Background Brief on …

Workers' Compensation

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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 self-insure. According to the 2006 year-end figures, SAIF Corporation had about a 46 percent share of the premium in the Oregon market. Private insurance companies (the largest being Liberty Northwest) accounted for about 40 percent, and the remaining 14 percent of premium share is self-insured employers.

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 premium rates have also declined significantly over this time period. There will be a 1.3 percent decrease in the workers' compensation "pure" premium rate for 2010, which marks the fourth straight year for a rate decrease and the 20th consecutive year with no rate increase.

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 Director of the Department of Consumer and Business Services **(DCBS)** on matters concerning workers' compensation.

Today, the 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 the 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, either with their employer or a physician, to receive workers' compensation benefits. The claim form is sent by the employer or doctor to the employers' insurer within three (doctor) or five (employer) days. In turn, the insurer, who 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 appeal the denial to the Hearings Division of the Workers' Compensation Board. If a claim is accepted, the letter will be a notice of acceptance specifying the medical conditions that will be covered under the claim. The insurer will also pay time-loss (compensation while not working as a result of the occupational injury or disease).

A worker that is temporarily or permanently disabled by an accepted work-related injury may receive payment from the insurer for medical treatment, lost wages, and permanent disability.

The payments are made at 14-day intervals for as long as the injured worker's attending physician (the primary medical provider, responsible for treatment and care) verifies the worker's inability to work or when the claim closes.

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 is due the worker. 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 this notice, 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). In most circumstances, the employer is required to reinstate the worker to the job they had at the time of the injury, and the reinstatement usually applies for up to three years from the date of injury. However, this does not apply if the attending physician certifies that the worker is unable to return to regular work, if the worker is participating in vocational assistance, if the worker refuses to accept a modified job during their recovery period or if they choose to work for another employer after being cleared to return to work.

Some workers 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 Employer-at-Injury Program, which helps the worker stay on the job or back to work with the employer. Oregon's workers' compensation benefits also include death benefits. Claim amounts vary on the type of benefit awarded to the worker.

Medical Service Providers

During the interim period of the claims process (the timeframe between when a claim is filed and the determination from the insurer), an injured worker can receive medical treatment from a health care provider of their choice. Examples of what the insurer pays during the interim period include diagnostic services, required medication to alleviate pain, and services to stabilize the claimed condition and prevent 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).

The worker must also 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.

Medical doctors, doctors of osteopathy, oral or maxillofacial surgeons, certified chiropractors, podiatrists, naturopathic physicians, and physician assistants can serve as an attending physician. While there are no limitations on the

amount of visits and time periods that medical doctors, doctors of osteopathy, 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 are limited to 60 consecutive calendars days or 18 visits from the date of the worker's first visit on the initial claim, whichever comes first.

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, authorize time-loss payments or reduced work hours or duties for up to 60 days, release the worker to return to work within 60 days, and decide when the worker is medically stationary for up to 90 days. They must refer the worker to an attending physician for a closing examination if the worker appears to have permanent impairment. Other 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 managed care organization (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 with health care providers they choose. 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.

Recent Legislation

House Bill 2420 (2009) expands the types of cancer that is included in the existing firefighter presumption for employment caused occupational diseases under the workers' compensation system to include brain, colon, stomach, testicular, prostate, throat, mouth, rectal, and breast cancer; multiple myeloma, non-Hodgkin's lymphoma, and leukemia. The presumption is applied to non-volunteer firefighters who have completed at least five years of employment and are first diagnosed by a physician after July 1, 2009. The presumption cannot be applied to claims filed more than seven years following the termination of employment as a non-volunteer firefighter, and it can be rebuttable by clear and convincing evidence that the cancer was not caused or contributed to in material part by the firefighter's employment, or if tobacco use was the major contributing cause of the cancer. The presumption cannot be applied to prostate cancer if the first diagnosis was made after the firefighter reaches the age of 55.

Senate Bill 110 (2009) is a result of the enactment of Senate Bill 835 (2007), which directed MLAC to conduct a study regarding the adequacy of death-related benefits available to workers' families and dependents under workers' compensation law. The measure increases benefits paid for final disposition and funeral expenses in death claims from 10 times to 20 times the average weekly wage, and clarifies that costs for final disposition and funeral expenses is to be paid by the workers' compensation insurer or self-insured employer. The benefits that a child or dependent from the ages of 18 to 23, with no surviving parent, is increased to 4.35 times 66-2/3 percent of the average weekly wage, and benefits continue

until the child ceases to attend a higher education program, graduates from an approved institute or program, or until their 23rd birthday, whichever is earlier.

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