# SENATE COMMITTEE ON PUBLIC AFFAIRS

**February 5, 1999 Hearing Room B**

**3:00 p.m. Tapes 6 - 9**

**MEMBERS PRESENT: Sen. Gene Derfler, Chair Derfler**

**Sen. Joan Dukes, Vice-Chair Derfler**

**Sen. Charles Starr**

**Sen. Thomas Wilde**

**MEMBER EXCUSED: Sen. Eileen Qutub**

**STAFF PRESENT: Brian E. Smith, Administrator**

**Rachel E. Halupowski, Administrative Support**

**MEASURE/ISSUES HEARD: Introduction of Committee Bills**

**SB 213 Public Hearing and Work Session**

**SB 223 Public Hearing and Work Session**

**SB 222 Public Hearing**

**SB 221 Public Hearing and Work Session**

**SB 220 Public Hearing**

**SB 288 Public Hearing**

**SB 289 Public Hearing and Work Session**

**These minutes are in compliance with Senate and House Rules. Only text enclosed in quotation marks reports a speakerís exact words. For complete contents, please refer to the tapes.**

| TAPE/# | Speaker | Comments |
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| **TAPE 6, A** | | |
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| 000 | Chair Derfler | Opens meeting at 3:10 p.m. and opens a work session to consider LC 1574 and LC 1575. |
| **INTRODUCTION OF COMMITTEE BILLS** | | |
| 004 | Rob Douglas | Oregon Self-Insurers Association. Presents **(EXHIBIT A)**. Asks the committee to introduce LC 1574 and LC 1575. States LC 1574 deals with who can self-insure. States LC 1575 deals with assessments and currently the Director of the Department of Consumer and Business Services (DCBS) sets the assessment. States that according to the Oregon Self-Insurers Association, once the assessment is set there is no effective appeal for dispute, or a forum for contesting the assessment. Believes LC 1575 will create a forum for contesting assessments. |
| **031** | **Chair Derfler** | **MOTION: Moves LC 1574 dated 2/5/99 and LC 1575 dated 2/5/99, BE INTRODUCED as committee bills.** |
| | | **VOTE: 4-0**<br><br>**EXCUSED: 1 ñ Qutub** |
| | **Chair Derfler** | **Hearing no objection, declares the motion CARRIED.** |
| 036 | | **LC 1574 is introduced as SB 591 and LC 1575 is introduced as SB 592.** |
| 037 | Chair Derfler | Closes work session and opens SB 213 public hearing. |
| **SB 213 PUBLIC HEARING** | | |
| 046 | Mary Neidig | Administrator Workersí Compensation Division (WCD). States during interim an extensive review was done by her office:<br><br>• Intensive review of each program the Workersí Compensation Board and the WCD are responsible for administering. The review was done by Management Labor Advisory Committee (MLAC).<br>• Independent review by the Secretary of Stateís office recommending legislation.<br>• Thorough review by the Workersí Compensation management team to regulate existing programs. Transfer to the private sector any activities where delivery of benefits or services is required by law but do not need to be performed by state government. Reduce the cost of administering the Workersí Compensation system. |
| 093 | John Shilts | Manager, Benefits Section, Workerís Compensation Division. Presents **(EXHIBIT B)**. Explains SB 213 deals with the increase in the Workersí Benefit Fund (WBF) balance. States the issue of SB 213 is whether to allow a sunset of a provision keeping a fund balance at 12 months, or to revert to a six month fund |

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| | | balance. States the WBF was created by HB 2044 in 1995 and SB 213 would combine several funds to provide financing to programs that assist injured workers and their families. Explains the chart attached to his testimony gives information in regard to the various programs funded by the WBF. States under the former ORS 656.506, the fund balance would have been reduced by 1999 to a target level that would cover six months of expenditure. States, in 1997, SB 484 delayed the WBF balance by allowing a 12 month fund balance, requiring MLAC to review the fund balance issue and make recommendations to the legislature. |
| 125 | Shilts | Explains the SB 484 provision will end on December 31, 1999. States a twelve month fund balance will provide for the higher fund balance and will generate higher investment income for the fund. States assessment rates can be lowered in the long term with more investment income. Explains the projections for 2001, with a 12 month fund balance, would be $134 million, requiring a 4.2 cents per hour assessment rate. Supports SB 213 and asks the committee to pass SB 213 with a minimum 12 month fund balance. |
| 163 | Chair Derfler | Closes public hearing on SB 213 and opens work session. |
| **SB 213 WORK SESSION** | | |
| **165** | **Sen. Starr** | **MOTION: Moves SB 213 to the floor with a DO PASS recommendation.** |
| | | **VOTE: 4-0**<br><br>**EXCUSED: 1 ñ Qutub** |
| | **Chair Derfler** | **Hearing no objection, declares the motion CARRIED.**<br><br>**SEN. STARR will lead discussion on the floor.** |
| 175 | Chair Derfler | Closes work session on SB 213 and opens public hearing on SB 223. |
| **SB 223 PUBLIC HEARING** | | |
| 182 | Patricia Aldworth | Policy Manager, Workersí Compensation Division. Presents **(EXHIBIT C)**. States SB 223 would eliminate the requirement for the DCBS to establish treatment standards for different medical categories. States it has taken three years, by a former medical director and a medical committee, to come up with treatment standards for only one medical condition (Carpal Tunnel Syndrome). States in 1998 MLAC examined all regulatory functions and decided DCBS should not establish treatment standards. |
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| 220 | Mark Melgard | Retired Neurosurgeon, former Medical Director of Workersí Compensation Division. Concerned that care for the injured worker is the responsibility of Workersí Compensation. Comments that most common medical services for claims should have standards, not necessarily all medical services, such as tuberculosis or leprosy. States the statute designates a lot of responsibilities for the department, but deletes medical standards. States it is the primary responsibility of WCD to look at medical care. |
| 272 | Chair Derfler | Asks if Melgard is willing to work with the WCD to come up with solutions. |
| 273 | Melgard | States he would be willing to work with WCD. |
| 280 | Chair Derfler | Closes public hearing on SB 223 and opens work session for SB 223. |
| **SB 223 WORK SESSION** | | |
| **285** | **Sen. Starr** | **MOTION: Moves SB 223 to the floor with a DO PASS recommendation.** |
| | | **VOTE: 3-0**<br><br>**EXCUSED: 2 ñ Dukes, Qutub** |
| | **Chair Derfler** | **Hearing no objection, declares the motion CARRIED.**<br><br>**SEN. DUKES will lead discussion on the floor.** |
| 290 | Chair Derfler | Closes work session on SB 223 and opens public hearing on SB 222. |
| **SB 222 PUBLIC HEARING** | | |
| 304 | Tom Mattis | Deputy Administrator, Workersí Compensation Division. Presents **(EXHIBIT D)**. States SB 222 reflects WCDís effort for administrative reform. Evaluates whether the steps the WCD proposes taking are consistent with the committeeís vision of the WCD role. States the specific policy question before the committee is whether the membership and duties of the Medical Advisory Committee on Medical Care should be amended. States the composition of the committee should be more reflective of the range of medical providers that are in the Workersí Compensation system and the range of issues. States the following duties of the committee are imposed by statute: to advise the director of medical care, to review and make recommendations regarding proposed standards for the evaluation of disabilities, and prepare/submit medical rules for the directorís consideration. States that under the current law some of the major medical players are not represented. States the statute calls for a dentist on the committee, but one could not be recruited to serve on the committee. |

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| 353 | Mattis | States SB 222 would amend ORS 656.794 by taking out reference to specific types of medical providers. States SB 222 will give the director full latitude to seek committee advice, and help the director make better policy decisions relating to medical care and resolving medical treatment disputes. Supports SB 222. |
| 375 | Chair Derfler | Asks if there is only one committee. |
| 378 | Mattis | States they have only one statutory committee on medical care, but WCD uses advisory committees for rule making, and paperwork reduction task force. |
| 380 | Chair Derfler | Asks if the committee is closed to outside advisors. |
| 390 | Mattis | States the committee can invite input from anyone they choose, but to be a member the type and number of advisors are described in the statute. |
| 405 | Chair Derfler | Comments that the statute allows more flexibility in the make-up of the committee. |
| 411 | Mattis | States the statute allows WCD to include as many and different types of medical providers needed and allows WCD to focus on the issues they deem necessary. |
| 416 | Melgard | Presents **(EXHIBIT E)**. Concerned about the way SB 222 is written. Believes if the types of doctors chosen to be part of the committee are not specified, it may disturb the present committee. States a dentist on the committee is unnecessary. |
| **TAPE 7, A** | | |
| 000 | Melgard | Refers to his chart exhibit and states seventy percent of medical services are provided by medical doctors. Suggests more medical input to the committee, from doctors who are providing the services to the injured worker. States, at the present time, the WCD has a representative for the insurers, employers, and the employees, as well as a chiropractor, naturopath, and an osteopath. Suggests a representative from the MCOs and the addition of three to five additional doctors. |
| 054 | Chair Derfler | States that the Oregon Medical Association (OMA) are concerned about SB 222, so the committee will not move into work session on the bill. Closes public hearing on SB 222 and opens public hearing on SB 221. |
| **SB 221 PUBLIC HEARING** | | |
| 063 | Mattis | Presents **(EXHIBIT F)**. States SB 221 questions whether the WCD should continue to be solely responsible for certifying Workersí Compensation claims examiners, and whether reform goals reflected in SB 221, are consistent with the public policy goals of the 70th Legislative Session. States, under the current law, |

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| | | claims examiners must be certified by WCD. States certification is obtained by passing a certified claims examiner training course or by passing an examination administered by WCD. States certification is maintained by completing 24 hours of continuing education every two years. States SB 221 amends ORS 656.780 to restrict WCDís role in setting standards for claim examiners certification and enforcing insurer compliance. |
| 108 | Mattis | States WCD will take no position on proposed changes to SB 221 as long as there are no conflicts with WCDís primary purpose, and it does not negate the budget savings, or impose other costs on WCD. States WCD and MLAC support SB 221. |
| 114 | Chair Derfler | Asks how it is determined if people are certified. |
| 116 | Mattis | States that while WCD is performing an on-site compliance audit, the auditor asks for the staffís records to be sure all staff is certified. |
| 118 | Chair Derfler | Asks how often compliance audits are performed. |
| 120 | Mattis | Replies WCD must audit once every three years. |
| 126 | Chair Derfler | Asks what penalty is imposed on a non-certified staff member. |
| 127 | Mattis | Believes the penalty is $1,000, but he would need to verify that amount. |
| 131 | Sen. Wilde | Asks what numbers, in terms of examination, show how many firms are not currently certified. |
| 139 | Mattis | States those numbers are not available at this time, but he will present them to the committee at a later date. |
| 145 | Chris Davie | State Accident and Insurance Fund (SAIF) Corporation. Presents **(EXHIBIT G)**. Supports SB 221. States SB 221 does not eliminate examiner certification, it merely transfers program administration from DCBS to the insurers. States DCBS will have the authority to sanction insurers for failure to comply with the rules and statutes. States there will be no impact on adjuster skills. States SB 221 will reduce the cost of WCD administration. |
| 170 | Jerry Keene | Attorney, Portland, Certification Trainer. States the word "standards" is not defined by practice or usage, since the certifications were first required in 1990. States the standards have been limited to training and education standards. States, for the record, there is no language in SB 221 that would authorize the department to use "standards" to enforce or regulate response to certain processing conduct, or reactions to particular claims. Believes the industry is helping the smaller insurers appreciate the certification process as a way to screen out potential employees and to keep up educational standards. Believes a profession that requires training and education standards, where the examiner is part doctor, part lawyer, be recognized as an industry and suggests legislation to |

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| | | make the industry regulate itself. |
| 221 | Chair Derfler | Asks him to clarify that it is to the advantage of the insurance company to have good certified examiners. Asks if SB 221 is needed, since it would be in any companyís best interest to hire certified examiners. |
| 225 | Keene | States that not everyone set up to process the claims are set up as educators to train their employees to become professional claims examiners. States, since 1990, claims examiners have been able to make unilateral decisions that effect peoples lives. States the need to impose professional standards of what makes a proper claim examiner. States that standards should be internalized in the profession, not imposed by legislation. States the industry should be training their people. |
| 255 | Chair Derfler | Asks, if the industry set up their own organization, could the department eliminate the training of the claim examiners. |
| 257 | Keene | States he had established a volunteer organization to address this issue, but SB 221 came along quickly. |
| 261 | Chair Derfler | Closes public hearing on SB 221 and opens work session on SB 221. |
| **SB 221 WORK SESSION** | | |
| **266** | **Sen. Starr** | **MOTION: Moves SB 221 to the floor with a DO PASS recommendation.** |
| | | **VOTE: 4-0**<br>**AYE: In a roll call vote, all members present vote Aye.**<br>**EXCUSED: 1 ñ Qutub** |
| | **Chair Derfler** | **The motion CARRIES.**<br>**SEN. STARR will lead discussion on the floor.** |
| 280 | Chair Derfler | Closes work session on SB 221 and opens public hearing on SB 220. |
| **SB 220 PUBLIC HEARING** | | |
| 284 | Mattis | Presents **(EXHIBIT H)**. States SB 220 asks whether insurers should continue to |

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| | | determine injured workersí disabilities and close claims, or submit them to WCD for determination and closure, or whether insurers are required to close all claims. States that the reform goal of WCD is to focus on administration, regulation, and enforcement, as reflected in SB 220. States when a workerís attending physician finds the worker has recovered from the injury as much as possible, or the injury is no longer the major contributing cause of the disability, the workerís claim is closed. |
| 303 | Chair Derfler | Asks who determines if the claim is closed. |
| 304 | Mattis | States the determination is made by the attending physician. |
| 316 | Vice-Chair Dukes | Asks if there is any situation where the insurance company has the option to close or not close a claim. |
| 318 | Mattis | States the insurance company has had the option of closing claims or sending claims to WCD since 1987 on a limited basis and since 1990 on a regular basis. |
| 320 | Vice-Chair Dukes | Asks if the doctor makes the final determination that the injured worker is no longer injured. |
| 330 | Mattis | States the physician makes the determination. Notes that if there is question of whether the worker is medically stationary, or if the claim is prematurely closed, or if the disability award made by the insurance company is appropriate, the worker has a right to contest the closure to a reconsideration process. States the process provides skilled disability evaluation specialists to review the claim and use a medical arbiter to ensure impairment was properly determined. |
| 335 | Vice-Chair Dukes | Clarifies that doctors are not giving indefinite reports and the insurance companies are making decisions on their own. |
| 338 | Mattis | Notes there have been times when the physician has not given a detailed report and this poses a problem. States that in those cases the claim will be based on the preponderance of evidence and objective findings. |
| 351 | Vice-Chair Dukes | Asks, if the insurance company can close the claim, can the injured worker opt to appeal. |
| 353 | Mattis | States that is the case. States in some cases the insurer will send the claim to WCD who will close the claim and rate the impairment. States, if there is a dispute, it will go through the reconsideration process. |
| 355 | Chair Derfler | Asks to explain the timing on the reconsideration process. |
| 359 | Mattis | Explains the process was set up in 1990 to settle conflicts over workersí impairment rating or the money amount awarded for a permanent disability. States matters of this nature can be appealed to the department, and the |

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| | | independent group will review the conflicts and will attempt to get away from settling using the litigation process. States the department has 18 working days to complete the reconsideration process unless a medical arbiter is required and, in that case, the department has an additional 60 days to complete the process. |
| 387 | Mattis | States some insurers do close claims. States SAIF Corporation has closed 98% of its claims for the last eight quarters. States some do not close claims for a variety of reasons. States 74% of all claims are closed by insurers, while WCD closes about 26%. |
| **TAPE 6, B** | | |
| 000 | Mattis | States, over time, WCDís closure of claims has dropped to the current 26%. States WCD has adjusted to the decline by eliminating 6 positions. States SB 220 will amend 14 statutes to make insurers solely responsible for claim processing, the function of claim closure, reclassifying non-disabling claims, and the review of total disabilities. States Section 19 of SB 220 gives flexibility for WCDís closure responsibilities for a smooth transition. States the ending date for SB 220 was left open to help insurers discuss their concerns of the best time to cut off. Recommends a 24-month phase out with all department closure ceasing by June 30, 2001. States the closure cease date will be in the amendments they are offering. Addresses focusing on WCDís primary mission of enforcement and regulation, as well as transferring responsibilities to the private sector that need not be filled by the government. |
| 050 | Mattis | States Attachment B summarizes the administrative reform objectives. States the fiscal impact assumes a 12-18 month phase-out, which will reduce WCDís by a little over one million dollars for 1999-2001. States the reductions for 2001-2003 will reduce $1.7 million from the current budget level. |
| 059 | Vice-Chair Dukes | Asks what happens to smaller insurance companies who do not have the ability to close claims. |
| 061 | Mattis | States the smaller agencies can send the claims to WCD, or they may hire a claim closure service. |
| 066 | Vice-Chair Dukes | Ask what would happen to them if SB 220 passes. |
| 068 | Mattis | States those agencies will either need to do the claim closures themselves, or hire a third party administrator to close the claim, or hire a claim closure service. |
| 072 | Vice-Chair Dukes | Asks if claim closure services are expensive. |
| 074 | Mattis | States he knows of one company that charges $50 per claim on the average, but has no definitive numbers at this time. |
| 095 | Tim Nesbitt | Executive Director, Oregon State Council of Service Employees International Union (SEIU). Opposes terminating the department from closing claims. States |

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| | | the cost savings will be shifted to the insurers who will bear the expense of hiring and training staff. Explains the new costs will be paid in the administrative expense portions of premiums. Notes that not all insurers are ready, or asking, to close all claims. Believes claim closures by as many as 200 different insurers may not be more efficient than DCBS centralized claim closures for the insurers who are not doing closures, presently. States claim closures by insurers are more likely to be appealed by the affected workers. Suspects that insurers who close their own claims may be underrating claims and low-balling the benefits, without protective oversight. |
| 125 | Nesbitt | States the Secretary of State agrees with audits regarding insurers closing claims, and recommends allocating staff to the field audit unit to conduct audits frequently. States there is no specification as to the number of audits, selection, or the number of staff needed to conduct the audits. States SB 220 does not preclude or mandate the audit function needed if claim closure is phased out. Asks SB 220 to be amended reflecting a deadline of June 31, 2001, which should be reflected in the ñ1 amendments. |
| 161 | Sen. Wilde | Comments on Nesbittís statement that a larger percentage of the claim closures were overturned on appeal. Asks if he has figures available. |
| 164 | Nesbitt | States he will find those figures for him shortly. |
| 165 | Brad Witt | Oregon American Federation of Labor and Congress of Industrial Organizations (AFL-CIO). Opposes terminating the department from claim closures. States that, based on a meeting held on 2/4/99, the AFL-CIO feels comfortable, during the transition period, eliminating the evaluation unit. States the concerns about quality control in closing claims would be adequately addressed if given sufficient time to develop the necessary data to determine the appropriate auditing level. Supports SB 220 with the -1 amendments. |
| 184 | Nesbitt | States the figures he has on closure overturn is based on 1997 data and he will provide that data at a later date. |
| 189 | Steve Telfer | Legislative Counsel to the Alliance of American Insurers (AAI). Presents **(EXHIBIT I)**. Supports SB 220, SB 221, SB 222 and SB 223. States all the bills are solid, well thought out and all should pass. States SB 220 would eliminate the authority of the department to close Workersí Compensation claims, yet, AAI has some concerns that there will be no outlet for addressing claims when the attending physician will not or cannot properly rate permanent impairment. Comments he would be happy to work with Liberty and SAIF on those claim issues. |
| 224 | Chair Derfler | Asks, for insurers who cannot close claims, if they can take their cases to another claims examiner. |
| 228 | Telfer | States there are many ways to close claims. States if SB 220 passes as drafted, there would be no circumstance where the insurer, if the intended physician blew it, has a way to seek reconsideration. |
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| 241 | Davie | Presents **(EXHIBIT J)**. Supports SB 220. Believes efficiency will be increased by allowing the insurers to close claims. States the department should be in place as a regulatory function. States, based on drafted amendments, the department is given broad authority to rescind an insurance companyís closure. States that if the insurance company makes any small mistake during claim closure, the claim can be reopened. States the department indicates they are willing to work on an amendment that is more focused on issues they are willing to address. States he has not yet seen the ñ1 amendments. |
| 288 | Davie | States the redefinition of the provisions for disability rating standards could eliminate the authority of using the arbiterís finding when there is a request for reconsideration. States the arbiter is the independent doctor selected by the department to examine the workerís condition. States that, under those circumstances, SB 220 would preclude the department from using the findings. Explains that the way the statute is written, the attending physician is in charge of diagnosing permanent impairment. States that if the department sees findings that do not make sense, the department will then close the claim. States that if awards are given in excess, in cases that do not look right, then SAIF can ask for reconsideration. States by eliminating the evaluation section, SB 220 requires all claims to be closed by the insurance company, but it does not give the insurance company the right to challenge its own closure. Proposes an alternative approach to address this issue: if the insurance company believes the attending physicianís findings are inappropriate, the insurer could issue a notice of closure using those findings. States that the closure notice would be labeled to enable WCDís appellate unit to get an audit from an independent arbiter and issue a second opinion. |
| 344 | Chair Derfler | Asks how to address the issue with two different opinions. |
| 346 | Davie | States that if there is disagreement, then the department uses a medical arbiter or a panel of three doctors to issue judgment. States that if the proposed amendment was adopted, the worker would continue to receive the partial permanent disability award, based on the attending physicianís findings, and would only be reduced or discontinued if WCD found the findings inappropriate and issued a new award for disability. States he can ask Legislative Counsel to draft an amendment. |
| 371 | Chair Derfler | States there is a lengthy process with disputes to be sure the worker is treated fairly. |
| 376 | Davie | States the insurance company would close the claim, determine the amount of permanent disability, and immediately begin payments on the award, even though the insurer may feel the amount was inappropriate. |
| 383 | Lisa Trussell | Associated Oregonís Industries (AOI). States she shares the concerns of Telfer and Davie. Explains the reconsideration process is thorough, but not drawn out. States the standards are in place to prevent low-ball evaluation of the claims. |
| **TAPE 7, B** | | |
| 000 | Trussell | States Ways and Means mentioned that 25% of all claims go to reconsideration, |

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| | | regardless of who closed the claims. Believes, if these issues are addressed, AOI supports SB 220. |
| 012 | Chair Derfler | Asks if the process is adequate. |
| 014 | Trussell | Believes the process is adequate. States the department is currently closing 26% of the claims. |
| 016 | Davie | Explains there is a provision in the statute that states if the award granted increases by a certain percentage, there is a penalty automatically assessed that goes to the worker. |
| 030 | Jackie Ganer | Injured worker, Beaverton. States her claim was closed by an acupuncturist and it took two years for a medical arbiter to review the claim. States she was injured in August 1995 and the claim was closed in January of 1996. States the claim was reopened for reconsideration in 1998. States claims are not being evaluated by medical physicians. States that if an MCO provider has an acupuncturist or a chiropractor on the roll, they are allowed to close claims without any consideration from a private physician. |
| 049 | Mattis | Reiterates that the MCO panel reviewed her claim and an outside physician was not allowed to evaluate her claim. States that a worker treated within an MCO would have a review conducted by a panel physician or physicians. |
| 063 | Chair Derfler | Asks if it is a panel of doctors. |
| 066 | Keene | States the worker chooses an attending physician within the MCO. Comments that the law states that the attending physician provides the impairment findings. States the MCO gives the worker a broader choice of who their attending physician will be. States there may be confusion about terms surrounding this claim. |
| 077 | Ganer | States the MCO chiropractor did close the claim. States her MCO required her to leave her attending medical physician and claim the chiropractor as her attending physician. States that if she obtained a chiropractor or an acupuncturist, that type of person became the primary physician. |
| 086 | Chair Derfler | Asks if she was able to choose that doctor. |
| 089 | Ganer | States that, at the risk of losing care, attending physicians are not allowed to provide care for patients without losing attending physician status. |
| 095 | Chair Derfler | Believes the attending physician would be most knowledgeable about her condition and can rate the impairment best. States, if problems occur, a panel of doctors would review the issues. |
| 100 | Keene | States that MCO panels review decisions about whether particular treatments |

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| | | recommended are reasonable and necessary. States MCO panels do not review impairment. |
| 104 | Chair Derfler | States Ganer had the chiropractor treat her, but she expected someone other than the chiropractor to close the claim. |
| 108 | Keene | States the department would not uphold a closure without attempting to get the attending physicianís assessment. States that if the attending physician does not feel comfortable making complicated measurements, it can be arranged for another doctor to do an assessment, then the attending physician can either agree or disagree with the second doctor. |
| 119 | Vice-Chair Dukes | States the attending physician could refer a patient for acupuncture while remaining the attending physician. Believes Ganerís MCO chose to make the acupuncturist the attending physician. |
| 127 | Keene | States he is unaware of any MCOís ability to restrict the workers from changing physicians, other than what the law states (only two changes of attending physician). |
| 134 | Ganer | States that when she was injured, the hospital she worked for insisted that she be treated by their physician. States she was sent to their occupational health department for evaluation. Explains that after a month she was told to choose a new doctor. States she was required to see those two physicians. States she was told, and given in writing, that if she went out of the system, she would lose her benefits under the Workersí Compensation system. States when she chose to have conservative treatment in lieu of surgical treatment she was told she had to assume the physician implementing the conservative treatment would become her attending physician. States she was not informed of the consequences, nor did she choose her first two physicians. States that after two years it was overturned. States "independent medical examiner" (IME) is not a term used any more. States she interviewed two of the physicians who did her IME and both stated 90%-100% of their income came from implementing IMEs. States neither have actively participated in a continuing education effort. States one of them said that no claims had been filed against him and the other would give no comment. States that insurance companies are hiring physicians who are not board certified. States neither of the two physicians who implemented her IME were practicing physicians, nor were they board certified. |
| 184 | Ganer | Asks how a cervical injury can be evaluated by a physician without a vaginal examination. States an evaluation without a proper examination should not be allowed by the insurance companies. |
| 206 | Ernest Delmazzo | Member of Injured Worker Alliance. Presents **(EXHIBIT K)**. States that he refused to attend an illegal fourth IME and the insurance company recently closed his claim. States that, with the evaluations unit being dissolved, his choice for recourse would be through the court system. |
| 239 | Chair Derfler | Asks if he could do a reconsideration if he was not satisfied. States the reconsideration hearing must take place within 18 days and posting must occur within 60 days. |

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| 242 | Delmazzo | States the evaluations unit has overturned actions of insurance companies and, without the unit, the process is being extended. States his case was closed without the attending physicianís approval. States the insurance company dismissed his attending physician because Delmazzo had not seen that doctor in over two years. States that giving the insurance company unilateral decision making powers is wrong. States many IMEs have been in trouble with various states due to malpractice and violation of laws. States Oregon doctors under investigation are given the option to hand over their license in lieu of being investigated. |
| 290 | Delmazzo | States a person conducting the examination shall determine the conditions of the examination. States that, subject to the physicianís approval, the worker can use video camera and tape recorder to record the examination. States that if the physician will not let them video tape, the physician must state why. States the Oregon Board of Medical Examiners has noticed an increase in complaints from patients who have undergone IMEs. States some of the issues are: poor understanding of the nature of the IME, insensitivity for the claimantís underlying medical problems, rudeness to the individual being examined, complaints of significant discomfort during the follow up examination, and failure to provide adequate explanation. |
| 347 | Chair Derfler | States the committee has no control over these issues. |
| 349 | Delmazzo | States by allowing the insurance companies full authority over claim closure, IMEs will determine the claim closure. Believes SB 220 will increase suffering among injured workers and is a violation of civil rights of Oregon workers. |
| 376 | Delmazzo | States that every avenue the worker has to get help is being taken away from them. States in his experience it is common practice to close claims without the attending physician. States most IME clinicsí revenue comes entirely from insurance companies and employers. |
| **TAPE 8, A** | | |
| 000 | Chair Derfler | States that if he is not happy with his closed claim, he can go to the department for a reconsideration process. States the department has an arbiter that will reexamine his case and find if the attending physician was correct or not. |
| 008 | Delmazzo | States, in most cases, they are not doctors but registered nurses. |
| 010 | Chair Derfler | States they are doctors. States the arbiter is completely separate from the insurance company. States the department has 18 days to respond to reconsideration and they have 60 days to set up the determination. |
| 020 | Delmazzo | Comments that some of the stateís doctors are the same IMEs used during the claim closure cases. |
| 021 | Chair Derfler | Asks if the state doctors are good. |

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| 024 | Delmazzo | States the doctors "Öknow where the paycheck comes from." |
| 061 | Chair Derfler | Suggest writing up changes for MLAC. |
| 066 | Delmazzo | States MLAC will not have any more public meetings, unless they deem it necessary. States he is being ignored by the Governor. |
| 075 | Merle Campbell | Resident, Boring, Oregon. Opposes SB 220. States the horror stories about IMEs are true, based on his experience with his wifeís compensation case. States there is no possibility of litigation without going to the Supreme Court. States the "chips are stacked" in favor of the attorneys, insurance agents, and employers. States SB 220 is one-sided and there is no level playing field. States there are statutory limitations on attorney fees from settlements. States there are no limitations on what the employers or the insurers pay their attorneys. |
| 110 | Campbell | Believes there are a lot of Workersí Compensation abuses and that reform has gone awry, leaving a disparity of equality. |
| 131 | Chair Derfler | Notes injured workers benefits have increased from 200-500% since the introduction the new measurements. |
| 134 | Campbell | Relates story of his wife being forced into a settlement. States in her case there were violations of the Americanís with Disabilities Act and she was intimidated into settling for $20,000. States his wife took an IME exam and her doctor is a liar. States there is no way to remedy the situation without litigation. |
| 155 | Chair Derfler | Closes public hearing on SB 220 and opens public hearing on SB 288. |
| **SB 288 PUBLIC HEARING** | | |
| 161 | | Staff presents **(EXHIBIT L)**. |
| 162 | Greg Malkasian | Manager, Compliance Section, WCD. Presents **(EXHIBIT M)**. Supports SB 288. States that the Rehabilitation Facility Premium Refund is available to private non-profit facilities that provide vocational training and employment opportunities for disabled and severely handicapped individuals. States the refund represents 75% of the premium paid by those facilities for Workersí Compensation Insurance. States SB 288 will eliminate the fund. States MLAC conducted a review of several funding programs from the Workersí Benefit Fund, represented by equal contributions by employee and an assessment by employer and, in the review, MLAC set qualified standards for reasonable basis to continue funding the program. States the most significant standard was that funding provides direct benefits to the injured workers. States the refund program does not meet specific standards to provide equal representation or support to injured workers and/or their employers. |
| 213 | Malkasian | States SB 288 repeals ORS 656.530, eliminating the current premium refund program. States, with recommended amendments, SB 288 will provide |

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| | | $4,453,000 to the Department of Human Resources, to be used with available matching federal funds to maintain an approximately equal level of funding to these facilities over the next biennia. States SB 288 does not continue support beyond the next biennia. States there is an emergency clause to clarify that the premium refund program ends as of June 30, 1999 for all qualifying facilities past and present. |
| 244 | Sen. Wilde | Asks if the committee is making SB 288 a "political hot potato." States Human Resource budgets are generally the first to be cut when budget issues arise. |
| 255 | Malkasian | States MLAC will review the funding sources and determine if they are appropriate. States MLAC felt the program was important, but not appropriate to receive funding from WBF. |
| 271 | Witt | Supports SB 288. Believes appropriate decisions have been made. |
| 280 | John Portis | Injured worker, former member local 296, Portland. Presents **(EXHIBIT N)**. States he is currently in a vocational rehabilitation program. States the funding is needed to keep disabled people productive in our society. States without vocational rehab he would have nothing. States it is important to him to guarantee that the smaller programs are funded. States he wants to go back to work. States he was belittled by IMEs. States the Workersí Compensation system needs to be simplified. |
| 360 | Tim Kral | Director of the Oregon Rehabilitation Association. Presents **(EXHIBIT O)**. States the programs that have been funded by the Rehabilitation Facility Premium Refund have received monies to expand, grow, and provide services to people who would otherwise be wards of the state. Explains the refund typically amounts to 1-2% of the gross operating revenue. States concerns about the facilities continued survival without the funding. Opposes SB 288. |
| 400 | Jan Kral | Director Shangri-La Corporation. Presents **(EXHIBIT P)**. States she has struggled to develop budgets with public funding and the rebate has been an important part of the funding stream for her organizations. Believes that without the refund many programs would not be able to keep their doors open. States SB 288 resolves the issue for the next two years, but has no solutions after that time. States fundraising around the communities could help support some of the needs, but it will not reach a steady $200,000 needed for the biennia to offset the losses. States the facilities must come up with the rest of the funding for costs. Concerned there be an alternative funding solution before SB 288 is passed. |
| **TAPE 9, A** | | |
| 000 | Bobby Mink | Deputy Director, Department of Human Resources. States it is important for his department to have time to figure out other ways to fund the non-profit programs. States his department is grateful to have negotiated funding for the next two years. States the programs serve about 10,000 people per year, mostly disabled people, and it is a priority for his department to employ disabled people. States he understands MLACís policy statement. |
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| 024 | Wilde | States that Human Resources was excited by getting Fairview closed last session. States that those people were placed into the community, where their funding now seems precarious. Asks if the people have become disposable. |
| 035 | Mink | States that his department is closing Fairview in a responsible way by developing group homes that will be adequately staffed. States the programs they are developing today will be in consideration when building the budget in the next biennia. States there are no answers today, but it is under consideration. States he cannot foretell what the landscape will be two years from now. States they are responsible to those people leaving Fairview. |
| 049 | Chair Derfler | Comments that Mrs. Kral and the Shangri-La program employ people from Fairview. |
| 051 | Sen. Wilde | Comments his issues arise because he wants to see the Shangri-La program continue. |
| 052 | Chair Derfler | Expresses concern for how these facilities will be funded and states he will not pass SB 288 without some assurance there is a back up funding program. |
| 057 | Ed Johnson | Disabled worker, Lincoln County. States employers are less apt to hire a disabled person. States, in the past, workers have been cut off by the state. States he earned $50,000 a year and after the injury could not make his house payments. States he has nine years of personal experience with Workersí Compensation. States the injured worker is not protected, but the employer and insurance agents are protected. |
| 110 | Johnson | States the laws are supposed to protect the injured worker. States, if he could have had his surgery five years ago, he could have gone on with his life. States it took over seven years to get surgery for a disk in his spinal cord. States it is frustrating to lose everything: self-respect, self-esteem, family, and friends. States the system bounces the injured worker around. |
| 127 | Chair Derfler | Closes public hearing SB 288 and opens public hearing on SB 289. |
| **SB 289 PUBLIC HEARING** | | |
| 130 | Aldworth | States SB 289 will streamline the appeals process for non-subjectivity determination (the first step of looking at the issue of non-compliant employers, and whether the injured worker is actually subject to the Workersí Compensation laws). States because of recent case law, the board must decide the non-subjectivity determination issue under the Administrative Procedures Act. States if the worker is not subject to the Workersí Compensation laws, then WCD will issue an order letting the worker know he/she is not subject. |
| 160 | Chair Derfler | Asks for an example of a non-subjectivity employee. |
| 162 | Roger Pearson | Managing Attorney for Workersí Compensation Board. States an independent |

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| | | contractor would be an example of a non-subjectivity employee. |
| 163 | Aldworth | States the non-subjectivity determination appeals go to the Workersí Compensation Board, but because of the recent case law, the board is forced to hear the appeal under different procedures than is used for any other issue before the board. States the non-subjectivity appeals are often joined with other non-compliant employer issues, so the Administrative Law Judge (ALJ) of the board can hear all of the case issues at once. States this poses a problem for the judge, who will need to write two separate orders: the non-subjectivity issue to be written according to the Administrative Procedures Act and the other for the rest of the case. States both must be written because there must be two different routes of appeal. States in cases of non-subjectivity determination cases, once the order is written by the ALJ (Proposed and Final Order), it is then subject to exceptions. States if the order is appealed it goes to the division for a final order and then to the Court of Appeals. States that every other issue goes before the ALJ, an opinion is written and, if appealed, it is appealed to the board before going to the Court of Appeals. |
| 193 | Aldworth | States SB 289 will simplify the system by not requiring two separate orders. States there are about 30 non-subjectivity orders appealed to the board each year, but for the parties involved there is a certain amount of confusion. |
| 207 | Roger Pearson | Presents **(EXHIBIT Q)**. Supports the proposal as presented. States the appellate process will mirror the existing appellate process with non-compliant employer orders. |
| 218 | Chair Derfler | Closes hearing on SB 289 and opens work session on SB 289. |
| **SB 289 WORK SESSION** | | |
| **224** | **Sen. Wilde** | **MOTION: Moves SB 289 to the floor with a DO PASS recommendation.** |
| | | **VOTE: 3-0**<br><br>**AYE: In a roll call vote, all members present vote Aye.**<br><br>**EXCUSED: 2 - Dukes, Qutub** |
| | **Chair Derfler** | **The motion CARRIES.**<br><br>**SEN. DERFLER will lead discussion on the floor.** |
| 237 | Chair Derfler | Closes work session on SB 289 and adjourns the meeting at 6:45 p.m. |

Submitted By, Reviewed By,

Rachel E. Halupowski, Brian E. Smith,

Administrative Support Administrator

**EXHIBIT SUMMARY**

**A ñ LC 1574 & LC 1575, written summary, staff, 13 pp**

**B ñ SB 213, written testimony and chart, John Shilts, 2 pp**

**C ñ SB 223, written testimony, Patricia Aldworth, 2 pp**

**D ñ SB 222, written testimony, Tom Mattis, 2 pp**

**E ñ SB 222, chart, Mark Melgard, 1 p**

**F ñ SB 221, written testimony, Tom Mattis, 2 pp**

**G ñ SB 221, written testimony, Chris Davie, 1 p**

**H ñ SB 220, written testimony and graph, Tom Mattis, 7 pp**

**I ñ SB 220, written testimony, Steve Telfer, 1 p**

**J ñ SB 220, written testimony, Chris Davie, 3 pp**

**K ñ SB 220, written testimony, Ernest Delmazzo, 1 p**

**L ñ SB 288, -1 amendment, staff, 1 p**

**Mñ SB 288, written testimony, Greg Malkasian, 2 pp**

**N ñ SB 288, written testimony, John Portis, 1 p**

**O ñ SB 288, written testimony, Tim Kral, 1 p**

**P ñ SB 288, written testimony, Jan Kral, 1 p**

**Q ñ SB 289, written testimony, Roger Pearson, 3 pp**