Lessons from the Oregon Workers' Compensation System

Duncan S. Ballantyne

Workers Compensation Research Institute

WCRI

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Cambridge, Massachusetts
March 2008

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Executive Summary

When considering changing their workers' compensation systems, state policymakers often want to learn more about the system in Oregon—a state with a reputation for achieving certain desirable outcomes, including reasonable income benefits that are typically delivered accurately and promptly with lower litigation levels, and employer costs that are affordable and stable.

Many of the positive outcomes of the Oregon system likely flow directly from the design of certain system features. The Workers Compensation Research Institute (WCRI) undertook this study to identify features that account for Oregon's better-than-typical results, particularly the features that might constitute lessons for other states. Although many lessons are possible from the Oregon experience, this report focuses on four key lessons. The reader is encouraged to visit the Web site of the Department of Consumer and Business Services (DCBS) at http://www.oregon.gov/DCBS/index.shtml for more information on the programs and system features of the Oregon system.

Two cautions are in order: First, many system features create mutually reinforcing incentives that shape positive results. When that occurs, other states adopting only part of a high-achieving state's package of features are unlikely to achieve those positive results. Second, a process that works in one state is not guaranteed to achieve identical results in another state. One of the basic principles of physics also applies to workers' compensation systems: the principle of inertia. As a result, every state should expect that in the wake of even large system changes, participants will try to find ways to continue past practices.

How do outcomes in Oregon compare with those of other states? As is customary and unfortunate in workers' compensation, the data are uneven in terms of completeness, comparability, and currency. Concerning costs to employers, the *2006 Oregon Workers' Compensation Premium Rate Ranking Summary* shows that Oregon employers in the voluntary market paid, on average, the 42nd-highest workers' compensation premium rates in the nation (DCBS, 2006a). Oregon is also noted for its insurance rate stability: 18 years without an increase in pure premium rates.

Benefit levels in Oregon appear to be above average. Data from the U.S. Department of Labor, Office of Workers' Compensation Programs (2006), show that the statutory maximum weekly amount for temporary total disability (TTD) benefits (as a percentage of the statewide average weekly wage) was the sixth highest in the country as of January 1, 2006. In Oregon, permanent partial disability (PPD) benefits are considered generous if they meet or exceed national medians for maximum benefits. Using a measure called the benefit level index (BLI), the DCBS compares maximum PPD benefits among states by controlling for differences in wage levels and expressing the result for a given state relative to the median state (a BLI value of 1.00). Using this measure for 2005 benefit levels, Oregon's BLI values of 1.64 (scheduled PPD benefits) and 1.31 (unscheduled PPD benefits) indicate that the state's maximum benefit levels were above the national median (DCBS, 2005b).[1]

No recent data are available to compare the timeliness of initial TTD payments in Oregon with that in other states, but Oregon data show that the industry average for the share of first TTD payments made within 14 days ranged from 86 percent to 91 percent in the period 1997–2006 (DCBS, 2007b). Likewise, no data are available to compare litigiousness and the speed of dispute resolution in Oregon with those in other states; however, data from the Oregon Workers' Compensation Board show a median of 140 days (4.6 months) from request to formal-hearing order in 2005 (DCBS, 2006b).

Lesson 1: The Workers' Compensation Advisory Committee Is Unusually Effective as a Force for Orderly System Improvement because of Certain Features of Its Design and Operations

Many system participants we spoke with in Oregon consider labor and management cooperation through its workers' compensation advisory committee, called the Management–Labor Advisory Committee (MLAC), to be one of the workers' compensation system's greatest strengths. One DCBS official we spoke with described a partnership between the MLAC and the DCBS: "Labor and management are the co-owners of the system. Working through MLAC and DCBS, they evaluate and recommend policy. Other parties (doctors, attorneys, insurers, etc.) are in the role of service providers. Labor and management realize that there is a balance to be maintained in the system, which leads to orderly change against a backdrop of stability."

[1] Oregon no longer distinguishes between scheduled and unscheduled PPD benefits for injuries occurring on or after January 1, 2005.

Evidence of Impact

Most system participants agree that the MLAC has played a major role in fostering orderly system change and continuous improvement in Oregon in the past ten years. Chapter 2 contains examples of legislative changes that came about as a result of MLAC initiation or review. That chapter also discusses how the MLAC addressed the contentious issue of using independent medical examinations and summarizes the changes made in 2005.

Critical Success Factors for the MLAC

We identified six factors in the design and operation of the MLAC that are associated with its effectiveness in bringing about orderly and lasting change in the Oregon system. A central theme is that the governor and (usually) the legislature funnel stakeholder proposals for change through the advisory-committee process, keeping the interests of management and labor at the forefront of the debate. The MLAC's annual budget is small—$50,000 for the period 2005–2007. However (as mentioned in the following list), the committee receives considerable support from the DCBS in conducting studies and drafting legislative proposals.[2]

1. *Labor and management, not other interest groups, influence but do not control the system through the MLAC.* The MLAC is composed of five voting representatives from business and five from labor; the DCBS director is an ex officio member. Other stakeholder groups are not members. Working collaboratively with the DCBS, the governor, and the legislature, the MLAC shapes the workers' compensation system. The interests of other participants (e.g., insurers, attorneys, physicians, rehabilitation providers,

[2] The DCBS does not have an estimate of the dollar value of these additional resources.

and consultants of various kinds) are considered and mediated in negotiations between labor and management through the MLAC.

2. *The governor vows to veto any workers' compensation bill that does not gain advisory committee (i.e., labor and management) endorsement.* This feature has been the cornerstone of Oregon's advisory-committee process. In making such a vow, the governor has effectively said no to other interest groups unless management and labor have approved. MLAC members we spoke with said that when vetoing a bill that does not gain MLAC endorsement, some governors have referred the issue back to the committee to "fix the problem."
3. *The legislature usually defers to the MLAC.* In Oregon the advisory committee enjoys the support of legislators. There are no stated rules for deference to MLAC. Rather, it is generally understood by legislative caucus leaders and committee chairs that workers' compensation bills should first be vetted by the MLAC. The DCBS reinforces this by reviewing introduced legislation and providing a list to MLAC cochairs so they can consider scheduling MLAC review. Also, if a bill does come before a legislative committee, it is common for the MLAC chair to ask whether the MLAC has reviewed the bill. According to DCBS officials, given the turnover among the legislative ranks, it is important for the DCBS to continually educate legislators about these informal understandings and the positive dynamics that result.
4. *The state agency actively supports the MLAC by conducting studies and drafting legislative proposals.* Most MLAC members we interviewed said it is critical that the state agency conduct special studies to provide input to their deliberations. As one member put it, "Change is compelling if data support the need for change."
5. *Public input is encouraged through testimony at MLAC meetings and other mechanisms.* This enables all parties to express concern, advocate, raise questions, and voice opposition. Overall, public input improves decision making and lends credibility to the advisory-committee process.
6. *Subcommittees are often used to hear testimony, narrow issues and consider changes to legislative proposals.* This is important because it enables the advisory committee to draw on technical experts on technical issues, and it allows for division of labor among MLAC members who are volunteers.

On the whole the Oregon system (through the MLAC and other system features) has succeeded in balancing the values of stability and flexibility remarkably well, resulting in a system stable enough to be predictable yet flexible enough to change when necessary. In many states the two values are not compatible.

Lesson 2: The State Agency's Commitment to Setting System Goals, Measuring and Monitoring Performance, and Imposing Sanctions against Substandard Performance Results in Consistently Accurate and Timely Delivery of Benefits, Although Opportunities May Exist to Reduce Agency Reporting and Regulatory Costs

The DCBS annually measures its performance in meeting departmental goals. Under the goal "Protect consumers and workers in Oregon," the DCBS has defined a key performance measure applicable to workers' compensation: "percent of injured workers who receive timely and accurate benefits."[3] The DCBS publishes an Annual Performance Progress Report.

Evidence of Impact

The 2005–06 Annual Performance Progress Report shows the aggregate claims-handling performance of insurers and self-insurers annually from fiscal years 2001 through 2006. From fiscal years 2002 through 2006, the target percentage of Oregon workers receiving accurate and timely benefits was raised from 91 percent to 95 percent.[4] Actual performance increased from 87.2 percent in fiscal year 2001 to 91.8 percent in 2005 and then fell to 89.8 percent in fiscal year 2006 (DCBS, 2007a).[5]

Standards for Claim Reporting, First Payment, and Acceptance or Denial

Oregon sets timeliness standards for delivering benefits to workers in three areas as part of its Quarterly Claims Processing Performance (QCPP) audit. The areas

[3] Key performance measures are the highest-level, most outcome-oriented performance measures used to report externally to the legislature and interested citizens.

[4] No target was set for fiscal year 2001.

[5] Current data are not available to compare the accuracy and timeliness of claims handling by insurers and self-insurers in Oregon with those in other states.

and applicable standards are (1) claim filing: 90 percent of claims for indemnity benefits reported to the Workers' Compensation Division (WCD) of the DCBS within 14 days of the acceptance or denial date; (2) first payment: 90 percent of first payments for temporary disability made within 14 days of the date the employer knew of the claim;[6] and (3) claim acceptance or denial: 90 percent of claims accepted or denied within 60 days of the date the employer knew of the claim.

The QCPP audit uses reports submitted by all payors in Oregon. On a quarterly basis, the WCD compiles the information from the reports and provides each payor with a computer-generated summary of its performance before posting industry averages on the DCBS Web site. In fiscal year 2006, 99 percent of indemnity claims were reported promptly, 88 percent of TTD payments were timely, and 91 percent of claims were accepted or denied promptly (DCBS, 2007b). This performance has been remarkably consistent over time. Payors are subject to penalties (issued administratively) if their performance falls below the standard in any of the three areas.

WCD COMPLIANCE AUDITS

The WCD conducts on-site audits to assess claims-processing compliance.[7] The WCD defines 14 audit areas and specifies expected performance levels for accuracy and timeliness for each area. Each claims-processing location is audited at least once in every two- to three-year audit cycle according to the audit areas. Penalties are imposed based on the number of audit categories falling below each audit threshold, not on each infraction.

OPPORTUNITIES TO REDUCE REPORTING AND REGULATORY COSTS

Oregon's active-agency approach to regulating the delivery of benefits by insurers and self-insurers is partly reflected in the comparatively larger state agency needed

[6] This standard applies if temporary disability is immediate and authorized. If it is not immediate, the applicable date is when the attending physician authorizes temporary disability. If the payor requested verification and did not receive it during the first 14 days, the applicable date is when authorization is received.

[7] Copies of WCD audit reports are available at http://www.cbs.state.or.us/wcd/compliance/fau/ptd/audinfo.html.

to administer the workers' compensation system. In a study of the Iowa workers' compensation system, we compared total administrative expenditures per employed worker in fiscal year 2003 among ten states with 1–2 million workers (Ballantyne, 2004, tab. 6.1). At $28.10 per employed worker, Oregon administrative expenditures were much higher than the median of the ten states ($5.07). However, DCBS officials told us that workers' compensation administrative expenditures in Oregon fund some program areas (e.g., Oregon OSHA and the Insurance Division of the DCBS) that typically are not included in administrative expenditures in other states. According to the DCBS officials, for all workers' compensation regulatory and adjudication functions, the estimated average expenditure for each employed worker was $19.64 in fiscal year 2003.[8] Thus, although comparable Oregon administrative expenditures per employed worker in fiscal year 2003 were not as high as originally thought, they remained significantly higher than the median of ten similarly sized states. It would not be surprising if the cost burden (resulting from rules, paperwork, reporting, etc.) imposed on payors was also higher in Oregon.

We asked system participants, "Are Oregon's higher administrative expenditures a worthwhile investment in positive outcomes?" Most public and private respondents answered yes. DCBS officials stated that Oregon's Office of Regulatory Streamlining is setting statewide standards for reorganization that apply to the DCBS, and the WCD is undertaking a regulatory redesign initiative with the goal of reducing the regulatory burden.

Some employers and insurers responded to our question by saying that administrative expenditures could be reduced further and opportunities to eliminate unnecessary regulatory functions and burdensome administrative rules still exist. One insurer cited the burden of the DCBS requiring written justification from a payor seeking approval to suspend a worker's benefits when, for example, the worker fails to submit to a medical examination. Some insurers and self-insurers questioned the complexity of the WCD's informal dispute resolution process in cases related to payors' orders finalizing TTD benefit periods or determinations of PPD benefits, especially the need to review every aspect of a claim. Another insurer mentioned the complexity of determining and reporting the timeliness of initial TTD payments.

The DCBS officials told us that Oregon's larger regulatory presence is a re-

[8] The comparable figure for fiscal year 2005 was $19.09.

flection of what policymakers have asked the WCD to do and, while the WCD's regulatory role has increased, the division has reduced full-time equivalent staff counts by almost 20 percent, from 291 in fiscal year 1997 to 235 in fiscal year 2007.

Lesson 3: A Combination of System Features Can Increase Certainty and Decrease Litigation over Permanent Partial Disability Benefits

Oregon public policymakers have designed several system features that work together to increase certainty about the determination and payment of PPD benefits as well as to reduce litigation over the benefit delivery. These system features are mutually reinforcing; that is, they work in combination to produce the results described here.

EVIDENCE OF IMPACT

The DCBS collects internal data on the share of scheduled and unscheduled PPD dollars awarded each year from 1995 through 2004 at each of three levels. The first level is when the worker does not object to a payor's determination as to the amount and extent of PPD benefits to be paid periodically; we call this the voluntary-agreement level. The second (informal) level reflects PPD benefits awarded at reconsideration—Oregon's informal dispute resolution process designed to address issues arising when the worker is determined to be medically stationary, TTD benefits are terminated, and the amount of PPD benefits (if any) is determined. The third (hearings award) level reflects PPD dollars awarded after a formal hearing has been requested. DCBS internal data show that payors awarded 85–91 percent of unscheduled PPD dollars annually from 1995 through 2004 at the voluntary-agreement level. In the same period payors awarded an additional 7–15 percent of unscheduled PPD dollars at the informal level. Three percent or less of unscheduled PPD dollars were awarded at the hearings award level in the period. The data show similar results for scheduled PPD dollars. Thus, Oregon appears to achieve consistently high levels of voluntary agreement of PPD benefits. By comparison, in many states that WCRI has studied, formal hearings are commonly needed to address disputes over the amount of PPD benefits.

KEY SYSTEM FEATURES THAT INCREASE CERTAINTY AND REDUCE LITIGATION OVER PPD BENEFITS

We identified a package of six key system features and ten reinforcing features that result in enhanced certainty over PPD determination in Oregon and low levels of formal-hearing involvement. The goal of the package is to resolve disputes swiftly, informally, and with a minimum of friction costs.[9] The overall impact of these features of the Oregon system is that private decision makers in the PPD determination process (e.g., payors and attorneys) focus on applying the rules, rather than trying to game the system by obtaining dueling physician ratings. Following are the six key system features that increase certainty and reduce litigation:

1. *Reliance on the treating provider to offer the information needed to form the basis of an impairment rating.*[10] When the worker reaches maximum medical improvement, the WCD requires the treating physician to determine if the worker has a permanent physical impairment. If permanent impairment is confirmed, the physician completes a worksheet containing measurements and findings concerning the extent of the impairment for the condition that has been accepted by the payor. This worksheet provides the insurer or self-insurer with information to use in determining an impairment rating and calculating the amount of PPD benefits. The reconsideration and medical-arbiter processes (described in items 5 and 6 of this list, respectively) counterbalance the incentive for workers or their attorneys to select consulting physicians to maximize impairment ratings, or for insurers and self-insurers to refer workers to independent medical examination physicians to minimize impairment ratings.
2. *Use of a guide to rate permanent impairment.* Oregon uses its own guide for rating permanent impairment (that is, the degree of loss of use of a body

[9] Friction costs are the costs to private parties—employers, insurers, and workers—of processing and resolving claims. Included are attorney fees, medical-legal costs, data-processing costs, and the costs of other claims-related activities.

[10] The employee selects the treating provider without restriction in Oregon, except when the employer has contracted with a managed care organization (MCO). If enrolled in an MCO, the employee makes the initial choice from a list of providers developed by the MCO. Other restrictions on employee choice of treating provider include the limitation to two changes of physician and the limited attending physician status of some provider types outside MCOs.

part or system), thus allowing rating and compensation concepts to be consistent with Oregon statute and established case law.

3. *Objective criteria for determining loss of earning capacity at all stages.* Oregon is one of four states that, by rule, specify objective criteria to use in assessing the factors affecting loss of earning capacity (e.g., age, education, and occupation) in addition to permanent impairment.[11] These criteria must be considered at all levels of decision making, including all levels of dispute resolution.
4. *Active payor involvement in terminating TTD benefits and determining PPD benefits (initial claim closure).* Generally, when the worker is released by the treating physician to return to work or is determined to have reached maximum medical improvement, the payor initially closes the claim. Initial claim closure does not mean that the insurer or self-insurer has paid all known benefits. Rather, it signals that temporary disability benefits have ended and prompts consideration of permanency benefits.[12]
5. *Use of a swift and mandatory mechanism for administrative dispute resolution (called reconsideration) to address objections to initial claim closure.* The reconsideration process includes statutory time frames intended to avoid delays and is designed to minimize the need for attorney involvement on both sides. DCBS internal data show that typically an order is issued in 20–24 days when the case is not postponed and in 77–86 days when a postponement occurs (usually for an examination by a medical arbiter).
6. *Use of a medical arbiter.* About two-thirds of reconsideration requests involve a medical-arbiter examination because of a dispute over the extent of permanent impairment. A medical arbiter is a licensed physician who has been trained and approved by the WCD to conduct impartial examinations regarding the extent of physical impairment. The WCD maintains a list of about 540 physicians who are approved as medical arbiters.[13] When either side requests a medical-arbiter examination, both sides are supplied with a list of six physicians (in the same geographical area) chosen randomly by computer within the specialty the WCD determines is most appropriate to the worker's case, based on the treatment rendered by

[11] Other states requiring the use of objective criteria when rating disability are California, Kentucky, and New Mexico.

[12] We use the term *initial claim closure* to avoid any confusion with final claim closure.

[13] Oregon's arbiter list is posted on the DCBS Web site at http://www.cbs.state.or.us/external/wcd/compliance/bcu/phy_list.pdf.

physicians in the past.[14] Each side in the dispute can eliminate, or "deselect," one name from the list.[15] Then a WCD staff member selects among the remaining doctors based on which doctor is next in the rotation, is closest to the worker, and practices the specialty that best matches the condition being reviewed. Alternatively, the parties can mutually agree (stipulate) to a name on the list of six physicians, but that rarely happens. Either side can request an examination by a medical-arbiter panel composed of three physicians of the appropriate medical specialty.[16] Thus, instead of parties spending resources on dueling experts, the state agency in Oregon provides direct access to an impartial physician who is paid for by the insurer or self-insurer.

REINFORCING FEATURES

The six key elements of Oregon's approach to reducing litigation over PPD determination would not be fully effective in the absence of the following ten reinforcing features that have been carefully designed into the system. Again, the full package is necessary for the system to work as efficiently as it does.

1. PPD benefits initially awarded by the insurer or self-insurer must be paid within 30 days while the total amount is being reviewed.
2. Tight time frames are specified and performance monitored for each stage in the process.
3. Agency rules apply at all levels of decision making, bringing consistency to the process and minimizing the incentives to end-run any particular step in the process.
4. Only the specifically accepted condition is rated.[17] This is important be-

[14] To ensure impartiality, physicians previously involved in the claim are excluded from selection. Physicians associated with facilities or clinics where the worker has received treatment or evaluation are also eliminated from consideration.

[15] WCD officials we spoke with estimated that deselection occurs in about 80–85 percent of cases involving a request for an arbiter examination.

[16] According to WCD officials, an estimated 12 percent of cases with a medical-arbiter examination involve a request for a panel.

[17] Oregon law states that, when initially accepting a claim and later when terminating TTD benefits, the payor must specify which conditions are compensable, subject to appeal if the worker disagrees. Medical conditions secondary to the claimed injury must also be rated.

cause it limits the scope of what is being rated, thus minimizing one possible source of inter-rater variability.

5. Medical evidence is generally introduced through medical reports rather than live testimony or depositions.
6. Failure to attend or cooperate with a medical-arbiter examination within 60 days eliminates the worker's opportunity to have the exam.
7. Workers' attorney fees at reconsideration are statutorily limited to 10 percent of the additional PPD amount obtained as a result of reconsideration, as opposed to 25 percent of increased compensation when a hearing is requested on the extent of PPD benefits.
8. A penalty is paid by the payor to the worker when the PPD rating has been increased by 25 percent or more at reconsideration compared with the insurer's or self-insurer's initial rating at initial claim closure and the worker is found at reconsideration to be at least 20 percent disabled. The amount of the penalty is 25 percent of the dollar amount of the increase in compensation. This feature reduces the incentives to game the rating process.
9. No new evidence may be introduced after reconsideration, and the PPD rating is related to the workers' permanent disability as of the date of the reconsideration order.
10. Issues raised at a formal hearing are limited to those that were raised during reconsideration.

Lesson 4: Return to Work Is Enhanced when Special Programs Are Designed for That Purpose

A fundamental goal of any system is to return injured workers to their jobs quickly and enable them to earn close-to-preinjury wages. Oregon addresses this goal in two ways. First, the statute governing workers' compensation prohibits employment discrimination and provides reemployment rights to injured workers. Second, for accepted claims Oregon offers three return-to-work programs, backed by a special fund, along with a "safety net" of services workers can access even after their claims have been settled through compromise-and-release agreements. DCBS internal data show that about one in seven injured workers who receive income benefits is involved in one of Oregon's return-to-work programs.[18]

[18] In fiscal year 2006, 14.2 percent of closed indemnity claims involved one or more return-to-work programs as of the 13th quarter after injury.

Package of Return-to-Work Programs in Oregon

Oregon policymakers have fashioned some potentially powerful program elements aimed at stimulating early return to work and long-term recovery of wages for injured workers. The key lies in funding a package of wage incentives, protection for the employer in case the worker becomes reinjured, and reimbursement of the costs of fitting a worker to a job. Oregon's package consists of

- the Workers' Benefit Fund (WBF), based on both worker and employer assessments, which funds the programs and serves to stimulate experimentation in Oregon about ways to improve return to work;
- the Employer-at-Injury Program (EAIP), which is designed to stimulate return to modified work, primarily with the preinjury employer;
- the Preferred Worker Program (PWP), which provides incentives to employers to hire injured workers who have permanent disabilities that prevent them from returning to their regular work;
- the vocational assistance program, paid for by the insurer or self-insurer, which is similar to vocational rehabilitation services in other states; and
- extended eligibility for the PWP after workers settle their claims, which provides a reemployment safety net.

Evidence of Impact

We know of only one study that compares return-to-work rates in Oregon with those in other states. In an evaluation of permanent partial disability and return to work in New Mexico, the RAND Institute for Civil Justice compared the median number of days off work after injury in New Mexico (1994–1996), Oregon (1992–1993), Washington (1993–1994), and Wisconsin (1989–1990). The study shows that, at 38 days, the median number of days in Oregon was slightly longer than in Wisconsin (36 days), somewhat shorter than Washington (45 days), and much shorter than New Mexico (77 days; Reville et al., 2001, tab. 7.7). Additional studies involving more states and more-recent data are needed to determine how Oregon's return-to-work performance compares with that of other states.

Workers' Benefit Fund

One purpose of the WBF is to fund Oregon's Reemployment Assistance Program, which includes the EAIP and the PWP.[19] The largest portion of WBF expenditures

[19] Another program in this category includes expenditures for the Oregon Health and Science University's Center for Research on Occupational and Environmental Toxicology.

involves inflation adjustments for long-term claims involving permanent total disability and survivor benefits. This fund is unique among states in that it is funded by an assessment of 1.5 cents for each hour worked (effective January 1, 2006) applied to each employer and worker. In fiscal year 2006 WBF expenditures were about $90.3 million (DCBS, 2006b, tab. 1). EAIP expenditures totaled $10.9 million and amounted to an assessment equal to 0.18 cent per hour for each employer and worker; and PWP expenditures totaled $7.6 million and amounted to an assessment of 0.13 cent per hour for each employer and worker (DCBS, 2006b, tab. 1; DCBS internal data). Most public and private system participants we spoke with said the existence of the WBF is very important in Oregon because it allows the DCBS, with guidance from the MLAC, to creatively use funds to experiment with ways of improving the system.

EMPLOYER-AT-INJURY PROGRAM

The EAIP is a collection of financial incentives for Oregon employers that is designed to encourage early return to modified work.[20] To be eligible for the EAIP, the worker must have one or more temporary restrictions that prevent performance of regular job duties. Payors administer early return-to-work placements under the EAIP, for which they receive a flat fee of $60 per placement. The WCD regulates placements under the EAIP and conditions for payment of financial incentives. Insurers reimburse employers for wage subsidies of 50 percent for up to three months (the major feature of the program) and up to certain maximum amounts for work site modifications, tools and equipment required for the job, clothing, and other expenses (e.g., tuition, fees, and books). Insurers and self-insurers are then reimbursed by the WCD.

WCD surveys of workers and employers who used the EAIP indicate widespread satisfaction with the program. The DCBS estimated that the $7.3 million spent on wage reimbursements under the EAIP in 2000 resulted in a $10.8 million savings in time-loss benefits over 13 quarters (DCBS, 2004a). WCD staff members we spoke with said they would "absolutely" recommend the EAIP to other states, and other stakeholders we interviewed spoke positively about the EAIP.

[20] More information about the EAIP is available on the DCBS Web site at http://www.cbs.state.or.us/external/wcd/rdrs/rau/returntowork.html.

VOCATIONAL ASSISTANCE PROGRAM

In general, a worker is eligible for vocational assistance if he or she has a permanent disability that prevents reemployment in any job that pays at least 80 percent of the preinjury wage. Benefits available under the vocational assistance program include maintenance indemnity payments (equal to temporary total disability benefits) during retraining; necessary expenses, including tuition, books, some travel costs, and tools; and professional rehabilitation services such as plan development, counseling, and placement. The maximum length of benefits is 16 months of training (21 months in exceptional cases), plus 4 months of direct employment services. The typical eligible worker receives 10 months of training followed by job placement services. Few workers return to work as a result of vocational assistance in Oregon: only 143 in 2005 (DCBS, 2006b).

PREFERRED WORKER PROGRAM

The PWP is designed to assist injured workers who cannot return to regular work to find new employment (with their preinjury employers or new employers) by offering incentives to employers who hire them. To be eligible, a worker must have a permanent disability as a result of a compensable injury and must not have been released to regular employment. An eligible worker automatically receives a Preferred Worker Identification Card from the WCD when the insurer or self-insurer reports, as part of initial claim closure, that the worker is released to restricted duty because of a compensable condition. The card informs prospective employers that they may be eligible for the program's benefits if they hire a preferred worker (Maier, 2003). A worker identified as preferred has three years to start using the program's benefits.

An employer who hires a preferred worker is entitled to the following benefits:

- Wage subsidy amounting to reimbursement of 50 percent of wages for up to six months.[21]
- Premium exemption: The employer does not have to pay workers' compensation premiums for the worker for three years.
- Claim cost reimbursement: If the worker suffers a new injury during the

[21] Higher benefits are available for exceptional levels of disability.

three-year exemption period, the payor is reimbursed for all claims costs (including administrative costs) related to the injury for the life of the claim.
- Reimbursement for work-site modification expenses.
- Reimbursement for purchases related to obtaining employment, such as tuition and books.

The WCD delivers these benefits through contracts between preferred workers and their employers.[22]

A DCBS survey of workers who used the PWP found that 92 percent would use the program again and considered all parts of the program valuable (DCBS, 2004b). However, some workers said they feared revealing themselves as an injured worker, and some were not sure what benefits are available.

REEMPLOYMENT "SAFETY NET" FOR WORKERS WHO SETTLE THEIR CLAIMS

Oregon policymakers have provided added protection for workers who have exhausted their lump-sum payments and still need help with reemployment. The protection comes in the form of eligibility to take advantage of the PWP even after a settlement. Most workers' representatives we spoke with regard this as a valuable safeguard. DCBS internal data for fiscal year 2004 show that about one-fifth of workers using the PWP took advantage of the safety-net feature.

[22] More information about the Preferred Worker Program is available on the DCBS Web site at http://www.cbs.state.or.us/external/wcd/rdrs/rau/pwp/pwp_index.html.

LESSONS FROM THE OREGON WORKERS' COMPENSATION SYSTEM

1

Introduction

Any state considering changing its workers' compensation system might do well to look at the features of the Oregon system. The state has a reputation for achieving desirable outcomes, including reasonable income benefits that are typically delivered accurately and promptly with lower litigation levels, and costs to employers that are affordable and stable. Other states might also be interested in knowing how the Oregon system accomplished those results despite being widely regarded as a higher-cost system in the mid-1980s. According to a report by the Department of Consumer and Business Services (DCBS), "In 1986, Oregon ranked sixth highest in the nation in average workers' compensation premium rates paid by employers and had one of the nation's highest occupational injury and illness claim frequencies. At the same time, medical and permanent disability costs for injured Oregonians were among the highest in the nation, while benefits were considered among the lowest" (DCBS, 2001, p. 1). Additionally, Oregon had garnered widespread recognition for excessive litigiousness and litigation delays.

How do outcomes in Oregon currently compare with those of other states? Unfortunately, the data are uneven in terms of completeness, comparability, and currency. Concerning costs to employers, the *2006 Oregon Workers' Compensation Premium Rate Ranking Summary* shows that Oregon employers in the voluntary market paid workers' compensation premium rates that, on average, were lower than 41 other states. Oregon's premium rate index in 2006 was $1.97 of payroll, or 79 percent of the national median (DCBS, 2006a). Oregon is also noted for its insurance rate stability—18 years without an increase in pure premium rates.

At the same time, benefit levels in Oregon appear to be above average. Data from the U.S. Department of Labor, Office of Workers' Compensation Programs

(2006), show that the statutory maximum weekly amount for temporary total disability (TTD) benefits (as a percentage of the statewide average weekly wage) was the sixth highest in the country as of January 1, 2006. What workers receive for permanent partial disability (PPD) benefits depends on both statutory benefit levels and practices for determining the extent of disability. Therefore, the best way to determine how Oregon's PPD benefits compare with those of other states is to compare what workers receive for a similar disability in different states. Unfortunately, the direct evidence is inadequate. Since at least 1995, the benchmark for Oregon PPD benefit generosity has been to meet or exceed national medians for maximum benefits. To measure PPD benefit generosity, the Research and Analysis Section of the DCBS developed the benefit level index (BLI). The BLI method compares maximum PPD benefits by controlling for differences in wage levels by state and expressing the result relative to the median state (which has a BLI value of 1.00). Using this measure for Oregon's 2005 benefit levels, BLI values of 1.64 (scheduled PPD benefits) and 1.31 (unscheduled PPD benefits) indicate that Oregon's maximum benefit levels were above the national median (DCBS, 2005b).

No recent data are available to compare the timeliness of initial TTD payments in Oregon with that in other states. However, as discussed in Chapter 2, Oregon data show that the industry average for the share of first TTD payments made within 14 days ranged from 86 percent to 91 percent in the period 1997–2006 (DCBS, 2007b). No data are available to compare litigiousness and the speed of dispute resolution in Oregon with those in other states, but data from the Oregon Workers' Compensation Board show a median of 140 days (4.6 months) from request to a formal-hearing order in 2005 (DCBS, 2006b).

Purpose of the Study

The Oregon system achieves positive outcomes for many reasons. Some observers may maintain, for example, that Oregon has long enjoyed a positive relationship between labor and management—a relationship conducive to a climate of orderly change and continuous improvement. However, that was not always the case. In 1989 the governor formed a special task force comprising labor and management representatives and sequestered them in Mahonia Hall, in the basement of the governor's mansion, until they forged a consensus on how to change the system.

It is likely that many of the positive outcomes Oregon has achieved flow directly from the design of certain features of the system and that the spirit of cooperation reinforces those features. We undertook this study to identify features that account for Oregon's atypically good results, particularly features that might serve as lessons for other states.

Before focusing on features of the Oregon system that might be effective in other states, we offer two cautions. First, some system features work together to create mutually reinforcing incentives that shape the positive results, and adopting part of such a package is unlikely to achieve the positive results seen in Oregon. Second, what works in one state will not necessarily achieve identical results in another state. One of the basic principles of physics—the principle of inertia—also applies to workers' compensation systems. As a result, in the wake of even large system changes, participants will likely find ways to continue past practices.

The Lessons

Many lessons are possible from the Oregon workers' compensation experience. We focus on the following four key lessons from the system in Oregon:

- *Lesson 1:* The workers' compensation advisory committee is unusually effective as a force for orderly system improvement because of certain features of its design and operations.
- *Lesson 2:* The state agency's commitment to setting system goals, measuring and monitoring performance, and imposing sanctions against substandard performance results in consistently accurate and timely delivery of benefits, although opportunities may exist to reduce agency reporting and regulatory costs.
- *Lesson 3:* A combination of system features can increase certainty and decrease litigation over permanent partial disability benefits.
- *Lesson 4:* Return to work is enhanced when special programs are designed for that purpose.

The purpose of this study is to acquaint the reader with these lessons along with the positive outcomes that Oregon has experienced, describe specific system features that explain how Oregon has achieved those outcomes, and identify some features or approaches that might be transferable to other states.

Among the states WCRI has studied, Oregon has the best collection of useful data about its workers' compensation system published on the state agency Web site. The abundance of published information and analysis posted on the Web site indicate two very important cultural values in the system that have contributed to its performance and stability: (1) a quest for data to manage the system more ob-

jectively and accurately; and (2) the transparency and openness of the administration. The reader is encouraged to access the content-rich DCBS Web site (http://www.oregon.gov/DCBS/index.shtml) for more detailed information about how Oregon's workers' compensation programs and system features operate.[1]

Research Approach

To conduct this study, we used a combination of review of Oregon literature, data analysis, and interviews with diverse system participants.

After reviewing the statute governing workers' compensation, the literature, and previous studies of the Oregon workers' compensation system,[2] we sent DCBS officials and members of Oregon's Management–Labor Advisory Committee (MLAC) a questionnaire asking them about the major strengths and weaknesses of the Oregon workers' compensation system and requesting that they rate (on a scale of 1 to 5, weak to strong) the strength of some possible lessons for other states. We also asked respondents to suggest additional lessons. The four lessons we chose for this study were those rated most highly by respondents. We then requested data from the Information Management Division of the DCBS to learn how the programs and features operate, including trends in program activity and outcomes associated with these activities.

Next we conducted semistructured interviews with both public and private system participants to explore the four lessons in depth. Persons interviewed included 14 members of DCBS staff in the Director's Office, the Workers' Compensation Division, and the Information Management Division; nine current MLAC members; one former member of MLAC management; three former legislators; representatives of two Oregon insurers; three workers' attorneys; and three defense attorneys. From those individuals, we learned how the various features of the Oregon system operate in practice, the pros and cons of each feature, and how features might be improved. Finally, we submitted the draft of the report to the people we interviewed and asked them to review our observations for accuracy.

[1] Research reports specific to workers' compensation are available at http://www4.cbs.state.or.us/ex/imd/external/reports/index.cfm?fuseaction=dir&ItemID=1992.

[2] A DCBS publication, *Biennial Report on the Oregon Workers' Compensation System, Eighth Edition: December 2006,* provides an excellent description of how the system currently performs. The report is available at http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?fuseaction=version_view&version_tk=178007&ProgID=FEARA006.

Organization of the Report

The report is organized around the four lessons listed earlier. Chapter 2 discusses the role of the MLAC in bringing about orderly change and fostering continuous improvement in the workers' compensation system. We discuss the structure and evolution of the MLAC, provide some evidence of orderly change in the workers' compensation system that was accomplished through MLAC involvement, provide a case study of how one such change was accomplished, describe six factors that system participants consider critical to the success of the MLAC, and identify additional factors that contribute to the MLAC's effectiveness.

In Chapter 3 we discuss Oregon's approach to ensuring timely and accurate delivery of workers' compensation benefits by insurers and self-insurers. We show how the actual performance of Oregon insurers and self-insurers compares with performance targets set by the state agency and identify system features associated with Oregon's approach to payor compliance. It is important to note that no recent data are available to compare the claims-handling performance of Oregon insurers and self-insurers with that of payors in other states.

Chapter 4 presents evidence that the percentage of PPD benefit dollars awarded at the formal-hearing level has recently approached zero, suggesting very low levels of formal litigation over PPD benefit determinations in Oregon. Again, we do not have comparable data to determine how this compares with litigation levels for PPD benefits in other states. In the chapter we describe a package of six key system features and ten reinforcing features associated with low levels of formal litigation over PPD determinations in Oregon.

Finally, in Chapter 5 we discuss five elements of Oregon's package of return-to-work programs and present historical return-to-work and wage recovery rates for workers in the 13th quarter after injury.

2

Lesson 1: The Workers' Compensation Advisory Committee Is Unusually Effective as a Force for Orderly System Improvement because of Certain Features of Its Design and Operations

Many system participants we spoke with in Oregon consider labor and management cooperation through the workers' compensation advisory committee—the Management-Labor Advisory Committee—to be one of the system's greatest strengths. When we asked "What are the major strengths of the Oregon workers' compensation system?" DCBS officials said, "Labor and management are the 'co-owners' of the system. Working through MLAC and DCBS, they evaluate and recommend policy. Other parties (doctors, attorneys, insurers, etc.) are in the role of service providers. Labor and management realize there is a balance to be maintained in the system, which leads to orderly change against a backdrop of stability."[1]

Background

The MLAC was created as a standing committee by the Oregon legislature in 1990. It was an outgrowth of a special task force made up of labor and management rep-

[1] DCBS, Information Management Division, e-mail to author, February 27, 2006.

resentatives that was formed by the governor in late 1989. Known as the "Mahonia Hall Group" because it met regularly in Mahonia Hall, in the basement of the governor's mansion, it consisted of seven labor representatives and seven business representatives handpicked by the governor.

The MLAC currently has ten voting members, half representing business and the other half labor, appointed by the governor and confirmed by the state senate; the DCBS director is an ex officio member.[2] Other stakeholder groups are not represented. Each MLAC member is appointed for a two-year term (and may be reappointed) and serves without compensation, except for travel reimbursements. The committee is overseen by cochairs selected by members of each group; cochairs serve until the committee recommends a change in leadership or until their terms expire. The day-to-day operations of the MLAC are handled by its administrator, who reports directly to the DCBS director, and by the committee's administrative assistant. The administrator's responsibilities include supporting the committee and managing the legislative agenda of the DCBS. The MLAC is funded through the general operating budget of the DCBS; for 2005–2007 the committee's annual operating budget was $50,000. Additionally, the DCBS offers considerable support to the MLAC by conducting studies and drafting legislative proposals.[3]

Generally, the MLAC is charged by law to study issues affecting the workers' compensation system and to report its findings and recommendations to the Oregon legislature. Specific statutory responsibilities include

- periodically reviewing Oregon's standards for evaluation of permanent disability and recommending any changes;
- advising the DCBS director on proposed changes in the operation of programs funded by the Workers' Benefit Fund (WBF, described in Chapter 5);
- reporting to the Legislative Assembly any findings and recommendations the committee considers appropriate; and
- reporting on state supreme court decisions that have a significant impact on the system, adequacy of workers' compensation benefits, medical and legal system costs, adequacy of assessments for reserve programs and administrative costs, and the operation of programs funded by the WBF.

[2] Senate Bill 369 reduced the number of voting members to ten in 1995.

[3] The DCBS does not have an estimate of the dollar value of these additional resources.

According to the MLAC Web site (http://www.oregon.gov/DCBS/MLAC/about_us.shtml), members are committed to the following set of values for workers' compensation:

- Balance and fairness
- Adequacy of benefits: benefits commensurate with the severity of the injury
- Affordability: a system that contributes to a healthy Oregon business climate
- Efficiency: a system that is streamlined and easy to use
- Stability and flexibility: a system stable enough to be predictable but flexible enough to change when necessary

The primary activities of the MLAC involve reviewing and recommending changes to the workers' compensation law that are acceptable to management and labor. Committee members also advance proposals to be considered as statutory changes. Further, the DCBS director can recommend areas of the law that he or she desires would like the committee to address, or the MLAC can initiate studies of the system on its own. Typically, DCBS staff conduct the studies and then report to the committee.

The MLAC meets up to 12 times each year, with additional meetings held when needed to address urgent, pending issues. During the legislative session, from one to three additional meetings may be held each month. When the MLAC is considering a new aspect of the system, a subcommittee (consisting of MLAC members) is usually formed to define issues to be studied, consider research results presented by DCBS staff, receive public testimony, recommend legislative changes (if any) to the full committee, and reconcile any changes to legislative proposals. Subcommittees may also be formed to review legislative proposals advanced by the DCBS or system participants and make recommendations to the full committee.

Evidence of Impact

The Oregon workers' compensation system has enjoyed relative stability since at least 1995.[4] Most system participants we spoke with agreed that the MLAC has

[4] Legislation was introduced in 1995 to revise the definitions of compensability, disabling claims, and objective findings and to state that the exclusive remedy provision of the law applies to all claims. But, after consensus was reached on seven key issues in 1995, negotiations broke down within the committee, and the legislature passed a bill without MLAC endorsement. The bill was subsequently signed into law by the governor.

played a major role in achieving orderly system change and continuous improvement in Oregon over the past ten years.

In 2005 four major bills were passed by the legislature and signed into law by the governor. The MLAC spent a significant amount of time developing and refining the bills as follows (Oregon Workers' Compensation Division, 2005):

- Senate Bill (SB) 119 expanded the use of the Preferred Worker and Employer-at-Injury programs (described in Chapter 5) to encourage additional return-to-work services, such as job search assistance.
- SB 386 established new thresholds that must be met to rescind permanent total disability (PTD) benefits and established a higher wage threshold for determining if a worker's earning capacity qualifies him or her to receive (or continue to receive) PTD benefits.
- House Bill 2408 clarified that workers who are released to return to their regular work are eligible only for PPD benefits based on impairment.
- SB 311 modified the regulation of independent medical examinations.

According to a DCBS handout titled "Workers' Compensation: Management–Labor Advisory Committee," the MLAC has provided the following types of input into developing proposals or supporting proposed changes:

- Supporting the narrowed use of "preexisting conditions" for claim denials, resulting in an easing of the standard that workers must meet for their claims to be accepted
- Supporting a change in the interval that insurers and self-insurers have to accept or deny a claim from 90 to 60 days
- Supporting a change in the maximum weekly TTD amount from 100 percent to 133 percent of the state average weekly wage
- Supporting the inclusion of wages from all jobs when calculating the workers' average weekly wage
- Developing changes to how PPD benefits are determined, linking them to the worker's wages and eliminating different levels of benefits for different injured body parts
- Supporting the worker's right to have an impartial medical examination, paid for by the insurer or self-insurer, under certain circumstances when the claim is in litigation
- Supporting the worker's right to refuse offers of modified work without loss of indemnity benefits under certain circumstances

- Supporting authorizing the DCBS director to advance benefit payments to workers when their insurers or self-insurers are in default
- Supporting workers' attorney fees for unreasonable delays in providing benefits when the worker prevails in a medical or vocational dispute
- Supporting the expansion of the treatment and time-loss authority of nurse practitioners when treating injured workers

The next section examines the process by which the MLAC addressed the contentious issue of using independent medical examinations that resulted in the passage of SB 311 in 2005.

The MLAC in Action: A Case Study of Changes in Independent Medical Examinations

In many states the use of independent medical examinations (IMEs) by insurers and self-insurers has raised controversy. Workers often view IME physicians as partial to the insurers and self-insurers that hire them. Oregon is not an exception. Labor MLAC members we spoke with said they had heard "rumblings" of discontent from workers about IME doctors for some time. Here we present the chronology of the IME changes to provide a step-by-step description of MLAC involvement in the Oregon system in 2004 and 2005.

MLAC activities in 2004

In early 2004 labor MLAC members expressed their concerns about IMEs to their management counterparts. The committee then asked the DCBS to conduct a study of the IME system in Oregon. The DCBS formed an 11-member IME study committee consisting of DCBS staff and conducted a study from February through November 2004. The specific charge by the MLAC to the IME study committee was to describe the current status of IMEs, with a focus on workers' reports of their experiences, a description of the IME industry, data on IME frequency and costs, clarification of who is selected to be sent to an IME by an insurer or self-insurer and why, results of IMEs, the connection to worker-requested medical examinations, and a review of IME letters and reports. The MLAC also asked the study committee to identify areas of concern and draft recommendations (DCBS, 2004c).

The IME study design consisted of the following:

- Conducting six surveys: (1) 450 injured workers who had attended IMEs, (2) claimants' attorneys, (3) defense attorneys, (4) attending physicians, (5) 407 IME physicians, and (6) IME facilities or companies
- Conducting three focus groups composed of insurers and third-party administrators
- Developing several statistical reports
- Collecting feedback from injured workers to the Ombudsman for Injured Workers Office of the DCBS and the Benefit Consultation Unit of the Worker's Compensation Division (WCD)
- Conducting a review of insurer letters and subsequent IME reports
- Researching issues such as the impact that worker-requested medical examinations and medical-arbiter examinations are having on the system, sanctions against workers failing to attend IMEs, and the procedures the Board of Medical Examiners follows in handling IME complaints

The IME study committee presented its report to the MLAC on December 2, 2004. In the report the study committee identified eight areas of concern:

1. IME physician bias toward insurers and self-insurers
2. No process in place for handling complaints by injured workers concerning IMEs
3. No professional and ethical standards for IME physicians and no oversight
4. Distances injured workers must travel to IMEs
5. Lack of information provided to injured workers about IMEs
6. Workers not showing up for their IMEs
7. Attending physicians not reviewing IME reports with their patients
8. Diagnostic studies not available from attending physicians for IME physicians to review

The report also listed some options for addressing areas of concern: adopt the already-successful medical-arbiter process (see Chapter 4), have the DCBS randomly select IME physicians for the insurer or self-insurer to use in the worker's geographical location, and develop various changes to the statute.

At the December 2, 2004, MLAC meeting, an IME subcommittee was formed, consisting of two labor members and two management members. At the first subcommittee meeting on December 9 (lasting more than four hours)

- labor and management representatives were selected as cochairs;
- the WCD administrator presented background information;
- DCBS staff presented an overview of the IME study;
- the WCD administrator presented four recommendations for consideration; and
- subcommittee members heard public comment and received written testimony focused primarily on the eight areas of concern previously listed.

During the second meeting on December 14, subcommittee members

- heard public testimony on the first area of concern;
- met during a public work session to discuss issues, requested additional information from the DCBS, and attempted to reach consensus on the issues;
- heard public testimony from a chiropractor, several IME physicians, a representative from the Oregon Injured Worker Alliance, and DCBS representatives on another area of concern; and
- convened a second work session.

Subcommittee members met again on December 15 to hear public testimony, conduct work sessions on the additional areas of concern, and review a draft summary of decisions made at the December 14 work session. The subcommittee also asked the WCD to outline which proposed changes would require rule and statute revisions.

MLAC ACTIVITIES IN 2005

At a regularly scheduled MLAC meeting on January 6, 2005, a cochair of the IME subcommittee updated MLAC members on the progress of the subcommittee. The cochair indicated that DCBS staff would prepare a final document containing the subcommittee's recommendations at the next subcommittee meeting and the subcommittee would present final recommendations at the next MLAC meeting. At a fourth meeting of the IME subcommittee, members received additional oral and written testimony, discussed recommendations prepared by DCBS staff, and arrived at a number of subcommittee recommendations to be presented at the next MLAC meeting on February 14.

Based on the work of the IME subcommittee, SB 311 was drafted in January 2005 and introduced by a senator on January 13. At a February 10 MLAC meet-

ing, the IME subcommittee cochair gave a report on testimony regarding SB 311 that was given to the Senate Commerce Committee. At the February 14 MLAC meeting, the WCD administrator presented draft amendments to SB 311, committee members discussed three unresolved issues, additional testimony was received from IME physicians, and committee members voted to approve the recommendations of the IME subcommittee plus additional recommendations made during the meeting. SB 311 then proceeded through the legislative process; it was approved substantially as amended by the Oregon Senate and House in July 2005 and was signed by the governor on July 29 (effective January 1, 2006).

THE NEW LAW (SENATE BILL 311)

Key provisions of the new law include the following (Oregon Workers' Compensation Division, 2005):

- Insurers and self-insurers must select an IME physician from a DCBS-approved list.
- Qualifications to be on the approved list would be developed by the DCBS in consultation with interested parties and would be based on standards set by either IME professional organizations or the American Board of Medical Examiners.[5]
- The DCBS must develop a process for responding to complaints about IMEs.
- Sanctions were established against medical service providers who fail to provide diagnostic records in a timely manner and monetary penalties against workers who fail to attend IMEs without justification or prior notification.

Most public and private system participants we interviewed were satisfied with the outcome of the process (SB 311) and the role that the MLAC played in addressing the issue of IMEs and proposing changes. MLAC members we interviewed said that initially management and labor disagreed about the need to address this issue; labor had heard about abuses, but management did not believe

[5] The 2007 legislature changed the qualifications standards to the standard developed by the Oregon Independent Medical Examination Association because of copyright issues with the national standard.

a problem existed. According to the MLAC members, the impetus for the study came from labor, and the need for the MLAC to take action was heightened by the perception that if members did not address the issue, the legislature would do so on its own. Most members said that once the MLAC began discussions, members reached agreement on changes early and easily. When the bill was introduced, it proceeded smoothly through the legislative process. MLAC members credited the success of the process to the credibility of the IME study, hard work by subcommittee members, trust among MLAC members, and the possibility of finding common ground on the issue.

CRITICAL SUCCESS FACTORS FOR THE MLAC

When we interviewed state agency officials, MLAC members, and other system stakeholders, we asked, "What are the critical success factors for the MLAC in bringing about orderly and lasting change in the Oregon workers' compensation system?" They identified six major factors. The central theme of their responses was that the governor and (usually) the legislature funnel stakeholders' proposals for change through the advisory-committee process, keeping the interests of management and labor at the forefront of the debate. We discuss each of the six factors listed here, in the order of importance that respondents assigned to them:

1. Labor and management, not other interest groups, influence but do not control the system through the MLAC.
2. The governor vows to veto any bill that has does not gain advisory committee (i.e., labor and management) endorsement.
3. The legislature usually defers to the MLAC.
4. The state agency actively supports the MLAC by conducting studies and drafting legislative proposals.
5. Public input is encouraged through testimony at MLAC meetings and other mechanisms.
6. Subcommittees are often used to hear testimony, narrow issues, and consider changes to legislative proposals.

A note of caution is worth mentioning. These factors seem to facilitate orderly change and continuous improvement in the Oregon workers' compensation system, but there are no guarantees that the factors will work the same way in another system. Our experience in studying most workers' compensation systems suggests that states vary according to such intangibles as the history of the law,

the work culture, labor–management relations, the mix of workers and industries, and past attempts to change the system. Given these variations, a different mix of factors may be needed to achieve orderly and lasting change in other states. The reader is encouraged to analyze each factor described here and evaluate their applicability to another state.

LABOR AND MANAGEMENT, NOT OTHER INTEREST GROUPS, INFLUENCE BUT DO NOT CONTROL THE SYSTEM THROUGH THE MLAC

In most jurisdictions, workers and employers are just two of the many interest groups that shape the workers' compensation system through the political process. Too often the interests of both workers and employers take a backseat to the interests of other system participants, such as insurers, attorneys, physicians, rehabilitation providers, and consultants of various kinds. In Oregon, labor and management are essential partners in the workers' compensation system. The interests of groups other than workers and employers are mediated in negotiations between labor and management through the MLAC.

Labor and management, as represented in the MLAC, serve to influence the Oregon workers' compensation system, not control it. Public officials and MLAC members explained that the DCBS, MLAC, governor, and legislature work collaboratively to bring about positive change. For example, sometimes the state agency initiates change and seeks MLAC endorsement, and sometimes change is initiated through the advisory-committee process. Other changes are set in motion by legislators and are usually reviewed by the MLAC. On occasion, when the MLAC does not endorse a legislative proposal, the governor intervenes and asks the committee to study and reconsider the issue. The result is a system in which change is orderly rather than crisis driven and is focused on issues important to labor and management.

Management and labor influence is vested in the MLAC. Only the five labor and five management representatives on the committee can vote. Most observers said that this feature is critical to the success of the committee. For a proposal to gain MLAC endorsement, at least a majority of labor members and a majority of management members (three of each) must vote in favor. If that is not achieved, the MLAC is considered to have taken no action on a proposal.

We asked MLAC members, public officials, and other system participants, "What general conditions facilitate labor and management influence over the system?" Most observers noted that the state has a positive climate of labor and management cooperation in which the MLAC works well. Another key is the relatively equal strength of labor and management in the state. Labor is a strong and active voice. Data from the U.S. Department of Labor, Bureau of Labor Statistics (2007, tab. 5), show that at 14.5 percent, Oregon had the 14th-highest percentage of employed workers who were union members in 2005. Likewise, because industry in Oregon is fairly diverse, power is not concentrated in the hands of a few employers or industries.

THE GOVERNOR VOWS TO VETO ANY WORKERS' COMPENSATION BILL THAT DOES NOT GAIN ADVISORY COMMITTEE (I.E., LABOR AND MANAGEMENT) ENDORSEMENT

Support by the governor is the cornerstone of Oregon's advisory committee. As one former MLAC management representative put it, "A strong-willed governor sets a tone of 'We are going to do this.'" Indeed, that tone was set by the governor in 1990 when, with help from the director of the Department of Insurance and Finance (the predecessor to the DCBS), he formed the special task force called the Mahonia Hall Group. Interestingly, the current governor was the director of the Department of Insurance and Finance at that time.

In vowing to veto any legislation that does not gain MLAC approval, the governor, in effect, says no to other interest groups unless management and labor approve. As one workers' attorney said, this stance has its pros and cons. On the one hand, the governor is insulated from partisan politics in workers' compensation and can screen public policy decisions through knowledgeable people on the committee. On the other hand, the governor can become too protected from interests in the workers' compensation community and use the committee as a scapegoat for not responding to these interests.

System participants pointed out two recent instances in which the governor's resolve was tested:

- During the 2003 legislative session, a bill was introduced to extend the authority of nurse practitioners to order treatment and authorize indemnity benefits. The version of the bill that was passed was not supported by the MLAC, and the governor vetoed it. Later that session a compromise bill passed and was signed by the governor, incorporating changes that included a provider certification process and a sunset provision to allow the MLAC to study the effects of the changes before the law could take effect permanently. In 2007, as a result of the interim study, MLAC-supported

legislation was passed that made the expanded treatment authority permanent.

- Similarly, in 2005 the legislature passed a bill to extend the status of chiropractors as attending physicians as part of a five-year study. The MLAC did not endorse the bill, and the governor vetoed it. At the same time, the governor asked the department and the MLAC to study the role of chiropractors and other health care providers in the workers' compensation system. Based on the resulting study and MLAC recommendations, House Bill 2756 passed in 2007 and became effective in 2008. It allows chiropractors, podiatrists, naturopaths, and physician assistants expanded rights to act as attending physicians, also subject to a provider certification process.

MLAC members said that the governor's resolve to veto any bill not endorsed by the committee can also spur the committee to action. As an example, they cited the governor's emphasizing that the committee "fix" the perceived problem of IME abuses.

THE LEGISLATURE USUALLY DEFERS TO THE MLAC

The advisory committee in Oregon enjoys the support of the legislative leadership, which usually defers to the MLAC on workers' compensation issues. Public officials explained that no formal rules for such deference exist. Rather, legislative caucus leaders and committee chairs understand that workers' compensation bills should first be vetted by the MLAC. The department reinforces this by monitoring the submission of new bills by legislators and intervening to suggest that a bill be sent to the MLAC for review before it is assigned to a committee. Also, if a bill comes before a committee without having been reviewed by the MLAC, the caucus leader or committee chair often asks, "Has this bill been reviewed by the MLAC?" DCBS officials told us that, given turnover in the legislative ranks, it is important for them to continually educate legislators about these informal understandings and the positive dynamics that result.

According to former legislators and current and former MLAC members we interviewed, most members of the Oregon legislature support the work of the MLAC. They said that legislators occasionally voice concerns that their role in setting public policy is being usurped by the MLAC, and some legislators have a hard time explaining that the MLAC rejected a change advocated by constituents. In most cases, however, legislative leaders reinforce deference to the MLAC.

THE STATE AGENCY ACTIVELY SUPPORTS THE MLAC BY CONDUCTING STUDIES AND DRAFTING LEGISLATIVE PROPOSALS

Most MLAC members we talked with said it is "critical" for the DCBS to conduct ongoing studies of the Oregon system and special studies in support of the MLAC. According to one member, "Change is compelling if data support the need for change." A former MLAC member said, "It is important to have committee deliberations grounded in data." The case study of the MLAC in action presented earlier illustrates the importance of agency-generated data during committee deliberations. WCD officials told us department staff members commonly either draft proposals for MLAC consideration or reflect consensus reached during the committee process in the form of a legislative proposal.

PUBLIC INPUT IS ENCOURAGED THROUGH TESTIMONY AT MLAC MEETINGS AND OTHER MECHANISMS

As previously discussed, although management and labor play a central role in the Oregon system, other parties have an important voice in the process. The case study regarding change to IMEs illustrates that public input improves decision making and lends credibility to the advisory-committee process. One public official said that public testimony at an MLAC meeting is also a practical alternative to testimony at legislative hearings.

Observers indicate that through the MLAC, all parties can express concern, advocate, raise questions, and voice opposition. The WCD also provides several other mechanisms for ongoing input from system stakeholders, such as public forums, conferences and training sessions run by the WCD, and customer surveys. Additionally, the WCD uses external advisory committees to review administrative rule changes.

SUBCOMMITTEES ARE OFTEN USED TO HEAR TESTIMONY, NARROW ISSUES, AND CONSIDER CHANGES TO LEGISLATIVE PROPOSALS

As indicated by the case study, the bulk of issue identification, public testimony, and deliberation over proposals is done during subcommittee sessions. That is important because it enables the MLAC to consult experts on technical issues and it allows for division of labor among committee members who are volunteers.

Meetings of the full committee are often used for raising issues, determining priorities, subcommittee reporting, and voting on proposals.

OTHER CONTRIBUTING FACTORS

In the course of discussions with MLAC members, state agency officials, and other system participants, we learned about additional features that enhance the work of the MLAC but are not essential to its operation. First, unlike governors in some states where organized labor or business association affiliation is important, the Oregon governor, when seeking nominees for MLAC membership, tend to look for individuals who have a demonstrated ability to work collaboratively. The qualities of an MLAC candidate that could further the best interests of the entire system seem to be valued highly. Public officials said that this improves the chances of achieving change through consensus, because members tend not to have predetermined agendas or entrenched positions on important issues.

Second, it is helpful, but not essential, that MLAC members have experience in workers' compensation. Members we spoke with said management representatives tend to be more experienced in workers' compensation because it is part of their job responsibilities. Some labor members who admitted having no experience in workers' compensation said they tended to look initially to one or two experienced members for guidance. On the whole, MLAC members on both sides told us that experienced members provide stability and that inexperience can be overcome if the committee includes some "old pros" to guide new members. In fact, two MLAC members participated in the 1990 Mahonia Hall negotiations and have served on the committee for more than ten years.

Trust among members is another intangible factor. Most members agreed that this is desirable. Public officials said that in the past ten years or so, members have appeared willing to adopt a long-term view characterized by incremental improvement, which one could characterize as trust. Some members told us basic trust is enhanced by Oregon's favorable climate of cooperation between labor and management and the tendency of governors to appoint individuals who are able to work collaboratively. Others believe the two-year term is a safeguard; members who do not work collaboratively tend not to get reappointed.

Another intangible factor in the effectiveness of the MLAC is the relatively small population of the state. One MLAC member remarked, "In Oregon, everybody knows each other."

On the whole the Oregon system (through the MLAC and other system features) has achieved a successful blending of stability and flexibility; the system is stable enough to be predictable and flexible enough to change when necessary. In many states the two values are unbalanced.

3

Lesson 2: The State Agency's Commitment to Setting System Goals, Measuring and Monitoring Performance, and Imposing Sanctions against Substandard Performance Results in Consistently Accurate and Timely Delivery of Benefits, Although Opportunities May Exist to Reduce Agency Reporting and Regulatory Costs

The Department of Consumer and Business Services in Oregon is particularly active among state agencies we have studied in establishing agency targets for the delivery of benefits to injured workers and measuring performance against those targets. For example, the DCBS sets standards for insurers and self-insurers, compiles industry averages based on reports submitted by payors, provides feedback in the form of reports posted on the agency Web site and reports sent to payors, issues penalties administratively based on performance reported by payors, and audits payors' claim files to determine if reports to the agency are accurate and indemnity and medical payments are accurate and timely. Most system participants we spoke with said that Oregon's approach to compliance helps ensure that injured workers receive benefits accurately and predictably.

Background

According to a DCBS report, "Prior to legislative reform [in 1990], there were concerns about claims processing: The evaluation of the extent of disability was inconsistent, claims decisions and initial time-loss payments were slow, and delays in claim closure resulted in unrecoverable overpayments by insurers. These factors contributed to a claims-processing environment that fostered litigation" (DCBS, 2005a, p. 23).

An initial response to this concern was an agency focus on certifying industry claims examiners starting in 1990. By November 22, 1999, there were 1,342 certified claims examiners. Legislation in 1999 shifted the responsibility for certification to insurers, self-insurers, and third-party administrators. The department was empowered to impose civil penalties against payors employing uncertified examiners.

In Oregon each agency of state government must develop key performance measures (KPMs), the highest-level, most outcome-oriented performance measures used to report externally to the legislature and concerned citizens. KPMs communicate in quantitative terms how well the agency is achieving its mission and goals.[1]

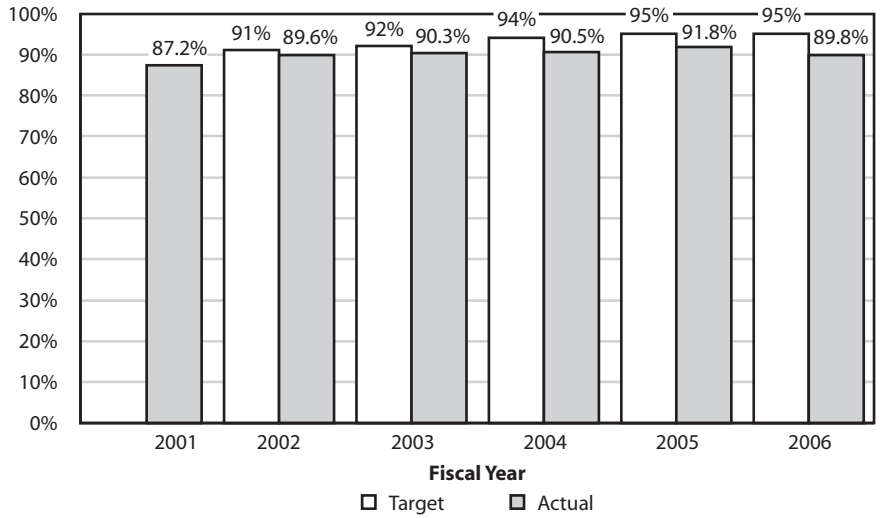
The DCBS started developing KPMs in 1991 and currently has a total of 15 (DCBS, 2007a). However, not all KPMs apply to workers' compensation. Here we focus on the current DCBS goal, "Protect consumers and workers in Oregon," and the current KPM applicable to workers' compensation, "percent of injured workers who receive timely and accurate benefits." As discussed in the following sections, the DCBS measures and monitors compliance with this KPM by analyzing and summarizing reports submitted to the WCD by insurers and self-insurers and by conducting periodic field audits to verify that the information being submitted is accurate.

Evidence of Impact

The DCBS *Annual Performance Progress Report (APPR) for Fiscal Year 2005–06* (2007) shows the performance of individual insurers and self-insurers from fiscal years 2001 through 2006 compared with the targets for fiscal years 2002 through 2006. Figure 3.1 shows that the target for fiscal year 2006 was 95 percent of workers receiving timely and accurate benefits, and the actual performance was 89.8 percent. From fiscal years 2002 through 2005, the target was raised from 91 percent to 95 percent. As shown in the figure, actual payor performance increased from 87.2 percent in fiscal year 2001 to 91.8 percent in 2005 and then decreased to 89.8 percent in fiscal year 2006. Thus, 87.2 percent or more of workers received timely and accurate benefits in each of the past six years. No current data are available to compare the timeliness and accuracy of benefit delivery in Oregon with those in other states.

[1] Agencies may have additional, more detailed measures for internal management.

Figure 3.1 Percentage of Injured Workers Receiving Timely and Accurate Benefits in Oregon, 2001–2006



Source: DCBS, 2007a.

Standards for Claim Reporting, First Payment, and Acceptance or Denial

Starting in 1992 Oregon began setting timeliness standards for delivery of benefits to workers as part of its Quarterly Claims Processing Performance (QCPP) audit. The three areas and the applicable standards are as follows:

- *Claim filing:* 90 percent of claims for indemnity benefits (both initial and aggravation) reported to the WCD within 14 days of the acceptance or denial date

- *First payment:* 90 percent of first temporary disability payments made within 14 days of one of the following dates: the date the employer knows of the claim, if temporary disability is immediate and authorized; the date the treating physician authorizes temporary disability, if temporary disability is not immediate; or the date authorization is received, if the payor requested verification of the injury and did not receive such verification during the first 14 days
- *Claim acceptance or denial:* 90 percent of claims accepted or denied within 60 days of the date the employer knew of the claim

Compilation and Posting of Industry Averages

The QCPP audit begins with reports that payors submit to the WCD. The WCD compiles information from the reports into its Claims Information System and uses the data to calculate industry averages every quarter, which are posted on the DCBS Web site. In fiscal year 2006, 22,931 indemnity claims were reported and 22,757 (99 percent) were timely. In the same year 88 percent of first TTD payments were timely and 91 percent of claims were promptly accepted or denied. First payment performance in Oregon has been remarkably consistent in the past ten years; from fiscal years 1997 through 2006, the applicable percentage varied from 86 percent to 91 percent (DCBS, 2007b).

DCBS data for fiscal year 2005 show that the median interval from employer knowledge of the claim to claim acceptance was 41 days and the median interval to denial was 48 days (DCBS, 2006b, fig. 7). Oregon has experimented with changing the interval allowed for payors to accept or deny claims. In 1990 that interval was extended from 60 to 90 days. Following that change, the median actual intervals for acceptance and denial generally increased from fiscal years 1990 through 2001. Legislation in 2001 reduced this interval back to 60 days; thereafter the median interval to acceptance fell from 46 days in fiscal year 2001 to 40 days in 2003, and the median denial interval fell from 60 to 51 days in the same period.

Every insurer and self-insurer that files a report receives a quarterly summary of their performance before the industry averages are posted on the DCBS Web site. A payor is subject to a civil penalty (issued administratively) if it has quarterly activity of five or more claims and its percentage of timeliness falls below the standard in any of the three areas. A penalty is calculated for each category based on the number of quarters the payor falls below the standard performance level each year. For example, the total penalty for falling below the 90 percent threshold for timely first payment in the first quarter is $100. The amount increases to $175 in the second quarter, $250 in the third quarter, and $350 in the fourth quarter. In fiscal year 2006, DCBS internal data show that the DCBS issued 241 penalty citations totaling $104,000, an average of $432 each.[2]

WCD Compliance Audits

The WCD conducts on-site claims-processing compliance audits to determine whether insurers and self-insurers are performing according to the statute and rules governing workers' compensation. Each claims-processing location is audited at least once in every audit cycle. The goal of the WCD is to complete each cycle in about two years. DCBS internal data show that during the audit cycle from April 2004 to August 2006, five or six WCD auditors audited 240 companies at 51 locations.

During a WCD audit, the auditor requests a list of indemnity claims reported in the 12-month period ending 6 months before the start of the audit and randomly selects a statistically valid sample of claims using a formula.[3] For example, if 100 indemnity claims were reported in the period, the auditor would select 74 claims for the audit sample. In addition, the auditor selects up to 20 PTD and death claims showing as active in the WCD database. The WCD also gathers a sample of medical-only claims from a list of claims with injury dates at least 180 days before the audit. That sample has 50 percent of the number of claims selected for the indemnity sample. The auditor may also review a special sample of claims to address issues unique to certain locations or certain payors.

The areas audited and the expected performance levels are as follows:

- *Accuracy of disability payments:* 90 percent of disability payments made accurately as ordered or as the file facts dictated
- *Timeliness of ongoing temporary disability payments:* 90 percent of temporary disability payments (not including first payments) issued every 14 days and not more than 7 days in arrears

[2] The DCBS can levy a much larger fine against any payor displaying a pattern of misconduct. For example, in 2007 the DCBS fined one insurer $5 million ($4 million will be suspended if the payor complies with the order) for failing to comply with Oregon laws for reporting and paying assessments, processing claims of injured workers, and reporting proof of insurance coverage.

[3] The sample selected ensures a confidence interval of 95 percent with a tolerance level of plus or minus 5 percent.

- *Accuracy and timeliness of reimbursements (e.g., transportation, prescriptions, meals) to workers:* 90 percent accurate and timely
- *Accuracy and timeliness of PPD payments:* 90 percent accurate and timely
- *Accuracy and timeliness of PTD payments:* 90 percent accurate and timely
- *Accuracy and timeliness of death benefit payments:* 90 percent accurate and timely
- *Accuracy and timeliness of (initial) closure notices:* 90 percent accurate and timely[4]
- *Accuracy of PPD ratings:* 90 percent accurate, and sufficient information in the file to rate permanent partial disability
- *Accuracy and timeliness processing of medical-only claims:* 90 percent accurate and timely in the following areas: claim properly classified as medical-only, claim accepted or denied promptly, and acceptance letter in file indicating the condition that was accepted
- *Timeliness of medical bill payments:* 90 percent timely
- *Accuracy of claim closure reporting forms:* 90 percent accurate (return to work and release to work information included, accurate date when the claim was qualified for closure)
- *Accuracy of reporting of claim acceptance or denial:* use of proper form and accuracy of reporting
- *Accuracy of reporting of first payment:* not under a specific percentage threshold; if there is more than one violation, a penalty is usually imposed
- *Accuracy of special fund reimbursement:* 90 percent accurate[5]

Penalties are based on the number of audit categories falling below the audit threshold, not each infraction (for one to three categories, the penalty is $625; four to five categories, $1,250; six to seven categories, $1,875; and eight or more categories, $2,500).

At the conclusion of each on-site performance audit, the WCD provides each payor with a final report of findings. The composite results of audits of each payor since March 2004 are posted in a sortable table on the DCBS Web site (http://www.cbs.state.or.us/external/wcd/compliance/fau/ptd/statsbyloc.xls).

[4] An initial claim closure notice is issued when temporary disability is terminated and the worker has reached maximum medical improvement.

[5] Pertains to Oregon's Retroactive Reserve, which reimburses insurers and self-insurers for cost-of-living increases in certain (older) cases.

Opportunities to Reduce Reporting and Regulatory Costs

Oregon's active-agency approach to regulating the delivery of benefits by insurers and self-insurers is partly reflected in the comparatively larger agency needed to administer the workers' compensation system. When studying the Iowa workers' compensation system, WCRI compared total administrative expenditures per employed worker in fiscal year 2003 among ten states with 1–2 million workers (Ballantyne, 2004, tab. 6.1). Using those data, at $28.10 per employed worker, Oregon administrative expenditures were much higher than the median of the ten states ($5.07). However, DCBS officials told us that workers' compensation administrative expenditures in Oregon fund some program areas (e.g., Oregon OSHA and the Insurance Division of the DCBS) that other states typically do not include in administrative expenditures. For example, a DCBS internal analysis of actual fiscal year 2005 expenditures shows that OSHA and insurance regulatory costs represented 28.2 percent of the workers' compensation total. According to DCBS officials, for all workers' compensation regulatory and adjudication functions, the estimated average expenditure per employed worker was $19.09 in fiscal year 2005.[6] It would not be surprising if the administrative cost burden (resulting from rules, paperwork, reporting, etc.) imposed on payors was also higher in Oregon.

We asked system participants, "Do you regard these higher expenditures as a worthwhile investment in positive outcomes in Oregon?" Most public and private respondents answered yes. For example, one labor representative noted, "I do feel that it's a worthwhile investment. You must be able to have adequate oversight within the system. We need accurate and intensive data in which to identify problems and to make decisions that actually fix the problem." Most employers and insurers told us that administrative expenditures were generally worthwhile. However, some acknowledged that administrative expenditures could be reduced. One business representative gave this response to our question: "Generally yes. But we have to continue evaluating if the functions we have the agency performing are appropriate functions."

Oregon's Office of Regulatory Streamlining is setting statewide standards for reorganization that apply to the DCBS, and the WCD is undertaking a regulatory redesign initiative with the goal of reducing the regulatory burden. Elements of

[6] According to DCBS internal data, in fiscal year 2005, workers' compensation administrative expenditures in Oregon (excluding Oregon OSHA and the Insurance Division of the DCBS) were $30,563,128.

the planned redesign include electronic data interchange for proof of coverage and medical bill reporting, and elimination of the requirement for guaranty contracts for proof of coverage. One insurer representative specifically addressed regulatory costs, saying, "WCD administrative review of procedures is a worthwhile expense compared to the cost of litigation. However, there continue to be opportunities to eliminate unnecessary regulatory functions and burdensome administrative rules." The insurer cited the burden to payors of supplying the required written justification for approval to suspend a worker's benefits when, for example, the worker fails to attend a medical examination. Some insurers and self-insurers question the complexity of the WCD's informal dispute resolution process over objections to payors' orders that finalize the period for which TTD benefits are due and/or determinations of PPD benefits, especially the need to review every aspect of a claim. Another insurer mentioned the complexity in determining and reporting the timeliness of initial TTD payments.

One WCD official said, "Our larger regulatory presence in Oregon is a reflection of what policymakers have asked the division to do." The official pointed out that, in every legislative session in recent years, the DCBS has been asked to do more. DCBS internal data show that, in the meantime, the WCD has reduced the number of full-time equivalent staff by almost 20 percent, from 291 in fiscal year 1997 to 235 in fiscal year 2007.

The same WCD official stated that the department is constantly evaluating programs and regulatory functions to determine ways to reduce and streamline unnecessary functions and to better leverage assigned functions. One example of this is the WCD's regulatory redesign project, in which project teams are engaged in describing and reviewing current claim-related regulatory functions, determining if the WCD should be engaged in certain activities, and, if so, identifying how the regulatory function should be performed.

4

Lesson 3: A Combination of System Features Can Increase Certainty and Decrease Litigation over Permanent Partial Disability Benefits

In many states that WCRI has studied, the determination of PPD benefits is among the most contentious issues, often requiring attorney involvement and formal hearings to resolve. Oregon public policymakers have designed several system features that work together to increase certainty about the determination and payment of PPD benefits and, at the same time, reduce litigation over the delivery of those benefits. These system features are mutually reinforcing, working in combination to produce the favorable results. Describing the key to Oregon's overall approach to reducing litigation, DCBS officials said, "The scope of issues for litigation is limited. Administrative dispute resolution, mediation, and other system design features resolve disputes relatively quickly, lower friction costs, and reduce incentives to litigate."

Data are not available to determine the percentage of PPD cases resolved by agreement and the frequency of informal dispute resolution and formal hearings in Oregon and make comparisons with other states.[1] However, as discussed in this chapter, Oregon's rate of resolution of scheduled and unscheduled PPD benefit dollars without involving the formal-hearing process is impressive.

[1] No DCBS data are available on the percentage of claims with PPD benefits that were resolved at each of the three levels. Because multiple issues are addressed, the DCBS does not identify claims as involving benefit types.

EVIDENCE OF IMPACT

The DCBS maintains data on the share of scheduled and unscheduled PPD dollars awarded each year at three levels: (1) the initial award level, referred to here as the voluntary-agreement level; (2) the appeal award level, referred to here as the informal level; and (3) the hearings award level, referred to here as the formal-hearing level.[2] At the voluntary-agreement level, the worker does not object to the payor's determinations of the amount and extent of PPD benefits to be paid periodically. At the informal level, PPD benefits may be awarded at reconsideration, which is the informal dispute resolution process in Oregon designed to address issues that arise when a claim is initially closed (i.e., when the worker is determined to be medically stationary, TTD benefits are terminated, and the amount of PPD benefits is determined). At the formal-hearing level, PPD benefits may be awarded after a formal hearing has been requested, agreed on before a formal hearing is held at the Oregon Workers' Compensation Board, awarded by a judge at the board, or awarded by the Oregon Court of Appeals or Oregon Supreme Court.

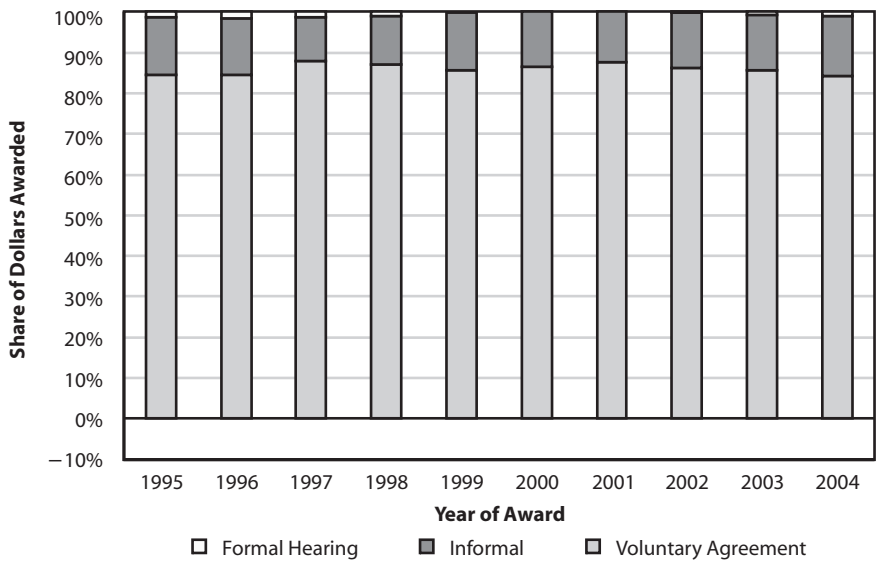
Figure 4.1 shows the percentage of scheduled PPD dollars awarded at each of the three levels over a ten-year period from 1995 through 2004. Notice first that the percentage of scheduled PPD dollars awarded by payors at the voluntary-agreement level was above 84 percent each year. This percentage ranged from a low of 84.3 in 2004 to a high of 87.8 in 1997. Next, the percentage of scheduled PPD dollars awarded at the informal level ranged from a low of 10.7 percent in 1997 to a high of 14.7 percent in 2004. The percentage of scheduled PPD dollars awarded at the formal-hearing level ranged from a low of −0.3 percent in 1999 to a high of 1.7 percent in 1996.

DCBS data show that the total amount of claimant attorney fees fell from $21.4 million in 1991 to $15.9 million in 1999 and then fluctuated in 2000 through 2005 from a low of $16.1 million in 2001 to a high of $18.1 million in 2005. Total defense legal costs (including all costs, in addition to fees) fell from $28.2 million in 1992 to $23.9 million in 2000 and then rose to $29.4 million in 2005 (DCBS, 2006b).

Figure 4.2 shows a similar story for unscheduled PPD dollars awarded at each of the three levels from 1995 through 2004. The percentage of unscheduled PPD

[2] It is important to note that DCBS data do not include PPD dollars that were included in a compromise lump-sum settlement.

Figure 4.1 Share of Scheduled PPD Dollars Resolved at Various Levels, 1995–2004

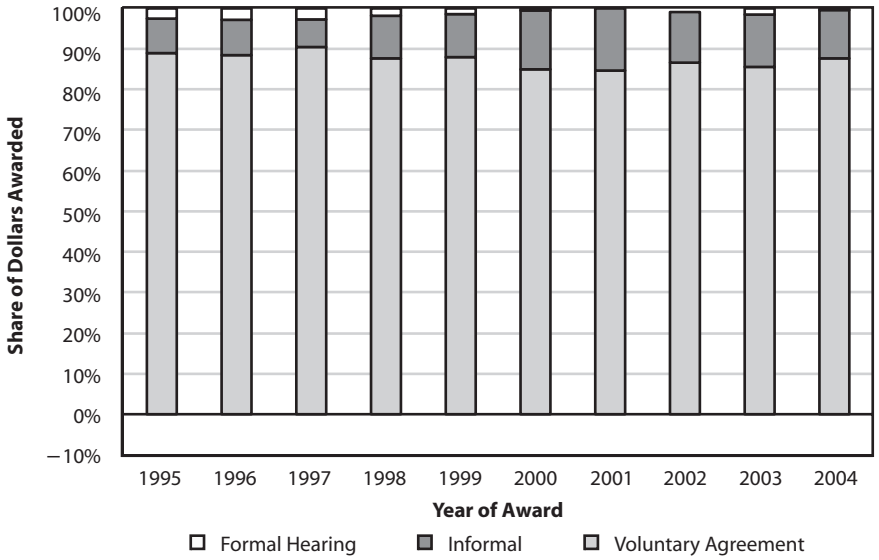


Note: Because individual awards can be reduced or increased on appeal, a negative dollar amount is possible when awards are aggregated at the informal and formal-hearing levels. That was the case in 2002, when dollars awarded at the formal-hearing level represented −0.3 percent of total dollars awarded.
Key: PPD: permanent partial disability.
Source: Internal data from the Department of Consumer and Business Services, Information Management Division, Research and Analysis Section.

dollars awarded voluntarily also remained above 84 percent each year; the shares ranged from a low of 84.7 percent in 2001 to a high of 90.5 percent in 1997. The percentage of scheduled PPD dollars awarded at the informal level ranged from a low of 6.8 percent in 1997 to a high of 15.3 percent in 2001. The percentage of unscheduled PPD dollars awarded at the formal-hearing level ranged from a low of –0.9 percent in 2002 to a high of 2.8 percent in 1996.[3] The resolution rates for un-

[3] Because individual awards can be reduced or increased on appeal, a negative dollar amount is possible when awards are aggregated at the informal and formal-hearing levels. That was the case in 2002, when dollars awarded at the formal-hearing level represented –0.9 percent of total dollars awarded.

Figure 4.2 Share of Unscheduled PPD Dollars Resolved at Various Levels, 1995–2004



Note: Because individual awards can be reduced or increased on appeal, a negative dollar amount is possible when awards are aggregated at the informal and formal-hearing levels. That was the case in 2002, when dollars awarded at the formal-hearing level represented −0.9 percent of total dollars awarded.
Key: PPD: permanent partial disability.
Source: Internal data from the Department of Consumer and Business Services, Information Management Division, Research and Analysis Section.

scheduled PPD dollars are particularly impressive given that unscheduled permanent partial disability in Oregon in this period was rated according to functional impairment plus additional loss-of-earning capacity factors such as age, education, and adaptability to other occupations. Thus, Oregon appears to achieve consistently high levels of voluntary agreement of unscheduled PPD benefits. In most states WCRI has studied, determination of unscheduled PPD benefits is particularly litigious.

Attorneys on both sides confirmed that it is rare for a dispute over PPD benefits to involve a formal hearing. A case that does require a hearing and a judge's decision usually involves large disparities between the impairment rating based on findings by the treating physician and the rating determined by a medical arbiter at the informal stage (as discussed later in the chapter). According to the attorneys we spoke with, a judge rarely increases or decreases the PPD award determined by the medical arbiter—an indication of the powerful role the arbiter plays in Oregon. If such a case goes beyond the informal stage, it usually is resolved in the form of a compromise-and-release agreement (known as a claims disposition agreement in Oregon).

Key System Features That Increase Certainty and Decrease Litigation over PPD Benefits

A package of six system and ten reinforcing features enhance the certainty of PPD determinations in Oregon and keep the incidence of formal hearings low. The goal of the feature package is to resolve disputes swiftly, informally, and with a minimum of friction costs. The overall impact of Oregon's package is that private decision makers in the PPD determination process (e.g., payors and attorneys) focus on applying the rules rather than subverting the system by obtaining dueling physician ratings. The combination of six system features and ten reinforcing features creates an environment in which litigation is minimized; no one feature is primarily responsible for the system result.

Reliance on the Treating Provider to Offer the Information Needed to Form the Basis of an Impairment Rating

The employee selects the treating provider in Oregon, except when the employer has contracted with a managed care organization (MCO). If enrolled in an MCO, the employee makes the initial choice from a list of providers developed by the MCO. The employee is allowed two changes of provider. Additional changes require approval by the insurer or self-insurer or the WCD. Chiropractors are rarely part of the rating process, because their status as attending physicians only extends for 30 days or 12 visits on the initial claim.[4]

When the worker reaches maximum medical improvement, the WCD requires that the treating physician determine if the worker has a permanent impairment. This is usually accomplished by sending the treating provider a worksheet that

[4] Legislation in 2007 (effective 2008) changed the limits to 60 days or 18 visits on the initial claim. Included are chiropractors, naturopaths, podiatrists, and nurse practitioners.

causes the provider to submit measurements and findings concerning the extent of permanent impairment for the condition that has been accepted by the insurer or self-insurer. Thus, unlike in most states WCRI has studied, the role of the treating physician in Oregon is to provide measurement and findings concerning the worker's permanent impairment to the payor—not to provide an impairment rating. Trained insurer or self-insurer claims examiners then compute a permanent impairment rating using the state's guide according to DCBS rules.

The reconsideration and medical-arbiter processes described later in the chapter counterbalance the incentive for workers or their attorneys to select treating physicians to maximize impairment ratings, or for employers or insurers to refer workers to treating physicians to minimize impairment ratings.

USE OF A GUIDE TO RATE PERMANENT IMPAIRMENT

Oregon uses its own guide for rating permanent impairment. Disability rating standards (contained in Oregon Administrative Rules, Chapter 436, Division 035) establish standards for rating permanent partial disability under the statute governing workers' compensation. The portion of the standards that covers permanent impairment rating is largely based on the American Medical Association *Guides to the Evaluation of Permanent Impairment, Third Edition* (AMA *Guides*). Permanent impairment ratings are expressed as a percentage of the body as a whole. DCBS officials told us that the use of a proprietary guide allows rating and compensation concepts to be consistent with the Oregon statute and established case law. New concepts can be incorporated as needed, administratively, through the rule-making process, not according to the AMA *Guides.* The result is more-predictable total PPD awards.

OBJECTIVE CRITERIA FOR DETERMINING LOSS OF EARNING CAPACITY AT ALL STAGES

Oregon is one of four states that specify objective criteria when rating factors related to loss of earning capacity, such as age, education, and occupation.[5] The rules must be followed at all levels of decision making, including all levels of dispute resolution.

[5] Other states that require the use of objective criteria when rating loss of earning capacity are California, Kentucky, and New Mexico.

Briefly, the factors in Oregon (called social–vocational factors) are age, education, and adaptability. For the age factor, determined as of the date of issuance of the rating, workers age 40 and above receive a value of 1; all others receive a 0 value.

The education factor is based on the worker's formal education and specific vocational preparation (SVP)—the time the typical worker needs to acquire the knowledge, skills, and abilities necessary to perform a specific job. For the formal education factor, workers who have earned a high school diploma or GED are given a value of 0; workers with less education receive a value of 1. A value for a worker's SVP is given based on jobs performed in the past five years. The SVP is determined by identifying those jobs and locating their SVPs in the *Dictionary of Occupational Titles* or a specific job analysis. Points (from 1 to 4) are assigned (using a table) according to the job with the highest SVP. The education and SVP factors are added to arrive at a final value for the education factor.

The adaptability factor is the worker's base functional capacity (BFC), or demonstrated physical capacity before the injury or disease, compared with the worker's maximum residual functional capacity (RFC), or remaining ability to perform work-related activities. BFC is determined by using the *Dictionary of Occupational Titles* to identify the strength factor for the most physically demanding job the worker performed in the past five years. Another method for measuring BFC is to use a preinjury evaluation of physical capacities. In general, for orthopedic claims to the spine, hips, and shoulders, RFC is determined by the treating provider, by a physical capacities evaluation, or by a work capacities evaluation. For dates of injury on or after January 1, 2005, adaptability is determined by applying the worker's extent of total impairment to an adaptability scale in the rules and then comparing that value to another value from a scale that compares the BFC to the RFC. The higher of the two values is used.

The age and education factors are added together, and the result is multiplied by the adaptability factor to determine the social–vocational factor (in percentage points). The percentage points for impairment and the social–vocational factor are then added together to arrive at a work disability percentage.

As an illustration, suppose a 45-year-old worker with a tenth-grade education falls off a loading dock, injuring his back and shoulder. He receives a combined 22 percent whole-body impairment rating from the insurer and does not return to regular work. His age factor is 1 because he is more than 40 years old. His education factor is 4: 1 for lack of a high school diploma or GED plus an SVP of 3. His adaptability score is 5. The age and education total (5) multiplied by the adaptability score (5) equals 25. That amount (as a percentage) is added to the 22 percent impairment rating, giving the worker a total work disability rating of 47 percent.

For dates of injury on or after January 1, 2006, the impairment benefit is paid only if the worker (1) returns to work at his or her regular employment on the date of issuance of the rating or (2) is released for work by the attending physician. The impairment benefit is calculated as the impairment rating (expressed as percentage points) times the state average weekly wage (SAWW) at the time of injury. If the worker does not meet either of the two criteria, he or she receives the impairment benefit plus the work disability benefit. The work disability benefit is calculated as the work disability percentage (expressed as percentage points) times 1.5 the worker's average weekly wage at the time of injury, subject to statutory maximum and minimum weekly amounts.[6]

ACTIVE PAYOR INVOLVEMENT IN TERMINATING TTD BENEFITS AND DETERMINING PPD BENEFITS (INITIAL CLAIM CLOSURE)

Payors in Oregon are active in both monitoring the termination of TTD benefits and determining PPD benefits. Generally, when the treating physician releases the employee to work (with or without restrictions), or the employee is declared medically stationary (similar to maximum medical improvement) and the treating physician provides information on which to rate permanent disability, the insurer or self-insurer closes the claim and issues a Notice of Closure (NOC) within 14 days. Closure does not mean that the insurer or self-insurer has paid all known benefits. Rather, it signals that temporary disability benefits have ended and prompts consideration of permanency benefits. For that reason we refer to this process as initial claim closure.

The process has these important results:

- A summary of temporary disability benefits paid since the date of injury.
- Statements of return-to-work type, release-to-work type, employer type, and employment status. The WCD uses this information to, among other things, determine eligibility for the Preferred Worker Program and the vocational assistance program (see Chapter 5).
- A summary of the work disability and/or permanent impairment benefits awarded by the insurer or self-insurer.

[6] The maximum weekly amount is 133 percent of the SAWW and the minimum amount is 50 percent of the SAWW.

If the treating physician considers the information insufficient to determine the extent of permanent disability, TTD benefits continue, even though the worker is determined by the treating physician or an IME physician to have reached maximum medical improvement. Some insurers and defense attorneys we interviewed said that not basing TTD benefit terminations solely on maximum medical improvement can raise costs because TTD benefits continue until they can convince the treating physician to provide information regarding the extent of permanent impairment. Usually that information comes from an IME physician. As an alternative, the insurers and defense attorneys advocated for allowing payors to close a claim based on the preponderance of medical evidence and automatically involving a medical arbiter in disputes over the extent of permanent disability.[7]

The responsibility for claim closure in Oregon has evolved over time. Until 1987 only the WCD had the authority to initially close claims involving permanency and determine the amount of PPD benefits. Legislation enacted in 1987 gave the payor the right to initially close a claim when a worker is released to work and to rate permanency. In 1987 payors completed 36 percent of claim closures. In 1990 the authority of the insurer or self-insurer to close a claim was expanded to include when the attending physician finds the worker medically stationary and has released the worker to full- or light-duty work. At the same time, the DCBS was required to promulgate disability rating standards. In 1992 payors completed 58 percent of claim closures. From 1990 through 1999 the share of claims closed by payors increased gradually to 77 percent. Legislation in 1999 shifted the responsibility for all claim closures from the WCD to payors. By 2001 payors completed 100 percent of claim closures (DCBS, 2006b, fig. 25).

The process of gradually transferring the responsibility for closing claims to insurers and self-insurers is itself a lesson. This process has at least three features: (1) it first established the state agency as an impartial source of permanency ratings; (2) it required that the state agency provide standards and train industry claims adjusters to assume greater responsibility for claim closure; and (3) it gradually transferred claim closure authority to payors, thus reducing dependence on the state agency.

[7] Department officials note that temporary disability benefits paid after maximum medical improvement may be offset by the payor against payments of future disability benefits (permanent or temporary).

USE OF A SWIFT AND MANDATORY MECHANISM FOR ADMINISTRATIVE DISPUTE RESOLUTION (CALLED RECONSIDERATION) TO ADDRESS OBJECTIONS TO INITIAL CLAIM CLOSURE

Oregon has fashioned a specific mechanism for administrative informal dispute resolution to address objections to claim closure. Called reconsideration, the process is mandatory for a dispute to proceed to a hearing at the Workers' Compensation Board. The purpose of reconsideration is to minimize the need for attorney involvement on both sides. In fiscal year 2005, 16.5 percent of initially closed indemnity claims involved reconsideration, and 26.8 percent of resulting reconsideration orders were contested—that is, a formal hearing was requested (DCBS, 2006b, fig. 24). Figure 4.3 shows the steps and time frames of the reconsideration process, including the medical-arbiter process (described in the next section).

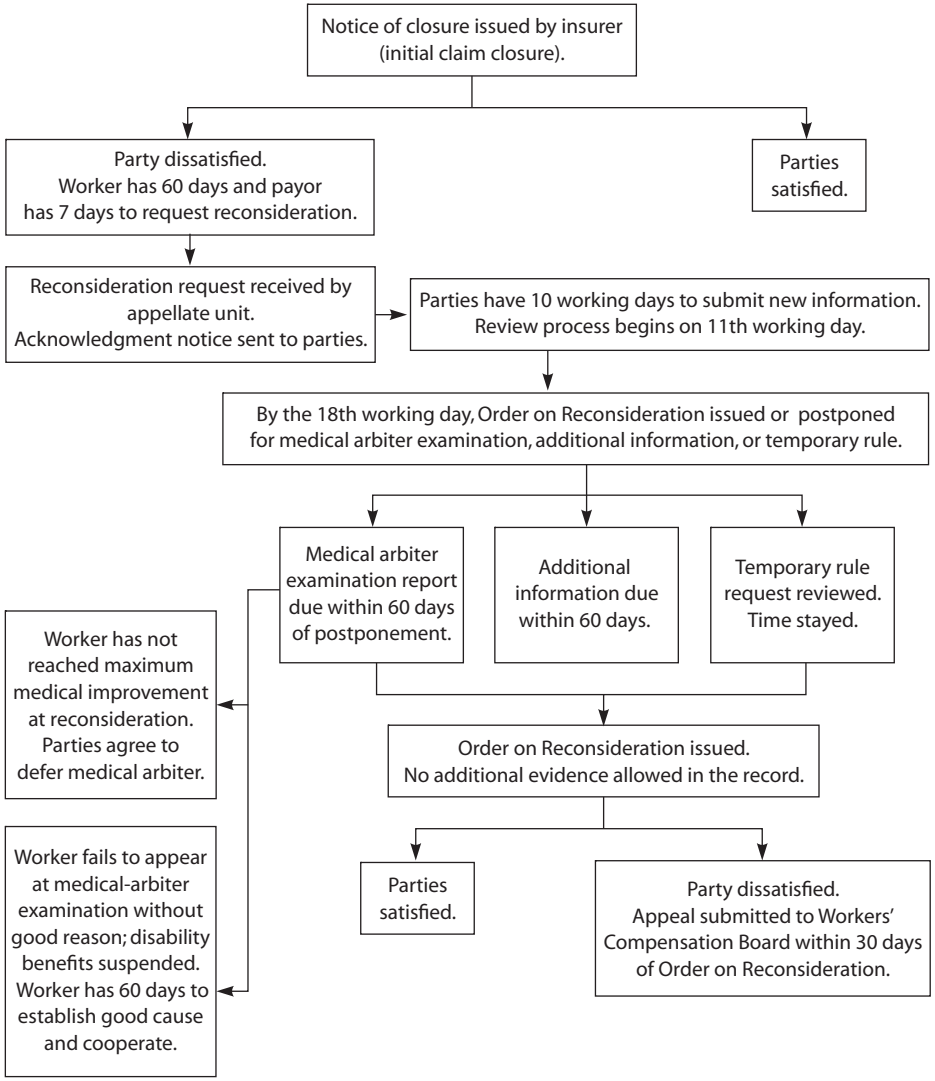
The process for resolving a dispute over initial claim closure is fairly swift. A worker who is dissatisfied with the NOC may request the reconsideration of the closure by the Appellate Review Unit (ARU) of the WCD within 60 days after the NOC was mailed. All parties have 10 working days after the ARU receives the reconsideration request to submit additional written evidence for consideration. The ARU then conducts a review of the closure order within 18 working days of receipt of the request and issues an order on reconsideration, or postpones issuance of the order for a medical-arbiter examination, additional information, or issuance of a temporary rule. Involvement of a medical arbiter adds 60 days or more to the process. WCD internal data for the first quarter of fiscal year 2003 through the third quarter of 2006 show that the ARU issued an order within 20 to 24 days from receipt of a request when the case was not postponed and within 77 to 86 days when it was postponed (usually for a medical-arbiter examination).

If either side is dissatisfied with a WCD order at reconsideration, that party may request a formal hearing at the Workers' Compensation Board within 30 days of the notice of closure. The board then schedules and holds a hearing (if necessary) in much the same manner as most states. Once a hearing is requested, a case is set for hearing within 90 days.

USE OF A MEDICAL ARBITER

Most public and private system participants in Oregon regard the use of medical arbiters as the cornerstone of the system's informal process of resolving disputes over initial claim closure. Using a medical arbiter puts the focus on functional impairment findings and medical opinions related to those findings to form the basis of PPD benefit determinations. One defense attorney characterized the medical-

Figure 4.3 Initial Claim Closure and Reconsideration Processes in Oregon, 2007



Source: DCBS, 2006b.

arbiter process as "taking PPD out of the hands of lawyers and placing it in the hands of doctors."

A medical arbiter is a licensed physician who has been trained and approved by the WCD to conduct impartial examinations. WCD officials told us that at first the medical-arbiter process relied heavily on IME physicians. That has changed over time; currently about eight of ten arbiter evaluations are performed by private-office physicians. Nonetheless, roughly three-fourths of IME physicians have served, or continue to serve, as medical arbiters on an occasional basis. In 2006 medical-arbiter referrals numbered 2,571, and referrals in 2004 and 2005 were at 2,825 and 2,635, respectively.

The ARU maintains a list of about 540 physicians approved as medical arbiters.[8] When either party requests a medical-arbiter examination, both parties receive a list of six physicians (in the same geographical area) chosen randomly by computer from among the specialty that ARU determines is most appropriate to the worker's case according to treatment rendered by physicians in the past.[9] For example, if treatment included a spinal fusion performed by an orthopedic surgeon, orthopedic surgeons would be selected from the list of active medical arbiters. Less complicated injuries allow for some latitude in selection of the medical specialty.

The process for selecting an arbiter from the list of six is important. WCD officials said, "Perhaps no other aspect of the medical-arbiter process has received greater attention from stakeholders than the selection of the arbiter physician. At the heart of this issue exists a longstanding sense of frustration among those in the industry over the lack of input they have in the medical-arbiter process" (Oregon Workers' Compensation Division, 2003, p. 16). In response to this concern, the WCD conducted a pilot study in 2001 to give parties a greater say in the selection of arbiter-physicians. The result was implementation of a process in 2002 that allows both parties the option of eliminating, or "deselecting," one name from the list of six. WCD officials have estimated that deselection occurs in about 80–85 percent of cases involving a request for an arbiter examination.

The selection process proceeds in one of three ways. Most often a member of the WCD's appellate service team selects the medical arbiter based on the following criteria: (1) the doctor who is next in the rotation, (2) the doctor who is closest to the worker, and (3) the doctor whose specialty best matches the condition being reviewed. Alternatively, the parties can mutually agree on (stipulate to) a name on the list of six physicians. WCD officials told us that parties select an arbiter in this manner in only about 1 percent of requests. We asked, "Why don't attorneys more often stipulate to an arbiter up front, rather than deselecting and letting the appellate service team make the final selection?" Attorneys we spoke with cited a combination of reasons: the tight time frame allowed for selection or deselection (three days), difficulty reaching agreement between attorneys on an arbiter because of suspicion by one side as to why a name was proposed by the other, and general satisfaction with the arbiter pool (thus making deselection sufficient to eliminate objectionable arbiters). Naturally, mutual selection is not likely if the worker is unrepresented.

The third option for medical-arbiter selection, according to WCD officials, is based on the Oregon Administrative Rules that allow the parties to stipulate to most issues within the reconsideration process. Therefore, it is possible for the parties to agree on any doctor from the complete list of approved arbiters and submit that name to the ARU for approval. WCD officials told us this option is rarely taken.

When a case demands evaluations of more than one accepted condition, more than one medical-arbiter examination may be required. Either side can request a medical-arbiter panel examination conducted by three physicians of the appropriate medical specialty. WCD officials estimate that 12 percent of cases involving a medical-arbiter examination involve a request for a panel.

Before an arbiter is selected, an ARU appellate review specialist develops a list of case-specific questions to be addressed by the arbiter. After an arbiter is selected, the specialist contacts the worker and briefs him or her on what to expect.

The medical arbiter or panel is responsible for rendering an examination report within 60 days of postponement. Arbiter fees are paid for by the insurer or self-insurer. Fees vary by the level of the exam (from $307.20 for level 1 to $511.80 for level 3),[10] the level of the report (from $52.80 for level 1 to $106.20 for level 3), and the level of file review (from $52.80 for level 1 to $819.00 for level 5). WCD officials said that most medical-arbiter fees fall into the level-2 category and that a typical total fee for all three parts would be $621.00.

[8] The list of medical arbiters is posted on the DCBS Web site at http://www.cbs.state.or.us/external/wcd/compliance/bcu/phy_list.pdf.

[9] To ensure impartiality, physicians previously involved in the claim are excluded from selection. Physicians associated with facilities or clinics where the worker has received treatment or evaluation are also eliminated from consideration.

[10] The various levels are determined by the DCBS based on the complexity of the examination, the report requirements, and the extent of the record review compared with the universe of claims in the medical-arbiter process. A fee of $153.60 is provided for a level-4 (partial) examination.

According to WCD officials, about two-thirds of reconsideration requests involve a medical-arbiter examination because of a dispute about impairment. Thus, the impartiality of the arbiter is crucial to the success of informal dispute resolution over PPD determination.

We asked WCD officials, "What features of the medical-arbiter process help ensure impartiality?" In response they offered the following combination of nine features:

1. All written materials and communications pertaining to the medical-arbiter process emphasize impartiality.
2. Workers receive pre-exam calls from an ARU specialist explaining the process.
3. All physicians involved in the process undergo training, and their work is periodically reviewed.
4. Arbiter-physicians must sign a conflict-of-interest statement for each referral.
5. Arbiter-physicians are selected randomly by computer according to geographic proximity and medical specialty required.
6. Physicians previously involved in the claim are precluded from performing an exam. Likewise, a worker is never sent to a clinic for an exam if he or she had been seen there earlier in the claim.
7. Arbiter-physicians are sequestered during the reconsideration process. Parties are prohibited from direct contact with the arbiter, but may seek clarification through the ARU.
8. The WCD ensures the uniformity of medical records and provides standardized PPD exam questions (derived from administrative rules) to alleviate the problem of leading questions.
9. The WCD provides a grievance procedure for workers.

In theory, instead of parties spending resources on dueling experts, the workers' compensation agency provides direct access to an impartial arbiter-physician. However, some workers' attorneys told us that not all approved arbiter-physicians are impartial. They advocate for a greater range of choice than six physicians.

Reinforcing Features

The six key elements of Oregon's approach to reducing litigation over PPD determinations would not work as well as they do without the following ten reinforcing features that have been carefully designed into the system. Take away any one element and efficiency of the entire package would change.

1. *PPD benefits initially awarded on an NOC must be paid promptly while the total amount is being reviewed.* Payment must begin within 30 days of the NOC. The final amount could be increased or decreased at reconsideration. Only if the insurer or self-insurer subsequently appeals the reconsideration order to the Workers' Compensation Hearings Division is payment of any unpaid PPD benefits stayed.
2. *Tight time frames are specified and performance monitored for each stage in the process.* By statute the ARU has 18 working days to process a reconsideration request; the process takes an additional 60 days if a medical arbiter is involved.
3. *Agency rules apply at all levels of decision making, bringing consistency to the process and minimizing the incentives to end-run any particular step in the process.*
4. *Only the specifically accepted condition is rated.*[11] This is important because it limits the scope of what is being rated, thus minimizing one possible source of inter-rater variability.
5. *Medical evidence is generally introduced through medical reports rather than live testimony or depositions.* This reduces friction costs for both sides.
6. *Failure to attend or cooperate with a medical-arbiter examination within 60 days eliminates the worker's opportunity to have the exam.*
7. *Workers' attorneys receive lower fees at reconsideration.* Fees at reconsideration are statutorily limited to 10 percent of the additional PPD amount obtained as a result of reconsideration.[12] This provides incentives for workers to try to obtain satisfaction at reconsideration without an attorney being involved.
8. *A penalty is paid by the payor to the worker when the PPD rating has been increased by 25 percent or more at reconsideration compared with the insurer's or self-insurer's initial rating at initial claim closure and the worker is found at reconsideration to be at least 20 percent disabled.* The amount of the penalty is 25 percent of the dollar amount of the increase in compensa-

[11] Oregon law states that, when initially accepting a claim and later when terminating TTD benefits, the payor must specify which conditions are compensable, subject to appeal if the worker disagrees. Medical conditions secondary to the claimed injury must also be rated.

[12] Attorneys receive 25 percent of the additional amount obtained at hearing.

tion. This provides disincentives for payors in some claims to make "low-ball" initial awards at claim closure.

9. *No new evidence may be introduced after reconsideration, and the PPD rating is related to the workers' permanent disability as of the date of the reconsideration order.* This limits disagreement and speeds resolution by helping to ensure that parties are arguing over the same set of facts.
10. *Issues raised at formal hearing are limited to those that were raised during reconsideration.*

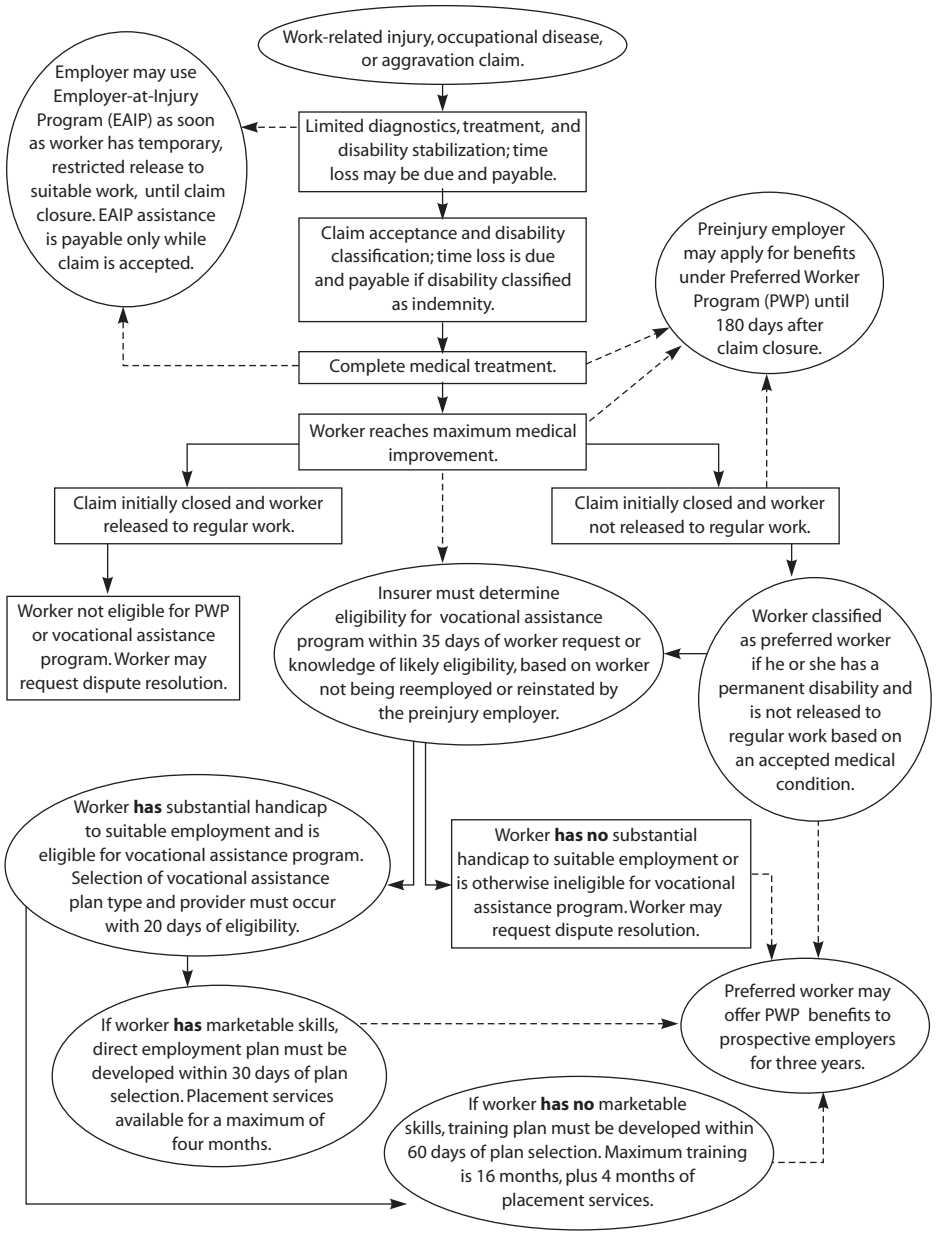
5

LESSON 4: RETURN TO WORK IS ENHANCED WHEN SPECIAL PROGRAMS ARE DESIGNED FOR THAT PURPOSE

A fundamental goal of the Oregon system is to return injured workers to their jobs quickly and enable them to earn wages that are close to preinjury wages. This goal is addressed in two ways. First, the statute governing workers' compensation prohibits employment discrimination and provides reemployment rights to injured workers. Second, with money from a fund established solely for this purpose, Oregon offers three programs designed to assist injured workers in returning to work: the Employer-at-Injury Program, a vocational assistance program, and the Preferred Worker Program. Figure 5.1 shows how the three programs work together to provide a strong return-to-work package, along with a "safety net" of services that workers can access even after their claims have been settled through compromise-and-release agreements.

In Oregon about one in seven injured workers who receive income benefits participates in one return-to-work program. DCBS data show that among accepted indemnity claims closed in fiscal year 2006 (evaluated as of the 13th quarter after injury), 14.2 percent took part in a return-to-work program. This figure is down from a high of 18.2 percent among claims arising in 1998 (DCBS, 2006b, fig. 15).

Figure 5.1 Flowchart of Return to Work in Oregon



Note: Dashed line indicates potential path of process.
Source: DCBS, 2006b.

Package of Return-to-Work Program in Oregon

Oregon policymakers have fashioned some potentially powerful program elements aimed at stimulating early return to work and long-term recovery of wages for injured workers. The key to the programs lies in funding a package of wage incentives, protection for the employer if a worker is reinjured, and reimbursement of costs of fitting a worker to a job. The package particularly benefits small- and medium-sized employers and their workers because their companies are not as likely as large employers to have well-developed modified-work and reemployment programs.

Oregon's return-to-work package has five components:

1. *Workers' Benefit Fund (WBF).* This unusual fund serves to encourage public policymakers to evaluate and experiment with ways to improve return-to-work outcomes for injured workers.
2. *Employer-at-Injury Program (EAIP).* The EAIP is designed to stimulate return to modified work, primarily with the preinjury employer.
3. *Vocational assistance program.* Services offered under this program are similar to private vocational rehabilitation services in other states.
4. *Preferred Worker Program (PWP).* The purpose of the PWP is to provide incentives to employers to hire injured workers unable to return to regular work. The program also offers assistance to that classification of injured worker to find employment.
5. *A reemployment safety net for workers who settle their claims.* In allowing eligibility for the PWP after workers receive compromise-and-release agreements, Oregon has fashioned a valuable protection for workers in the event that they do not readily return to gainful employment after settling their claims.

Evidence of Impact

We know of only one study that compares return-to-work rates in Oregon with those in other states. In an evaluation of permanent partial disability and return to work in New Mexico, the RAND Institute for Civil Justice compared the median number of days off work after injury in New Mexico (1994–1996), Oregon (1992–1993), Washington (1993–1994), and Wisconsin (1989–1990). The study shows that at 38 days, the median number of days in Oregon was slightly longer than in Wisconsin (36 days), somewhat shorter than Washington (45 days), and

much shorter than New Mexico (77 days; Reville et al., 2001, tab. 7.7). Additional studies involving more states and more-recent data are needed to determine how Oregon's return-to-work performance compares with that of other states.

The DCBS has established two key performance measures (KPMs) that address return to work:[1]

- *Return-to-work rates for injured workers:* KPM 4400-15 measures the difference in the percentage of eligible workers who return to work using return-to-work programs from those who do not use return-to-work programs (DCBS, 2007a, p. 1).
- *Wage recovery for injured workers:* KPM 4400-2 measures the percentage difference in wage recovery among workers who use return-to-work programs versus workers who do not.

To measure the performance of each of Oregon's three return-to-work programs, staff at the Information Management Division (IMD) of the DCBS compare workers who used the program with similar workers who were eligible for but did not use it. Defining the comparison group is an important part of this analysis, so IMD staff are careful to identify workers with similar claim severities at the time of maximum medical improvement. For the vocational assistance program, workers who used the benefits are compared with workers with permanent impairments who cannot return to any job paying 80 percent of their preinjury wages.[2] Workers who used the PWP are compared with workers with permanent impairments who could not return to regular work but were released by the treating provider to modified work.[3] Workers who used the EAIP are compared with workers who were awarded PPD benefits but were released by the treating provider to regular work. In research, determining a valid comparison group is often a challenge. IMD officials acknowledge that results may vary according to how a comparison group is defined and regularly compare the mean amount of indemnity and medical benefits paid for program users and nonusers to help ensure comparability.

DCBS data show consistently better return-to-work and wage recovery rates for program users than similar workers who do not participate in these programs. Table 5.1 compares the return-to-work rates of workers who use the EAIP, the PWP, and the vocational assistance program with workers who did not use each program from outcome years 1997 through 2006.[4] For example, in outcome year 2006, 76 percent of workers who used the EAIP were employed in the 13th quarter after injury compared with 71 percent of workers who did not use the program, a difference of 5 percentage points. The difference for this program was 3–7 percentage points from outcome years 1997 through 2006. In 2006, 83 percent of workers who used PWP benefits were employed in the 13th quarter after injury compared with 54 percent for workers who were identified as preferred workers but did not use the benefits, a 29-point difference. The difference for this program was 20–29 points from outcome years 1997 through 2006, with the largest difference occurring in 2006. Finally, 65 percent of workers who completed a vocational assistance program were employed in the 13th quarter after injury compared with 32 percent for workers who were eligible for vocational assistance but did not complete the program, a 33-point difference. The difference for the vocational assistance program was 21–35 points from outcome years 1997 through 2006, with the largest differences occurring in 2003 and 2004. Taken together, DCBS internal data show that in outcome year 2006, 77 percent of the users of the EAIP, the PWP, and the vocational assistance program were employed in the 13th quarter after injury compared with an employment rate of 64 percent for nonusers. That 13-point difference exceeds the KPM target of 12 points the DCBS set for 2006.

Table 5.2 shows similar data for the KPM concerning wage recovery for injured workers for outcome years 1997 through 2006. The data for outcome year 2006 show that workers who used the EAIP (measured 13 quarters after injury) achieved a higher rate of wage recovery (111 percent) compared with workers who did not use the EAIP (102 percent), a difference of 9 percentage points. For the EAIP the differences varied over time, from 2 percentage points in 1998 and 1999 to 9 points in 2003 and 2006. Similarly, workers who used PWP benefits achieved a higher rate of wage recovery in 2006 (116 percent) compared with workers who did not use PWP benefits (83 percent), a difference of 33 percentage points. For the PWP the differences varied from a low of 14 points in 2004 to a high of 33 points in 2006. Workers who completed the vocational assistance program achieved a higher rate of wage recovery (65 percent) in 2006 than did work-

[1] As discussed in Chapter 3, KPMs are the highest-level, most outcome-oriented performance measures that the DCBS uses to report progress to the legislature and stakeholders.

[2] These workers may have been involved in the PWP and EAIP programs as well.

[3] These workers may have been involved in the EAIP program as well.

[4] Return-to-work rates are measured in the 13th quarter after injury. For example, statistics for outcome year 2006 reflect outcomes for injuries in 2002, with measurements taken from April 2005 through March 2006, depending on the quarter of injury.

Table 5.1 Return-to-Work Rates among Users and Nonusers of Return-to-Work Programs in Oregon, 1997–2006

Outcome Year[a]	Employer-at-Injury Program			Preferred Worker Program			Vocational Assistance Program		
	Workers Who Used Program (% returned to work)	Workers Who Did Not Use Program (% returned to work)[b]	Percentage Point Difference	Workers Who Used Benefits (% returned to work)	Workers Who Were Eligible But Did Not Use Benefits (% returned to work)	Percentage Point Difference	Workers Who Completed Plans (% returned to work)	Workers Who Did Not Complete Plans (% returned to work)	Percentage Point Difference
1997	80	73	7	73	49	24	66	42	24
1998	77	72	5	77	54	23	72	44	28
1999	76	73	3	78	56	22	70	42	28
2000	78	72	6	79	55	24	72	42	30
2001	77	72	5	81	57	24	65	41	24
2002	75	71	4	78	57	21	61	40	21
2003	74	71	3	75	55	20	67	32	35
2004	73	69	4	75	52	23	67	32	35
2005	74	70	4	77	53	24	63	34	29
2006	76	71	5	83	54	29	65	32	33

[a] Return-to-work rates are measured in the 13th quarter after injury. For example, statistics for outcome year 2006 reflect outcomes for injuries in 2002, with measurements taken from April 2005 through March 2006, depending on the quarter of injury.

[b] Workers who did not use the program are defined as those who had relatively less-severe injuries (not requiring participation in the Preferred Worker Program or vocational assistance) and who had characteristics similar to those of workers using the Employer-at-Injury Program.

Source: DCBS, 2006b.

Table 5.2 Wage Recovery Rates among Users and Nonusers of Return-to-Work Programs in Oregon, 1997–2006

Outcome Year[a]	Employer-at-Injury Program			Preferred Worker Program			Vocational Assistance Program		
	Workers Who Used Program (% returned to work)	Workers Who Did Not Use Program (% returned to work)[b]	Percentage Point Difference	Workers Who Used Benefits (% returned to work)	Workers Who Were Eligible But Did Not Use Benefits (% returned to work)	Percentage Point Difference	Workers Who Completed Plans (% returned to work)	Workers Who Did Not Complete Plans (% returned to work)	Percentage Point Difference
1997	109	106	3	98	74	24	67	50	17
1998	103	101	2	99	77	22	76	49	27
1999	103	101	2	101	80	21	74	49	25
2000	107	101	6	101	79	22	71	45	26
2001	107	102	5	97	82	15	72	53	19
2002	113	105	8	103	85	18	76	48	28
2003	112	103	9	102	82	20	72	45	27
2004	107	99	8	95	81	14	72	39	33
2005	103	98	5	108	79	29	60	41	19
2006	111	102	9	116	83	33	65	39	26

[a] Wage recovery rates are measured in the 13th quarter after injury. For example, statistics for outcome year reflect outcomes for injuries in 2002, with measurements taken from April 2005 through March 2006, depending on the quarter of injury.

[b] Workers who did not use the program are defined as those who had relatively less severe injuries (not requiring participation in the Preferred Worker Program or vocational assistance), who have similar characteristics to those using the Employer-at-Injury Program.

Source: Department of Consumer and Business Services, Information Management Division, Research and Analysis Section internal data.

ers who did not complete the program (39 percent), a difference of 26 percentage points. That difference varied from a low of 17 points in 1997 to a high of 33 points in 2004. DCBS internal data show that, in outcome year 2006, the overall difference in wage recovery for workers who used return-to-work programs was 16 percentage points higher than that for workers who did not use the programs. That performance exceeds the 15-point KPM target the DCBS set for 2006.

That the DCBS measures return-to-work and wage recovery rates on a yearly basis is impressive. We know of no other state that measures these two key indicators of workers' compensation system performance on an ongoing basis. Readers interested in the methodology for measuring return-to-work rates and wage recovery rates are encouraged to contact the manager of the Reemployment Assistance Unit of the WCD at (503) 947-7575.

Workers' Benefit Fund

Before discussing Oregon's three return-to-work programs, it is import to understand how the EAIP and PWP are funded. The WBF in Oregon was created in 1995 to fund a wide variety of workers' compensation programs, plus a portion of the DCBS operating costs associated with administering WBF programs. Of particular interest here is the funding of the Reemployment Assistance Program, which includes the EAIP and the PWP.[5] The WBF is unique among states in that it is funded by an assessment equal to 1.5 cents per hour worked (effective January 1, 2006) applied to each employer and worker. In fiscal year 2006, WBF expenditures were about $90.3 million, of which about $20.2 million was for the Reemployment Assistance Program. Expenditures for the EAIP ($10.9 million in fiscal year 2006) amounted to an assessment equal to 0.18 cents per hour applied to each employer and worker; and PWP expenditures ($7.6 million) amounted to an assessment of 0.13 cents per hour applied to each employer and worker (DCBS, 2006b). We know of no other state workers' compensation fund that includes worker contributions.

Most public and private system participants we spoke with said the existence of the WBF was very important in Oregon because it allows the DCBS, with guidance from the Management–Labor Advisory Committee, to creatively use WBF money to experiment with ways of improving the system. Such experiments are carefully evaluated by the DCBS to determine if they improve outcomes for injured workers.

[5] Other programs in this category include expenditures for the Oregon Health and Science University's Center for Research on Occupational and Environmental Toxicology, and rehabilitation facilities expenditures.

Employer-at-Injury Program

The EAIP is a package of financial incentives for Oregon employers that is designed to encourage early return to modified work.[6] Modified work can take the form of reduced work hours, modified tasks, a different job or work site, or other activities.

The program was created in 1993; in 1995 it was extended to include workers with medical-only claims as well as those with indemnity claims. To be eligible for the EAIP, a worker must have one or more temporary restrictions that prevent performance of regular job duties. Since 1995 about half of EAIP placements have been for medical-only claims. Insurers and self-insurers administer early return-to-work placements under the EAIP, for which they receive a flat fee of $60 per placement. The WCD regulates placements under the EAIP and conditions for payment of financial incentives. With the insurer's assistance, the employer identifies modified-work positions, obtains a temporary release to work from the worker's treating physician, and places the person in a modified job. Temporary alternative work somewhere other than with the preinjury employer is permitted. Insurers reimburse employers for

- wage subsidies of 50 percent for up to three months;
- up to $2,500 for work-site modifications;
- up to $1,000 for tools and equipment required for the job;
- up to $400 for clothing; and
- up to $1,000 for tuition, fees, and books.

Insurers and self-insurers are then reimbursed by the DCBS.

Under Oregon law, the insurer or self-insurer may reduce or terminate TTD benefits if the worker refuses a suitable offer of modified work. However, legislation effective mid-2001 allows the worker to refuse such an offer when the job re-

[6] More information about the EAIP is available on the DCBS Web site at http://www.cbs.state.or.us/external/wcd/rdrs/rau/returntowork.html.

quires a commute that is beyond the worker's physical ability or is more than 50 miles, the placement is not with the preinjury employer or not at the preinjury employer's work site, or the placement is inconsistent with the employer's practices or a collective bargaining agreement.

Table 5.3 shows activity for the EAIP from 1993 through 2005. In 2005, 6,474 workers with placements were approved (at an average cost per placement of $1,549) involving 1,475 employers. Wage subsidy is the major feature of the program. DCBS internal data for calendar year 2000 show that 97 percent of program expenses were for wage subsidy. For 2006 DCBS internal data show that 14 percent of placements occurred at employers with 49 or fewer workers, 9 percent at employers with between 50 and 99 workers, 23 percent at employers with between 100 and 499 employees, and 53 percent at employers with 500 or more employees. Thus, most placements are with larger employers (i.e., those with more than 500 employees). WCD officials told us that they would like to see EAIP use increase among smaller employers. However, smaller employers may not have the resources necessary to use the EAIP, and insurers may not always encourage them to do so. According to WCD officials, more study and input from new program users are needed before any program changes are made to make the program more attractive to smaller employers. They said that one key to success lies in allowing employers and insurers easy access to the program.

DCBS internal data for 2000 show that about 25 percent of placements involving indemnity claims occurred in the manufacturing industry. An estimated 5 percent of EAIP placements occurred in alternate work sites (that is, with other than the preinjury employer).

Table 5.3 shows that EAIP use peaked in 1998, when 8.6 EAIP placements were approved per 100 estimated total accepted claims. Since then, that rate has fluctuated from 8.2 in 1999 to a low of 6.5 in 2002. Most observers we spoke with suggested those results reflected an improving economy in Oregon since 2001.

A DCBS study of the EAIP conducted in 2000 indicates that about half of placements for claims classified as medical-only occurred within three days of the injury (Maier, 2001). Because the waiting period in Oregon is three days, it is possible that the EAIP contributes to the reduction in the number of indemnity claims by encouraging return to work within the waiting period. In 2000 the average time from injury to placement was 90 days; the median was 16 days. The average length of a placement was 79 days and the average length of the wage subsidy was 46 days. Oregon administrative rules include safeguards against prolonging modified work. In 2000 the average placement hourly wage was $12.00, 96 percent of the preinjury hourly wage of $12.40. However, under Oregon law, temporary partial disability benefits (equal to two-thirds of the difference between preinjury

Table 5.3 Activity of the Employer-at-Injury Program, 1993–2005

Year[a]	Estimated Total Accepted Claims	Workers With Placements Approved	Workers With Placements Approved (per 100 estimated total accepted claims)	Employers	Average Cost per Placement	EAIP Expenditures (millions)
1993	118,755	446	0.4	140	$830	$0.0
1994	129,137	2,400	1.9	727	$1,268	$1.8
1995	124,446	3,739	3.0	1,189	$1,326	$3.9
1996	123,877	6,079	4.9	1,345	$1,245	$5.3
1997	120,303	8,357	6.9	1,515	$1,180	$10.1
1998	117,425	10,066	8.6	1,776	$1,160	$9.9
1999	114,460	9,440	8.2	1,837	$1,124	$11.6
2000	112,743	7,855	7.0	1,579	$1,210	$10.4
2001	106,265	8,585	8.1	1,656	$1,283	$10.6
2002	98,750	6,405	6.5	1,236	$1,408	$10.4
2003	90,357	5,953	6.6	1,313	$1,481	$8.4
2004	86,784	6,610	7.6	1,490	$1,481	$9.6
2005	86,857	6,474	7.5	1,475	$1,549	$9.4
Percentage change	−26.9%	1351.6%	1884.7%	953.6%	86.6%	422.2%[b]
Annual average percentage change	−2.6%	25.0%	28.3%	21.7%	—	—
Annual average percentage change, adjusted for inflation	—	—	—	—	2.7%	13.4%[b]

Note: Program was expanded to cover medical-only claims in 1995.

a EAIP expenditures are fiscal year. All other data are calendar year.

b Calculated from fiscal years 1994 through 2004.

Key: EAIP: Employer-at-Injury Program.

Source: DCBS, 2006c.

and new wages) must be paid. Thus, most workers receive wages and benefits that are almost equal to preinjury wages.

EAIP IMPACT

From December 2003 through January 2004, the DCBS conducted surveys of workers, employers, and vocational consultants who used the EAIP and found widespread satisfaction with the program (DCBS, 2004b). Ninety-six percent of employers said that they would use the program again. Wage reimbursement and positive influences on the worker (e.g., attitude and productivity) were most often cited as beneficial features. Suggestions for improving the program centered on streamlining the approval and reimbursement processes. Among workers surveyed, 74 percent thought their jobs were good fits for them, 42 percent ultimately returned to their regular work, and 8 percent returned to work with modifications. The DCBS survey of vocational consultants found that the program (especially wage subsidies) was very popular with them. Suggestions for improving the program centered on increased awareness of the program and streamlining the reimbursement process.

The DCBS has estimated that for $7.3 million spent on wage reimbursements under the EAIP in 2000, there was a $10.8 million savings in time-loss benefits among claims evaluated in the 13th quarter after injury (DCBS, 2004a).

DCBS staff members we spoke with "absolutely" recommend the EAIP to other states. They said that implementation of the EAIP has likely reduced the need for the vocational assistance program and for the PWP, reduced the duration of disability, and averted or minimized permanent disability awards. However, data are not available to prove these claims.

All system participants we interviewed spoke positively about the EAIP. One self-insurer said that job retention, or "keeping workers on the property," is the key to return to work and that the EAIP helps promote this. Most large employers told us they are committed to modified-work programs and would probably do the same thing in the absence of the EAIP. Some said that the EAIP encourages them to bring workers back to work earlier and be more creative in designing a modified-work program. One self-insurer spoke of developing temporary light-duty assignments. For example, a welder who hurt a hand may be assigned to be a crossing guard at full pay for two weeks to allow his hand to heal. The self-insurer pointed out that modified-work programs help improve employee morale and minimize friction between the management and labor.

VOCATIONAL ASSISTANCE PROGRAM

Insurers and self-insurers provide vocational assistance services, usually through professional rehabilitation organizations. The test for eligibility for the vocational assistance program is a substantial handicap, which in general means the worker has a permanent disability that prevents reemployment in any job that pays at least 80 percent of the preinjury wage. Benefits available under the vocational assistance program include maintenance indemnity payments (equal to temporary total disability benefits) during retraining; necessary expenses, including tuition, books, some travel costs, and tools; and professional rehabilitation services, such as plan development, counseling, and placement. Maximum program duration is 16 months of training (21 months in exceptional cases) plus 4 months of direct employment services. The typical eligible worker receives 10 months of training followed by job placement services (DCBS, 2006b).

Table 5.4 summarizes the activity of the vocational assistance program from fiscal years 1991 through 2005. In that period the number of cases opened fell 49.3 percent, from 1,432 in 1991 to 726 in 2005. DCBS officials offered two reasons for the decline in use of vocational assistance. First, legislation in 1988 limited eligibility for the program.[7] Second, legislation in 1990 permitted compromise and release of worker rights and employer liabilities (known as claim disposition agreements in Oregon). According to DCBS officials, since then those agreements have become a much-used means of ending a worker's eligibility for vocational assistance in exchange for a cash settlement.

DCBS internal data on cases with vocational assistance closed in 2005 show that 4 cases involved direct employment plans and 264 cases involved training plans. Among 631 cases closed, 286 were closed because of a compromise-and-release agreement.

VOCATIONAL ASSISTANCE PROGRAM IMPACT

Few workers return to work as a result of vocational assistance: just 143 workers in 2005 compared with 895 in 1991. The declining number of vocational assis-

[7] House Bill 2900, effective 1988, limited eligibility to workers who could pass a new test for substantial handicap. The legislation also removed from eligibility those workers whose five-year aggravation rights had expired.

Table 5.4 Activity of the Vocational Assistance Program, 1991–2005

Fiscal Year	Cases Opened	Cases Closed	Reported Costs, Closed Cases (in millions)	Average Cost Per Closed Case
1991	1,432	2,294	$25.5	$11,127
1992	1,277	1,757	$20.2	$11,482
1993	1,332	1,498	$17.9	$11,967
1994	1,187	1,316	$15.4	$11,682
1995	1,192	1,331	$14.8	$11,100
1996	1,064	1,196	$14.2	$11,861
1997	816	937	$12.0	$12,778
1998	756	813	$10.8	$13,268
1999	739	690	$9.0	$13,005
2000	714	610	$9.2	$15,112
2001	755	607	$9.2	$15,105
2002	737	627	$9.8	$15,691
2003	782	586	$9.7	$16,595
2004	765	629	$10.4	$16,578
2005	726	631	$10.3	$16,310
Percentage change	−49.3%	−72.5%	−59.6%	46.6%
Annual average percentage change	−4.7%	−8.8%	—	—
Annual average percentage change, adjusted for inflation	—	—	−8.7%	0.1%

Source: DCBS, 2006b.

tance cases reflects, in part, statutory changes that restrict vocational assistance to the most severely injured workers lacking transferable skills. As discussed earlier, DCBS data show that workers who completed a vocational assistance plan had better outcomes regarding return to work and recovery of wages (see Tables 5.1 and 5.2).

Between December 2003 and January 2004, the DCBS conducted customer surveys of workers who completed vocational assistance plans and found that 59 percent were satisfied or very satisfied with their plan. Workers who received training considered it very important. However, only 48 percent of workers said that they completed their vocational assistance plans (DCBS, 2004b).[8]

Preferred Worker Program

The purpose of the PWP is to help injured workers who are not able to return to regular work find new employment (with the preinjury employer or new employer) by offering incentives to employers. The current version of the PWP was developed in 1990, although incentives such as wage subsidies and work-site modifications were available many years earlier in Oregon. To be eligible, a worker must have a permanent disability as a result of a compensable injury and must not have been released to regular employment.

By rule the insurer or self-insurer is responsible for notifying eligible workers about assistance available from the PWP. This occurs within five days of a worker's release for work by the treating physician after the worker has been determined to have reached maximum medical improvement, on determination of eligibility or ineligibility for vocational assistance, or on approval of a compromise-and-release agreement.

The WCD automatically issues a Preferred Worker Identification Card to an eligible worker when the insurer or self-insurer reports, as part of initial claim closure, that the worker is released to restricted duty because of a compensable condition. Most cards are issued during the initial claim closure process. An information sheet accompanies the card. The card informs a prospective employer that it may be eligible for program benefits by employing the preferred worker (Maier, 2003). A worker can also request qualification as a preferred worker by contacting the WCD. A preferred worker has three years from identification to start using the program's benefits.

From 1990 until July 2005, the PWP was totally a worker-initiated program. The worker was responsible for finding a job, letting the employer know about the benefits available through the program, and negotiating getting a job using the PWP incentives. In 2004 the Management–Labor Advisory Committee recommended that the rules allow the preinjury employer to use the program with-

[8] Following its review of the vocational assistance program in 2004, the Management–Labor Advisory Committee supported a package of law and administrative changes to improve flexibility and speed delivery of vocational assistance programs.

out affecting the worker-initiated part of the program. The program was changed (effective July 1, 2005) to allow preinjury employers to take advantage of the incentives.

Recently the WCD has provided additional services to workers in conjunction with the PWP. Preferred workers are informed about Job Match, a program available only to preferred workers and employers who want to hire them. Job Match is an on-line listing of job openings along with other state employment resources. In addition to Job Match, employers can place orders with the Oregon Employment Department asking for preferred worker candidates, and preferred workers can indicate they want to use PWP incentives when they sign up at the Employment Department. This makes it possible for the Employment Department to match preferred workers with available jobs.

An employer who hires a preferred worker is entitled to the following benefits:

- *Wage subsidy:* The employer receives reimbursement of 50 percent of the preferred worker's wages for up to six months.[9]
- *Premium exemption:* The employer does not have to pay workers' compensation premiums for the worker for three years. If the worker moves to a new job within the three-year period, the premium exemption may be transferred to the new employer.
- *Claim cost reimbursement:* If the worker suffers a new injury during the three-year exemption period, the WCD reimburses the insurer or self-insurer for all claim costs, including administrative costs, related to the injury for the life of the claim.
- *Reimbursement or WCD payment for work-site modification.* Work-site modification may involve changing the workstation or work site, or modifying job duties. Up to $25,000 can be reimbursed or paid by the WCD during the eligibility period, for one or two jobs.
- *Reimbursement or WCD payment for purchases related to obtaining employment:* Such expenses include tuition, books, and fees (up to $1,000); lodging, meals, and travel expenses to attend training (up to $500); tools and equipment (up to $2,000); clothing (up to $400); union dues (initiation fees or back dues and current dues for one month); licenses and related costs necessary for occupational certification (up to $500); and moving expenses.

[9] Higher benefits are available for employers hiring preferred workers with exceptional levels of disability.

The WCD delivers these benefits through contracts between preferred workers and their employers.[10] In Multnomah County (which includes Portland), the WCD has initiated a pilot program that works with the state's Office of Vocational Rehabilitation Services to provide job placement assistance to workers residing in that county.

CONTRACT ACTIVITY AND PROGRAM PARTICIPATION

Table 5.5 shows the number and types of individual contracts written under the PWP from 1991 through 2005. DCBS officials told us that in any fiscal year, the number of workers using PWP benefits is roughly equal to the number of contracts involving premium relief and exemption (451 contracts in fiscal year 2006). Work-site modifications and obtained-employment purchases are included in more than half of the contracts involving premium relief and exemption.

As shown in Table 5.6, PWP expenditures totaled $7.6 million in fiscal year 2006. Of that amount, wage subsidies ($2.7 million) represented the largest portion, followed by work-site modifications ($2.4 million), claim cost reimbursements ($2.2 million), and purchases related to obtaining employment ($0.3 million).

Table 5.7 shows that the number of PWP cards issued has declined by 52.1 percent from 4,189 in fiscal year 1991 to 2,006 in 2006. When we asked WCD officials about the decrease, they said a worker may not receive a card automatically if the insurer or self-insurer fails to correctly complete the closure form (Form 1503). The WCD sends a letter to each worker whose claim was initially closed with permanent disability but who did not receive a PWP card automatically. The letter invites the worker to call program staff to discuss eligibility. WCD officials told us that the response rate from those letters is 7–9 percent. The WCD also sends a letter to a worker who settled a claim through a compromise-and-release agreement and has not yet received a card. No mechanism exists for automatically issuing a PWP card to a worker with a settlement; the worker must contact the WCD to obtain a card. This suggests some missed opportunities to notify eligible workers of their right to participate in the PWP.

[10] More information about the Preferred Worker Program is available on the DCBS Web site at http://www.cbs.state.or.us/external/wcd/rdrs/rau/pwp/pwp_index.html.

Table 5.5 Activity of the Preferred Worker Program, 1991–2006

Fiscal Year	PWP Contracts Involving			
	Premium Exemptions[a]	Wage Subsidies	Work-Site Modifications	Obtained-Employment Purchases
1991	1,046	999	201	88
1992	1,043	957	379	215
1993	1,005	965	396	225
1994	979	1,040	513	317
1995	976	1,007	372	406
1996	1,110	1,149	496	586
1997	1,019	1,097	469	610
1998	908	1,012	450	640
1999	725	818	373	605
2000	633	700	341	397
2001	570	622	262	312
2002	440	495	230	283
2003	410	472	206	233
2004	473	513	240	245
2005	434	449	247	244
2006	451	487	255	254
Percentage change	−56.9%	−51.3%	26.9%	188.6%
Annual average percentage change	−5.5%	−4.7%	1.6%	7.3%

Note: Each of the program's benefits is counted as a separate contract.

[a] According to DCBS officials, in any fiscal year, the number of workers using PWP benefits is roughly equal to the number of contracts involving premium relief and exemption.

Key: PWP: Preferred Worker Program.

Source: DCBS, 2006b.

Table 5.6 Expenditures of the Preferred Worker Program, 1991–2006

Fiscal Year	Wage Subsidies (in millions)	Work-Site Modifications (in millions)	Obtained-Employment Purchases (in millions)	Claim Cost Reimbursements (in millions)	Total Expenditures (in millions)
1991	$3.1	$0.7	$0.1	$0.0	$3.9
1992	$3.2	$1.9	$0.1	$0.4	$5.6
1993	$2.8	$2.0	$0.1	$1.1	$6.1
1994	$3.5	$2.8	$0.3	$1.9	$8.4
1995	$3.7	$2.5	$0.3	$2.6	$9.1
1996	$3.8	$2.7	$0.5	$3.1	$10.1
1997	$4.9	$3.1	$0.6	$3.2	$11.8
1998	$4.4	$3.4	$0.7	$3.2	$11.7
1999	$4.6	$2.6	$0.6	$3.7	$11.5
2000	$3.8	$2.3	$0.4	$3.4	$9.9
2001	$3.9	$2.0	$0.3	$3.0	$9.2
2002	$2.9	$1.9	$0.3	$3.1	$8.2
2003	$2.7	$1.7	$0.2	$2.4	$7.0
2004	$3.1	$2.2	$0.2	$2.7	$8.2
2005	$3.0	$2.3	$0.2	$2.0	$7.5
2006	$2.7	$2.4	$0.3	$2.2	$7.6
Percentage change	−12.3%	221.8%	352.5%	493.5%[a]	95.3%
Percentage change adjusted for inflation	−41.0%	116.6%	204.6%	313.9%[a]	31.5%
Annual average percentage change, adjusted for inflation	−3.5%	5.3%	7.7%	10.7%[a]	1.8%

Note: Components may not add up to total because of rounding.

[a] Calculated from 1992 through 2006.

Source: DCBS, 2006b.

As noted in Table 5.7, about one-fifth of workers with PWP cards issued in fiscal year 2003 used PWP benefits. We asked public officials and private participants about this participation statistic and they offered three major explanations. First, some workers are unaware of the program and how it works. Second, implementation of the EAIP may have resulted in fewer workers needing PWP assistance in becoming reemployed. Third, some workers are reluctant to identify

Table 5.7 Participation in the Preferred Worker Program, 1991–2006

Fiscal Year	PWP Cards Issued	Workers Using PWP Benefits	Workers Using PWP Benefits per 100 PWP Cards Issued
1991	4,189	1,523	36.4
1992	3,548	1,116	31.5
1993	3,104	990	31.9
1994	3,351	981	29.3
1995	3,627	1,114	30.7
1996	4,223	1,102	26.1
1997	3,535	957	27.1
1998	2,938	759	25.8
1999	2,814	605	21.5
2000	2,469	573	23.2
2001	2,316	534	23.1
2002	2,590	516	19.9
2003	2,238	491	21.9
2004	2,147	n/a	n/a
2005	2,235	n/a	n/a
2006	2,006	n/a	n/a
Percentage change	−52.1%	−67.8%	−39.7%
Annual average percentage change	−4.8%	−9.0%	−4.1%

Key: n/a: not available; PWP: Preferred Worker Program.
Source: DCBS, 2006b.

themselves as disabled and thus choose not to inform their prospective or new employers of their preferred worker status.

PWP IMPACT

As discussed earlier, DCBS data on the PWP show that, during the 13th quarter after injury, employment rates for workers who used the PWP have been at least 20 percentage points higher than eligible workers who did not use the program (DCBS, 2006b).[11]

A WCD survey (conducted from December 2003 through January 2004) found that among workers who used the PWP, 92 percent would use the program again and considered all parts of the program valuable (DCBS, 2004b). Eighty-five percent of those surveyed were not familiar with the availability of Job Match listings posted on the Internet. The survey also revealed that among workers who were eligible for the PWP but did not use it, 94 percent said they plan to use it. Some workers said they feared revealing themselves as injured workers, and some were not sure what benefits were available. Fifty-nine percent of workers were unaware that they could use the program for their preinjury employers, and 68 percent did not use Job Match, primarily because they did not know it existed.

Reemployment "Safety Net" for Workers Who Settle Their Claims

In most states WCRI has studied, when a worker settles a claim with a compromise-and-release agreement, the worker waives all future rights to workers' compensation benefits. This usually includes indemnity and medical benefits and (increasingly) rights to future vocational rehabilitation benefits in return for receipt of a lump-sum payment.[12]

If the worker has not returned to work at the time of the compromise-and-release agreement, often he or she must use the lump-sum payment to pay for subsistence expenses and the cost of finding another job. This leads to the question, "What if workers exhaust their lump-sum settlements and have not returned to work?" Anecdotally, workers appear to rely on other social programs, such as unemployment insurance or welfare.

Oregon policymakers have fashioned a safety net (i.e., added protection) for workers who have exhausted their lump-sum payments and still need help becoming reemployed. The protection comes in the form of eligibility to take advantage of return-to-work incentives inherent in the PWP after a settlement. Most workers' representatives we spoke with regard this as a valuable safeguard.

How well is the PWP safety net working in Oregon? DCBS internal data for

[11] These figures exclude workers who were also eligible for vocational assistance.

[12] In some states waiver of future vocational rehabilitation benefits in return for a lump-sum payment is known as a "voc rehab buy-out."

fiscal year 2004 show that 373 of 1,471 total PWP contracts were started after workers settled their claims. This suggests that about one-fifth of workers using the PWP are using its safety-net feature.

Summary

The package of programs available to Oregon workers—the EAIP, the vocational assistance program, and the PWP—appears to provide a comprehensive approach to stimulating return to work for injured workers, along with the system's worker safety net. Public officials acknowledge that additional improvement in these programs is possible and that, through the Management–Labor Advisory Committee, they are continually evaluating the programs and considering ways to improve outcomes.

References

Ballantyne, D. 2004. *Workers' compensation in Iowa: Administrative inventory.* Cambridge, MA: Workers Compensation Research Institute.

Department of Consumer and Business Services (DCBS). 2001. *Oregon workers' compensation: Monitoring the key components of legislative reform.* Retrieved from http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?fuseaction=version_view&version_tk=175171&ProgID=FEARA006 (accessed January 4, 2008).

———. 2004a. *Program evaluation—Overview.* Retrieved from http://www.oregon.gov/DCBS/MLAC/docs/support_docs/2_19_04_programevaluation.pdf (accessed January 4, 2008).

———. 2004b. *Return-to-work customer surveys, December 2003–January 2004.* Retrieved from http://www.oregon.gov/DCBS/MLAC/docs/support_docs/2_19_04_rtwcustsurveys.pdf (accessed January 12, 2008).

———. 2004c. *Workers' compensation insurer medical examination study.* Retrieved from http://www.cbs.state.or.us/wcd/communications/imestudyrpt.pdf (accessed January 7, 2008).

———. 2005a. *Biennial report on the Oregon workers' compensation system, seventh edition: January 2005.* Retrieved from http://www.cbs.state.or.us/external/imd/rasums/2362/05web/05_2362.pdf (accessed January 4, 2008).

———. 2005b. *Workers' compensation benefits: How do Oregon's restructured disability benefits rank nationally?* Retrieved from http://dcbs-reports.cbs.state.or.us/rpt/index.cfm?fuseaction=version_view&version_tk=176012&ProgID=CCRA060 (accessed January 4, 2008).

———. 2006a. *2006 Oregon workers' compensation premium rate ranking summary.* Retrieved from http://www.cbs.state.or.us/imd/rasums/2082/06web/06_2082.pdf (accessed January 4, 2008).

———. 2006b. *Biennial report on the Oregon workers' compensation system, eighth edition: December 2006.* Retrieved from http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?fuseaction=version_view&version_tk=178007&ProgID=FEARA006 (accessed January 7, 2008).

———. 2006c. Various characteristics of the workers' compensation system, calendar years 1968–2006. Retrieved from http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?fuseaction=version_view&version_tk=176229&ProgID=CCRA020 (accessed January 13, 2008).

———. 2007a. *Department of Consumer and Business Services: Annual performance progress report (APPR) for fiscal year 2005–06.* Retrieved from http://www.oregon.gov/DAS/OPB/docs/APPR06/ConsBusSrv_APPR06.pdf (accessed January 7, 2008).

———. 2007b. *Quarterly claims processing performance audit: Industry average.* Retrieved from http://www.cbs.state.or.us/external/wcd/compliance/fau/avgfile.pdf (accessed January 7, 2008).

Maier, M. 2001. *The Employer-at-Injury Program, 2000.* Department of Consumer and Business Services. Retrieved from http://www.cbs.state.or.us/external/imd/rasums/3123/web00/3123.htm (accessed January 4, 2008).

———. 2003. *Oregon workers' compensation return-to-work programs, 2003.* Department of Consumer and Business Services. Retrieved from http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?fuseaction=version_view&version_tk=175941&ProgID=CERA006 (accessed January 4, 2008).

Oregon Workers' Compensation Division. 2003 (Summer/Fall). *Workers' compensation focus* VII (1).Retrieved from http://www.cbs.state.or.us/wcd/communications/publications/focus/summer03.pdf (accessed January 7, 2008).

———. 2005. *Workers' compensation focus on the 2005 legislature* IX (2). Legislative special edition. Retrieved from http://www.cbs.state.or.us/wcd/communications/publications/focus/legis05.pdf (accessed January 4, 2008).

Reville, R., L. Boden, J. Biddle, and C. Mardesich. 2001. *An evaluation of New Mexico workers' compensation permanent partial disability and return to work.* Santa Monica, CA: RAND.

U.S. Department of Labor, Bureau of Labor Statistics. 2007. Table 5: Union affiliation of employed wage and salary workers by state. Washington, DC: U.S. Government Printing Office. Retrieved from http://www.bls.gov/news.release/union2.t05.htm (accessed January 4, 2008).

U.S. Department of Labor, Office of Workers' Compensation Programs. 2006. Table 6: Benefits for temporary total disability provided by workers' compensation statutes in the U.S. Retrieved from http://www.dol.gov/esa/regs/statutes/owcp/stwclaw/tables-pdf/table6.pdf (accessed January 7, 2008).

OTHER WCRI PUBLICATIONS

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THE ANATOMY OF WORKERS' COMPENSATION MEDICAL COSTS AND UTILIZATION IN WISCONSIN, 6TH EDITION. Stacey M. Eccleston, Petia Petrova, and Xiaoping Zhao. February 2007. WC-07-09.

BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 2006. Stacey M. Eccleston and Te-Chun Liu. October 2006. WC-06-14.

ANALYSIS OF THE WORKERS' COMPENSATION MEDICAL FEE SCHEDULES IN ILLINOIS. Stacey M. Eccleston. July 2006. WC-06-28.

STATE POLICIES AFFECTING THE COST AND USE OF PHARMACEUTICALS IN WORKERS' COMPENSATION: A NATIONAL INVENTORY. Richard A. Victor and Petia Petrova. June 2006. WC-06-30.

THE COST AND USE OF PHARMACEUTICALS IN WORKERS' COMPENSATION: A GUIDE FOR POLICYMAKERS. Richard A. Victor and Petia Petrova. June 2006. WC-06-13.

HOW DOES THE MASSACHUSETTS FEE SCHEDULE COMPARE TO PRICES ACTUALLY PAID IN WORKERS' COMPENSATION? Stacey M. Eccleston. April 2006. wc-06-27.

THE IMPACT OF PROVIDER CHOICE ON WORKERS' COMPENSATION COSTS AND OUTCOMES. Richard A. Victor, Peter S. Barth, and David Neumark, with the assistance of Te-Chun Liu. November 2005. WC-05-14.

ADVERSE SURPRISES IN WORKERS' COMPENSATION: CASES WITH SIGNIFICANT UNANTICIPATED MEDICAL CARE AND COSTS. Richard A. Victor. June 2005. WC-05-16.

WCRI FLASHREPORT: *ANALYSIS OF THE PROPOSED WORKERS' COMPENSATION FEE SCHEDULE IN TENNESSEE.* Stacey M. Eccleston and Xiaoping Zhao. January 2005. FR-05-01.

WCRI FLASHREPORT: *ANALYSIS OF SERVICES DELIVERED AT CHIROPRACTIC VISITS IN TEXAS COMPARED TO OTHER STATES.* Stacey M. Eccleston and Xiaoping Zhao. July 2004. FR-04-07.

WCRI FLASHREPORT: *SUPPLEMENT TO BENCHMARKING THE 2004 PENNSYLVANIA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE.* Stacey M. Eccleston and Xiaoping Zhao. May 2004. FR-04-06.

WCRI FLASHREPORT: *IS CHIROPRACTIC CARE A COST DRIVER IN TEXAS? RECONCILING STUDIES BY WCRI AND MGT/TEXAS CHIROPRACTIC ASSOCIATION.* April 2004. FR-04-05.

WCRI FLASHREPORT: *POTENTIAL IMPACT OF A LIMIT ON CHIROPRACTIC VISITS IN TEXAS.* Stacey M. Eccleston. April 2004. FR-04-04.

WCRI FLASHREPORT: *ARE HIGHER CHIROPRACTIC VISITS PER CLAIM DRIVEN BY "OUTLIER" PROVIDERS?* Richard A. Victor. April 2004. FR-04-03.

WCRI FLASHREPORT: *BENCHMARKING THE 2004 PENNSYLVANIA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE.* Stacey M. Eccleston and Xiaoping Zhao. March 2004. FR-04-01.

EVIDENCE OF EFFECTIVENESS OF POLICY LEVERS TO CONTAIN MEDICAL COSTS IN WORKERS' COMPENSATION. Richard A. Victor. November 2003. WC-03-08.

WCRI MEDICAL PRICE INDEX FOR WORKERS' COMPENSATION. Dongchun Wang and Xiaoping Zhao. October 2003. wc-03-05.

WCRI FLASHREPORT: *WHERE THE MEDICAL DOLLAR GOES? HOW CALIFORNIA COMPARES TO OTHER STATES.* Richard A. Victor and Stacey M. Eccleston. March 2003. FR-03-03.

PATTERNS AND COSTS OF PHYSICAL MEDICINE: COMPARISON OF CHIROPRACTIC AND PHYSICIAN-DIRECTED CARE. Richard A. Victor and Dongchun Wang. December 2002. WC-02-07.

PROVIDER CHOICE LAWS, NETWORK INVOLVEMENT, AND MEDICAL COSTS. Richard A. Victor, Dongchun Wang, and Philip Borba. December 2002. WC-02-05.

WCRI FLASHREPORT: *ANALYSIS OF PAYMENTS TO HOSPITALS AND SURGERY CENTERS IN FLORIDA WORKERS' COMPENSATION.* Stacey M. Eccleston and Xiaoping Zhao. December 2002. FR-02-03.

BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 2001–2002. Stacey M. Eccleston, Aniko Laszlo, Xiaoping Zhao, and Michael Watson. August 2002. WC-02-02.

WCRI FLASHREPORT: *CHANGES IN MICHIGAN'S WORKERS' COMPENSATION MEDICAL FEE SCHEDULE: 1996–2002.* Stacey M. Eccleston. December 2002. FR-02-02.

TARGETING MORE COSTLY CARE: AREA VARIATION IN TEXAS MEDICAL COSTS AND UTILIZATION. Richard A. Victor and N. Michael Helvacian. May 2002. WC-02-03.

WCRI FLASHREPORT: *COMPARING THE PENNSYLVANIA WORKERS' COMPENSATION FEE SCHEDULE WITH MEDICARE RATES: EVIDENCE FROM 160 IMPORTANT MEDICAL PROCEDURES.* Richard A. Victor, Stacey M. Eccleston, and Xiaoping Zhao. November 2001. FR-01-07.

WCRI FLASHREPORT: *BENCHMARKING PENNSYLVANIA'S WORKERS' COMPENSATION MEDICAL FEE SCHEDULE.* Stacey M. Eccleston and Xiaoping Zhao. October 2001. FR-01-06.

WCRI FLASHREPORT: *BENCHMARKING CALIFORNIA'S WORKERS' COMPENSATION MEDICAL FEE SCHEDULES.* Stacey M. Eccleston. August 2001. FR-01-04.

MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION: A NATIONAL INVENTORY, 2001–2002. Ramona P. Tanabe and Susan M. Murray. December 2001. WC-01-04.

WCRI FLASHREPORT: *BENCHMARKING FLORIDA'S WORKERS' COMPENSATION MEDICAL FEE SCHEDULES.* Stacey M. Eccleston and Aniko Laszlo. August 2001. FR-01-03.

THE IMPACT OF INITIAL TREATMENT BY NETWORK PROVIDERS ON WORKERS' COMPENSATION MEDICAL COSTS AND DISABILITY PAYMENTS. Sharon E. Fox, Richard A. Victor, Xiaoping Zhao, and Igor Polevoy. August 2001. DM-01-01.

THE IMPACT OF WORKERS' COMPENSATION NETWORKS ON MEDICAL AND DISABILITY PAYMENTS. William G. Johnson, Marjorie L. Baldwin, and Steven C. Marcus. November 1999. WC-99-5.

FEE SCHEDULE BENCHMARK ANALYSIS: OHIO. Philip L. Burstein. December 1996. FS-96-1.

THE RBRVS AS A MODEL FOR WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: PROS AND CONS. Philip L. Burstein. July 1996. WC-96-5.

BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 1995–1996. Philip L. Burstein. May 1996. WC-96-2.

FEE SCHEDULE BENCHMARK ANALYSIS: NORTH CAROLINA. Philip L. Burstein. December 1995. FS-95-2.

FEE SCHEDULE BENCHMARK ANALYSIS: COLORADO. Philip L. Burstein. August 1995. FS-95-1.

BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 1994–1995. Philip L. Burstein. December 1994. WC-94-7.

REVIEW, REGULATE, OR REFORM: WHAT WORKS TO CONTROL WORKERS' COMPENSATION MEDICAL COSTS. Thomas W. Grannemann, ed. September 1994. WC-94-5.

FEE SCHEDULE BENCHMARK ANALYSIS: MICHIGAN. Philip L. Burstein. September 1994. FS-94-1.

MEDICOLEGAL FEES IN CALIFORNIA: AN ASSESSMENT. Leslie I. Boden. March 1994. WC-94-1.

BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES. Stacey M. Eccleston, Thomas W. Grannemann, and James F. Dunleavy. December 1993. WC-93-4.

HOW CHOICE OF PROVIDER AND RECESSIONS AFFECT MEDICAL COSTS IN WORKERS' COMPENSATION. Richard B. Victor and Charles A. Fleischman. June 1990. WC-90-2.

MEDICAL COSTS IN WORKERS' COMPENSATION: TRENDS & INTERSTATE COMPARISONS. Leslie I. Boden and Charles A. Fleischman. December 1989. WC-89-5.

WORKER OUTCOMES

COMPARING OUTCOMES FOR INJURED WORKERS IN NINE LARGE STATES. Sharon E. Belton, Richard A. Victor, and Te-Chun Liu, with the assistance of Pinghui Li. May 2007. WC-07-14.

COMPARING OUTCOMES FOR INJURED WORKERS IN SEVEN LARGE STATES. Sharon E. Fox, Richard A. Victor, and Te-Chun Liu, with the assistance of Pinghui Li. February 2006. WC-06-01.

WCRI FLASHREPORT: *WORKER OUTCOMES IN TEXAS BY TYPE OF INJURY.* Richard A. Victor. February 2005. FR-05-02.

OUTCOMES FOR INJURED WORKERS IN CALIFORNIA, MASSACHUSETTS, PENNSYLVANIA, AND TEXAS. Richard A. Victor, Peter S. Barth, and Te-Chun Liu, with the assistance of Pinghui Li. December 2003. WC-03-07.

OUTCOMES FOR INJURED WORKERS IN TEXAS. Peter S. Barth and Richard A. Victor, with the assistance of Pinghui Li and Te-Chun Liu. July 2003. WC-03-02.

THE WORKERS' STORY: RESULTS OF A SURVEY OF WORKERS INJURED IN WISCONSIN. Monica Galizzi, Leslie I. Boden, and Te-Chun Liu. December 1998. WC-98-5.

WORKERS' COMPENSATION MEDICAL CARE: EFFECTIVE MEASUREMENT OF OUTCOMES. Kate Kimpan. October 1996. WC-96-7.

BENEFITS AND RETURN TO WORK

FACTORS THAT INFLUENCE THE AMOUNT AND PROBABILITY OF PERMANENT PARTIAL DISABILITY BENEFITS. Philip S. Borba and Mike Helvacian. June 2006. WC-06-16.

RETURN-TO-WORK OUTCOMES OF INJURED WORKERS: EVIDENCE FROM CALIFORNIA, MASSACHUSETTS, PENNSYLVANIA, AND TEXAS. Sharon E. Fox, Philip S. Borba, and Te-Chun Liu. May 2005. WC-05-15.

WHO OBTAINS PERMANENT PARTIAL DISABILITY BENEFITS: A SIX STATE ANALYSIS. Peter S. Barth, N. Michael Helvacian, and Te-Chun Liu. December 2002. WC-02-04.

WCRI FLASHREPORT: *BENCHMARKING OREGON'S PERMANENT PARTIAL DISABILITY BENEFITS.* Duncan S. Ballantyne and Michael Manley. July 2002. FR-02-01.

WCRI FLASHREPORT: *BENCHMARKING FLORIDA'S PERMANENT IMPAIRMENT BENEFITS.* Richard A. Victor and Duncan S. Ballantyne. September 2001. FR-01-05.

PERMANENT PARTIAL DISABILITY BENEFITS: INTERSTATE DIFFERENCES. Peter S. Barth and Michael Niss. September 1999. WC-99-2.

MEASURING INCOME LOSSES OF INJURED WORKERS: A STUDY OF THE WISCONSIN SYSTEM—A WCRI Technical Paper. Leslie I. Boden and Monica Galizzi. November 1998.

PERMANENT PARTIAL DISABILITY IN TENNESSEE: SIMILAR BENEFITS FOR SIMILAR INJURIES? Leslie I. Boden. November 1997. WC-97-5.

WHAT ARE THE MOST IMPORTANT FACTORS SHAPING RETURN TO WORK? EVIDENCE FROM WISCONSIN. Monica Galizzi and Leslie I. Boden. October 1996. WC-96-6.

DO LOW TTD MAXIMUMS ENCOURAGE HIGH PPD UTILIZATION: RE-EXAMINING THE CONVENTIONAL WISDOM. John A. Gardner. January 1992. WC-92-2.

BENEFIT INCREASES AND SYSTEM UTILIZATION: THE CONNECTICUT EXPERIENCE. John A. Gardner. December 1991. WC-91-5.

DESIGNING BENEFIT STRUCTURES FOR TEMPORARY DISABILITY: A GUIDE FOR POLICYMAKERS—Two-Volume Publication. Richard B. Victor and Charles A. Fleischman. December 1989. WC-89-4.

RETURN TO WORK INCENTIVES: LESSONS FOR POLICYMAKERS FROM ECONOMIC STUDIES. John A. Gardner. June 1989 WC-89-2.

INCOME REPLACEMENT FOR LONG-TERM DISABILITY: THE ROLE OF WORKERS' COMPENSATION AND SSDI. Karen R. DeVol. December 1986. SP-86-2.

Cost Drivers and Benchmarks of System Performance

MONITORING 2002–2004 REFORMS IN CALIFORNIA: COMPSCOPE™ BENCHMARKS, 8TH EDITION. Carol A. Telles, Rui Yang, Evelina Radeva, and Ramona P. Tanabe, with the assistance of Igor Polevoy. January 2008. WC-08-01.

MONITORING 2003 REFORMS IN FLORIDA: COMPSCOPE™ BENCHMARKS, 8TH EDITION. Carol A. Telles, Rui Yang, Evelina Radeva, and Ramona P. Tanabe, with the assistance of Igor Polevoy. January 2008. WC-08-02.

BASELINE METRICS FOR MONITORING 2005 REFORMS IN ILLINOIS: COMPSCOPE™ BENCHMARKS, 8TH EDITION. Carol A. Telles, Rui Yang, Evelina Radeva, and Ramona P. Tanabe, with the assistance of Igor Polevoy. January 2008. WC-08-03.

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MONITORING 2004 TENNESSEE REFORMS: COMPSCOPE™ BENCHMARKS, 8TH EDITION. Carol A. Telles, Rui Yang, Evelina Radeva, and Ramona P. Tanabe, with the assistance of Igor Polevoy. January 2008. WC-08-10.

COMPSCOPE™ BENCHMARKS FOR WISCONSIN, 8TH EDITION. Carol A. Telles, Rui Yang, Evelina Radeva, and Ramona P. Tanabe, with the assistance of Igor Polevoy. January 2008. WC-08-11.

WHY ARE BENEFIT DELIVERY EXPENSES HIGHER IN CALIFORNIA AND FLORIDA? Duncan S. Ballantyne and Carol A. Telles. December 2002. WC-02-06.

COMPSCOPE™ BENCHMARKS: MASSACHUSETTS, 1994–1999. Carol A. Telles, Aniko Laszlo, and Te-Chun Liu. January 2002. CS-01-03.

COMPSCOPE™ BENCHMARKS: FLORIDA, 1994–1999. N. Michael Helvacian and Seth A. Read. September 2001. CS-01-1

WCRI FLASHREPORT: *WHERE THE WORKERS' COMPENSATION DOLLAR GOES.* Richard A. Victor and Carol A. Telles. August 2001. FR-01-01.

PREDICTORS OF MULTIPLE WORKERS' COMPENSATION CLAIMS IN WISCONSIN. Glenn A. Gotz, Te-Chun Liu, and Monica Galizzi. November 2000. WC-00-7.

AREA VARIATIONS IN TEXAS BENEFIT PAYMENTS AND CLAIM EXPENSES. Glenn A. Gotz, Te-Chun Liu, Christopher J. Mazingo, and Douglas J. Tattrie. May 2000. WC-00-3.

AREA VARIATIONS IN CALIFORNIA BENEFIT PAYMENTS AND CLAIM EXPENSES. Glenn A. Gotz, Te-Chun Liu, and Christopher J. Mazingo. May 2000. WC-00-2.

AREA VARIATIONS IN PENNSYLVANIA BENEFIT PAYMENTS AND CLAIM EXPENSES. Glenn A. Gotz, Te-Chun Liu, and Christopher J. Mazingo. May 2000. WC-00-1.

BENCHMARKING THE PERFORMANCE OF WORKERS' COMPENSATION SYSTEMS: COMPSCOPE™ MEASURES FOR MINNESOTA. H. Brandon Haller and Seth A. Read. June 2000. CS-00-2.

BENCHMARKING THE PERFORMANCE OF WORKERS' COMPENSATION SYSTEMS: COMPSCOPE™ MEASURES FOR MASSACHUSETTS. Carol A. Telles and Tara L. Nells. December 1999. CS-99-3.

BENCHMARKING THE PERFORMANCE OF WORKERS' COMPENSATION SYSTEMS: COMPSCOPE™ MEASURES FOR CALIFORNIA. Sharon E. Fox and Tara L. Nells. December 1999. CS-99-2.

BENCHMARKING THE PERFORMANCE OF WORKERS' COMPENSATION SYSTEMS: COMPSCOPE™ MEASURES FOR PENNSYLVANIA. Sharon E. Fox and Tara L. Nells. November 1999. CS-99-1.

COST DRIVERS AND SYSTEM PERFORMANCE IN A COURT-BASED SYSTEM: TENNESSEE. John A. Gardner, Carol A. Telles, and Gretchen A. Moss. June 1996. WC-96-4.

THE 1991 REFORMS IN MASSACHUSETTS: AN ASSESSMENT OF IMPACT. John A. Gardner, Carol A. Telles, and Gretchen A. Moss. May 1996. WC-96-3.

THE IMPACT OF OREGON'S COST CONTAINMENT REFORMS. John A. Gardner, Carol A. Telles, and Gretchen A. Moss. February 1996. WC-96-1.

COST DRIVERS AND SYSTEM CHANGE IN GEORGIA, 1984–1994. John A. Gardner, Carol A. Telles, and Gretchen A. Moss. November 1995. WC-95-3.

COST DRIVERS IN MISSOURI. John A. Gardner, Richard A. Victor, Carol A. Telles, and Gretchen A. Moss. December 1994. WC-94-6.

COST DRIVERS IN NEW JERSEY. John A. Gardner, Richard A. Victor, Carol A. Telles, and Gretchen A. Moss. September 1994. WC-94-4.

COST DRIVERS IN SIX STATES. Richard A. Victor, John A. Gardner, Daniel Sweeney, and Carol A. Telles. December 1992. wc-92-9.

PERFORMANCE INDICATORS FOR PERMANENT DISABILITY: LOW-BACK INJURIES IN TEXAS. Sara R. Pease. August 1988. WC-88-4.

PERFORMANCE INDICATORS FOR PERMANENT DISABILITY: LOW-BACK INJURIES IN NEW JERSEY. Sara R. Pease. December 1987. WC-87-5.

PERFORMANCE INDICATORS FOR PERMANENT DISABILITY: LOW-BACK INJURIES IN WISCONSIN. Sara R. Pease. December 1987. wc-87-4.

ADMINISTRATION/LITIGATION

WORKERS' COMPENSATION IN MONTANA: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. March 2007. WC-07-12.

WORKERS' COMPENSATION IN NEVADA: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. December 2006. WC-06-15.

WORKERS' COMPENSATION IN HAWAII: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. April 2006. WC-06-12.

WORKERS' COMPENSATION IN ARKANSAS: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. August 2005. WC-05-18.

WORKERS' COMPENSATION IN MISSISSIPPI: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. May 2005. WC-05-13.

WORKERS' COMPENSATION IN ARIZONA: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. September 2004. WC-04-05.

WORKERS' COMPENSATION IN IOWA: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. April 2004. WC-04-02.

WCRI FLASHREPORT: *MEASURING THE COMPLEXITY OF THE WORKERS' COMPENSATION DISPUTE RESOLUTION PROCESSES IN TENNESSEE.* Richard A. Victor. April 2004. FR-04-02.

REVISITING WORKERS' COMPENSATION IN MISSOURI: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. December 2003. WC-03-06.

WORKERS' COMPENSATION IN TENNESSEE: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. April 2003. WC-03-01.

REVISITING WORKERS' COMPENSATION IN NEW YORK: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. January 2002. wc-01-05.

WORKERS' COMPENSATION IN KENTUCKY: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. June 2001. WC-01-01.

WORKERS' COMPENSATION IN OHIO: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. October 2000. WC-00-5.

WORKERS' COMPENSATION IN LOUISIANA: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. November 1999. WC-99-4.

WORKERS' COMPENSATION IN FLORIDA: ADMINISTRATIVE INVENTORY. Peter S. Barth. August 1999. WC-99-3.

MEASURING DISPUTE RESOLUTION OUTCOMES: A LITERATURE REVIEW WITH IMPLICATIONS FOR WORKERS' COMPENSATION. Duncan S. Ballantyne and Christopher J. Mazingo. April 1999. WC-99-1.

REVISITING WORKERS' COMPENSATION IN CONNECTICUT: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. September 1998. WC-98-4.

DISPUTE PREVENTION AND RESOLUTION IN WORKERS' COMPENSATION: A NATIONAL INVENTORY, 1997–1998. Duncan S. Ballantyne. May 1998. WC-98-3.

WORKERS' COMPENSATION IN OKLAHOMA: ADMINISTRATIVE INVENTORY. Michael Niss. April 1998. WC-98-2.

WORKERS' COMPENSATION ADVISORY COUNCILS: A NATIONAL INVENTORY, 1997–1998. Sharon E. Fox. March 1998. WC-98-1.

THE ROLE OF ADVISORY COUNCILS IN WORKERS' COMPENSATION SYSTEMS: OBSERVATIONS FROM WISCONSIN. Sharon E. Fox. November 1997.

REVISITING WORKERS' COMPENSATION IN MICHIGAN: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne and Lawrence Shiman. October 1997. WC-97-4.

REVISITING WORKERS' COMPENSATION IN MINNESOTA: ADMINISTRATIVE INVENTORY. Carol A. Telles and Lawrence Shiman. September 1997. WC-97-3.

REVISITING WORKERS' COMPENSATION IN CALIFORNIA: ADMINISTRATIVE INVENTORY. Carol A. Telles and Sharon E. Fox. June 1997. WC-97-2.

REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne. March 1997. WC-97-1.

REVISITING WORKERS' COMPENSATION IN WASHINGTON: ADMINISTRATIVE INVENTORY. Carol A. Telles and Sharon E. Fox. December 1996. WC-96-10.

WORKERS' COMPENSATION IN ILLINOIS: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne and Karen M. Joyce. November 1996. WC-96-9.

WORKERS' COMPENSATION IN COLORADO: ADMINISTRATIVE INVENTORY. Carol A. Telles and Sharon E. Fox. October 1996. WC-96-8.

WORKERS' COMPENSATION IN OREGON: ADMINISTRATIVE INVENTORY. Duncan S. Ballantyne and James F. Dunleavy. December 1995. WC-95-2.

REVISITING WORKERS' COMPENSATION IN TEXAS: ADMINISTRATIVE INVENTORY. Peter S. Barth and Stacey M. Eccleston. April 1995. wc-95-1.

WORKERS' COMPENSATION IN VIRGINIA: ADMINISTRATIVE INVENTORY. Carol A. Telles and Duncan S. Ballantyne. April 1994. WC-94-3.

workers' compensation in new jersey: administrative inventory. Duncan S. Ballantyne and James F. Dunleavy. April 1994. WC-94-2.

workers' compensation in north carolina: administrative inventory. Duncan S. Ballantyne. December 1993. WC-93-5.

workers' compensation in missouri: administrative inventory. Duncan S. Ballantyne and Carol A. Telles. May 1993. WC-93-1.

workers' compensation in california: administrative inventory. Peter S. Barth and Carol A. Telles. December 1992. WC-92-8.

workers' compensation in wisconsin: administrative inventory. Duncan S. Ballantyne and Carol A. Telles. November 1992. WC-92-7.

workers' compensation in new york: administrative inventory. Duncan S. Ballantyne and Carol A. Telles. October 1992. WC-92-6.

the ama guides in maryland: an assessment. Leslie I. Boden. September 1992. WC-92-5.

workers' compensation in georgia: administrative inventory. Duncan S. Ballantyne and Stacey M. Eccleston. September 1992. WC-92-4.

workers' compensation in pennsylvania: administrative inventory. Duncan S. Ballantyne and Carol A. Telles. December 1991. WC-91-4.

reducing litigation: using disability guidelines and state evaluators in oregon. Leslie I. Boden, Daniel E. Kern, and John A. Gardner. October 1991. WC-91-3.

workers' compensation in minnesota: administrative inventory. Duncan S. Ballantyne and Carol A. Telles. June 1991. WC-91-1.

workers' compensation in maine: administrative inventory. Duncan S. Ballantyne and Stacey M. Eccleston. December 1990. WC-90-5.

workers' compensation in michigan: administrative inventory. H. Allan Hunt and Stacey M. Eccleston. January 1990. WC-90-1.

workers' compensation in washington: administrative inventory. Sara R. Pease. November 1989. WC-89-3.

workers' compensation in texas: administrative inventory. Peter S. Barth, Richard B. Victor, and Stacey M. Eccleston. March 1989. WC-89-1.

reducing litigation: evidence from wisconsin. Leslie I. Boden. December 1988. WC-88-7.

workers' compensation in connecticut: administrative inventory. Peter S. Barth. December 1987. WC-87-3.

use of medical evidence: low-back permanent partial disability claims in new jersey. Leslie I. Boden. December 1987. WC-87-2.

use of medical evidence: low-back permanent partial disability claims in maryland. Leslie I. Boden. September 1986. SP-86-1.

Vocational Rehabilitation

improving vocational rehabilitation outcomes: opportunities for early intervention. John A. Gardner. August 1988. WC-88-3.

appropriateness and effectiveness of vocational rehabilitation in florida: costs, referrals, services, and outcomes. John A. Gardner. February 1988. WC-88-2.

vocational rehabilitation in florida workers' compensation: rehabilitants, services, costs, and outcomes. John A. Gardner. February 1988. WC-88-1.

vocational rehabilitation outcomes: evidence from new york. John A. Gardner. December 1986. WC-86-1.

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Occupational Disease

liability for employee grievances: mental stress and wrongful termination. Richard B. Victor, ed. October 1988. WC-88-6.

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workers' compensation and the changing age of the workforce. Douglas J. Tattrie, Glenn A. Gotz, and Te-Chun Liu. December 2000. WC-00-6.

medical privacy legislation: implications for workers' compensation. Ramona P. Tanabe, ed. November 2000. WC-00-4.

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THE AMERICANS WITH DISABILITIES ACT: IMPLICATIONS FOR WORKERS' COMPENSATION. Stacey M. Eccleston, ed. July 1992. WC-92-3.

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- Are there alternative solutions that merit consideration? What are their consequences?

The Institute's work takes several forms:

- Original research studies on major issues confronting workers' compensation systems
- Original research studies of individual state systems where policymakers have shown an interest in reform and where there is an unmet need for objective information
- Sourcebooks that bring together information from a variety of sources to provide unique, convenient reference works on specific issues
- Periodic research briefs that report on significant new research, data, and issues in the field
- Benchmarking reports that identify key outcomes of state systems