The Governor's
Workers' Compensation
Labor Management Advisory Committee

Co-Chairs:

Ross Dwinell
United Grocers,
Portland

Rep. Bob Shiprack
Oregon State
Building &
Construction
Trades Council,
Beavercreek

Committee Members:

Mark Davison
Safeway Stores, Inc.,
Clackamas

Jon Egge
M.P. Plumbing,
Clackamas

Irv Fletcher
Oregon AFL-CIO,
Salem

J.D. Hutchison
Hoffman Construction
Company,
and

Tom Leedham
Teamsters Local 206,
Portland

Ed Redman
WTD Industries,
Portland

Jeanine Meyer Rodriguez
Oregon Public
Employees Union,
Salem

Chris Short
Int'l Woodworkers of
America Local 3-261,
Coos Bay

Dan Simmons
Dept. of General Services,
Salem

Steve Socotch
Oregon AFL-CIO,
Portland

Cecil Tibbetts
Am. Federation of State,
County and Municipal
Employees,
Sherwood

Lisa M. Trussell
ORPAC Foods, Inc.,
Clayton

April 30, 1990

Governor Neil Goldschmidt
254 State Capitol
Salem, OR 97310

Dear Governor Goldschmidt:

On December 21, 1989, you wrote a letter to fourteen Oregon citizens requesting them to be part of an important effort for Oregon. You specifically asked that seven employee representatives and seven employer representatives join with you as a Workers' Compensation Labor and Management Committee to negotiate a strategy to control the costs of Oregon's workers' compensation program. You further asked that the committee complete its work by April 15, 1990.

The committee held its first meeting at your home on January 5, 1990. We met every Tuesday at your Executive residence from January 9, 1990, to April 10, 1990. The committee's preliminary report was completed on Wednesday April 11, 1990. At your request, the committee has continued to meet to review our report for technical changes and consider amendments proposed by members of the Oregon Legislature. The full committee or its working subcommittee has met with you, the Department of Insurance and Finance, and Legislative leadership six times since our preliminary report was submitted. The actions of your committee on the suggested amendments are reflected in our letter to President Kitzhaber, Speaker Katz, Senate Minority Leader Senator Brenneman and House Minority Leader Representative Campbell.

Our work is now complete. We commend this report to you as a working format to bring both short-term and long-term changes that will control costs in Oregon's workers' compensation system.

From a worker's perspective, benefits include the following:

* Safety committees and increased emphasis on safety education and safety enforcement

* Increasing by over 45 % the number of compliance officers in the OREGON-OSHA Division to conduct workplace inspections

* Managed medical care system to deliver high quality and consistent standard of medical service to all workers

* Disabilities rated by a worker's own attending physician, with a neutral, nonadversarial appeal process

* Increasing to $305/per degree of scheduled injuries such as carpal tunnel syndrome

* Reinstatement right for up to three years

* Workers may choose lump-sum settlement for vocational and indemnity issues while retaining protection for required medical treatment

* Workers retain some penalty fees now paid to attorneys, with assurance that insurer decisions are reasonable

* Enhanced preferred worker program encourages hiring previously injured workers

* Workers have increased certainty and convenience:
- claims can't be denied after two years for any reason
- less litigation on extent of liability
- fewer medical exams, less inconvenience
- quicker determination of responsible insurer

From an employer's perspective, the report contains improvements in the following areas:

* More precise definition of compensability removes injuries and occupational diseases not clearly work-related

* Managed medical care system controls costs while delivering high quality and consistent standard of medical care, with unncessary care eliminated

* Small business ombudsman as advocate

* Reduced litigation reduces cost:
- DIF Director has jurisdiction for many penalty and fee disputes
- reduced litigation for "responsibility" questions
- reduced litigation for extent of disability issues

* Opportunity to negotiate settlements increases early resolution of some claims, to provide certainty about extent of liability

* Payment of benefits is limited pending appeal

* No time-loss payments to incarcerated workers

We believe this proposal is consistent with your charge of creating a workers' compensation system that is fair and affordable: fair to the injured worker and affordable for Oregon employers.

We want to emphasize three issues that we consider critical to our proposal. The first issue is our proposal to increase the number of compliance officers in the OREGON-OSHA Division by over 45%. Every member of the committee is committed to a safer Oregon workplace. The basic truth is that fewer workplace accidents mean lower workers' compensation costs. You cannot be in favor of lowering the cost of workers' compensation if you are not in favor of greater workplace safety. This basic truth is the cornerstone of organized labor's agreement to our proposal. It is not in the drafted proposal because that part of the agreement will be an item at the next Emergency Board meeting on May 17 and 18, 1990. We cannot emphasize enough how important the OREGON-OSHA funding proposal is to the stability and credibility of our agreement.

The second issue is the need for greater representation by the small business community on boards and commissions working with issues that affect the small business community. Our committee requests that you name at least one, and preferably two small business representatives to the standing Workers' Compensation Management and Labor Committee, which will function as an oversight committee of our workers' compensation system.

The third issue concerns the standing Management and Labor Committee. We know that most citizens will judge our work product by the substance of the individual proposals that have been made. In our opinion, the greatest benefit for the citizens of Oregon was the process by which we achieved our agreement. Our proposal was achieved by the two parties most directly affected by our workers' compensation system: workers and employers. Due to the concerns that influenced your decision to form the committee, it is our strongest recommendation that you institutionalize the committee to strengthen the role of labor and management as the future of workers' compensation in our state is formed. It is our hope to work with the Department of Insurance and Finance to evaluate their present workload and to work with them as they implement the various programs needed to carry out the intent of our proposal.

A final comment about attempting to judge the impact of our proposal by how much money is saved by a particular proposal: The cost impact of workers' compensation legislation cannot be estimated with precision for two primary reasons. First, the past may not represent the future. Workers' compensation costs are determined by many legal, regulatory, economic, and human behavioral factors. Intervening changes in all these conditions cannot be simultaneously assessed.

Second, we have difficulty accurately knowing costs for the recent past. Most claims are reported within a few weeks of injury, but many claims take years to reach final disability determination. Three or four years is normal for permanent total and many serious permanent partial disability cases. The remarriage and mortality uncertainties remain for decades in estimated costs of pension benefit cases.

Cost impact is estimated using claim cost averages and claim percentages by injury type, the number of degrees of partial disability awarded each year, temporary disability duration patterns, dependency characteristics, medical cost proportions by injury type, and several such statistics descriptive of claim costs. These values change over time and can be known only as preliminary estimates for recent years. Furthermore, we cannot fully anticipate how changes we model in these factors will interact with all the other factors as well as with the economic, social, and human behavioral changes occurring between the recent past and the years ahead.

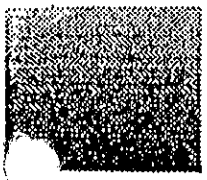
Some system changes have cost impact in different stages. The impact in the first year of a change may differ from the impact in later years after employers, insurers, workers, and other system participants adapt to changes. Changes in the appeals processes, disability standards, evidence rules, vocational rehabilitation opportunities, or funded assistance programs are examples where results may differ as participants learn how new rules apply to each new case. The total impact of any system change may never be final and can be difficult to assess even in retrospect.

Finally, many people in Oregon watched our progress with a degree of skepticism about our ability to reach agreement on this issue. Your belief in our ability to compromise and do what is in the best interest of all Oregonians gave us the confidence to succeed. Again, on behalf of all of us, thank you again for your faith in our ability to undertake this task and prove one more time that the impossible is only a little difficult.

Respectfully submitted,

Ross Dwinell
Co-Chairman

Bob Shiprack
Co-Chairman



The Governor's
Workers' Compensation
Labor Management Advisory Committee

REPORT FROM THE GOVERNOR'S WORKERS' COMPENSATION
LABOR MANAGEMENT ADVISORY COMMITTEE

The Governor originally charged the Workers' Compensation Labor-Management Advisory Committee to finish its work by April 15, 1990. The committee's preliminary report was completed on April 11, 1990. At the Governor's request, the committee has continued to meet with legislative leadership in both parties to discuss suggested changes that they or their members may have to the committee's preliminary report. The committee or its subcommittee has met with the Governor and legislative leadership six times since our preliminary report was submitted.

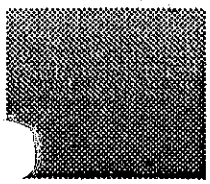
The following information is a compilation of comments generated during discussion of our draft legislative proposal with the membership of the Oregon Legislature and the response of the Labor-Management Committee to the concerns raised.

Many suggestions brought to the attention of the Labor-Management Committee by legislative leaders were discussed and will be incorporated as amendments into the final legislative draft. Other concerns required an explanation of legislative intent. There were still other recommended changes which the Committee declined to adopt because we believed they would have undermined the integrity and balance of our negotiated agreement.

We wish to acknowledge the assistance which the members of the Legislature have provided to us in making this a better legislative proposal.

Ross Dwinell
Co-Chairman

Bob Shiprack
Co-Chairman



The Governor's
Workers' Compensation
Labor Management Advisory Committee

Report from *The Governor's Workers' Compensation Labor Management Advisory Committee*

To

President John Kitzhaber

Speaker Vera Katz

Senate Minority Leader John Brenneman

House Minority Leader Larry Campbell

May 1, 1990

The Governor's
Workers' Compensation
Labor Management Advisory Committee

April 30, 1990

Governor Neil Goldschmidt
254 State Capitol
Salem, OR 97310

Dear Governor Goldschmidt:

On December 21, 1989, you wrote a letter to fourteen Oregon citizens requesting them to be part of an important effort for Oregon. You specifically asked that seven employee representatives and seven employer representatives join with you as a Workers' Compensation Labor and Management Committee to negotiate a strategy to control the costs of Oregon's workers' compensation program. You further asked that the committee complete its work by April 15, 1990.

The committee held its first meeting at your home on January 5, 1990. We met every Tuesday at your Executive residence from January 9, 1990, to April 10, 1990. The committee's preliminary report was completed on Wednesday April 11, 1990. At your request, the committee has continued to meet to review our report for technical changes and consider amendments proposed by members of the Oregon Legislature. The full committee or its working subcommittee has met with you, the Department of Insurance and Finance, and Legislative leadership six times since our preliminary report was submitted. The actions of your committee on the suggested amendments are reflected in our letter to President Kitzhaber, Speaker Katz, Senate Minority Leader Senator Brenneman and House Minority Leader Representative Campbell.

Our work is now complete. We commend this report to you as a working format to bring both short-term and long-term changes that will control costs in Oregon's workers' compensation system.

From a worker's perspective, benefits include the following:

* Safety committees and increased emphasis on safety education and safety enforcement

* Increasing by over 45 % the number of compliance officers in the OREGON-OSHA Division to conduct workplace inspections

* Managed medical care system to deliver high quality and consistent standard of medical service to all workers

* Disabilities rated by a worker's own attending physician, with a neutral, nonadversarial appeal process

* Increasing to $305/per degree of scheduled injuries such as carpal tunnel syndrome

* Reinstatement right for up to three years

* Workers may choose lump-sum settlement for vocational and indemnity issues while retaining protection for required medical treatment

* Workers retain some penalty fees now paid to attorneys, with assurance that insurer decisions are reasonable

* Enhanced preferred worker program encourages hiring previously injured workers

* Workers have increased certainty and convenience:
- claims can't be denied after two years for any reason
- less litigation on extent of liability
- fewer medical exams, less inconvenience
- quicker determination of responsible insurer

From an employer's perspective, the report contains improvements in the following areas:

* More precise definition of compensability removes injuries and occupational diseases not clearly work-related

* Managed medical care system controls costs while delivering high quality and consistent standard of medical care, with unncessary care eliminated

* Small business ombudsman as advocate

* Reduced litigation reduces cost:
- DIF Director has jurisdiction for many penalty and fee disputes
- reduced litigation for "responsibility" questions
- reduced litigation for extent of disability issues

* Opportunity to negotiate settlements increases early resolution of some claims, to provide certainty about extent of liability

* Payment of benefits is limited pending appeal

* No time-loss payments to incarcerated workers

We believe this proposal is consistent with your charge of creating a workers' compensation system that is fair and affordable: fair to the injured worker and affordable for Oregon employers.

We want to emphasize three issues that we consider critical to our proposal. The first issue is our proposal to increase the number of compliance officers in the OREGON-OSHA Division by over 45%. Every member of the committee is committed to a safer Oregon workplace. The basic truth is that fewer workplace accidents mean lower workers' compensation costs. You cannot be in favor of lowering the cost of workers' compensation if you are not in favor of greater workplace safety. This basic truth is the cornerstone of organized labor's agreement to our proposal. It is not in the drafted proposal because that part of the agreement will be an item at the next Emergency Board meeting on May 17 and 18, 1990. We cannot emphasize enough how important the OREGON-OSHA funding proposal is to the stability and credibility of our agreement.

The second issue is the need for greater representation by the small business community on boards and commissions working with issues that affect the small business community. Our committee requests that you name at least one, and preferably two small business representatives to the standing Workers' Compensation Management and Labor Committee, which will function as an oversight committee of our workers' compensation system.

The third issue concerns the standing Management and Labor Committee. We know that most citizens will judge our work product by the substance of the individual proposals that have been made. In our opinion, the greatest benefit for the citizens of Oregon was the process by which we achieved our agreement. Our proposal was achieved by the two parties most directly affected by our workers' compensation system: workers and employers. Due to the concerns that influenced your decision to form the committee, it is our strongest recommendation that you institutionalize the committee to strengthen the role of labor and management as the future of workers' compensation in our state is formed. It is our hope to work with the Department of Insurance and Finance to evaluate their present workload and to work with them as they implement the various programs needed to carry out the intent of our proposal.

A final comment about attempting to judge the impact of our proposal by how much money is saved by a particular proposal: The cost impact of workers' compensation legislation cannot be estimated with precision for two primary reasons. First, the past may not represent the future. Workers' compensation costs are determined by many legal, regulatory, economic, and human behavioral factors. Intervening changes in all these conditions cannot be simultaneously assessed.

Second, we have difficulty accurately knowing costs for the recent past. Most claims are reported within a few weeks of injury, but many claims take years to reach final disability determination. Three or four years is normal for permanent total and many serious permanent partial disability cases. The remarriage and mortality uncertainties remain for decades in estimated costs of pension benefit cases.

Cost impact is estimated using claim cost averages and claim percentages by injury type, the number of degrees of partial disability awarded each year, temporary disability duration patterns, dependency characteristics, medical cost proportions by injury type, and several such statistics descriptive of claim costs. These values change over time and can be known only as preliminary estimates for recent years. Furthermore, we cannot fully anticipate how changes we model in these factors will interact with all the other factors as well as with the economic, social, and human behavioral changes occurring between the recent past and the years ahead.

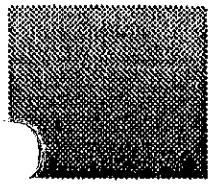
Some system changes have cost impact in different stages. The impact in the first year of a change may differ from the impact in later years after employers, insurers, workers, and other system participants adapt to changes. Changes in the appeals processes, disability standards, evidence rules, vocational rehabilitation opportunities, or funded assistance programs are examples where results may differ as participants learn how new rules apply to each new case. The total impact of any system change may never be final and can be difficult to assess even in retrospect.

Finally, many people in Oregon watched our progress with a degree of skepticism about our ability to reach agreement on this issue. Your belief in our ability to compromise and do what is in the best interest of all Oregonians gave us the confidence to succeed. Again, on behalf of all of us, thank you again for your faith in our ability to undertake this task and prove one more time that the impossible is only a little difficult.

Respectfully submitted,

Ross Dwinell
Co-Chairman

Bob Shiprack
Co-Chairman



The Governor's Workers' Compensation Labor Management Advisory Committee

REPORT FROM THE GOVERNOR'S WORKERS' COMPENSATION LABOR MANAGEMENT ADVISORY COMMITTEE

The Governor originally charged the Workers' Compensation Labor-Management Advisory Committee to finish its work by April 15, 1990. The committee's preliminary report was completed on April 11, 1990. At the Governor's request, the committee has continued to meet with legislative leadership in both parties to discuss suggested changes that they or their members may have to the committee's preliminary report. The committee or its subcommittee has met with the Governor and legislative leadership six times since our preliminary report was submitted.

The following information is a compilation of comments generated during discussion of our draft legislative proposal with the membership of the Oregon Legislature and the response of the Labor-Management Committee to the concerns raised.

Many suggestions brought to the attention of the Labor-Management Committee by legislative leaders were discussed and will be incorporated as amendments into the final legislative draft. Other concerns required an explanation of legislative intent. There were still other recommended changes which the Committee declined to adopt because we believed they would have undermined the integrity and balance of our negotiated agreement.

We wish to acknowledge the assistance which the members of the Legislature have provided to us in making this a better legislative proposal.

Ross Dwinell
Co-Chairman

Bob Shiprack
Co-Chairman

ATTENDING PHYSICIAN.

During meetings with majority and minority leaders from the House and Senate, concern was expressed over the Committee's proposal to limit attending physicians to medical doctors or doctors of osteopathy and to further limit the compensable services which a non-attending physician may provide without the written authorization of an attending physician.

The Committee believed that it was necessary to limit an attending physician to a medical doctor or doctor of osteopathy since the attending physician is the "gatekeeper" for entry into the workers' compensation system and thus should be an individual possessing as comprehensive a license as possible. The Committee believed that the medical doctor or doctor of osteopathy having a broader training in all aspects of medicine would be in a better position to make referrals to other treating physicians.

Several legislative leaders suggested that a "gatekeeper" function wouldn't be as critical where managed care organizations were available and all medical service within the managed care organization would be subject to utilization and peer review. A number of legislators also expressed concern that the draft proposal would not allow a non-attending physician to make findings of impairment or authorize payment of temporary disability benefits.

After extensive debate, the Committee agreed to modify the proposed draft to allow any medical service provider to provide medical services, which includes authorizing temporary disability compensation and make findings regarding the workers impairment if such medical services are authorized by a contract with a managed care organization. The Committee believes these suggestions are consistent with the overall purpose of establishing incentives for all medical service providers to become members and actually participate in managed care organizations.

DEFINITION OF OBJECTIVE FINDINGS IN SUPPORT OF MEDICAL EVIDENCE.

Sen. Kitzhaber and Rep. Katz on behalf of the House and Senate majority caucus felt the committee's definition of objective findings which may be used to support medical evidence was too restrictive in that it seemed limited to the type of findings which would be found primarily in soft tissue injuries.

An alternative suggestion was suggested which would not be so limited but would still retain the requirement of objectivity. After further debate and discussion the Committee agreed to adopt a definition of objective evidence which would include, but not be limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings.

STANDARD USED TO SET ASIDE A COMPROMISE AND RELEASE AGREEMENT.

It was suggested to the Committee that requiring a compromise and release agreement to be unconscionable before allowing the Board to set it aside would impose a test which would rarely, if ever, be met. As an alternative, it was suggested that the agreements should be set aside if found to be unreasonable as a matter of law.

The Committee agreed to make the change.

The Senate and House majority caucus both suggested that a "30 day cooling off period" be established in which the claimant could change their mind after signing a release.

That amendment was adopted by the Committee.

WHO MAY BECOME A CERTIFIED MANAGED CARE ORGANIZATION.

The Committee received comments from several health care providers regarding the definition of who may apply for certification as a managed care organization. An additional question was raised regarding the ability of an insurer to become eligible for certification as a managed care organization.

This issue received a great deal of attention from the Committee both before and after consultation with legislative leaders regarding who was intended to be covered as a medical service provider and who was intended to be allowed to enter into contracts with managed care organizations.

The Committee agreed that the term medical service provider should also include health care organizations and agreed that any group of medical service or health care providers may apply for certification as managed care organizations. The Committee further agreed to a definition which states that a medical service or health care provider shall not include a self insured employer or an insurer who is licensed to provide workers' compensation insurance.

EFFECTIVE DATES OF THE ACT.

A number of technical questions were raised by members with respect to the effective dates of the Act in addition to the question of whether an emergency clause was needed.

The Committee requested the Department of Insurance and Finance to review certain comments received regarding effective dates for technical accuracy and this has been incorporated into the draft.

The Committee concluded that an emergency clause was necessary in order to allow the immediate appointment of the Workers' Compensation Management-Labor Advisory Committee to allow the Committee to be prepared to review standards for rating disability and managed care certification rules upon enactment of the Act.

APPLICATION OF COST CONTROL MEASURES TO MEDICAL PROVIDERS.

A question was raised during meetings with the House and Senate majority leadership regarding the application of fee schedules to all medical service providers.

It was pointed out that utilization and treatment standards would be applicable to medical service providers while fee schedules are applicable to hospitals.

Section 14 (8) of the draft proposal contains authority for the director of the Department of Insurance and Finance to establish a fee schedule for inpatient hospital services and Section 14 (10) contains rulemaking authority for the director to establish utilization and treatment standards for all medical services required under chapter 656.

TEMPORARY TOTAL DISABILITY.

Both Senate and House Caucuses expressed a concern whether the language on page 23, lines 14-19 of the proposed draft actually penalized the worker for his attending physicians failure to respond to a request for verification of the workers ability or inability to work.

The Committee reviewed the issue and concluded the drafted language did not express their intent and had paragraph (4) redrafted so that the claimant is not penalized by denial of TTD if his attending physician is uncooperative. The penalty will run against the doctor in that the needed services are not compensable until the proper verification is sent.

COMPENSATION; OCCUPATIONAL DISEASE CLAIMS.

Concerns were raised in a seperate memorandum from Sen. Kerans regarding the Committee's proposed language regarding the compensability of worsened conditions. Sen. Kerans was specifically concerned that the Committee's proposed language would deny compensation to workers whose preexisting disease or condition is aggravated even if the worker shows that the work activity was a material contributing cause of the condition. [Emphasis provided]

The Committee's proposed language is intended to allow such claims where the worker is able to show the work activity was the major contributing cause of the disease or its worsening. This expressly states the law as it had been interpreted by the courts prior to a 1988 Workers Compensation Board opinion which interpreted a statutory ambiguity to apply the material contributing cause test. The Committee's proposal is intended to do nothing more than restore what had been well settled case law in Oregon for many years.

VOLUNTARY PRE-HEARING CONFERENCES.

The Senate and House Caucuses raised an issue whether the Committee intended to prohibit voluntary pre-hearing conferences by the deletion of language on page 38 line 10 of the proposed draft.

After discussion the Committee agreed to reinsert the deleted language to authorize voluntary pre-hearing conferences.

OBJECTIVE DEFINITION OF PAIN

The Committee reexamined the proposed language which provided that pain would not be considered in the evaluation of disability unless the pain resulted in objectively verifiable impairment.

Sen. Kitzhaber suggested the proposal be modified. Sen. Kerans offered his opinion that certain conditions would not be found compensable under the proposed language even where the worker suffers a legitimate impairment.

The Committee discussed these concerns after which it was agreed to delete the language as the first sentence in that paragraph expressed the committee's intent.

REQUIRE SENATE CONFIRMATION OF THE WORKERS' COMPENSATION MANAGEMENT/LABOR ADVISORY COMMITTEE.

The fact that the proposed draft does not require Senate confirmation of Management/Labor Committee nominees was raised during the House/Senate majority leadership meeting by Rep. Katz.

After discussion with the Governor, the Committee agreed to add a provision requiring Senate confirmation of nominees for the Management/Labor Advisory committee.

APPLICATION OF STANDARDS FOR RATING DISABILITY; ABILITY TO MODIFY THE STANDARDS ON RECONSIDERATION.

Sen. Kitzhaber, Rep. Katz and other members raised the question of how a claimant may have an award modified to allow the standards used for rating disability to consider a factor which is not contemplated in the standards but should be.

There was considerable debate during the course of the Committee's deliberations regarding the question of how to incorporate sufficient flexibility into the standards used for rating disability so that an individual in an unforseeable circumstance may be allowed just consideration of their claim. The concern expressed by members of the Legislature rekindled the debate within the Committee and after consultation with the Department of Insurance and Finance, the Committee agreed to add a statutory provision which will allow the director to stay the 15 day time requirement if it is determined during mandatory reconsideration of a claim that the standards did not adequately address a claimants unforseen circumstance. This would allow time to implement an emergency rule which would amend the standard for the purpose of that particular claim, taking the unique circumstances into consideration and allowing for an appropriate adjustment in the claimants rating of impairment. This would codify a procedure which presently exists in Department administrative rules.

TECHNICAL AMENDMENT TO THE DEFINITION OF ATTENDING PHYSICIAN.

Sen. Kitzhaber and Rep. Katz presented a concern which had been brought to their attention that the proposed definition of attending physician should be clarified if the intent was to include only medical doctors or doctors of osteopathy.

The Committee adopted a clarification which states that an attending physician is a medical doctor or doctor of osteopathy licensed under ORS 677.100 through 677.228.

MEDICAL PAYMENTS OUTSTANDING UNDER DISPUTED CLAIM SETTLEMENT.

A proposed amendment was received by the Committee which would have required direct payment from insurers, employers or self insured employers to medical providers for any medical services rendered prior to settlement under the worker elected method of payment provision.

The Committee specifically exempted medical claims under the compromise and release section and so the proposed amendment was found to be not applicable.

MEDICAL SERVICES TO BE PROVIDED THROUGH CONTRACTS WITH OTHER PROVIDERS.

The Committee received a proposed amendment to require managed care organizations to sub-contract for medical services which they provide.

The Committee considered this proposal but noted that Section 12 of the bill requires a managed care organization applicant to show the ability to provide all medical services that may be required under chapter 656 and give workers adequate flexibility to choose medical service providers under the plan in order to become certified by the director. The Committee declined to adopt the proposed amendment on the grounds that its intent is addressed in the bill draft.

MEDICAL STAFF PRIVILEGES.

The Committee received an amendment stating that nothing in the Act would affect the granting of medical staff privileges or conduct of peer review.

The Committee observed that a specific function of a managed care organization was to conduct peer review as referenced in Section 12 (d) of the proposed draft but agreed that nothing in the draft was intended to interfere with medical staff privileges. The Department of Insurance and Finance was requested to consult with the Attorney General's office and determine if a problem existed - and if one exists get the appropriate amendment drafted. This has been done.

PRIMARY CARE PHYSICIAN.

An amendment was received which proposed to delete the reference to family practitioner, general practitioner or internal medicine practitioner.

The Committee declined to adopt the amendment since the concept of a primary care physician was intended to be limited to those having a broad scope of practice.

TREATMENT OF DATA GENERATED BY PEER REVIEW.

Concern was expressed to the Committee that the proposed draft doesn't provide sufficient confidentiality or immunity to medical service providers who perform utilization review. An amendment was offered which provides that any such data generated shall be treated in accordance with the rules of evidence relating to the admissibility of reports of committees formed to supervise the granting, restriction or denial of clinical privileges at a health care facility.

The Committee is aware of the sensitivity of this issue and the care with which this data must be handled. The Committee is also concerned that certified managed care organizations be allowed to conduct meaningful utilization review and that the Department have access to this data for the purposes of managed care certification.

The Committee agreed to adopt the proposed amendment pending review of the issue by the Attorney General who is drafting alternative language to accomplish the objectives of the amendment. This has been done.

ANTITRUST EXEMPTION.

A proposed amendment was received which provides that actions taken by medical service providers in forming consortiums or otherwise entering into contracts to provide health care services shall be considered to be lawful state practices.

As with the previous amendment, the Committee is aware of the concerns raised over possible antitrust liability when managed care cost control measures are implemented, but is of the opinion that the proposed draft would not subject medical service providers to such claims.

However, the Committee agreed to conditionally adopt the proposed amendment if there is any concern that antitrust liability may result. Appropriate language has been drafted by the Attorney General and adopted by the Committee.

REQUIRE THAT UTILIZATION AND TREATMENT STANDARDS NOT CONFLICT WITH STANDARDS OF CARE REQUIRED UNDER ORS 677.095.

Concern was expressed to the Committee that the authority allowing the director to establish utilization and

treatment standards not result in increased liability for failing to meet the community standards of care required of all ordinarily careful physicians pursuant to ORS 677.095.

The Committee questioned whether any regulation regarding utilization or treatment standards could force physicians to adopt a lower standard of care than the statutory standard required under ORS 677.095. It was certainly not the Committee's intent in providing authority to develop utilization and treatment standards to conflict with those found in ORS 677.095. Accordingly, the Committee declined to adopt the proposed amendment but agreed to adopt language which states that any utilization or treatment standards adopted pursuant to Section 14 (10) of the Act will not be inconsistent with ORS 677.095. After consultation with the Attorney General's office, appropriate amendments have been drafted and adopted by the Committee.

CONCERN REGARDING PRIMARY CARE PHYSICIAN REFERRALS.

Concern was expressed during the meeting with the House and Senate minority caucus that an individual who is under the care of a primary care physician shouldn't be forced to accept a managed care organization medical provider upon referral for a potentially life threatening surgical procedure.

The Committee shared the concern expressed, particularly in situations similar to that given in the example, but noted that the director is given authority under Section 12 (4)(h) of the draft to propose any rule necessary to provide quality health care to injured workers. It is the Committee's belief that the director would have the authority to develop rules to address such situations and, further, had the authority to refuse to certify, revoke or suspend the certification of any managed care plan failing to meet the requirements of any rules proposed under authority of the Act.

LIMITING CORPORATE OFFICERS WHO MAY BE NON-SUBJECT WORKERS FOR THE PURPOSES OF CHAPTER 656 TO TWO WHERE THE CORPORATION IS INVOLVED IN THE COMMERCIAL HARVEST OF TIMBER.

An objection was raised with the Committee over the proposal to limit among corporate officers who may be considered non-subject workers.

The Committee believed this provision is needed to curb abuses among those attempting to avoid the application of workers' compensation statutes.

EXTEND THE TIME PERIOD DURING WHICH A NON ATTENDING PHYSICIAN MAY TREAT AN INJURED WORKER FROM 30 DAYS TO 6 MONTHS.

The Committee received a suggestion to extend the 30 day/12 visit period to 6 months.

The Committee considered this suggestion along with others in relation to the question concerning attending physicians but ultimately decided to eliminate the statutory restrictions on all providers if they are members of a managed care organization.

THE 20 PERSON EXEMPTION FROM THE APPLICATION OF THE REINSTATEMENT PROVISION.

The Committee received an objection to the 20 person exemption for employers from the application of the worker reinstatement provisions on the grounds that is arbitrary and inequitable.

The Committee was provided with statistics which show that the 20 person limit covers approximately 72% of all employees in the Oregon. The Committee believes the 20 person exemption fairly balances the interests of employers and employees.

A question was raised whether a 20 person limit could be manipulated by an employer by reducing his employment rolls below the 20 person limit when the worker returns to work. An amendment was adopted to insure that the 20 person limit could not be manipulated.

CONCERNS REGARDING SAIF CORPORATION.

Many members of the legislature expressed concern over a various aspects of SAIF's operations. Most of the concerns relate in some way with SAIF's recent cancellation/non-renewal actions.

The Committee did not address any aspect of SAIF's operation or any other question involving the insurance aspects of workers' compensation. This was not part of the charge given the Committee by the Governor and these questions were not examined.

PENALTY PROVISIONS.

An issue was raised by a member about the penalty provisions on page 25, lines 26-31 and their relationship to Section 28 on page 52 of the proposed draft.

The Committee concluded they were in conflict and adopted the necessary amendment to resolve the matter.

PERSONAL APPEARANCE DURING REVIEW OF COMPROMISE AND RELEASE AGREEMENTS.

A member questioned why a worker would be required to personally appear before the Workers' Compensation Board when he/she is not represented by an attorney and has signed a release.

The Committee discussed this problem and adopted an amendment which provides that at the workers request they may appear before the Board at such hearings.

EFFECTIVE DATE CONTAINED IN SECTION 13.

The Senate and House Caucuses raised an issue about the operative clause (Section 13, page 20) and the phrase "worker changes employment, whichever first occurs."

After much discussion the Committee amended the section to read "or the worker changes physician or doctor, whichever event first occurs."

NUMBER OF MEDICAL ARBITERS COMPRISING A PANEL.

Several members questioned how many medical arbiters comprise a 'panel' as set forth on page 30 line 29.

After discussion the Committee agreed to add the number (3).

TIME PERIOD ALLOWED FOR DENIAL.

Several members inquired as to the intent of the language on page 24 lines 10-28 of the proposed draft and why the Committee changed the 60 day denial period to 90 days.

After discussion of this concern, the Committee restated it's belief that a longer period in which to investigate a claim would lead to fewer denials of claims.

MODIFICATION OF THE EMPLOYER RESPONSIBILITY STANDARDS.

Several members expressed concern with the proposed language relating to allocation of responsibility between employers and insurers on new injury or occupational disease claims and offered alternative proposals.

The Committee struggled with this issue throughout the negotiations and adapted a number of revisions to their drafts. The Committee believes the concerns raised by the members are valid, however, and has agreed to delete a portion of the language on page 72 of the draft leaving intact the "last injurious exposure rule". It is the intent of the Committee to direct the Workers' Compensation Labor-Management Advisory Committee to study this issue further and provide a recommendation during the next regular session of the Legislature.

PROPOSAL FOR AN INITIAL ATTENDING PHYSICIAN.

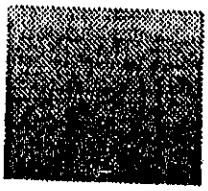
A member suggested the concept of an "initial attending physician" be adopted as a compromise to the question of who may be an attending physician.

The Committee considered this proposal together with several others before reaching the decision to eliminate the statutory restrictions on all medical providers if they are members of a managed care organization.

EFFECT OF RELEASE FOR WORK ON TIME LOSS PAYMENTS.

Concern was expressed by a member who suggested the proposed draft would allow insurers to terminate time loss payments when a worker is released to work but has not actually returned to work.

The Committee noted that the proposed language would allow a worker to receive temporary disability benefits if the worker is released to modified work even if the worker has not actually begun work. If the worker is released to regular work, but has not actually begun work, temporary disability benefits terminates. This is consistent with the law in Oregon prior to 1987.



The Governor's
Workers' Compensation
Labor Management Advisory Committee

Executive Summary

LC 369-18:

This Agreement modifies or changes 50 sections of the Workers' Compensation law. A summary of those changes is as follows:

SECTION 1:

SAFETY COMMITTEES:

Requires every employer of ten or more employees to establish and administer a safety committee in accordance with the rules adopted by ORS 656.182. Any employer of ten or fewer employees shall establish and administer a safety committee if the director finds that the employer has a loss work day case incident rate in the top 10% of the rate for employers in the state.

SECTION 2:

Requires that members of the safety committee be either volunteers or elected by their peers. Requires the Department to prescribe guidelines for the training of safety committee members.

SECTION 3:

OCCUPATIONAL INJURY:

Requires that an occupational injury be established by medical evidence supported by objective findings. Limitations of occupational injury are:

A. No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

B. If a compensable injury combines with a pre-existing disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment.

C. A compensable injury does not include an injury incurred as the result of engaging in or performin any recreational or social activity primarily for the worker's personal pleasure.

ALCOHOL AND DRUG USE:

If Alcohol or drugs are found to be by clear and convincing evidence, the major contributing cause of an injury the claim shall not be compensable unless the employer's culpability is involved.

ATTENDING PHYSICIAN:

Means a medical doctor or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon.

OBJECTIVE FINDINGS:

Means medical evidence, including but not limited to; range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings.

SECTION 4:

Sets certain limits for the number of exempt corporate officers or directors in the construction and logging trades.

SECTION 5:

If a non-complying employer is a corporation, other than a non-profit corporation, the corporation and the officers and directors thereof shall be jointly and severally liable for court costs and attorney fees.

SECTION 6:

The average weekly wage will now be computed by the Employment Division as of May 15th of each year.

SECTION 7:

Increases scheduled disability from $145 per degree to $305 per degree.

SECTION 8:

Minor change.

SECTION 9:

LUMP SUM SETTLEMENT:

Allows for compromise and release, except for medical benefits, of an accepted claim. Requires that the Workers' Compensation Board approves the release. **Allows for 30 day cooling off period.**

SECTION 10:

MANAGED CARE ORGANIZATION (MCO):

This section makes substantial changes in the way medical care will be delivered.

Requires a pharmacist or dispensing physician to dispense generic drugs to a worker.

Excludes palliative care. However if the attending physician believes palliative care is appropriate, an appeal may be made to the medical director and the findings of the director is binding.

Allows the director to establish quality of care and utilization treatment standards for all physicians not involved in managed care organizations.

Allows a medical service provider who **is not in a MCO and not** qualified to be an attending physician to provide medical services to injured workers for a period of 30 days from the date of injury or disease or for 12 visits whichever first occurs without the authorization of attending physician. Thereafter, medical services provided to injured workers without the written authorization of an attending physician are not compensable. A medical service provider who **is not in a MCO and** is not an attending physician cannot authorize the payment of temporary disability compensation or make findings of impairment for the purpose of evaluating the worker's disability.

Allows insurers or self-insured employers to contract with MCO's certified by the Department of Insurance and Finance. Unless the worker has elected to receive care from the primary care physician prior to or at the time of making a claim, the worker shall select and receive medical services from physicians inside the MCO prescribed by contract. However, emergency medical treatment may be received from a non-panel physician. **Insurers or self-insured employers may agree by contract with MCO physicians and doctors as to the extent of compensation authorized and medical services provided for.**

SECTION 11:

Minor change.

SECTION 12:

MCO CERTIFICATION:

Medical service and heatlh care providers may become a MCO and requires the director to certify these organizations.

Requires that MCOs not discriminate against or exclude from participation in the plan any class, type or group of medical service providers. The plan must include an adequate number of each class of medical service providers to give the worker flexibility to choose medical service providers from among those individuals who provide service under the plan. Requires that the MCO provide methods of peer and service utilization review to prevent

inappropriate or excessive treatment. The plan must provide for excluding from participation those individuals who violate these treatment standards. MCOs **are required** to provide programs involving cooperative efforts by the worker, the employer and the managed care providers to promote work place safety and early return to work for injured workers.

Workers who elect prior to or at the time of making a claim may receive medical care from their primary care physician defined to mean; a physician who is qualified to be an attending physician, and is a family practitioner, a general practitioner or an internal medicine practitioner and such a physician maintains the worker's medical records and has a documented relationship with the worker. The primary care physician must agree to refer the worker to the managed care organization for any physical therapy or other specialized treatment. The physician also agrees to comply with the rules, terms and conditions regarding medical services performed by the MCO.

SECTION 13:

Establishes that on the effective date of this Act a worker who is receiving medical treatment for an accepted injury or occupational disease may continue to do so and be exempt from Sections 11 & 12 until the worker is found to be medically stationary or the worker changes **physician or doctor** whichever event first occurs.

SECTION 14:

The director may adopt rules prescribing standards of care and utilization guidelines for the treatment for all medical providers. Eliminates the requirement that the director is specifically prohibited from adopting or administering rules which treat manipulation when performed by a physician, as anything other than a separate therapeutic procedure which is paid in addition to other services or office visits.

The director may exclude from the application of fee schedules and inpatient hospital services, those services performed by managed care organizations certified pursuant to this Act.

Allows the director to settle disputes which exist between insurer or self-insured employers and medical service providers when such disputes involve medical service fees.

SECTION 15:

AUTHORIZATION FOR TIME LOSS:

Provides that temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested and failed to receive from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease unless the physician is unavailable through no fault of the worker.

Also provides that the physician billing not be paid until the physician provides the verification of the worker's ability or inability to work.

Workers who fail to appear at an appointment with the worker's attending physician, the insurer or self-insured employer must give the worker notice of a rescheduled exam by Certified mail. If the worker does not keep this appointment for reasons other than cancellation or rescheduling by the physician the insurer or self-insured employer without prior approval of the Department may suspend payment to the worker until the worker appears for a rescheduled appointment with the attending physician.

BAUMAN:

Provides that claims must be accepted or denied within 90 days after the employer has notice or knowledge of a claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains information indicating that the claim is not compensable or that the paying agent was not responsible for the claim, the insurer or self-insured employer at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of denial. However, if the worker requests a hearing on such denial the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable.

ACCEPTANCE NOTICE:

Insurers, when sending out notice of acceptance shall specify what conditions are compensable. Makes minor changes to non-disabling claims.

PENALTIES:

The director shall have exclusive jurisdiction over proceedings regarding a payment of penalties as a result of an insured or self-insured employer's unreasonable delay or refusal to pay compensation or to accept or deny claims. If a penalty is awarded, 100% of the penalty will be paid to the worker. If the worker is represented by an attorney 50% of the penalty goes to the attorney. If the matter is before a hearing referee and there are multiple issues and the referee awards a penalty, the payment as prescribed in this section will be in lieu of attorney fees.

SECTION 16:

CARRIER CLOSURE:

This section allows carrier closure of all claims. It also allows that time loss may be suspended when the attending physician approves in writing the worker's return to regular employment.

MANDATORY RECONSIDERATION:

If the worker, insurer or self-insured employer objects to a determination order issued by the Department, the objecting party must first request reconsideration of the order. At the reconsideration proceedings, the worker, insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical or other evidence that should have been but was not submitted by the attending physician. Reconsideration shall be completed within 15 days from the date or request. If additional compensation is awarded by the Evaluations Division, and the worker is represented by an attorney, the attorney shall receive up to 10% of additional compensation awarded. **In the event the standards do not apply the director may suspend the 15 day reconsideration rule and issue an emergency rule to amend the standard. Such rule will be reviewed by the Management/Labor Committee.**

MEDICAL ARBITRATOR:

If either party disagrees with the redetermination, at the request of either party, the director shall refer the claim to a medical arbitrator or panel of arbitrators to examine the worker. The findings of the arbitrator shall be

submitted to the Department for reconsideration of the determination order or notice of closure. No other medical evidence of the worker's impairment is admissable.

FRAUD:

An insurer or self-insured employer may take credit or offset of previously paid compensation benefits or payments against any further workers' compensation benefits or payment due a worker when it is established by admission of the worker, civil judgement or criminal judgement that the previously paid benefits or payments were obtained through fraud by the worker.

SECTION 17:

Requires that all closure notices advise workers of their right to consult with the ombudsman.

SECTION 18:

AGGRAVATION CLAIMS:

After the last award or arrangement of compensation, an injured worker is entitled to additional compensation including medical services for worsened conditions resulting from the original injury when such worsening is established by medical evidence supported by objective findings. However, if an injury occurring outside the scope and course of employment is the major contributing cause of the condition, the worsening is not compensable. A worsened condition does not presume to have been established by either or both of the following:

The worker's absence from work for any given amount of time as a result of the worker's condition from the original injury; or inpatient treatment of the worker at a hospital for the worker's condition from the original injury.

A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation.

If a worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than fluctuations in the condition contemplated by the previous permanent disability award.

SECTION 19:

Minor change.

SECTION 20:

HEARINGS AND STANDARDS:

Requires that the evaluation of the determination order or carrier closure of the worker's disability by a referee shall be as of the date of issuance of determination order or notice of claim closure pursuant to ORS 656.268. Findings of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings.

Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by a preponderance of the evidence that the standards adopted by ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the determination order or notice of closure pursuant to ORS 656.268. If the referee finds that the claim has been closed prematurely, the referee shall issue an order rescinding the notice of closure.

We have removed the requirement that the Board implement mandatory informal dispute resolution process.

SECTION 21:

DISPUTED CLAIM SETTLEMENTS:

In any cases where there is a bona fide dispute over compensability of a claim, the parties may, without the approval of the referee, Board or the Court, by agreement make such disposition of the claim as is considered reasonable. We have eliminated the requirement that the insurer or self-insured employer repay medical service and health insurance providers.

SECTION 22:

BOARD REVIEW AND STANDARDS:

Requires that the evaluation of the worker's disability by the Board shall be as of the date of the determination order or notice of closure pursuant to ORS 656.268. Any findings of fact regarding the worker's impairment must be established by the medical evidence that is supported by objective findings.

SECTION 23:

DENIED CLAIMS:

If a denial is overturned by the referee or Board, time loss benefits are owed from the date of the order until final resolution is reached. If ultimately found payable under a final order, benefits withheld under this subsection shall accrue interest.

ACCEPTED CLAIMS:

If the insurer or self-insured employer objects to the award of permanent partial disability such an award is not payable until the appeal process is complete. Any permanent disability withheld and payable, shall accrue interest from the date of the order appealed from through the date of payment.

SECTION 24:

Minor change.

SECTION 25:

Minor change.

SECTION 26:

MEDICAL DISPUTES REVIEWED BY DIRECTOR:

If an injured worker, insurer or self-insured employer believes that an injured worker is receiving medical treatment that is excessive, inappropriate,

ineffectual or in violation of the rules regarding the performance of medical services such issue may be referred to the director. Unless the director issues an order finding that no bona fide medical service dispute exists, the director shall review medical information and records regarding the treatment. The director may refer the matter to a physician or panel of physicians for their review and consultation. Any review of the director's findings may be modified only if the order is not supported by substantial evidence in the record.

At least one member of any such medical panel shall be a practitioner of the medical healing art of the medical service provider whose treatment is being reviewed.

Physicians who participate pursuant to this section shall not be examined or subject to administrative or civil liability regarding their participation or medical findings.

SECTION 27:

CARRIER CLOSURE AND PENALTIES:

After carrier closure, the Evaluation Division orders an increase by 25% or more of the amount of compensation to be paid to the worker for permanent disability not attributable to a change in the worker's condition and the worker is found after review to be at least 20% permanently disabled, the insurer or self-insured employer shall pay to the claimant a reasonable fee provided for in this section.

SECTION 28 and 29:

Eliminates the Court of Appeals settling disputes over the amount of attorney fees.

SECTION 30:

DEFENSE ATTORNEY FEES NOT SUBJECT TO BOARD REVIEW:

This section eliminates the provision that the payment for legal services by an attorney, other than a salaried staff attorney representing the insurer or self-insured employer, be invalid unless approved by the referee or Board.

SECTION 31 THROUGH SECTION 36:

PREFERRED WORKER REIMBURSEMENT:

Establishes the **re-employment assistance reserve.** Eliminates handicapped workers' and preferred workers' reserve. In order to encourage the employment of individuals who have incurred compensable injuries that result in permanent disability and prevent the worker's return to regular employment, that such worker is eligible to receive from the director notification of preferred worker status. The employers hiring workers in this status shall be exempt from insurance premiums or premium assessments under this chapter for up to three years. Any claim costs for injuries or diseases incurred by those workers for the first three years from the date of hire shall be reimbursed quarterly.

SECTION 37:

Minor change.

SECTION 38:

SMALL BUSINESS OMBUDSMAN:

Creates the office ombudsman for small business. The ombudsman shall report directly to the director. The ombudsman shall provide information assistance to small business with regard to workers' compensation insurance and claim processing matters.

SECTION 39:

REFEREE EVALUATIONS:

Requires the Board to conduct annual survey of all attorneys regularly participating in workers' compensation cases in such a manner as to allow the attorneys to rate anonymously the referees as to knowledge of the workers' compensation law, judicial temperament, capability to handle hearings, diligence, efficiency and other similar factors.

SECTION 40:

STANDARDS:

This section provides standards for the evaluation of disabilities. The criteria for evaluation of disabilities under ORS 656.214 (5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job. Impairment is established by a preponderance of medical evidence based upon of objective findings.

SECTION 41:

MANAGEMENT/LABOR COMMITTEE:

The Governor shall appoint a workers' compensation Management/Labor Advisory Committee composed of 14 appointed members. 7 members **from organized labor** shall represent subject workers and 7 members shall represent subject employers. In addition to the appointed members, the director shall serve ex-officio as a member of the committee. The committee shall periodically review the standards for evaluation of permanent disability and shall recommend to the director factors to be included or such other modifications of application of standards as the committee considers appropriate. The committee shall reports its findings to the director and/or the Legislature.

SECTION 42:

Minor change.

SECTION 43:

OCCUPATIONAL DISEASE CLAIMS:

Occupational claims means any disease or infection arising out of or in the course of employment caused by a substance or activities an employee is not ordinarily subjected or exposed other than a period of regular actual employment therein . . . The worker must prove the employment conditions were the major contributing cause of the disease or its worsening. Existence

of the disease or worsening must be established by medical evidence supported by **objective** findings.

SECTION 44:

Minor change.

SECTION 45:

REINSTATEMENT:

A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment on demand for such reinstatement if the position exists and is available. The worker's former position is available even if that position has been filled by a replacement while the injured worker absent. A certificate by the attending physician that the physician approves the worker's return to the worker's regular employment shall be prima facia evidence that the worker is able to perform such duties.

The right to reinstatement **to the worker's former position** under this section terminates when whichever the following events first occur:

The worker's attending physician determines that the worker cannot return to the former position of employment unless the worker appeals that decision to the medical arbitrator.

The worker is eligible and participates in vocational assistance under ORS 656.340.

The worker accepts employment with another employer after becoming medically stationary.

The worker refuses a bona fide offer from the employer of light duty or modified work prior to becoming medically stationary.

Seven days from the date that the worker's physician declares the worker to be medically stationary and released for work.

Three years from the date of injury.

The right to reinstatement under this Section does not apply to a worker hired under a temporary basis as a replacement for an injured worker.

A seasonal worker employed to perform less than six months work in a calendar year. A worker employed through hiring halls in the construction trade.

A worker whose employer employs 20 or fewer workers **at the time of injury and upon demand for reemployment.**

SECTION 46:

Makes minor changes.

SECTION 47:

Is amended and adds Sections **48** through **54.**

SECTION 48:

Makes minor changes to non-disabling injury claims.

SECTION 49:

EMPLOYER RESPONSIBILITY:

When a worker sustains a compensable injury the responsible employer shall remain responsible for future compensation medical services and disability relating to the injured body part unless the worker sustains a new compensable injury involving the same body part.

EMPLOYER RESPONSIBILITY UNDER ORS 656.307:

No employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer, or the employer or insurer has consented to the issuance of an order designating paying agent under ORS 656.307. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer,

regardless of whether or not the worker has filed a claim against that employer or insurer.

SECTION 50:

INCARCERATED WORKERS:

An injured worker is not eligible to receive compensation for periods of time during which the worker is incarcerated for the commission of a crime.

SECTION 51:

CENTS PER HOUR:

The director shall analyze **for the construction, logging and saw mills industries** the hours worked data collected and shall report to the 66 Legislative Assembly and the recommendations the director considers appropriate regarding changes in the manner of changing workers' compensation premiums to a cents per hour system.

SECTION 52:

CLAIMS EXAMINERS' CERTIFICATION:

Not later than January 1, 1990 the director shall establish a certification program to instruct workers' compensation claims examiners on the requirements of this chapter and the rules adopted pursuant there to. The director may certify programs administered by insurers or self-insured employers or their professional associations. Individuals with more than one year of workers' compensation claims examining experience shall be certified by the director without having to undergo the certification program.

SECTION 53:

Existing liabilities of the handicapped workers' reserve shall be transferred to the re-employment assistance reserve.

SECTION 54:

Effective date:

It is the intent of the Management/Labor Advisory Committee that the provisions of this bill be implemented as soon as possible.

SECTION 55:

EMERGENCY CLAUSE:

Shall take affect upon passage.

RED/jh