were no specific limits on who could make impairment findings	Only attending physicians are allowed to make findings of impairment. 656.245(3)(b)(B) See discussion below about limiting who can be attending physician.	Clarified chiropractic physicians can make findings of impairment when acting as the attending physician (HB 2045, 2009) See discussion below about who can be an attending physician.
Permanent partial disability benefit increase		Benefits for scheduled permanent disability were $145 per degree	Increased permanent partial disability benefits to $305 per degree for scheduled injuries. 656.214(2)	Tied PPD benefits to changes in average weekly wage (SB 732, 1991). Subsequent PPD increases made in SB 369 (1995), HB 2549 (1997), SB 460 (1999), SB 485 (2001). Major revision to PPD benefit calculation. Changed from scheduled/unscheduled system to impairment/work disability. The law had a sunset of 2008 (SB 757, 2003). The sunset was repealed (HB 2244, 2007).

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Reinstatement rights		Reinstatement was allowed after a compensable injury if the position was available and the worker was not disabled from performing the duties. Any duly licensed physician could approve the worker's return to work.	Allowed reinstatement until the earlier of the following: - Three years from date of injury; - A medical determination is made the worker cannot return to the former employment; - The worker is eligible and participates in vocational assistance; - The worker accepts suitable employment with another employer after medically stationary; or - 7 days after the worker is notified by insurer that the worker has been released for employment (unless worker requests reinstatement in the 7 days) 659.415 Clarified definition of "available" position. If a former position is not available, allowed the worker to fill an existing vacant position that is suitable. Clarified the attending physician authorizes the return to work or other suitable employment. 659.415(1) Clarified the right to reinstatement does not apply to the temporary worker hired to replace the injured worker, to seasonal workers employed less than 6 months, to workers hired out of hiring halls, or to an employer with 20 or fewer employees. 659.415	Added reemployment rights for workers disabled from performing regular work, with similar timeframes as reinstatement rights (SB 369, 1995) Limited reemployment provisions to employers with six or more employees (HB 2352, 2001) Clarified interaction between family leave protections and reinstatement rights (HB 2460, 2007)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Settlement allowed for some benefits, without losing lifetime medical treatment	Opportunity to negotiate settlements increases early resolution of some claims, to provide certainty about extent of liability	Settlements were not allowed.	Allowed claim disposition agreements, subject to approval by the Board, except for medical services. Allowed attorney fee for settlements. 656.236(1) and 656.278(5)(b) Disallowed reimbursement from department return-to-work programs or retroactive (cost of living adjustments) for settled claims without prior approval of director. 656.289	Further clarified what matters could be settled by CDA. Specified insurers and self-insured employers with an approved settlement are not subject to future responsibility proceedings (except for medical services). Specifies workers can only release benefits via CDA. Specified noncomplying employers cannot be party to settlement (SB 369, 1995) Clarified administrative law judges could mediate and approve agreements (SB 253, 2007)
Penalties paid to workers (not attorneys)		Penalties were allowed against insurer for unreasonable delay or unreasonable refusal to pay compensation (25% of amounts due plus attorney fee).	Conferred jurisdiction over penalty to the director. Split penalty between worker and attorney. 656.262	Made attorney fees for unreasonable delay separate from the amount of penalty paid to worker. Made fee proportionate to the benefit to the injured worker. Required board to set fee by rule, giving consideration to results achieved and time devoted to the case. Removed payment of fee to unrepresented worker. (SB 620, 2003) Set maximum fee at $3,000 and indexed future maximum to changes in average weekly wage (HB 3345, 2009) Changed fee to a reasonable fee, considering benefit to injured

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Penalties paid to workers (not attorneys)		Penalties were allowed against insurer if worker appealed claim closure and additional compensation due.	Added additional penalties based on percent of increased award of permanent disability, paid directly to worker. 656.268	worker. Clarified unreasonable delay of payment applies to attorney fees and costs. Set maximum fee to $4,000 and retained provision that future increases to change in average wages (HB 2764, 2015) If increase in compensation is due to arbiter exam or adoption of a temporary rule, the penalty is not assessed (SB 369, 1995) If increase is due to information that the insurer or self-insured employer could not have reasonably known at time of claim closure, the penalty is not assessed (HB 2404, 2005)
Improved return to work benefits		Employers got benefits for hiring preferred workers, including premium cost reimbursement for two years and prohibiting a preferred workers' new injury from affecting the employer's rate.	Changed payment of return-to-work benefits to insurer or self-insured employer. Expanded premium cost benefit and the prohibition on new injuries affecting employer experience to three years. Added claim cost reimbursement for new injures for three years and specified no insurance premiums or assessments are paid on a preferred worker for three years 656.622	Codified ability to reimburse employers for getting workers back to work quickly, including worksite modifications. Allowed department to reimburse to insurers and self-insured employers for program expenses. (SB 369, 1995)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Improved return to work benefits		Limited return to work benefits to workers with a compensable injury who could not return to work without substantial work or worksite modifications	Clarified the worker must have permanent disability resulting from an injury or disease and cannot return to regular employment to receive benefits 656.622(3)	Clarified that premium exemption is for the first three years from date of hire (HB 2197, 2009)
		The return-to-work program was called the Workers' Reemployment Reserve	Changed the program name to the Reemployment Assistance Reserve. 656.506, 656.530, 656.538	Removed Reemployment Assistance Program funding for rehabilitation facilities (SB 288, 1999)
		Money could be transferred from the Handicapped Worker Reserve to the Workers' Reemployment Reserve	Disallowed the transfer between funds. 656.612	
			Ceased the Handicapped Workers Program as of May 1, 1990.	
Claim timeframes and penalties		The insurer had 60 days to accept or deny a claim.	Extended to 90 days to accept/deny claim – 656.262(6)	Reduced processing time to 60 days (SB 485, 2001)
			Prohibited claim denial after two years for any reason and established an appeal process 656.262(6)	Substantially reworded language about two year claim denial timeframe (SB 369, 1995)
		Specific items were required to be in a notice of acceptance.	Added requirement that the notice of acceptance list what conditions are compensable. 656.262(6)(a)	Allowed workers to file for a new or omitted condition and established processing requirements (SB 369, 1995)
		Allowed a worker to request reclassification of a nondisabling claim.	Set a one-year time frame for a worker to request the director reclassify a nondisabling claim. 656.262(6)(c) and 656.262(12)	Shifted responsibility for processing reclassification to the insurer or self-insured employer. Allowed director review of decision. (SB 220, 1999).

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Claim timeframes and penalties		Claims were required to be reported to the director, but nothing specific about reclassified and nondisabling claims	Clarified insurers must report to the director when a nondisabling claim is reclassified as disabling. Otherwise nondisabling claims are not reported (codified as 656.277)	Added attorney fee for successful reclassification request (HB 2764, 2015)
Fewer medical exams		A worker was required to attend medical examinations at the request of the insurer, self-insured employer, or director.	Applied limitation on medical exams under 656.268 to required medical examinations under 656.325, including limiting findings of impairment to attending physicians. 656.325(1)	Allowed worker-requested medical examination (paid by insurer) in specified circumstances (SB 485, 2001) Required director certification of independent medical examination providers. Allowed workers to object to exam location. Implemented penalty against worker for failure to attend IME. Allowed sanction against medical provider for failing to provide diagnostic records (SB 311, 2005)
	Small business ombudsman as advocate	No provision for small business ombudsman.	Established the small business ombudsman to assist small businesses with insurance and claim processing matters. 656.709	Required ombudsman to be appointed (or terminated) with concurrence of the Governor. Required quarterly report to Governor regarding services provided. (HB 2522, 2003)
	Definition of compensable injury	An injury was defined as arising out of and in the course of employment requiring medical services, or resulting in disability or death.	Required a compensable injury be established by medical evidence supported by objective findings and defined "objective findings." 656.005(7)(a) and 656.005(19)	Further clarified definition of combined condition and objective findings (SB 369, 1995)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
	Definition of compensable injury		Imposed major cause standard for consequential and combined conditions. 656.005(7)(a)(A) and (B)	Limited compensability of preexisting conditions, codified in 656.225. Also limited medical services for conditions caused in material part by the injury. Defined preexisting condition in 656.005 (SB 369, 1995) Added arthritis exception to preexisting condition definition (SB 485, 2001)
			Excluded injuries caused by the worker's use of alcohol or a controlled substance (based on clear and convincing evidence). 656.005(7)(b)(C)	Clarified burden of proof for injuries due to worker's use of alcohol or controlled substance are based on preponderance of evidence (SB 369, 1995)
		Occupational disease claims were allowed without a specific burden of proof	Clarified the burden of proof for occupational diseases is that the worker prove employment conditions were the major contributing cause of the disease or its worsening, established by medical evidence supported by objective findings. 656.802	Clarified definition of mental disorder. Specified application of preexisting conditions to occupational disease claims and set burden of proof in that situation (SB 369, 1995) Added presumption for firefighter cancer (HB 2420, 2009) and PTSD (SB 507, 2019)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
	Definition of compensable injury	Aggravation claims were allowed with a physician's report of worsened conditions. If evidence as a whole showed worsening, the claim was allowed.	Required claim for aggravation be established by medical evidence and supported by objective findings. Set limits on what is considered a worsened condition. 656.273	Clarified aggravation claim must be established by medical evidence of an actual worsening of the compensable condition. Required claim be filed in writing (SB 369, 1995) Clarified timelines for aggravation claims related to nondisabling claims. (SB 220, 1999 and SB 316, 2001) Required worker's attending physician to sign aggravation claim and that once the form is submitted, the insurer must process the claim (HB 2405, 2005)
Quicker determination of responsible insurer and less litigation on extent of liability	Reduced litigation reduces cost - reduced litigation for "responsibility" questions	No provisions for determining which insurer is responsible.	Created process to determine responsibility for payment of claims when a new injury for same condition occurs. Set timelines for filing claims and providing notice (codified as 656.308)	Revised process to require an insurer that disputes responsibility to issue a written denial of claim advising worker of rights and setting appeal timeframe. Allowed maximum $1,000 attorney fee for prevailing in a responsibility denial. Clarified process for a worker with a disputed claim settlement agreement (SB 369, 1995) Increased maximum attorney fee to $2,500 and indexed the fee to changes in average weekly wages (HB 3345, 2009)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
	Reduced litigation reduces cost - DIF Director has jurisdiction for many penalty and fee disputes	Medical fee schedule was allowed without a clear appeal path.	Established formal dispute process at division for resolving medical fee disputes. 656.248(13)	Added worker as party to fee disputes or non payment of bills (SB 369, 1995) Clarified fee disputes are permissive based on request of the parties to the dispute (HB 2197, 2009)
		Required medical treatment disputes be referred to a panel of three physicians, with a selection process by worker and insurer. Required panel to review dispute within 40 days of panel selection. Allowed panel to perform tests and examine the worker.	Conferred authority to review medical treatment disputes to the director, including a 30-day deadline for review and an appeal process to the board only. Allowed the director to ask a provider to perform tests or examine the worker. Established process to request a panel to review a medical treatment, and required at least one panel provider be of same specialty as the disputed treatment and not have previously provided treatment to the worker. 656.327	Clarified type of disputes allowed regarding treatment. Set 60-day time frame for director to review appeal. Clarified record allowed at hearing and the appeal of director's order is to Court of Appeals (SB 369, 1995) Allowed an individual physician to review the dispute (instead of a panel) (SB 369, 1995)
		A worker was allowed to appeal a claim closure to the department, which included a personal interview with the worker.	Required appeals of claim closures to go through reconsideration process at the department with time and record limits. Established attorney fees out of additional award of compensation. Established medical arbiter process and medical arbiter panels for disputes involving impairment rating. 656.268(4), (5), (6), (7), 656.295, 656.319	Required request for reconsideration within 60 days of claim closure. Allowed department to postpone reconsideration for 60 days if more information was needed. Shortened appeal of order on reconsideration to 30 days. Allowed benefit suspension if worker failed to cooperate with arbiter examination. Stated no hearing on any issue can be held if it is not raised during reconsideration (SB 369, 1995)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
	Reduced litigation reduces cost - DIF Director has jurisdiction for many penalty and fee disputes	Hearing referees at the Board were required to apply a clear-and-convincing-evidence standard when evaluating disputes about the worker's disability.	Required referee and board to apply a preponderance-of-the-evidence standard when evaluating disability. Set limit on referee's and board's evaluation of dispute based on the date of the reconsideration order. Allowed referee and board to rescind the notice of closure. 656.283(7)	Disallowed hearing on any issue if not raised during reconsideration process, unless the issue arises out of the reconsideration order (SB 369, 1995)
	Reduced litigation reduces cost - reduced litigation for extent of disability issues	Standards for the evaluation of disability were established after consultation of advisory committees and reports to the legislature. Disability standards were tied to those set as of July 1, 1988. The agency was required to report standards to the legislature.	Removed the requirements to consult with advisory committees and legislative review. 656.726(3) Delegated to the director the authority to define "earning capacity" by rule. 656.214(5) Clarified that impairment is established by preponderance of medical evidence based on objective findings. 656.726(2)(f)	Specified impairment is the only factor in evaluating a worker's disability if the worker returns to regular work at the job at injury; the attending physician releases the worker to regular work, the job is available, but the worker does not return; or the attending physician releases the worker to regular work but worker is terminated for reasons unrelated (SB 369, 1995) Significant changes to calculation of PPD by removing scheduled/unscheduled awards and changing to impairment and work disability. Changed the criteria department applies when setting standards. The law had a sunset of 2008 (SB 757, 2003). The sunset was repealed (HB 2244, 2007)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
	Reduced litigation reduces cost - reduced litigation for extent of disability issues		If there is no standard for the worker's impairment, allowed the director to adopt a temporary rule addressing the worker's impairment. Required MLAC to review the temporary rules. 656.726(2)(f)	Changed return to work criteria for impairment benefit standard to apply if the worker has been released to regular work by the attending physician or nurse practitioner or has returned to regular work at the job held at the time of injury (HB 2408, 2003) Removed requirement for MLAC to review temporary rules related to impairment rating (SB 234, 2003) Removed requirement for director to adopt temporary rule for a disability not covered by the standards, and instead include it in the reconsideration order (HB 2218, 2007)
	Payment of benefits is limited pending appeal	Appeals by an insurer or employer did not stay benefits.	Provided for a stay of payment of benefits when the insurer/employer appeals a reconsideration order, requests board review, or appeals to court. If order is reversed, temporary and permanent disability payments to worker are paid as of date order is appealed (including interest). 656.313	Clarified the stay provisions applied to orders issued by the director relating to vocational assistance (SB 369, 1995). Clarified death benefits to surviving spouse or children are not stayed on appeal (SB 369, 1995) Added specified vocational benefits to the list of payments allowed during appeal (SB 460, 1999)

Worker's perspective benefits	Employer's perspective benefits	Law before 1990	SB 1197 (1990)	Major law changes after 1990
	Payment of benefits is limited pending appeal			Provided for Workers' Benefit Fund reimbursement for vocational benefits paid until denial upheld (SB 119, 2005) Added upheld attorney fees and costs to the provision relating to interest accrual (HB 2764, 2015)
	No time loss payments for incarcerated workers	Payments to incarcerated workers were not addressed.	Prohibited payment of temporary disability benefits for a person incarcerated for committing a crime (codified as 656.160)	No changes.

Other provisions in SB 1197

These items were included in SB 1197 (1990) but did not fit specifically under the "benefits" in the introduction to the Mahonia Hall report.

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Established Management-Labor Advisory Committee (MLAC)	The director was allowed to appoint an Industrial Accident Advisory Committee – three members representing workers, three members representing employers, and three ex-officio (nonvoting) members (SAIF, other carriers, and self-insured employers). The committee reviewed topics at the director's request.	Created the Management-Labor Advisory Committee with 14 members (7 each representing organized labor and subject employers) and the director serving as ex officio. Appointments are made by Governor and confirmed by the Senate. Required the committee to review permanent disability standards. In addition to reporting on topics requested by the director, required the committee to report to the Legislative Assembly findings and recommendations as considered appropriate. 656.790	Committee reduced from 14 to 10 members (SB 369, 1995) Added areas for committee review: - Workers' Benefit Fund and programs (HB 2044, 1995) - Biennial review of permanent partial disability benefits (HB 2244, 2007) - Workers' Benefit Fund balance (HB 2788, 2019) Increased terms from two to three years (HB 2192, 2017)
Limitation on attending physician status and other treating providers	Any doctor or physician could be primarily responsible for the worker's treatment. The worker could choose any type of attending physician.	Limited full attending physicians to medical doctors, doctors of osteopathic medicines, and oral surgeons 656.005(12)(b)(A) Limited chiropractic physicians attending physician status to 30 days or 12 visits 656.005(12)(b)(B) Limited non-MCO, non-attending physician medical service providers to 30 days/12 visits. Required attending physician approval thereafter. Prohibited non-attending physicians from authorizing time loss 656.245(3)(b)	Clarified an MCO contract could specify attending physician status. Stated physicians could be similarly licensed by any country, state, or territory (SB 369, 1995) Allowed authorized nurse practitioners to treat for 90 days, authorize time loss for 60 days, and required referral to an attending physician for rating impairment. Required nurse practitioners to review informational materials and certify the review to the director.

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Limitation on attending physician status and other treating providers		Allowed nurse practitioners and physician assistants in Type A or Type B (and Type C with director approval) rural hospitals to authorize time loss for 30 days. 656.245(6)	Allowed nurse practitioners to "come along" to an MCO. Removed nurse practitioners from the rural hospital time loss statute. Sunset changes in 2008 (HB 3369, 2003). Sunset removed in 2007 (HB 2247) Removed emergency room physicians from definition of attending physician, but allowed them to authorize 14 days of time loss (SB 504, 2007) Extended attending physician status to chiropractors, podiatrists, physician assistants, and naturopaths for 60 days/18 visits and allowed time loss authorization for 30 days. Required providers to certify with the director that they reviewed informational materials before providing services. Clarified only MD/DO/maxillofacial surgeons serving as attending physician could make findings of impairment. (HB 2756, 2007) Clarified chiropractic physicians can make findings of impairment when acting as the attending physician (HB 2045, 2009)

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Limitation on attending physician status and other treating providers			Made podiatrists full attending physicians (HB 2743, 2011) Added MCO "come-along" provision for chiropractic physicians. Required report to MLAC on denied "come-along" requests (SB 533, 2013) Extended nurse practitioner treatment and time loss timeframe to 180 days. Required MCOs to allow treatment timeframes for 180 days (or longer at the MCO's discretion). (SB 533, 2013)
Limitation on coverage for certain corporate officers	Corporate officers who were directors and had substantial ownership interests were excluded from coverage	Narrowed exemption from coverage of corporate officers for corporations involved in timber harvest or building and construction. 656.027(9)(b)	Changed exemption for construction contractors based on business type (sole proprietor, LLC, corporation) and licensure status, including multiple updates to statutory reference changes. HB 2487 (1991), SB 63 (1995), HB 2337 (1995), SB 369 (1995), HB 2038 (1997), HB 2020 (1999), HB 2117 (2007), HB 3242 (2007)
Noncomplying employers joint and several liability	Not specified	Made non-complying corporation, officers, and directors jointly and severally liable for court costs and attorney fees. 656.052	Removed joint and several liability for corporation officers. Allowed court to award attorney fees if the director prevails. Allows attorney fees for defendant who prevails in certain circumstances (SB 369 and SB 601, 1995)

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Average weekly wage for benefit calculations	The average weekly wage was determined by the Employment Division for the last quarter of the calendar preceding the fiscal year in which compensation was paid.	Clarified the definition is tied to the Employment Division's average weekly wage calculation as of May 15 (656.211)	No substantive changes
Palliative care after medically stationary	The language about the provision of medical services was broad.	Limited palliative care after medically stationary date, subject to request by attending physician and approval by insurer (with appeal to director allowed) 656.245(1)(b)	Further spelled out what is allowed for palliative care and authorized provision of curative care in some instances. Added definition for palliative care (SB 369, 1995)
Generic drugs	There were no limitations on name-brand drugs.	Required pharmacists to dispense generic drugs. 656.245(1)(c)	No substantive changes
Medical fee schedule and treatment standards	Required the director to adopt fee schedule	Required the director to establish treatment and utilization standards for medical services. 656.248(11) Allowed the director to exclude MCOs from the fee schedule. 656.248(12) Established dispute process before the director for resolving medical fee disputes. 656.248(13) Allowed director to exclude hospitals from fee schedule based on economic necessity. 656.248(14)	Modified the basis for fee schedule to represent reimbursement generally and be based on any of the following: Medicare fee schedule, average fees of health insurance, reasonable rate of markup for medical devices, commonly used medical fee schedules, or the actual cost of providing services. Required health insurers to provide department information about fees. Clarified MCOs to use fee schedule unless contract provides otherwise. Clarified appeal process for fee disputes (SB 369, 1995) Requirement that director develop utilization standards repealed (SB 223, 1999)

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Temporary disability (time loss) payment changes	Payment of wage replacement benefits was required every two weeks. Payment of temporary disability payments continued until the attending physician released the worker to regular employment.	Limited payment of temporary disability if not verified by attending physician 656.268(4)(b) Allowed insurer to suspend temporary disability payments if worker fails to attend medical appointments 656.262(4)(c) Limited payment for medical services if attending physician has not provided verification of worker's inability to work to insurer 656.262(4)(d) Required temporary total disability to cease at the earlier of: 1) worker returns to regular or modified employment; 2) attending physician releases worker to regular employment; or 3) attending physician releases worker to modified employment, employment offered in writing, but the worker fails to begin such employment 656.268(4)	Refined language about what constitutes authorization by attending physician. Added nurse practitioners to authorization list (SB 369, 1995 and HB 3369, 2003). Clarified self-insured employers could continue to pay wages in lieu of time loss (SB 369, 1995) Added new reasons to stop time loss payments, including when attending physician ceases to authorize payment (and limited retroactive authorization of time loss to 14 days). Clarified only attending physician could authorize time loss and provided insurer ability to suspend time loss payments if not authorized by attending physician or the worker is enrolled in MCO and fails to treat with MCO (SB 369, 1995) Clarified timely payment of time loss for public officials (SB 484, 1997) Added specifics to when the worker can reject an offer of modified employment, including limitations on commute/distance, location of job, and consistency with employer processes or collective bargaining agreement (SB 485, 2001)

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Claim closure changes	Claim closure was required when the worker was medically stationery and had returned to regular work.	Allowed claim closure if the worker returned to work or the worker's attending physician released the worker to return to regular or modified employment. 656.268(4)(a)	Clarified closure is allowed when the worker's accepted injury is no longer the major contributing cause of the combined or consequential conditions and the worker is not engaged in training. Also allowed claim closure with agreement of attending physician when worker fails to treat for 30 days or fails to attend a closing exam (SB 369, 1995) To close claim required sufficient information to determine permanent impairment. Reorganized statute and consolidated provisions (SB 220, 1999)
Offset for benefits obtained through fraud	Not addressed	Allowed the insurer to recover benefits obtained fraudulently by worker. 656.268(14)	No substantive changes.
Right to consult Ombudsman for Injured Workers	There was an ombudsman for injured workers, but the insurer was not required to notify the worker of the right to consult with the ombudsman	Required the notice of closure to state the right of the worker to consult the Ombudsman for Injured Workers. 656.270	Repealed by HB 2197, 2009
Clarification of Board processes	The board's informal dispute resolution was mandatory for any request for hearing. The worker was allowed to be represented by a non-attorney in this process.	Removed the mandatory informal dispute resolution process. 656.283(10)	None.

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Reimbursement to providers after settlement	Established an arbitration process for disputes between insurers and medical service providers and health insurers about the extent of liability or reimbursements.	Removed the process from 656.289. Included process for payment to medical service providers when a settlement occurs. 656.313	For claims settled, clarified that medical service providers can recover the balance of amounts owing from worker, unless the worker agrees to pay for the bills out of settlement proceeds (SB 369, 1995 and SB 173, 2011)
Disputes and reports about attorney fees	Disputes about some attorney fees could be settled in circuit court. Fees for attorneys (except in-house counsel) representing insurers and employers required to be approved by board. Insurers and self-insured employers were required to report annual legal costs to the board	Removed this provision from 656.386 and 656.388 Removed this requirement from 656.388 Changed report to the director. 656.388(7)	No substantive changes.
Annual survey regarding board referees	There was an established process for hiring and review of board referees.	Added requirement for board to conduct annual survey of attorneys to collect ratings of board referees. 656.724(3)(b)	Updated statute to reflect Administrative Law Judge (instead of referee). Required board to publish results of survey listing each judge by name (SB 369, 1995) Required board chair to conduct survey, after consulting the board (SB 654, 1999)
Insurance Division review of self-insured employers and groups	The Insurance Division was required to conduct financial review of self-insured employers and groups under the Insurance Code	Removed requirement from 731.300	None

	Law before 1990	SB 1197 (1990)	Major law changes after 1990
Director study of hours worked data and cents per hour system	Not addressed	Required director to study hours-worked data for construction, logging, and sawmill industries and report to legislature recommendations about changing workers' compensation premiums to cents-per-hour system.	None
Certification of claims examiners	Not addressed	Required director to establish a certification program for claims examiners. Required insurers and self-insured employers to maintain a list of examiners. Grandfathered in existing examiners with more than one year experience. Allowed director to charge a fee for certification (codified in 656.780)	Required director to establish standards for certification, but delegated the administration of standards to insurers, self-insured employers, and third party administrators. Required these parties to retain records of certification, subject to inspection by the director. Allowed civil penalty for failure to maintain or produce certification records. Required insurers, self-insured employers, and third party administrators to only employ certified claims examiners (SB 221, 1999) Required director to approve curriculum used to train claims examiners on independent medical examinations (SB 311, 2005)