WORKERS' COMPENSATION

BACKGROUND BRIEF

Oregon has had some form of workers' compensation program since 1914. The program 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 or illnesses. 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 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 who 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 be self-insured. In 2015, SAIF had about a 52 percent share of the Oregon workers' compensation insurance market; private insurance companies accounted for 35 percent of the market. The remaining 13 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.

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HISTORY IN OREGON - 1990 REFORMS

In 1986, Oregon ranked sixth highest in the nation for average workers' compensation premium rates and had one of the highest rates for injury and illness claims. 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.

In general, 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, which 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 1.1 per 100 workers in 2015. Workers' compensation pure premium rates, the base rate that employers pay their insurance company for coverage, have cumulatively decreased 68.1 percent through 2016. In 2016, the rate decreased by 5.3 percent, on average, due to a number of factors, including lower medical costs and fewer and smaller claims for lost wages. Oregon's workers' compensation premiums are now among the lowest in the nation.

MANAGEMENT-LABOR ADVISORY COMMITTEE

The Management-Labor Advisory Committee (**MLAC**), originally known as the "Mahonia Hall Group," was initially created to draft the 1990 workers' compensation reforms. MLAC was later put into statute as an advisory body 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 DCBS's reserve programs and the operation of programs funded by the Workers' Benefit Fund. In addition, MLAC reviews standards regarding evaluation of permanent disability and advises DCBS and its Workers' Compensation Division (**WCD**) on proposed program changes. MLAC also reports findings and recommendations it considers appropriate to the Legislative Assembly. 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 their employer or a medical service provider **(MSP)** in order to receive workers' compensation benefits. The employer has five days and the MSP has three days to send the claim form to the employer's insurer. The claim is reviewed by the insurer and classified as either non-disabling, in which no time loss[1] 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 claimant can receive medical services. Payment to the MSP will be made by the insurer if the claim is accepted, or by the claimant's health benefit plan, if any, when the claim is denied. 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 workers cannot work due to their injury/disease, they must have their absence from work authorized by their MSP. They will not be paid for the first three calendar days for time off from 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 and then notify 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 and informing them of their right to request an appeal with the Workers' Compensation Board's **(WCB)** Hearings Division within 60 days or up to 180 days with cause. If a claim is accepted, the insurer will provide the worker with a Notice of Acceptance specifying the medical conditions covered under the claim.

A temporarily or permanently disabled worker 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 verifies the worker's inability to work or when the claim closes. Time-loss benefits are equal to two-thirds of the worker's wage but are capped at 133 percent of the state's average weekly wage with a floor equal to the lesser of 90 percent of wages a week or $50 per week. Time-loss benefits end when one of a number of conditions occurs: 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 attending physician determines that the worker is medically stationary (the condition 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 payments are due to the worker. Also, if an injured worker fails to seek medical care for more than 30 days

[1] Compensation provided to an injured worker who loses time or wages because of a compensable injury or illness.

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

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

MEDICAL SERVICE PROVIDERS

After a claim is filed, the worker chooses 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 have only one attending physician at a time, the worker can choose to change their attending physician twice and can make further changes with approval from the insurer or the DCBS Director. The attending physician may refer a worker to physicians, specialists or other care providers for consultations and necessary treatment.

An attending physician can be a medical doctor, osteopathic doctor, oral or maxillofacial surgeon, chiropractor, podiatrist, naturopathic physician or physician assistant. There are no limitations on the number of visits and time periods in which medical or osteopathic doctors, podiatrists or oral or maxillofacial surgeons can serve as an attending physician and authorize time-loss benefits. The other types of attending physicians have limitations on how long they can serve as an attending physician and authorize time off work. Authorized nurse practitioners cannot be an attending physician, but they can provide independent treatment and services as limited in statute.

Other medical service providers, except physical therapists, can treat the worker independently for 30 days from the date of the first visit on the initial claim or 12 visits but are not allowed to authorize time-loss payments or to modify work; they must be authorized by an attending physician or authorized nurse practitioner to provide treatment beyond initial 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, only 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 medical service provider from a list provided by the MCO. Under certain conditions, a worker's primary care physician

who is a family practitioner, general practitioner, internal medicine specialist, chiropractor or authorized nurse practitioner may be able to provide treatment to the worker.

Insurers have the right to request the worker to attend an independent medical examination **(IME)** with medical service providers of their choice. They can require up to three medical examinations per opening of the claim, and the worker can be fined or benefits can cease if they fail to attend the exam. Costs for the IME 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 dependents, as well as a lump sum for final 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, fatality benefits are determined by the state's average weekly wage, 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, subject to a family maximum benefit limit. The current total combined monthly benefit for all beneficiary classifications is $5,650.22. The total amount issued for disposition and funeral expenses is twenty times the state's average weekly wage, or $19,484.

The surviving spouse receives fatality benefits until death or remarriage. In general, a child or dependent receives benefits until age 18. However, they can receive benefits up to age 23 if they are attending high school or postsecondary education or training.

ADMINISTRATION

DCBS is the agency with regulatory oversight of the workers' compensation system. WCD ensures employers have insurance coverage in place, resolves medical and vocational disputes and ensures workers get timely and accurate benefits. The Division of Financial Regulation authorizes insurers to do business in Oregon and monitors companies' financial soundness. Oregon Occupational Safety and Health Administration **(OSHA)** monitors and ensures that employers provide safe workplaces.

Within DCBS is an independent advocate for small businesses and the professional advisors who serve them. The Ombudsman for Small Business is available to help businesses understand insurance coverage requirements and provide advice on how to shop for the coverage that best suits their needs. The office helps business owners in dispute with their insurance company about their premiums and during the appeal processes. The office educates business owners about their rights and responsibilities regarding workers' compensation.

Also within DCBS is an independent advocate for injured workers. The Ombudsman for Injured Workers can investigate and help resolve complaints. Though the office cannot provide legal advice, the staff can answer questions about benefits and the claims process. The office provides

seminars for labor groups, employers and insurers.

The WCB provides impartial resolution of disputes through mediation and formal hearings. The WCB's five members are appointed by the Governor and confirmed by the Senate. Administrative law judges preside over the hearings.

The regulation of the workers' compensation system is funded by two assessments. The premium assessment of 6.2 percent for insured employers pays for the general administration and enforcement of workers' compensation laws and workplace safety programs; self-insured employers and public self-insured groups pay 6.4 percent; private sector self-insured groups pay 7.2 percent. The Workers' Benefit Fund assessment is a total of 3.3 cents per hour worked that is equally shared by employers and workers. The Fund pays for return-to-work programs and cost-of-living adjustments to permanently and totally disabled workers and to the spouses and children of workers who died from an occupational injury or disease.

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