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Legislative Committee Services
State Capitol Building
Salem, Oregon 97301
(503) 986-1813

Background Brief on ...

Workers’ Compensation

Oregon has had some form of workers’ compensation program since 1914. The system is designed to provide appropriate medical treatment and benefits to help injured workers recover and return to work as soon as possible, and to resolve disputes quickly and fairly.

Workers’ compensation insurance provides medical treatment and lost wages to employees (or their dependents) in the case of employment-related accidents. In Oregon, workers’ compensation insurance is what is known as “no-fault” insurance – this essentially bypasses the concept of one party or the other being at fault, which in turn eliminates lawsuits arising out of work place injuries or illnesses.

Oregon employers are required to either carry workers’ compensation insurance or be self-insured. Almost all Oregon employees are covered by workers’ compensation, but employees are eligible for benefits whether or not their employers are in compliance with the law. The law specifies the types of employees that are not required to have workers’ compensation insurance coverage, including certain corporate officers, partners and family-member business owners, as well as independent contractors (ORS 656.027).

Employers can purchase insurance from the State Accident Insurance Fund (SAIF) Corporation (a publicly owned nonprofit company), from a private insurance company, or become self-insured. In 2009, SAIF had about a 41 percent share of the Oregon workers’ compensation insurance market; private insurance companies accounted for 42 percent of the market, with Liberty Northwest accounting for 10 percent. The remaining 18 percent of premium share are self-insured employers or employer groups, who must meet specific financial criteria, obtain excess workers’ compensation

insurance from an authorized company, and have deposits with the Department of Consumer and Business Services (DCBS) that protect injured workers in the event of the employer's bankruptcy.

History in Oregon - 1990 Reforms

In 1986, Oregon ranked sixth highest in the nation in average workers' compensation premium rates and had one of the country's highest injury and illness claim frequencies. Medical and disability costs for injured workers were among the highest anywhere, but benefit levels for some types of injuries were among the lowest in the country. Critics of the system had charged that too many benefits were provided for questionable disabilities and too many benefits were going to lawyers and dubious care providers. Significant changes were made in 1990, based upon the recommendations of a management-labor task force (commonly referred to as the "Mahonia Hall Group") convened by then-Governor Neil Goldschmidt.

Generally, the compromise increased benefits to injured workers but decreased the number of workers getting benefits. The definition of "compensable injury" was changed to require work exposure to be the "major contributing cause" of some conditions in order to qualify for benefits. Criteria for reopening claims were tightened. Other changes limited the status of chiropractors, eliminated naturopaths as attending physicians, restricted "palliative" care, eliminated the formal hearings process for resolving treatment disputes, required the use of strict standards in determining disability awards, allowed lump-sum settlements for accepted claims, and doubled benefit awards for certain injuries. There was also a substantial commitment made to the use of return-to-work and safety programs.

1995 Reforms

The system was further revised in 1995 through Senate Bill 369 that set more restrictive limitations on the compensability of pre-existing conditions, stress claims, and injuries involving drug or alcohol abuse. Senate Bill 369 also established a one-year claim-filing deadline,

established a new medical fee schedule, and established workers' compensation insurance as the exclusive remedy for worker illness or injury even if the claim is denied. The new law also redefined "casual labor" and increased the penalties on non-complying employers.

As a result of the 1990 and 1995 reforms, the number of accepted disabling claims has gone from 3.7 per 100 workers in 1987 to 1.3 per 100 workers in 2006. Workers' compensation pure premium rates, the base rate that employers pay their insurance company for coverage, have cumulatively decreased 62.8 percent through 2011. In 2012, the rate increased by 1.9 percent due to a number of factors, including Oregon's stagnant economy, the amount of collected premium versus the cost of medical benefits, and the leveling off of filed workers' compensation claims. The premium assessment, which pays for the administration of workers' compensation and workplace safety programs, decreased from 6.4 percent in 2011 to 6.2 percent in 2012.

Management-Labor Advisory Committee

The Management-Labor Advisory Committee (MLAC), originally known as the "Mahonia Hall Group," was initially created by Governor Goldschmidt to draft the 1990 workers' compensation reforms. The MLAC was later put into statute as advisory to the Legislature and the DCBS Director on matters concerning workers' compensation.

Today, MLAC is charged with studying the workers' compensation system in areas such as court decisions, adequacy of benefits, medical and legal costs, adequacy of assessments paid into the Department's reserve programs, and the operation of programs funded by the Workers' Benefit Fund. The Committee also reviews standards regarding evaluation of permanent disability and advises DCBS and its Workers' Compensation Division (WCD) on proposed program changes. The ten members are appointed by the Governor and confirmed by the Senate. There are five labor and five management representatives. The DCBS Director serves as an ex-officio member.

Claims Process

Workers who have work-related injuries or illnesses must file a claim with either their employer or a health care provider (HCP) in order to receive workers' compensation benefits. The claim form is sent by the employer or doctor to the employers' insurer within three days, if the claim was filed to the health care provider, or five days if filed with the employer.

The claim is reviewed by the insurer and classified as either non-disabling, in which no time loss¹ is authorized; or disabling, which means that time loss is authorized or a likelihood of permanent disability is determined. During the timeframe between when a claim is filed and the determination from the insurer (known as the interim period), the insurer will pay for limited medical treatment, such as diagnostic services, issue medication required to alleviate pain, and required services to stabilize the claimed condition and to prevent further disability. The insurer does not have to pay benefits if the claim is denied within 14 days of the date the employer knew about the injured worker's claim.

If the worker cannot work due to their injury/disease, they must have their absence from work authorized from their HCP. They will not be paid for the first three calendar days for time off of work unless the worker is off work for two weeks in a row or was an overnight inpatient at a hospital within the first 14 days/ If the claim is denied within the first 14 days from the date reported to the employer, the worker will not be paid for lost wages via the insurer.

The insurer must accept or deny the claim within 60 days, then notifies the WCD within 14 days of acceptance or denial. If a claim is denied, the injured worker will receive a letter from the insurer explaining why the claim is denied as well as their right to request an appeal with the Workers' Compensation Board's Hearings Division within 60 days or up to 180 days with cause. If a claim is accepted, the insurer will notify the worker with Notice of Acceptance

¹ Compensation paid to an injured worker as a result of occupational injury or disease.

letter that specifies the medical conditions covered under the claim.

A worker that is temporarily or permanently disabled by an accepted work-related injury may receive payment from the insurer for medical treatment, time loss benefits, and permanent disability. The payments are made at 14-day intervals for as long as the injured worker's attending physician (the primary HCP responsible for treatment and care) verifies the worker's inability to work or when the claim closes. Time loss benefits are stopped when one of a number of conditions occurs, such as the attending physician's failure to provide time loss authorization, the attending physician's release for the worker to return to regular work, or the worker's return to regular work at full wages.

When the injured worker's attending physician determines that the worker is medically stationary (it is not expected to improve with further treatment or the passage of time) or that the work injury is no longer the major cause of the disability, the worker is notified that the claim will be closed and how much, if any, permanent disability payment or additional medical benefits are due to the worker. Also, if an injured worker fails to seek medical care for more than 30 days without doctor approval, the insurer must close the claim.

Most Oregon employers with more than 20 workers are required to return injured workers to their job or a suitable job after the attending physician has released them to work. When the worker receives written notice they have been released to return to work by their attending physician, they must ask their employer for their job or another suitable job within seven calendar days (or sooner if required by either a collective bargaining contract or the employer's personnel policies). Generally, the employer must reinstate the worker to the job they had at the time of the injury, with the reinstatement usually applying for up to three years from the date of injury. If an employer offers modified work, the job duties must be approved by the attending physician and the duties must be in writing. If the wages from modified work are less than what was paid at the time of injury, time-loss benefits will make up

part of the lost wages. If the attending physician certifies that the worker is unable to return to regular work, or the worker is participating in vocational assistance, refuses to accept a modified job during their recovery period or if choose to work for another employer after being cleared to return to work, the employer is not required to reinstate the injured worker.

Some injured workers, such as those with a permanent disability, may qualify for vocational services, such as job placement and training; or participation in the Preferred Worker Program, which helps injured workers with a permanent disability to return to work, or the Employer-at-Injury Program, which helps the worker stay on the job or back to work with the employer.

Medical Service Providers

During the interim period, an injured worker can receive medical treatment from a HCP of their choice that is focused on stabilizing the claimed condition and preventing further injury or disability. When the claim is accepted, covered treatment expands to include medical treatment, prescription drugs, and transportation, meals, and lodging necessary to attend medical appointments (with some limitations).

Unless the worker's employer is covered by a managed care organization (**MCO**) contract, the worker must choose an attending physician, who is responsible for authorizing time loss benefits, overseeing medical care for the injury, authorizing reduced work hours or duties, releasing the worker to return to work, and deciding when the worker is medically stationary. While the worker can only have one attending physician at a time, the worker can change their attending physician two more times by choice, and can make further changes with approval from the insurer.

An attending physician can be any medical doctor, osteopathic doctor, oral or maxillofacial surgeon, chiropractor, podiatrist, naturopathic physician, or physician assistant. While there are no limitations on the amount of visits and time periods in which medical or osteopathic doctors or oral or maxillofacial surgeons can serve as an

attending physician, other authorized health care providers have limitations on how long they can serve as an attending physician.

Chiropractors, podiatrists, naturopathic physicians, and physician assistants can be an attending physician for up to 60 consecutive calendars days or 18 visits from the date of the worker's first visit on the initial claim, whichever comes first, and can only authorize time loss payments for 30 days from the first visit. Chiropractors have the authority to make impairment findings; podiatrists, naturopathic physicians, and physician assistants do not.

Authorized nurse practitioners cannot be an attending physician, but they can provide independent treatment for up to 90 days from the date of the worker's first visit on the initial claim, or if authorized by the worker's attending physician, and can provide compensable medical services for aggravation of the injury or illness if authorized by the attending physician. They also have the authority to authorize time-loss payments, reduced work hours or duties, and/or release the worker to work for up to 60 days from the date of the first visit on the initial claim. They also have the authority for determining whether a worker is medically stationary for up to 90 days, but most refer to an attending physician for a closing examination if the worker appears to have a permanent impairment.

Medical care providers who do not fall under these categories can treat the worker independently for 30 days from the date of the first visit on the initial claim or 12 visits, whichever occurs first, but are not allowed to authorize time-loss payments or to modify work, and must be authorized by an attending physician or authorized nurse practitioner to provide additional treatment after 30 days or 12 visits.

If the worker's employer is covered by a MCO contract, the insurer has the right to enroll the worker with the MCO at any time after the injury. Under those circumstances, medical providers designated to be attending physicians by the MCO can provide treatment to the

worker, and the worker may be required to select a health care provider from a list of providers sent by the insurer with an enrollment notice. A worker's primary care physician who is a family practitioner, general practitioner, intern medicine specialist, or authorized nurse practitioner may be able to provide treatment to the worker if they agree follow the guidelines of the MCO contract.

Insurers also have the right to request the worker to attend an independent medical examination (IME) with health care providers of their choice. They can require up to three medical examinations, and the worker can be fined or benefits can cease if they fail to attend the exam. Costs for the examination(s) are paid by the insurer, and expenses necessary for attending the exam are reimbursed.

Fatality Benefits

Oregon's workers' compensation benefits also include death benefits. The claims process is the same as for any on-the-job injury or occupational disease or illness. Upon acceptance of the claim, the insurer is required to make payments to the deceased worker's spouse, children, and other eligible beneficiaries, as well as disposition and funeral expenses. If an injured worker dies while receiving permanent total disability benefits, their spouse or other eligible beneficiaries may be entitled to continuing benefits.

Unlike temporary disability benefits, fatal benefits are determined by the state's average weekly wage (SAWW), and benefit amounts are adjusted [annually](#). The level of benefits depends on the beneficiary classification and whether they are dependent or not dependent on the surviving spouse:

Beneficiary	Maximum Monthly Total
Spouse or domestic partner	\$2,439.78
Child (dependent on surviving spouse or domestic partner)	\$365.95
Child (not dependent on surviving spouse or domestic partner)	\$914.87
Child/dependent	\$870.65
Child/dependent (no surviving parent)	\$2,439.78

In general, a child or dependent receives benefits until they become 18 years of age. However, they can receive benefits between the ages of 18 to 23 while they are attending higher education or until they cease higher education or graduates from an approved institute or program. The current total combined monthly benefit for all beneficiary classifications is \$4,879.19. The maximum amount issued for disposition and funeral expenses is twenty times the SAWW, or \$16,825.20.

Staff and Agency Contacts

Theresa Van Winkle
[Legislative Committee Services](#)
 503-986-1496

Department of Consumer and Business Services
[Workers' Compensation Division](#)
 503-947-7500

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