2012 Safety and Health table updates

Accepted disabling claims, employment, and claims rates, 1987-2012

Year	Accepted disabling claims	Employment	Claims rate
1987	41,033	1,105,200	3.71
1988	43,660	1,161,100	3.76
1989	39,170	1,214,900	3.22
1990	35,857	1,258,600	2.85
1991	31,479	1,258,600	2.50
1992	30,786	1,280,500	2.40
1993	30,741	1,317,100	2.33
1994	31,530	1,378,800	2.29
1995	30,564	1,431,600	2.13
1996	28,389	1,487,300	1.91
1997	27,922	1,547,800	1.80
1998	27,020	1,576,100	1.71
1999	25,769	1,602,700	1.61
2000	25,325	1,627,600	1.56
2001	24,607	1,616,400	1.52
2002	23,463	1,596,100	1.47
2003	21,823	1,585,800	1.38
2004	22,320	1,630,500	1.37
2005	22,111	1,677,500	1.32
2006	23,370	1,734,400	1.35
2007	23,431	1,762,700	1.33
2008	21,660	1,746,200	1.24
2009	18,949	1,637,400	1.16
2010	18,013	1,623,300	1.11
2011	18,690	1,641,300	1.14
2012	18,630	1,662,300	1.12

With the recession, between 2007 and 2010, employment declined by 7.9 percent and the number of ADCs declined by 23.1 percent. With recent slow economic growth, 2.3 percent between 2010 and 2012, the number of accepted disabling claims has also risen.

The claims rate is the number of accepted disabling claims per 100 covered employees. The claims rate has fallen over time. The rate has been at near-record lows over the past three years, with just 1.1 accepted disabling claim per 100 workers.

Note: Workers' compensation covered employment figures are based on data from the Employment Department.

CY 2011 and CY 2012 figures are subject to revision.

Compensable fatalities, 1987-2012

Year	Compensable fatalities	Fatality rate
1987	78	7.1
1988	81	7.0
1989	76	6.3
1990	64	5.1
1991	65	5.2
1992	63	4.9
1993	64	4.9
1994	55	4.0
1995	48	3.4
1996	54	3.6
1997	43	2.8
1998	52	3.3
1999	47	2.9
2000	45	2.8
2001	34	2.1
2002	52	3.3
2003	41	2.6
2004	45	2.8
2005	31	1.8
2006	37	2.1
2007	35	2.0
2008	45	2.6
2009	31	1.9
2010	17	1.0
2011	28	1.7
2012	30	1.8

There were 30 compensable fatalities reported in 2012.

A large rise in yearly fatality counts can occur because of multiple-fatality incidents. For example, in 2008, one incident resulted in the deaths of eight Oregon workers.

Compensable fatalities are counted in the year they are reported, which will not necessarily correspond to the year of occurrence.

Note: The fatality rate is the number of fatalities per 100,000 workers.

Occupational injuries and illnesses incidence rates, Oregon private sector, 1987-2012

Year	Total cases IR	Cases with days away from work	DART rate
1987	10.9	4.8	-
1988	11.1	4.9	-
1989	10.6	4.3	-
1990	10.1	3.9	-
1991	9.1	3.4	-
1992	9.1	3.3	-
1993	9.0	3.3	-
1994	8.7	3.0	-
1995	8.8	2.9	-
1996	7.8	2.6	-
1997	7.8	2.3	-
1998	6.9	2.1	-
1999	7.0	2.1	-
2000	6.3	1.9	-
2001	6.2	1.9	-
----------------> series break			
2002	6.0	1.9	3.2
2003	5.6	1.9	3.1
2004	5.8	1.9	3.1
2005	5.4	1.7	2.9
2006	5.3	1.7	2.8
2007	5.1	1.7	2.8
2008	4.6	1.5	2.5
2009	4.4	1.4	2.3
2010	4.0	1.5	2.2
2011	3.8	1.3	2.1
2012	Data available late Aug. to early Sept.		

These incidence rates are compiled from the Bureau of Labor Statistics' Occupational Injury and Illness Survey, and the data come from the employers' OSHA 300 Log. Beginning with the 2002 BLS survey, incidence rates are based on revised requirements for recording occupational injuries and illnesses. Due to the revised requirements, the rates since the 2002 survey may not be comparable with those of prior years.

The total-cases incidence rate is a measure of all recordable workplace injuries and illnesses for every 100 full-time employees. The cases-with-days-away-from-work incidence rate shows the cases that resulted in absences from work. The DART rate is a broader measure that includes days away from work, restriction, or job transfer. The DART rate fell about 34 percent between 2002 and 2011.

Oregon OSHA inspections, federal fiscal years 1988-2012

Federal fiscal year	Inspections	Workers covered by inspections	Percent in compliance
1988	5,697	147,414	23.3%
1989	5,136	167,432	24.2%
1990	4,826	164,052	21.4%
1991	5,506	163,807	18.8%
1992	5,739	206,170	17.7%
1993	5,613	245,929	20.1%
1994	5,022	262,589	20.9%
1995	5,470	227,412	25.2%
1996	5,181	195,375	26.2%
1997	4,555	182,058	28.2%
1998	5,172	152,324	28.0%
1999	5,435	168,258	30.7%
2000	5,069	165,151	28.2%
2001	5,370	197,722	27.8%
2002	5,642	196,193	26.1%
2003	5,355	217,724	26.4%
2004	5,097	207,463	24.9%
2005	4,890	274,457	22.2%
2006	4,873	355,103	26.2%
2007	5,049	244,111	25.5%
2008	5,248	221,994	23.7%
2009	5,542	212,372	24.0%
2010	5,261	132,245	27.3%
2011	4,592	105,395	29.5%
2012	4,101	127,109	28.6%

The average number of inspections per year from 1988 to 2012 is 5,178.

Inspections are classified in several ways. The broadest category identifies each inspection as either a safety inspection or a health inspection. In FFY 2012, 77.6 percent were safety inspections.

Some inspections result in a citation (violations of Oregon or federal standards found at the worksite). When there are no violations of safety or health rules, the worksite is called "in-compliance." The percentage of in-compliance inspections was 28.6 percent in FFY 2012.

Both the number of inspections and the compliance rate have remained relatively unchanged over the period under consideration with 2012's number of inspections at the lowest level yet.

Oregon OSHA citations, violations, and proposed penalties, federal fiscal years 1988-2012

Federal fiscal year	Citations	Violations	Penalties ($ millions)
1988	4,368	15,735	$1.9
1989	3,892	12,364	1.5
1990	3,794	14,009	2.8
1991	4,472	17,118	2.8
1992	4,721	19,424	3.2
1993	4,485	17,611	4.7
1994	3,970	15,292	4.6
1995	4,093	15,302	5.8
1996	3,823	12,434	2.9
1997	3,269	10,359	3.9
1998	3,725	11,366	2.4
1999	3,767	11,433	3.0
2000	3,642	11,094	2.3
2001	3,879	12,701	2.4
2002	4,170	12,703	2.1
2003	3,940	11,700	2.3
2004	3,827	11,805	2.4
2005	3,805	11,376	2.0
2006	3,595	10,020	2.4
2007	3,759	10,495	2.4
2008	4,004	10,623	2.5
2009	4,214	11,582	3.1
2010	3,825	10,311	1.7
2011	3,238	8,605	2.0
2012	2,928	7,676	1.7

Oregon OSHA issues a citation to an employer when one or more violations of Oregon or federal standards are found. The penalties listed here are the initial or proposed penalties levied when the citation was issued and do not reflect changes made due to the settlement of an appeal.

The average number of violations per citation has changed little since 1983. The average number before 1996 was four violations per citation; the average since has been three.

The average number of serious violations per citation has varied even less since 1988, with the average consistently close to one.

Oregon OSHA consultations, 1988-2012

Year	Number of consulta-tions	Workers reached	Participants in voluntary compliance programs: SHARP	VPP
1988	502	N/A	-	-
1989	671	N/A	-	-
1990	943	102,739	-	-
1991	1,741	250,623	-	-
1992	2,491	342,683	-	-
1993	2,089	249,387	-	-
1994	2,482	256,604	-	-
1995	2,153	231,113	-	-
1996	1,854	233,732	4	-
1997	1,828	153,922	9	1
1998	2,050	219,565	24	2
1999	2,127	233,665	42	3
2000	2,505	241,965	50	4
2001	2,828	260,695	69	4
2002	2,457	219,418	75	6
2003	2,060	230,245	80	9
2004	2,094	229,130	86	8
2005	2,124	187,449	104	9
2006	2,283	221,157	107	13
2007	2,098	203,369	126	16
2008	2,542	209,525	142	23
2009	2,898	268,631	161	24
2010	2,693	159,280	196	27
2011	2,652	158,535	174	28
2012	2,739	160,727	163	27

Oregon OSHA's consultative services help Oregon employers identify hazards and work practices that could lead to injuries or illnesses. Employers are provided recommendations for correcting identified hazards and for improving their safety and health programs. Consultative services also include the time-intensive process of assisting interested employers as they work toward SHARP recognition, and evaluating worksites for qualification in the Voluntary Protection Program. There have been more than 2,500 consultations each year since 2008.

SHARP is a recognition program that provides guidance and tools for developing an effective safety and health program. The program focuses on the implementation of a system based on management commitment and employee participation.

The Voluntary Protection Program was developed by federal OSHA as a way to recognize employers who demonstrate excellence in safety and health management. The key areas are management leadership, employee involvement, worksite analysis, hazard prevention and control, and safety and health training.

Safety and health training programs, 1998-2012

Year	Attendance at training sessions
1998	15,494
1999	27,104
2000	19,069
2001	26,478
2002	15,844
2003	26,290
2004	20,892
2005	27,129
2006	22,751
2007	30,054
2008	19,754
2009	30,874
2010	18,580
2011	29,064
2012	15,842

Oregon OSHA has provided education and training to thousands of workers and employers each year. These educational forums provide an opportunity to share ideas on occupational safety and health with national experts. The increases in attendance in odd-numbered years are due to the Governor's Occupational Safety and Health Conference. These conferences are coordinated and presented in partnership with businesses, associations, labor unions, etc.

In 2012, there were eight conferences held around Oregon. They addressed a variety of safety and health issues.

Oregon OSHA safety and health grant programs, 1989-2009

Biennium	Grants	Total awarded
1989-1991	11	$309,658
1991-1993	9	271,008
1993-1995	12	342,780
1995-1997	12	370,595
1997-1999	9	286,463
1999-2001	9	272,150
2001-2003	11	388,517
2003-2005	8	297,626
2005-2007	2	66,753
2007-2009	8	266,260

In existence since 1989, Oregon-OSHA's Training and Education Grants program has awarded 91 grants totaling nearly $2.9 million to help organizations develop education and training programs that reduce or eliminate hazards in an entire industry or in a specific work process. The maximum grant award is $40,000.

Examples of programs that have received grants are homebuilders' manuals and videos in Russian, Spanish, and English; an educational program for nurses to prevent ergonomic injuries; a dairy farmers' checklist and video; and lifting guidelines.

In 2010, due to a revenue shortfall, DCBS accepted the recommendation of the Safe Employment Education and Training Advisory Committee (SEETAC) to suspend the training grants program through June 2011. The grant program remains suspended and there were no grants awarded in 2012.

2012 Compensability and Claims Processing table updates

Total reported claims, FY 1989-2012

Fiscal year	Accepted disabling	Denied disabling	Percent denied disabling	Denied non-disabling
1989	40,515	6,640	14.1%	8,022
1990	35,918	9,534	21.0%	10,551
1991	31,156	8,024	20.5%	12,426
1992	28,577	7,522	20.8%	12,930
1993	29,125	6,013	17.1%	13,414
1994	29,731	6,235	17.3%	13,251
1995	29,740	6,535	18.0%	13,377
1996	27,373	5,958	17.9%	14,118
1997	26,918	5,515	17.0%	14,759
1998	26,032	5,354	17.1%	14,962
1999	24,857	5,244	17.4%	14,683
2000	24,405	4,899	16.7%	13,742
2001	23,850	4,717	16.5%	13,876
2002	22,126	4,704	17.5%	12,990
2003	21,493	4,420	17.1%	11,715
2004	20,004	4,117	17.1%	10,176
2005	21,020	4,030	16.1%	9,547
2006	21,445	3,516	14.1%	9,537
2007	22,449	3,873	14.7%	9,133
2008	21,734	3,533	14.0%	8,280
2009	18,874	3,408	15.3%	7,196
2010	17,162	3,143	15.5%	6,546
2011	17,171	2,813	14.1%	5,859
2012	15,915	2,535	13.7%	5,405

The number of disabling claims has declined by an average of 3.4 percent per year since FY 1989, although there has been considerable year-to-year variability. The number fell 8 percent in FY 2012. The main reason for the decrease in disablling claims in recent years is the job loss that accompanied the recent recession.

Over the past 20 years, the denial rate of disabling claims has generally declined, although with some variability.

Since 1998, the absolute number of denied nondisabling claims has fallen steadily.

These statistics are based on the original acceptance status reported by insurers. Status changes that may occur over time are not reflected.

Accepted nondisabling claims are not included in this report because insurers are not required to report them to the department.

Disabling occupational disease claims, FY 1989-2012

Fiscal year	Accepted	Denied	Percent denied
1989	3,980	2,041	33.9%
1990	3,496	2,761	44.1%
1991	3,068	2,115	40.8%
1992	3,101	2,293	42.5%
1993	3,217	1,939	37.6%
1994	3,305	2,037	38.1%
1995	3,446	2,089	37.7%
1996	3,446	1,965	36.3%
1997	3,591	1,993	35.7%
1998	3,329	1,768	34.7%
1999	2,884	1,657	36.5%
2000	3,064	1,524	33.2%
2001	3,250	1,590	32.9%
2002	3,218	1,794	35.8%
2003	3,341	1,646	33.0%
2004	3,164	1,751	35.6%
2005	3,447	1,698	33.0%
2006	3,681	1,555	29.7%
2007	3,660	1,560	29.9%
2008	3,448	1,441	29.5%
2009	3,153	1,409	30.9%
2010	2,730	1,329	32.7%
2011	2,541	1,105	30.3%
2012	2,234	957	30.0%

The denial rate of occupational disease claims has shown a steady decline, averaging 1.6 percent per year since 1990.

The total number of disabling occupational disease claims reported to the department has also generally declined over the period, although with considerable variability. In FY 2012, it was 10 percent lower than the previous year.

Historical data are subject to small changes.

Disabling aggravation claims, 1991-2012

Year	Accepted	Denied	Percent denied
1991	2,042	1,675	45.1%
1992	2,201	1,514	40.8%
1993	2,099	1,337	38.9%
1994	1,915	1,171	37.9%
1995	1,593	907	36.3%
1996	1,565	950	37.8%
1997	1,351	993	42.4%
1998	1,172	763	39.4%
1999	1,038	730	41.3%
2000	876	618	41.4%
2001	902	575	38.9%
2002	773	535	40.9%
2003	717	483	40.3%
2004	563	416	42.5%
2005	549	340	38.2%
2006	523	432	45.2%
2007	518	534	50.8%
2008	506	566	52.8%
2009	447	554	55.3%
2010	438	533	54.9%
2011	340	510	60.0%
2012	361	476	56.9%

After a claim has been closed, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. The number of these aggravation claims has generally declined during the past two decades. However, the number of these claims that have been denied has not declined as rapidly. As a result, the denial rate is now 57 percent.

Note: The counts are aggravation claims reported to the department by insurers. These exclude claims made under board own-motion authority for worsened conditions, which can be made after the five-year aggravation period expires.

Insurer claim acceptance and denial, median time lag days, 1988-2012

Year	Accepted	Denied
1988	33	49
1989	35	43
1990	31	35
1991	35	39
1992	40	45
1993	34	48
1994	40	48
1995	43	50
1996	44	60
1997	50	66
1998	52	64
1999	49	62
2000	49	61
2001	46	60
2002	40	50
2003	40	51
2004	39	45
2005	41	48
2006	41	48
2007	40	47
2008	41	48
2009	41	46
2010	42	49
2011	42	48
2012	41	47

In 1990, SB 1197 extended the time allowed for insurers to accept or deny a claim from 60 days to 90 days. SB 485 (2001) reduced the allowed time back to 60 days.

Between 2001 and 2002, there was a significant drop in the median number of days taken to accept and deny claims. Since then, the median has remained at or below 42 days for claim acceptance and at or below 51 days for claim denial.

Lag days are measured from employer knowledge date to originginal date of acceptance or denial for disabling claims.

Insurer timeliness of acceptance or denial and of first payments, 1990-2012

Year	Acceptance/ denial timely	First payment timely
1990	85.4%	80.1%
1991	91.5%	85.0%
1992	94.2%	87.2%
1993	96.0%	89.0%
1994	96.1%	88.3%
1995	95.1%	88.4%
1996	94.5%	88.2%
1997	93.2%	87.9%
1998	92.6%	87.4%
1999	92.8%	87.2%
2000	92.9%	88.3%
2001	92.3%	88.2%
2002	93.1%	89.5%
2003	90.2%	90.3%
2004	90.1%	91.5%
2005	89.5%	90.1%
2006	90.9%	88.3%
2007	91.2%	90.0%
2008	92.8%	89.9%
2009	93.6%	91.1%
2010	93.3%	91.5%
2011	94.2%	91.8%
2012	93.5%	90.5%

Insurer timeliness is measured by the rates at which claims are accepted or denied, and indemnity payments are made, in accordance with rules and statutes.

Insurer performance on timeliness of acceptance or denial of claims improved between 1990 and 1994, to 96.1 percent, after which it generally declined to a low of 89.5 percent in 2005. Recent performance has been in the 93 percent to 94 percent range.

Timeliness of first payments has also improved since 1990. Since 2009, at least 90 percent of the first payments of temporary disability benefits have been made timely.

Note: These data are self-reported by the insurers. The reports are audited by WCD.

Civil penalties issued, 1990-2012

Year	Number of Citations	Total Penalties Assessed	Average penalty per citation
1990	407	$158,325	$389.00
1991	420	156,775	$373.27
1992	506	163,101	$322.33
1993	621	166,650	$268.36
1994	679	197,025	$290.17
1995	525	139,325	$265.38
1996	491	140,850	$286.86
1997	629	244,175	$388.20
1998	813	254,925	$313.56
1999	789	243,375	$308.46
2000	844	248,875	$294.88
2001	738	204,400	$276.96
2002	947	301,900	$318.80
2003	1,241	343,875	$277.10
2004	677	206,675	$305.28
2005	745	360,600	$484.03
2006	951	588,150	$618.45
2007	915	575,800	$629.29
2008	1,140	596,775	$523.49
2009	739	404,525	$547.40
2010	526	286,525	$544.72
2011	661	369,500	$559.00
2012	744	398,700	$535.89

In 2011, the number of citations against insurers, and total penalties assessed, began to increase. In 2012, there were 744 citations and $398,700 in penalties. The average penalty per citation has been at least $500 every year since 2006.

Not included in these statistics are stipulated agreements. These may encompass various violations of rules and statutes under ORS Chapters 656 and 731 and set up various performance expectations.

Calls to the workers' compensation information line, 1990-2012

Year	Worker calls	Other calls	Total calls
1990	23,263	N/A	N/A
1991	21,475	N/A	N/A
1992	15,181	N/A	N/A
1993	18,243	N/A	N/A
1994	19,678	7,575	27,253
1995	17,503	6,699	24,202
1996	16,938	7,701	24,639
1997	15,737	8,425	24,162
1998	14,960	8,098	23,058
1999	13,711	7,930	21,641
2000	12,155	6,490	18,645
2001	11,662	6,936	18,598
2002	10,000	7,056	17,056
2003	9,813	7,397	17,210
2004	10,129	7,703	17,832
2005	9,463	6,270	15,733
2006	7,898	6,056	13,954
2007	7,359	4,947	12,306
2008	6,713	4,715	11,428
2009	5,446	4,214	9,660
2010	4,717	3,750	8,467
2011	2,714	1,918	4,632
2012	3,177	2,086	5,263

WCD has an information line to assist workers and others (800-452-0288).

Calls for assistance have steadily declined over the past two decades. In 2012, there were just over 3,000 calls from workers with questions about their claims, the claims process, or the workers' compensation system.

The line also received more than 2,000 calls from insurers, medical providers, attorneys, employers, legislators, and others in 2012.

Cases requiring language translation or worker advocacy are referred to the Office of the Ombudsman for Injured Workers.

2012 Advocates and Advisory Groups table updates

Ombudsman for Injured Workers inquiries, 1999-2012

Year	Inquiries
1999	9,492
2000	10,581
2001	10,944
2002	12,685
2003	14,730
2004	12,752
2005	12,809
2006	12,257
2007	11,512
2008	11,404
2009	11,624
2010	10,817
2011	9,496
2012	8,664

The Office of the Ombudsman for Injured Workers was created in 1987. Inquiries to the ombudsman come primarily from injured workers, but they are also initiated by attorneys, insurance companies, employers, and others. There were 8,664 inquiries in 2012, an average of about 35 per working day.

Small Business Ombudsman inquiries, 1991-2012

Year	Inquiries
1991	1,934
1992	3,655
1993	3,731
1994	3,727
1995	3,877
1996	3,545
1997	3,711
1998	4,514
1999	5,164
2000	3,109
2001	2,502
2002	5,209
2003	4,085
2004	3,883
2005	3,153
2006	3,280
2007	3,785
2008	1,584
2009	1,204
2010	915
2011	773
2012	785

The Office of the Ombudsman for Small Business was created in 1990. The number of inquiries peaked in 1999 and 2002. There were 785 inquiries in 2012.

2012 Medical Care and Benefits table updates

Medical payments by provider type, 2012

Provider type	Payments ($ millions)	Percent of Total Payments
Hospital Outpatient	$85.05	26.5%
Medical Doctor	62.79	19.6%
Hospital Inpatient	36.66	11.4%
Physical Therapist	31.82	9.9%
Other Medical Provider	22.91	7.1%
Ambulatory Surgical Center	19.23	6.0%
Pharmacy	18.88	5.9%
Medical Supplies	8.90	2.8%
Chiropractor	8.87	2.8%
Occupational Therapist	3.91	1.2%
Subtotal:	299.00	93.3%
Remaining provider types2:	21.46	6.7%
Total:	$320.46	100.0%

In 2012, an estimated $320.5 million was paid for workers' compensation medical services. This is an increase of 1 percent from the revised 2011 estimate of $317.3 million. Hospital outpatient services accounted for 26.5 percent of payments. 2012 was the fourth consecutive year in which hospital outpatient expenditures exceeded payments to medical doctors.

The Workers' Compensation Division requires that insurers with 100 or more accepted disabling claims report their medical payment data. New rules for the reporting of medical payments in OAR 436-160 (Medical Electronic Data Interchange) have replaced rules under OAR 436-009 (Bulletin 220).

1: Other Medical Provider payments are primarily for independent medical exams and ambulance services.

2: The Remaining Provider Types are osteopath, home health care, dentist, nursing home care, acupuncturist, physician assistant, podiatrist, laboratory services, optometrist, registered nurse practitioner, psychologist, radiologist, and naturopath.

Top 15 workers' compensation medical services, 2012

Service code	Description of service	Payments ($ millions)	Percent of total payments
97110	Therapeutic exercises	$24.23	7.6%
99213	Office/outpatient visit	19.77	6.2%
97140	Manual therapy	13.23	4.1%
D0003	Independent Medical Examination	9.40	2.9%
360	Operating Room Services	8.88	2.8%
99214	Office/outpatient visit	8.16	2.5%
99203	Office/outpatient visit	5.82	1.8%
97530	Therapeutic activities	5.18	1.6%
99283	Hospital: Emergency dept visit	4.86	1.5%
278	Hospital: Other Implants	4.81	1.5%
99204	Office/outpatient visit	3.61	1.1%
73721	MRI joint of lower extremity w/o contrast material	3.51	1.1%
250	Hospital: Pharmacy	3.28	1.0%
73221	MRI joint of upper extremity w/o contrast material	3.10	1.0%
120	Hospital: Room and board - Semi-Private	3.04	0.9%
	Subtotal:	120.89	37.7%
	Remaining services:	199.57	62.3%
	Total:	$320.46	100%

This table shows the top 15 service codes ranked according to total payments.

In 2012, the single medical service with the largest volume of payments, $24.23 million, was therapeutic exercises. The top 15 services combined accounted for more than one-third of all workers' compensation medical payments.

Three of the top 15 services are categorized as physical medicine, commonly performed by physical therapists. Five are evaluation and management services, either office or emergency room visits. Four are services represented by three-digit revenue codes. These are for hospital inpatient and facility services. Two are MRI services and one is for independent medical examinations.

Medical payments by fee schedule category, 2012

Group	Fee schedule category	Payments ($ millions)	Percent of total
Physician service	Physical Medicine	$54.19	16.9%
	Evaluation & Management	52.83	16.5%
	Radiology	27.31	8.5%
	Major Surgery[1]	21.76	6.8%
	Medicine	14.29	4.5%
	Minor Surgery[2]	9.15	2.9%
	Chiropractic	3.36	1.0%
	Laboratory	2.73	0.9%
	Unknown Professional Services	0.08	0.03%
Total physician services		185.70	57.9%
Facility Services	Inpatient Facility Fees	35.26	11.0%
	Outpatient Facility Fees	30.87	9.6%
	ASC Facility Fees	6.81	2.1%
	Other Facility Services	0.01	0.004%
Total hospital services		72.96	22.8%
OSCs, IMEs and IME-Related Services'	IMEs	9.76	3.0%
	Oregon Specific Codes	4.45	1.4%
	IME-Related services	0.41	0.1%
Total OSCs, IMEs and IME-Related Services		14.62	4.6%
Pharmaceuticals	Pharmacy NDCs	14.02	4.4%
	HO NDCs	2.76	0.9%
	Other NDCs	1.59	0.5%
Total Pharmaceuticals		18.37	5.7%
Other services	Non-hospital HCPCS[3]	16.37	5.1%
	DME & supplies	5.95	1.9%
	Anesthesiology	5.12	1.6%
	Dental	1.62	0.5%
	Other/Unknown[3]	0.006	0.002%
Total other services		29.07	9.1%
Total		$320.46	100.0%

As set forth in Oregon Administrative Rule (OAR) 436-009-0040, the insurer shall pay for medical services at the provider's usual

As set forth in Oregon Administrative Rule (OAR) 436-009-0040, the insurer shall pay for medical services at the provider's usual fee or in accordance with the fee schedule, whichever is less. Medical services not covered by a fee schedule are reimbursed at the provider's usual fees. New rules in effect in 2012 created fee schedules for several categories of previously non-fee-schedule services.

This table shows total payments and percent of total for fee-schedule-regulated service categories and non-fee-schedule categories. Physician services are those covered by the physician fee schedule (OAR 436-009-0050). Facility Services are paid according to the hospital cost-to-charge ratio (Bulletin 290) or the ASC fee schedule (OAR 436-009 Appendix C-D). Oregon-specific services accounted for $14.62 million, about two-thirds of which was for independent medical examinations (IMEs) and related services.

1: Major surgery includes all services with a 90-day global period

2: Minor surgery includes all services with a global period of less than 90 days

3: Non-fee-schedule services

Top 15 pharmacy payments by drug name, 2012

Drug name	Drug type	Therapeutic class	Payments ($ millions)	Percent of total payments
Oxycontin	Brand	Analgesics - opioid	$2.56	14.1%
Lyrica	Brand	Anticonvulsants	0.84	4.6%
Cymbalta	Brand	Antidepressants	0.84	4.6%
Hydrocodone w/ Acetaminophen	Generic	Analgesics - opioid	0.81	4.5%
Gabapentin	Generic	Anticonvulsants	0.80	4.4%
Lidoderm	Brand	Dermatologicals	0.63	3.5%
Celebrex	Brand	Analgesics - antiinflammatory	0.55	3.0%
Oxycodone HCL	Generic	Analgesics - opioid	0.48	2.7%
Morphine Sulphate ER	Generic	Analgesics - opioid	0.48	2.6%
Fentanyl	Generic	Analgesics - opioid	0.42	2.3%
Oxycodone w/ Acetaminophen	Generic	Analgesics - opioid	0.35	1.9%
Fentora	Brand	Analgesics - opioid	0.27	1.5%
Metaxalone	Generic	Musculoskeletal therapy agents	0.24	1.3%
Modafinil	Generic	ADHD, anti-narcolepsy, anti-obesity, anorexiants	0.24	1.3%
Cyclobenzaprine HCL	Generic	Musculoskeletal therapy agents	0.23	1.3%
Subtotal:			9.74	53.6%
Remaining Pharmacy Payments:			8.42	46.4%
Total:			$18.16	100.0%

In 2012, the top 15 pharmaceuticals accounted for 53.6 percent of total pharmacy payments.

Generic drugs made up 81 percent of the prescriptions dispensed to injured workers and 43 percent of pharmacy payments for prescription medications. Prescription medications accounted for 99.5 percent of total pharmacy payments. Medical supplies and other non-drug services provided by pharmacies made up for the remaining 0.5 percent of total pharmacy payments.

MCO contracts with insurers and self-insured employers, FY 1995-2012

Calendar year	Insurers	Self-insured employers	Total
1995	31	46	77
1996	39	46	85
1997	42	52	94
1998	41	55	96
1999	36	50	86
2000	40	52	92
2001	45	56	101
2002	41	61	102
2003	41	64	105
2004	36	62	98
2005	39	70	109
2006	37	67	104
2007	33	59	92
2008	33	64	97
2009	33	72	105
2010	32	76	108
2011	32	81	113
2012	31	85	116

At the end of 2012, there were four active certified managed care organizations. These four MCOs had 107 active contracts with insurers and self-insured employers at some point during fiscal year 2011. In November 2010, a fifth MCO was activated but never began business with workers' compensation insurers or self-insured employers and has subsequently been inactivated.

Note: These figures are based on reports submitted by MCOs and may change as new data are reported.

Employees with accepted disabling claims enrolled in MCOs, 1998-2012

Year	SAIF	Private insurers	Self-insured employers	Total
1998	76.8%	24.5%	23.2%	39.8%
1999	72.4%	20.9%	21.8%	37.1%
2000	76.3%	20.1%	27.9%	40.1%
2001	70.3%	12.3%	26.8%	35.6%
2002	67.5%	11.7%	27.8%	36.5%
2003	70.3%	8.2%	30.1%	39.1%
2004	69.7%	10.4%	30.7%	40.9%
2005	70.5%	7.8%	32.9%	42.1%
2006	67.0%	5.7%	33.2%	39.6%
2007	65.8%	6.7%	34.0%	39.8%
2008	64.1%	8.4%	33.3%	38.7%
2009	63.3%	8.9%	39.1%	39.5%
2010	62.6%	7.5%	42.6%	39.7%
2011	63.0%	7.7%	42.6%	40.2%
2012	67.5%	7.8%	49.2%	45.7%

The percentage of claimants with accepted disabling claims (ADCs) who have been enrolled in MCOs has varied between 36 percent and 46 percent. It had been stable at around 40 percent for the period 2006-2011. During those same five years, SAIF's percentage of ADCs enrolled has gone down while the share of private insurers and self-insured employers has increased. In 2012, SAIF's share of enrolled claims increased, as did self-insured employers.

Note: The 2002 private insurer figure includes estimated data from the Liberty group.

2012 Indemnity Benefits table updates

Indemnity and medical benefits paid, CY 1995-2012

Year paid	Total paid ($ millions)	Indemnity percent of total	Medical percent of total
1995	$460.19	56.9%	43.1%
1996	441.94	55.5%	44.5%
1997	431.91	53.9%	46.1%
1998	434.86	52.2%	47.8%
1999	435.40	51.9%	48.1%
2000	452.60	50.8%	49.2%
2001	474.04	50.9%	49.1%
2002	490.72	50.6%	49.4%
2003	483.35	48.8%	51.2%
2004	511.35	48.1%	51.9%
2005	544.45	46.3%	53.7%
2006	571.78	46.7%	53.3%
2007	582.03	47.7%	52.3%
2008	585.27	49.9%	50.1%
2009	611.33	48.9%	51.1%
2010	595.04	48.2%	51.8%
2011	595.04	46.7%	53.3%
2012	577.38	44.5%	55.5%

Total paid peaked in 2009. Since 2003, indemnity benefits paid have been less than 50 percent of total paid, declining to about 45 percent in 2012, a historic low.

Total paid is indemnity plus medical benefits for accepted and denied, disabling and nondisabling claims. Most of this is paid by insurers from premium. A small amount is reimbursement from the Workers' Benefit Fund. Total paid does not include most payments under the Re-employment Assistance Program or cost-of-living adjustments from the Retroactive Program.

Indemnity benefits are temporary disability, permanent partial disability, permanent total disability, vocational assistance, and death benefits, plus agreements and settlements. Temporary disability excludes most payments before compensability denial or after a department or court order; this applies to all the tables. Medical benefits paid are extrapolated from reported paid bills.

Some indemnity data are also estimated. Historical data are subject to small changes.

Indemnity benefits paid for accepted disabling claims, CY 1995-2012

Year	Benefits paid ($ millions)	Average benefits
1995	$247.78	$7,450
1996	232.66	7,618
1997	219.40	7,518
1998	212.85	7,491
1999	213.28	7,905
2000	215.17	8,263
2001	226.96	8,795
2002	234.60	9,629
2003	221.35	9,639
2004	233.17	10,120
2005	237.89	10,576
2006	251.63	10,647
2007	262.68	10,800
2008	276.16	11,894
2009	280.99	13,446
2010	269.14	14,026
2011	261.77	13,650
2012	240.71	12,509

Total indemnity benefits paid by insurers for accepted disabling claims also peaked in 2009, and the $241 million paid in 2012 is the lowest since 2005.

After peaking in 2010, average indemnity paid declined by almost 9 percent to $12,509 between 2011 and 2012. This average is indemnity paid divided by the number of claim resolutions in the year. The remaining tables provide details about benefits paid, claim resolutions, and resolved accepted disabling claims.

Some payment data are estimated. Historical data are subject to small changes.

Workers' Benefit Fund payments by benefit type, CY 1995-2012

Year	PTD ($ millions)	Death ($ millions)	EAIP disabling claims ($ millions)	EAIP non-disabling claims ($ millions)	PWP worker initiated ($ millions)	PWP employer initiated ($ millions)	PWP claim costs reimbursed ($ millions)	Total ($ millions)
1995	$29.39	$31.96	$4.95	$0.01	$6.19		$3.13	$75.63
1996	28.30	32.95	6.28	1.29	7.91		3.03	79.76
1997	28.19	34.72	6.62	3.21	8.87		3.01	84.63
1998	27.99	35.88	7.61	4.05	8.46		3.45	87.44
1999	27.61	36.79	6.78	3.82	7.23		3.71	85.94
2000	27.60	38.42	5.82	3.69	5.86		3.01	84.39
2001	26.28	38.82	7.04	4.02	5.77		3.19	85.13
2002	24.97	39.21	5.72	3.26	4.99		2.56	80.71
2003	23.35	38.22	5.76	3.01	4.41		2.27	77.03
2004	21.94	37.53	6.36	3.34	5.72		2.31	77.21
2005	21.49	36.95	6.74	3.29	5.03	$0.01	2.19	75.70
2006	20.57	36.92	7.92	3.96	4.57	1.05	2.04	77.02
2007	19.85	35.66	9.50	4.35	4.13	1.61	2.28	77.40
2008	19.42	35.80	12.66	5.53	4.56	1.88	2.34	82.17
2009	18.83	36.14	13.01	5.63	3.73	1.85	2.67	81.87
2010	17.70	35.24	11.69	4.81	3.04	1.68	2.68	76.84
2011	16.26	34.30	13.12	6.02	2.78	1.30	2.73	76.50
2012	14.85	32.62	13.71	6.42	2.76	1.59	2.18	74.12

The Workers' Benefit Fund provides funds for several programs that assist employers and injured workers. Assessment revenues, not insurance premiums, fund these programs. Employers and workers each pay half the assessment. The two major programs are the Retroactive Program and the Re-employment Assistance Program.

The Retroactive Program pays cost-of-living increases to workers or their beneficiaries based on changes in average wages. The two major benefits paid are for permanent total disability and death. In 2012, the Retroactive Program provided an estimated $47.47 million for PTD and death benefits. Since at least 1995, the majority of PTD and death benefits have been paid from this program.

The Re-employment Assistance Program provides incentives for injured workers to return to work, through the Employer-at-Injury Program (EAIP) and the Preferred Worker Program (PWP). Benefits common to both are wage subsidies, worksite modifications, and employment purchases. Total payments for EAIP first exceeded PWP in 2000 and, in 2012, total EAIP became triple total PWP payments.

Workers who have not been released to regular work but can return to transitional jobs are eligible for the EAIP. Use of this program allows many claims to remain nondisabling even though the workers have medical restrictions. For more details, see the return-to-work tables. Generally, EAIP payments for nondisabling claims have been about half that for disabling claims.

Workers who have a permanent disability and are unable to return to regular work are eligible for the PWP benefits, which may be initiated by either the worker or the employer. In addition, claim cost reimbursement is paid for preferred workers who suffer new injuries. PWP claim cost reimbursements are included in all tables that have statistics about indemnity or medical benefits paid.

Historical data are subject to small changes.

Claim resolutions, CY 1995-2012

Year	Initial claim, CDA	Initial claim, closure	Aggravation and medical condition, closure	Vocational training closure	Total claim resolutions
1995	714	30,482	1,822	242	33,260
1996	785	28,108	1,375	273	30,541
1997	854	26,789	1,252	288	29,183
1998	829	26,100	1,242	242	28,413
1999	947	24,615	1,212	207	26,981
2000	892	23,895	1,058	197	26,042
2001	954	23,543	1,104	203	25,804
2002	925	22,240	1,010	188	24,363
2003	927	20,869	962	205	22,963
2004	906	20,937	1,009	189	23,041
2005	953	20,404	938	199	22,494
2006	1,045	21,481	914	194	23,634
2007	1,159	22,083	860	220	24,322
2008	1,238	20,903	882	195	23,218
2009	1,389	18,484	825	199	20,897
2010	1,247	16,988	768	186	19,189
2011	1,262	16,978	757	181	19,178
2012	1,207	17,209	699	128	19,243

Accepted disabling claims may resolve multiple times. The trend for total claim resolutions has been down, from roughly 33,000 in 1995 to 19,000 currently.

Claim types are initial claims, aggravation, new or omitted medical condition, and vocational training. Resolutions are by claim closure or claim disposition agreement. Most claim resolutions are closures on initial claims.

For each of the past seven years, there have been more than 1,000 initial claims that have a CDA rather than claim closure. These counts exclude CDAs for nondisabling claims and for closed disabling claims.

Historical data are subject to small changes.

Indemnity paid for accepted disabling claims by benefit type, CY 1995-2012

Year	Temporary disability ($ millions)	PPD ($ millions)	PTD ($ millions)	Death ($ millions)	Claim disposition agreements ($ millions)	Disputed claim settlements ($ millions)	"Vocational assistance ($ millions) "	Vocational assistance ($ millions)
1995	$98.52	$59.80	$13.64	$9.00	$47.58	$9.94	$9.31	$247.78
1996	88.13	59.69	13.12	9.61	43.98	8.72	9.41	232.66
1997	82.36	55.22	12.61	10.33	42.89	8.18	7.81	219.40
1998	82.63	55.18	11.97	10.85	36.28	8.89	7.05	212.85
1999	83.70	53.40	11.45	11.09	38.59	8.66	6.39	213.28
2000	82.47	54.94	11.03	11.81	38.50	10.31	6.11	215.17
2001	92.07	58.96	10.51	12.04	37.75	9.53	6.10	226.96
2002	92.84	57.73	9.98	12.30	43.14	12.05	6.55	234.60
2003	84.64	57.99	9.54	13.12	39.45	10.56	6.04	221.35
2004	91.42	60.20	9.11	13.05	41.98	10.88	6.53	233.17
2005	92.02	63.65	8.95	13.66	42.11	11.03	6.49	237.89
2006	98.15	64.05	8.54	13.68	49.91	10.31	6.99	251.63
2007	104.93	65.00	8.38	14.38	50.75	11.94	7.30	262.68
2008	110.43	62.29	7.86	14.10	60.91	13.65	6.92	276.16
2009	111.74	61.03	7.37	14.55	61.92	16.96	7.42	280.99
2010	104.62	54.25	6.94	14.01	63.77	18.88	6.68	269.14
2011	100.65	50.27	6.54	14.70	64.27	18.74	6.60	261.77
2012	95.33	47.03	6.13	14.30	56.15	15.97	5.80	240.71

In 2012, 40 percent of indemnity benefits for accepted disabling claims were temporary disability payments, 20 percent were permanent partial disability (PPD) awards, 30 percent were agreements and settlements, and the remainder were paid for permanent total disability (PTD), death, and vocational assistance benefits. Agreements and settlements have accounted for at least 30 percent of indemnity since 2010.

Data are reported by the year of the insurer closure or order by the department or court. Temporary disability includes reports by insurers at claim closure and following a vocational assistance training plan, and estimates of unreported data such as for initial claims resolved by claim disposition agreement. Temporary disability data is partial for benefit changes after a department or court order. Some death and PTD benefits are estimated and neither includes cost-of-living adjustments paid from the Workers' Benefit Fund. Benefits paid on PTD claims after the worker has died are included in death benefits. Historical data are subject to small changes.

Average temporary disability days paid by type of claim resolution, CY 1995-2012

Year	Initial claim, CDA	Initial claim, closure	Aggravation and medical condition, closure	Vocational training closure	All claim resolutions
1995	261	50	117	205	60
1996	246	48	107	208	57
1997	221	45	97	222	54
1998	210	46	86	221	54
1999	211	46	84	208	55
2000	211	45	80	214	53
2001	222	48	92	213	57
2002	253	49	86	243	60
2003	229	49	73	221	58
2004	243	50	79	230	60
2005	259	51	86	209	63
2006	255	50	70	218	61
2007	246	50	96	215	63
2008	264	52	84	213	66
2009	236	60	69	237	74
2010	245	58	91	219	73
2011	237	54	88	257	70
2012	213	53	65	246	65

The average days of temporary disability paid for initial claim closures was 53 in 2012, down from the recent peak of 60 in 2009.

Temporary disability payments are not reported for initial claims that resolve by CDA, but a data call completed in March 2012 provided sample results that helped to improve our estimated averages. For 2012, the estimated average was 213 days, near the historic low.

Since 2008, the average for all claim resolutions has been 65 or more days paid. As new claims were decreasing, older and longer-duration claims increased in proportion, but that trend has now moderated. Generally, the trend is largely driven by days paid for initial claim closures, which are the majority of claim resolutions.

The data are reported for each claim resolution by the year of claim closure or claim disposition agreement. The average days are calculated per resolution rather than per claim. Historical data are subject to small changes.

Temporary disability for resolved accepted disabling claims, CY 1995-2012

Year	Resolved claims	Average days	Average dollars	Median days
1995	31,540	65	3,215	19
1996	29,070	62	3,101	17
1997	27,820	58	3,027	17
1998	27,069	58	3,088	18
1999	25,608	58	3,261	19
2000	24,781	56	3,290	18
2001	24,583	60	3,721	18
2002	23,081	63	3,962	18
2003	21,785	62	3,849	19
2004	21,875	63	4,124	19
2005	21,388	66	4,311	20
2006	22,559	64	4,287	19
2007	23,248	65	4,475	19
2008	22,190	69	4,914	20
2009	19,992	77	5,565	24
2010	18,442	77	5,714	23
2011	18,392	74	5,578	23
2012	18,773	70	5,391	23

Since at least 1995, the trend for resolved accepted disabling claims has been declining counts. An accepted disabling claim is resolved if it has had a claim closure or a CDA on the initial opening and if it is not currently in open or reopen status.

For claims resolved in 2012, the average number of temporary disability days paid per accepted disabling claim, counting all resolutions for a claim is 70 days, down from the past two years, but still historically high. The average temporary disability payment is $5,391, continuing the recent decline.

The data are reported by the year of the latest claim resolution. Historical data will show small changes as claims are reopened and closed.

Permanent partial disability, CY 1995-2012

Year	Claims resolved by closure, with PPD	Percentage of closed claims with PPD	Average PPD award
1995	9,470	30.7%	$6,362
1996	8,908	31.5%	$6,600
1997	8,041	29.8%	$7,015
1998	7,730	29.5%	$7,110
1999	7,290	29.6%	$7,336
2000	6,932	29.0%	$7,761
2001	6,995	29.6%	$8,280
2002	6,704	30.3%	$8,542
2003	6,221	29.8%	$9,080
2004	6,281	30.0%	$9,565
2005	6,270	30.7%	$9,973
2006	6,347	29.5%	$9,558
2007	6,336	28.7%	$9,774
2008	6,022	28.7%	$10,154
2009	5,737	30.8%	$10,517
2010	5,022	29.2%	$10,761
2011	4,801	28.0%	$10,942
2012	4,782	27.2%	$10,556

In general, about 30 percent of claims that resolve by closure have received permanent partial disability awards, and the 27 percent in 2012 is a recent historical low. Annual counts of closed claims with PPD have declined from almost 9,500 in 1995 to less than 5,000 currently.

In 2012, the average award for those claims was $10,556, the first decline since 2006. However, the trend since 1995 has been upward, due to statutory increases. The effects of a 2003 law change that instituted a formula for benefit level changes began to account for most PPD awards in 2006.

Closed claims do not include initial claims resolved by CDA, none of which receive a PPD award but all of which release future PPD liability. The trend for claims resolved by initial-claim CDA has been up, which may account for some of the decline in the number of PPD claims. CDA resolutions have been more than 6 percent of all claims resolved since 2009.

These data are reported by the year of the last claim closure. The average awards include the initial awards made by insurers and the net amounts that were awarded during the appeal process, summed over all claim closures. Data will change as claims are opened and closed.

Permanent total disability awards, CY 1987-2012

Year	Grant	Rescind	Net awards
1987	204	27	177
1988	209	14	195
1989	139	15	124
1990	81	36	45
1991	68	22	46
1992	47	5	42
1993	26	13	13
1994	36	9	27
1995	32	17	15
1996	17	6	11
1997	20	5	15
1998	16	6	10
1999	25	11	14
2000	14	6	8
2001	13	14	-1
2002	23	3	20
2003	14	6	8
2004	20	7	13
2005	20	4	16
2006	18	1	17
2007	15	1	14
2008	10	1	9
2009	13	0	13
2010	23	0	23
2011	10	1	9
2012	9	0	9

The number of permanent total disability awards declined dramatically between 1988 and 1990, when disability rating standards were adopted systemwide. The creation of CDAs in 1990 led to further decline.

PTD grants can be made by insurers or by the department through the appeal process. These counts include the reinstatement of awards that were rescinded by insurers or during earlier appeals.

Maximum PPD benefits, since July 1986

Dates of injury	Maximum scheduled PPD	Maximum unscheduled PPD	Maximum PPD
July 1986 - June 1987	$24,000	$32,000	-
July 1987 - June 1990	27,840	32,000	-
July 1990 - June 1991	58,560	32,000	-
July 1991 - June 1992	58,577	60,503	-
July 1992 - June 1993	60,601	62,592	-
July 1993 - June 1994	63,631	65,723	-
July 1994 - June 1995	66,722	68,915	-
July 1995 - Dec. 1995	67,402	69,617	-
Jan. 1996 - Dec. 1997	80,640	130,400	-
Jan. 1998 - Dec. 1999	87,168	138,224	-
Jan. 2000 - Dec. 2001	98,168	149,033	-
Jan. 2002 - Dec. 2004	107,328	162,272	-
--------------> Series break			
Jan. 2005 - June 2005	-	-	$263,917
July 2005 - June 2006	-	-	273,271
July 2006 - June 2007	-	-	276,517
July 2007 - June 2008			290,073
July 2008 - June 2009			302,946
July 2009 - June 2010	-	-	306,862
July 2010 - June 2011	-	-	314,061
July 2011 - June 2012	-	-	322,929
July 2012 - June 2013			322,447
July 2013 - June 2014			330,500

In 2003, SB 757 revised the PPD award structure, effective January 2005. It eliminated the distinction between scheduled and unscheduled PPD. The new structure reallocated benefits to better reflect earnings loss, providing less-generous benefits to some workers who can return to regular work, and more-generous benefits to those who cannot. The maximum PPD award was increased, but there has been no increased cost to the workers' compensation system.

The increase in PPD maximum amounts since 2005 is due to benefit levels now being escalated by the change in the AWW under the new law. The small decline in benefits beginning July 2012 reflects a recession-related decline in AWW. Maximum PPD benefit levels in the most recent year are more than double the pre-2005 unscheduled maximum.

2012 Return-to-Work Assistance table updates

Employer-at-Injury Program placements approved, CY 1995-2012

Year	Disabling claim placements	Nondisabling claim placements	Total worker placements	Employers	Mean cost per placement
1995	3,734	4	3,738	1,190	$1,326
1996	4,288	1,790	6,078	1,348	$1,245
1997	4,455	3,904	8,359	1,513	$1,180
1998	4,985	5,083	10,068	1,791	$1,167
1999	4,385	5,057	9,442	1,837	$1,132
2000	3,581	4,273	7,854	1,579	$1,215
2001	4,226	4,380	8,606	1,657	$1,292
2002	3,313	3,094	6,407	1,236	$1,411
2003	3,102	2,856	5,958	1,334	$1,477
2004	3,514	3,095	6,609	1,499	$1,472
2005	3,492	2,983	6,475	1,494	$1,553
2006	3,904	3,520	7,424	1,626	$1,604
2007	4,329	3,441	7,770	1,800	$1,787
2008	5,056	3,759	8,815	1,993	$2,066
2009	5,065	3,543	8,608	2,005	$2,168
2010	4,477	3,094	7,571	1,865	$2,182
2011	4,876	3,512	8,388	1,931	$2,286
2012	5,104	3,845	8,949	1,989	$2,255

The Employer-at-Injury Program was created to encourage placement of injured workers into transitional work while they recover from their injuries. Benefits available to employers and their workers include wage subsidy, worksite modification, and purchases. SB 369 of 1995 allowed benefits to become available for nondisabling claims.

Higher counts of workers and employers with placements after 2005 are evidence that recent law changes are promoting use and access to the program, despite declining claim counts. Modifications and purchases are being used more often due to administrative law changes in late 2007.

Historical data are subject to small changes. Disabling and nondisabling placements are counted by current claim status.

Preferred workers, CY 1995-2012

Year	Eligibilities	Eligibilities with benefit use	Percent of eligibilities with benefit use
1995	4,459	1,334	29.9%
1996	3,708	1,107	29.9%
1997	3,120	912	29.2%
1998	2,946	738	25.1%
1999	2,549	645	25.3%
2000	2,267	586	25.8%
2001	2,375	565	23.8%
2002	1,858	501	27.0%
2003	1,821	499	27.4%
2004	1,779	482	27.1%
2005	1,794	476	26.5%
2006	1,756	467	26.6%
2007	2,014	553	27.5%
2008	1,943	389	20.0%
2009	1,617	322	19.9%
2010	1,346	255	18.9%
2011	1,165	Available August 2014	
2012	1,186	Available August 2015	

Preferred workers have permanent work restrictions that prevent return to unmodified regular work. Preferred worker eligibilities in 2007 and 2008 were at their highest number since 2001, but declined to a record low in 2011.

Eligibility entitles a preferred worker to many years - unlimited since December 2007 - in which to begin using benefits. Counts of eligibilities with benefit use do become relatively stable within about three years of the eligibility date. The percent of eligibilities with benefit use fell below 29 percent in 1998; averaged 26.1 percent for over a decade; then fell to a record low of 18.9 percent in 2010.

Historical data are subject to small changes.

Preferred Worker Program contracts started, CY 1995-2012

Year	Workers starting one or more contracts	Wage subsidies	Worksite modifications	Purchases
1995	1,379	1,110	418	527
1996	1,448	1,111	515	638
1997	1,380	1,063	448	602
1998	1,273	957	448	668
1999	979	734	293	462
2000	871	673	282	344
2001	718	539	232	310
2002	594	473	200	250
2003	620	517	200	235
2004	620	488	265	249
2005	594	458	245	252
2006	573	482	232	225
2007	604	495	218	237
2008	697	463	231	583
2009	541	342	187	415
2010	494	305	185	384
2011	526	350	162	411
2012	416	270	136	295

Preferred Worker Program benefits include premium exemption and claim cost reimbursement, plus wage subsidy, worksite modification, and employment purchase contracts or agreements. Workers may use all these benefits more than one time.

Administrative law changes provided for use of program benefits at the injury employer's initiative beginning July 2005 and worksite creation purchases in December 2007. The number of workers starting contracts in 2012 was the lowest on record.

Workers may start contracts in multiple years. Historical data are subject to small changes.

Vocational assistance determinations, CY 1995-2012

Year	Total determinations	Ineligible	Eligible
1995	4,447	3,168	1,279
1996	4,084	2,975	1,109
1997	3,547	2,698	849
1998	3,441	2,647	794
1999	3,299	2,555	744
2000	2,421	1,705	716
2001	2,046	1,291	755
2002	2,046	1,308	738
2003	2,108	1,324	784
2004	2,495	1,723	772
2005	2,668	1,929	740
2006	2,439	1,749	690
2007	2,293	1,539	754
2008	2,665	1,960	705
2009	2,267	1,626	641
2010	1,137	566	571
2011	901	438	463
2012	719	350	369

Insurers determine eligibility or ineligibility for vocational assistance for workers with permanent partial disability who do not return to permanent work with the employer at injury. The department audits claim closures to assure that insurers determine eligibility.

In general, workers are eligible for vocational assistance if they have a substantial handicap that prevents re-employment in any job that pays at least 80 percent of the job-at-injury wages. Eligible determinations include insurer letters, eligibility orders, and eligibility restorations.

Although the total number of determinations in 2010 was the lowest on record to that time (about half the previous year), most of the change was among the ineligible workers. HB 2705 (2009) allows forgoing a determination when the worker has a regular work release.

Data may be reported by the insurer several months after the determination.

Vocational assistance eligibility closures, plans, and outcomes, CY 1995-2012								
Year	Total eligibility closures	Closed, no plan	Closed, direct employment plan	Closed, training plan	Outcome: return to work	Outcome: maximum services or job ended	Outcome: CDA	Outcome: other
1995	1,404	832	51	521	340	87	631	346
1996	1,243	698	39	506	337	58	582	266
1997	993	512	23	458	248	59	441	245
1998	874	455	6	413	208	50	424	192
1999	781	416	7	358	157	41	354	229
2000	725	395	4	326	171	46	323	185
2001	714	387	4	323	154	46	312	202
2002	787	453	7	327	140	70	390	187
2003	735	423	8	304	123	75	371	166
2004	779	449	5	325	128	60	375	216
2005	749	441	4	304	135	48	358	208
2006	743	410	7	326	143	48	368	184
2007	724	394	3	327	152	46	319	207
2008	714	412	5	297	109	45	351	209
2009	689	376	12	301	95	70	314	210
2010	634	336	10	288	81	62	325	166
2011	569	287	10	272	66	64	278	161
2012	475	239	2	234	68	46	222	139

Eligibility closures include insurer eligibility closures and eligibilities where there is a claim disposition agreement in full, but no eligibility closure. No-plan closures continue to account for 50 percent or more of eligibility closures. The claim disposition agreement continues to account for about 50 percent of eligibility closure outcomes.

Data may be reported by the insurer several months after the closure.

Employment and wage recovery advantage for return-to-work program users, FY 1997-2012								
Fiscal year	Employer-at-Injury Program	Preferred Worker Program	Vocational Assistance	All return-to-work programs	Employer-at-Injury Program	Preferred Worker Program	Vocational Assistance	All return-to-work programs
1997	7	24	24	10	3	24	17	4
1998	5	23	28	11	2	22	27	9
1999	3	22	28	10	2	21	25	9
2000	6	24	30	12	6	22	26	12
2001	5	24	24	11	5	15	19	11
2002	4	21	21	9	8	18	28	14
2003	3	20	35	10	9	20	27	14
2004	4	23	35	11	8	14	33	14
2005	4	24	29	11	5	29	19	12
2006	6	29	34	13	9	33	26	16
2007	5	23	31	10	6	20	40	12
2008	4	27	39	11	4	27	30	11
2009	4	27	35	11	3	24	41	11
2010	6	26	21	12	6	28	28	14
2011	6	32	34	12	6	28	17	13
2012	3	44	19	11	3	51	8	12
2012	3	44	19	11	3	51	8	12

The department analyzes data from the Oregon Employment Department to calculate percentage-point differences in employment and wage-recovery rates between workers with accepted disabling claims who used return-to-work programs and similar workers who did not. The measures are based on wages reported in the 13th quarter after the disabling injury or exposure, when most workers have recuperated and used return-to-work programs. Since 2000, at least 87 percent of the program use at that point has been the Employer-at-Injury Program.

2012 Disputes table updates

Appellate review requests and orders, 1991-2012

Year	Requests on closures	Percent of closures appealed	Requests on disabling classifications	Total orders issued	Percent of orders appealed to hearings
1991	6,014	16.5%	26	5,896	49.0%
1992	6,535	20.0%	73	6,463	53.4%
1993	5,937	18.5%	87	5,954	48.1%
1994	5,839	18.0%	99	5,953	47.8%
1995	6,543	20.1%	152	6,420	44.6%
1996	5,352	18.1%	128	5,857	41.2%
1997	4,306	15.2%	100	4,452	38.8%
1998	4,228	15.3%	123	4,282	38.9%
1999	4,025	15.5%	126	4,263	38.7%
2000	3,833	15.3%	132	3,988	33.7%
2001	3,979	16.0%	142	4,021	30.7%
2002	3,906	16.7%	188	4,122	29.6%
2003	3,749	17.1%	205	4,037	28.2%
2004	3,800	17.2%	186	3,950	29.1%
2005	3,531	16.4%	182	3,824	25.3%
2006	3,424	15.2%	198	3,637	24.1%
2007	3,788	16.4%	186	3,941	23.1%
2008	3,527	16.1%	149	3,743	19.2%
2009	3,409	17.5%	147	3,598	21.6%
2010	2,978	16.6%	167	3,215	22.0%
2011	2,714	15.1%	135	2,844	19.1%
2012	2,669	14.8%	135	2,681	19.1%

The WCD Appellate Review Unit provides administrative review of decisions made by insurers regarding claim closures and classifications of claims as disabling or nondisabling. Effective 2004, insurers may also appeal claim closures when they disagree with findings on impairment by attending physicians.

Since 1995, the trend in the number of requests for reconsideration of claim closures has been declining; it is currently at its lowest level. This is largely due to the decline in the number of closures.

Requests are a count of the disputed closures, regardless of the number of amending closures that are disputed. A case is a proceeding to resolve a disputed closure or disability classification, regardless of the number of amending orders by ARU.

Medical dispute requests and orders, 1990-2012

Year	Requests	Orders	Request-to-order median days
1990	1,172	310	28
1991	1,386	969	112
1992	1,518	1,412	63
1993	876	987	44
1994	466	467	33
1995	741	469	39
1996	716	856	120
1997	878	816	61
1998	801	816	89
1999	905	819	84
2000	991	948	114
2001	1,181	1,222	69
2002	1,049	918	81
2003	1,362	1,293	88
2004	1,350	1,264	87
2005	1,456	1,548	75
2006	1,651	1,745	41
2007	1,823	1,803	28
2008	3,319	2,740	24
2009	3,047	3,822	16
2010	2,950	2,665	11
2011	2,214	2,255	13
2012	2,076	2,104	13

Medical dispute resolution requests have fluctuated with court decisions and legislative changes. They declined sharply after a court decision limited the department's jurisdiction. SB 369 reversed this decision and the numbers have since increased.

In 1999, SB 728 gave authority to the Hearings Division to determine the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service. All other medical disputes are handled by the WCD Medical Resolution Team.

In 2008, the number of requests nearly doubled; this was due primarily to the initiation of alternative dispute resolution, which has resolved medical fee disputes quickly.

In 2012, the number of medical dispute orders was 2,104. The median time from request to order was 13 days.

Medical dispute issues, by year of request, 2007-2012

Year	Fees	Medical services	Treatments	Palliative care	MCO issues	Changes of attending physician	Independent medical exams	Compen-sability	Interim medical benefits
2007	27.8%	40.2%	8.1%	3.1%	7.9%	0.5%	0.4%	11.8%	0.2%
2008	63.3%	21.1%	5.4%	1.5%	5.8%	0.1%	0.2%	2.5%	0.1%
2009	56.2%	23.5%	6.9%	1.2%	8.0%	0.5%	0.4%	3.0%	0.4%
2010	56.7%	18.9%	6.2%	1.2%	8.8%	0.6%	0.4%	3.9%	0.1%
2011	35.7%	18.3%	6.3%	1.4%	6.8%	0.8%	0.2%	3.1%	0.0%
2012	34.4%	15.2%	5.5%	0.7%	8.7%	0.5%	0.2%	2.9%	0.1%

SB 728 (1999) gave responsibility to the Hearings Division for disputes in which the compensability of the underlying medical condition is at issue. These cases were 2.9 percent of all 2012 medical-dispute-resolution requests. SB 485 (2001) amended the law regarding payment for interim medical benefits (medical services provided before a claim's initial acceptance or denial). It added a process for these disputes.

Vocational dispute requests and resolutions, 1991-2012

Year	Requests	Resolutions	Request-to-resolution median days
1991	2,067	2,137	41
1992	1,643	1,725	29
1993	1,493	1,519	25
1994	1,389	1,373	24
1995	1,347	1,304	28
1996	996	1,037	35
1997	877	881	32
1998	716	715	26
1999	630	681	28
2000	549	563	35
2001	511	480	35
2002	512	530	63
2003	504	530	56
2004	551	551	42
2005	492	485	47
2006	456	495	30
2007	468	446	28
2008	469	504	36
2009	451	432	34
2010	306	323	35
2011	200	223	36
2012	176	177	34

The WCD Rehabilitation Review Unit provides administrative review of vocational disputes brought by workers. The number of requests has fallen since 1991, chiefly because of the decrease in the number of vocational assistance cases.

The median time to resolve a dispute was 34 days in 2012; 81 percent were done within the standard of less than 60 days.

Vocational dispute resolutions, by outcome, 2006-2012

Year	Agree-ments	Insurer prevail orders	Worker prevail orders	Other orders	Dismissals
2007	28.0%	21.5%	6.5%	0.9%	43.0%
2008	22.4%	30.2%	8.9%	3.6%	34.9%
2009	25.9%	22.5%	8.8%	3.9%	38.9%
2010	21.1%	21.7%	9.0%	3.1%	45.2%
2011	22.0%	22.4%	12.6%	3.6%	39.5%
2012	24.9%	19.8%	7.9%	2.3%	45.2%

The department strives to resolve vocational disputes through agreements, but agreements as a percentage of outcomes have shown a declining trend until recently.

Hearing requests, orders, time lags, and appeal rates, 1987-2012

Year	Requests	Orders	Request-to-order median days	Appeal rate
1987	20,397	23,680	224	8.1%
1988	23,316	26,386	114	9.0%
1989	27,549	24,890	116	8.7%
1990	24,018	25,073	147	7.3%
1991	19,673	21,368	133	12.2%
1992	17,490	19,580	125	12.6%
1993	16,422	16,888	119	11.3%
1994	16,527	15,751	121	11.3%
1995	14,862	16,798	124	10.6%
1996	12,351	13,341	120	11.5%
1997	11,266	11,596	122	12.5%
1998	11,059	11,271	121	11.7%
1999	11,084	10,846	124	11.5%
2000	10,654	10,935	128	11.0%
2001	11,074	10,269	126	10.6%
2002	10,679	10,830	128	9.8%
2003	10,177	10,429	136	10.9%
2004	9,980	9,531	127	9.6%
2005	9,297	10,006	146	9.0%
2006	9,130	9,442	143	9.4%
2007	9,355	9,261	138	8.6%
2008	9,173	9,084	133	7.9%
2009	8,568	9,044	141	7.8%
2010	8,183	8,580	134	8.0%
2011	7,631	7,759	127	7.7%
2012	7,638	7,536	123	7.5%

Hearing requests peaked in 1989. The 7,631 requests in 2011 was the lowest on record and about 28 percent of the 1989 figure.

Hearing requests have dropped for three primary reasons: fewer injuries and accepted disabling claims; law changes that have reduced litigation about permanent disability; and other reform measures implemented to reduce litigation, including the provision for claim disposition agreements.

HB 2900 (1987) required that a hearing be scheduled within 90 days and an order published within 30 days of the hearing. The median time between request and order was 123 days in 2012.

Notes: Counts include settlements that were received without a prior hearing request and cases generated in order to record a mediation result. Appeal rates are based on all hearing order types, not just appealable orders.

All data exclude safety cases. WCD contested cases are considered in only the Requests and Orders columns.

Percentage of hearing orders involving selected issues, 1987-2012

Year	Permanent disability	Claim denial	Partial denial	Insurer penalty
1987	46.1%	24.5%	9.3%	14.6%
1988	39.7%	24.5%	10.4%	16.4%
1989	31.9%	32.3%	7.3%	16.6%
1990	33.3%	34.8%	8.8%	14.6%
1991	18.2%	43.7%	14.5%	10.0%
1992	15.7%	40.9%	14.7%	7.5%
1993	12.6%	48.7%	14.5%	10.3%
1994	11.6%	44.7%	19.9%	12.5%
1995	10.4%	39.4%	27.5%	12.1%
1996	11.5%	38.2%	34.4%	8.4%
1997	10.1%	46.6%	24.6%	5.9%
1998	7.6%	42.9%	33.4%	7.2%
1999	7.8%	42.5%	33.9%	7.8%
2000	7.5%	40.7%	36.2%	7.4%
2001	6.1%	39.7%	38.7%	8.1%
2002	6.3%	39.7%	38.9%	6.6%
2003	5.6%	40.7%	38.0%	7.2%
2004	6.6%	39.7%	37.8%	7.5%
2005	5.3%	41.5%	38.1%	7.3%
2006	4.5%	39.8%	38.7%	7.7%
2007	4.6%	37.6%	40.6%	8.6%
2008	4.0%	36.3%	43.5%	7.8%
2009	3.9%	35.8%	44.8%	7.3%
2010	3.5%	34.3%	47.3%	6.9%
2011	2.8%	35.8%	47.3%	5.8%
2012	2.5%	36.6%	45.8%	6.7%

Permanent disability was the most frequent hearing issue until 1989, when whole claim denial replaced it. For 2008-2012, permanent disability was an issue in 4 percent or less of hearings. Since 1990, partial denial has risen from 9 percent to more than 47 percent of hearings orders.

Reasons for the relative frequency change of permanent disability were HB 2900 in 1987 (disability standards), SB 1197 in 1990 (department reconsiderations, medical arbiters, and CDAs), and SB 369 in 1995 (limitations on issues and evidence, and the definition of "gainful employment").

Notes: This table does not include all issues. Also, orders may deal with multiple cases, and each case may have multiple issues. Issues are not recorded for cases that are dismissed or withdrawn, so these percentages are based on opinion and order cases and settlements.

Workers' Compensation Board mediations, 1996-2012

Year	Mediations completed	Percent settled	Percent of settlements resolved by DCS
1996	128	84%	81%
1997	250	92%	82%
1998	233	90%	87%
1999	216	90%	84%
2000	280	89%	87%
2001	248	85%	93%
2002	285	86%	85%
2003	241	86%	88%
2004	268	84%	81%
2005	270	87%	82%
2006	356	88%	77%
2007	346	89%	79%
2008	398	90%	76%
2009	487	89%	80%
2010	439	91%	81%
2011	406	90%	82%
2012	387	89%	85%

The board's mediation program began in June 1996.

The 91 percent settlement rate of 2010 was the second highest on record.

A mediation is considered settled by a disputed claim settlement if any included case is closed by a DCS.

Data through 2005 are based on mediation worksheets; data for 2006 and after are based on mediation events in the board's data system.

Issues in WCB mediations, 1996-2012

Year	Disease	Compensability	Non-WCB issues
1996	50%	N/A	N/A
1997	50%	90%	40%
1998	44%	98%	47%
1999	63%	N/A	46%
2000	41%	97%	43%
2001	49%	99%	51%
2002	42%	95%	55%
2003	41%	99%	45%
2004	31%	97%	50%
2005	67%	94%	47%
2006	46%	81%	42%
2007	64%	81%	43%
2008	72%	79%	43%
2009	73%	80%	44%
2010	68%	83%	35%
2011	70%	83%	36%
2012	70%	86%	41%

"Disease" means compensability of an occupational disease; it includes mental disorder.

"Non-WCB issues" includes employment rights, Workers' Compensation Division issues, torts, contracts, and other civil actions.

In 2008, the cases resolved by mediation that included compensability as an issue dropped to an all-time low of 79 percent. The percentage of mediations that included non-WCB issues has ranged from 2010's record-low 35 percent to 55 percent.

Board review requests, orders, time lags, and appeal rates, 1987-2012

Year	Requests	Orders	Request-to-order median days	Appeal rates
1987	1,719	1,222	259	29.6%
1988	2,151	991	306	12.8%
1989	1,944	1,576	548	13.6%
1990	1,653	3,067	458	17.2%
1991	2,346	2,064	264	23.8%
1992	2,230	2,487	255	27.9%
1993	1,726	1,931	256	19.5%
1994	1,599	1,814	238	20.1%
1995	1,553	1,655	204	17.4%
1996	1,381	1,676	163	17.9%
1997	1,307	1,229	160	18.2%
1998	1,187	1,358	134	18.5%
1999	1,141	1,147	125	19.1%
2000	1,076	1,166	118	21.2%
2001	966	860	110	22.9%
2002	939	818	209	14.5%
2003	996	1,023	161	19.2%
2004	802	912	162	17.9%
2005	796	770	140	13.8%
2006	782	738	167	14.9%
2007	705	701	170	14.4%
2008	625	721	196	14.6%
2009	601	582	172	12.9%
2010	588	614	187	12.4%
2011	517	551	189	14.0%
2012	492	493	185	17.8%

The number of requests for board review peaked in 1991. Requests have dropped primarily because the number of hearing opinion and orders (judge's decision on the merits) has dropped from the high of 7,000 in 1988 to fewer than 1,200 in 2012.

HB 2900 (1987) required a board review to be scheduled within 90 days and an order published within 30 days of the review.

The appeal rate of board-review orders dropped immediately from the 1987 peak. One reason was that HB 2900 changed the court's review standard from de novo to "substantial evidence."

Note: Counts exclude crime-victim and third-party cases, reconsideration orders, and on-remand orders. Appeal rates are based on all board-review order types, not just orders on review.

Board own-motion orders, 1987-2012

Year	BOM orders
1987	612
1988	724
1989	703
1990	962
1991	1,135
1992	1,003
1993	927
1994	845
1995	751
1996	659
1997	616
1998	639
1999	593
2000	555
2001	431
2002	243
2003	395
2004	496
2005	466
2006	183
2007	179
2008	198
2009	166
2010	213
2011	156
2012	139

In 1987, the Legislature (HB 2900) limited worker benefits by own motion. The number of board own-motion orders peaked in 1991.

The 2001 Legislature (SB 485) provided for benefits when curative treatment is in lieu of hospitalization, new and omitted medical condition claims, and permanent disability. These actions may account for the increase in orders in 2003 to 2005 over 2002.

Lawmakers in 2005 (HB 2294) required that a condition must be compensable before an own-motion claim may be processed, reducing numbers of own-motion claims.

Court of Appeals requests, decisions, and time lags, 1987-2012

Year	Requests	Decisions	Request-to-decision median days
1987	362	287	335
1988	127	283	323
1989	214	108	281
1990	528	178	298
1991	491	332	293
1992	695	247	321
1993	377	285	295
1994	365	239	286
1995	288	172	299
1996	300	175	288
1997	224	160	318
1998	251	130	330
1999	219	126	343
2000	247	98	376
2001	197	102	426
2002	119	111	458
2003	196	64	457
2004	163	114	441
2005	106	80	440
2006	110	60	482
2007	101	59	453
2008	105	47	476
2009	75	38	553
2010	76	48	573
2011	77	49	586
2012	88	34	482

Appeals to the court peaked in 1992; in 2012, the number of appeals, 88, was just 12.6 percent of the peak value.

The primary reasons for the subsequent decline are the decreasing numbers of orders on review and the change in the court's review standard.

Time lags for court decisions climbed for six straight years between 1996 and 2002. Time lags reached a record-high 586 days (1.6 years) in 2011. In 2012, the median request-to-decision time declined somewhat to 482 days.

Notes: Decisions exclude court dismissals and remands where the court did not rule on the primary issue nor direct a resolution. Time lags exclude dismissals. The decision date is the date of the court's slip opinion.

Median time lag (days) from injury to order, 1987-2012

Year	Hearings	Board	Court
1987	758	1,067	1,496
1988	677	1,098	1,606
1989	602	1,320	1,512
1990	617	1,169	1,770
1991	659	978	1,512
1992	655	1,047	1,549
1993	598	966	1,443
1994	561	870	1,402
1995	574	817	1,490
1996	532	763	1,247
1997	502	723	1,484
1998	488	716	1,330
1999	485	685	1,446
2000	506	721	1,238
2001	496	714	1,281
2002	549	811	1,311
2003	541	780	1,369
2004	535	806	1,481
2005	559	827	1,446
2006	537	831	1,447
2007	533	834	1,440
2008	541	855	1,455
2009	564	890	1,790
2010	581	867	1,570
2011	539	902	1,681
2012	498	862	1,434

Times from injury to order have declined substantially since 1987, in large part due to the change in the mix of issues. Whole-claim denial is generally the first possible issue in a claim and hearings the first level of appeal.

Notes: Data are for all order types except Court of Appeals dismissals. The 2012 court lag of 1,434 days equates to nearly four years.

Disputed claim settlements at hearing and board review, 1987-2012

Year	Hearing		Board	
	DCS cases	Amount ($ millions)	DCS orders	Amount ($ millions)
1987	3,778	$18.2	N/A	N/A
1988	4,139	21.6	N/A	N/A
1989	4,365	22.5	N/A	N/A
1990	5,374	29.1	N/A	N/A
1991	6,021	32.6	N/A	N/A
1992	4,942	25.7	64	$0.980
1993	4,700	24.8	84	1.166
1994	4,100	20.8	64	0.778
1995	4,455	22.2	52	0.521
1996	4,001	19.1	55	0.608
1997	3,846	19.0	49	0.622
1998	3,921	20.3	35	0.374
1999	3,721	19.6	40	0.398
2000	4,019	22.8	55	0.706
2001	3,899	21.2	68	0.854
2002	3,931	23.1	68	0.860
2003	3,703	22.1	71	0.898
2004	3,219	20.7	62	1.065
2005	3,401	22.6	60	0.822
2006	3,176	22.5	45	0.735
2007	3,276	24.0	48	0.787
2008	3,325	26.4	54	1.395
2009	3,614	31.2	38	0.795
2010	3,349	32.8	45	1.131
2011	3,307	31.4	44	0.927
2012	3,218	29.1	35	0.844

The number of DCSs at hearing has dropped significantly since the peak in 1991, but their relative significance has risen. Between 1987 and 2011, DCSs grew from 16 percent to 43 percent of all hearing orders and from 26 percent to 76 percent of all settlements.

Total hearings DCS proceeds exceeded the 1991 peak for the first time in 2010.

Note: Since 2000, the board figures include DCSs approved after a remand or dismissal by the Court of Appeals.

Claim disposition agreements, 1990-2012

Year	CDAs approved	Total amount ($ millions)
1990	362	$6.9
1991	2,840	45.6
1992	3,229	47.0
1993	3,304	42.5
1994	3,260	41.8
1995	3,929	48.6
1996	3,564	45.0
1997	3,268	44.3
1998	3,074	37.7
1999	3,073	39.7
2000	3,144	39.9
2001	3,143	39.3
2002	3,207	44.9
2003	3,040	41.2
2004	2,869	43.8
2005	2,923	43.7
2006	2,954	52.2
2007	3,050	52.5
2008	3,182	62.6
2009	3,446	64.6
2010	3,304	65.7
2011	3,180	66.2
2012	2,956	58.5

SB 1197 authorized claim disposition agreements in 1990. In 2004, 2,869 CDAs were approved, the fewest since 1991. Since that time, the number of CDAs approved and total dollar amounts have risen. A record $66.2 million was paid in CDAs in 2011.

Total amounts include claimant attorney fees.

Claimant attorney fees and defense legal costs, 1987-2012

Year	Claimant attorney fees ($ millions)	Defense legal costs ($ millions)
1987	$14.4	N/A
1988	16.3	N/A
1989	16.6	$23.4
1990	17.8	26.1
1991	21.4	27.0
1992	21.4	28.2
1993	19.8	27.2
1994	18.9	25.7
1995	19.9	27.4
1996	17.5	25.3
1997	16.0	24.3
1998	16.1	24.2
1999	15.8	24.2
2000	16.7	23.9
2001	16.1	25.7
2002	17.2	25.3
2003	17.1	27.1
-------------------------->Series break #1		
2004	17.7	27.7
2005	18.4	29.4
2006	19.0	29.7
-------------------------->Series break #2		
2007	19.3	30.2
2008	21.1	32.4
2009	22.3	37.9
2010	22.6	38.3
2011	21.4	36.2
2012	19.7	36.0

Claimant attorney fees peaked in 1991 and 1992 at about 49 percent above 1987 fees; they didn't reach that level again until 2009.

Defense legal costs peaked in 1992 and were rising again after 2002, reaching the highest level on record in 2010.

Both claimant fees and defense costs declined in 2012.

Defense legal costs differ from claimant attorney fees in several ways: they are the actual amounts paid rather than the amounts in rule; they are not reversible on appeal; and there may be fees paid to multiple attorneys on a single dispute.

Information about series breaks:

Break #1. Beginning with 2004, data on fees at the Court of Appeals and in department medical service and vocational assistance disputes were available. For 2004-2006, these added fees were 1.5 percent to 1.9 percent of the total.

Break #2. For 2007, data on fees for WCD contested cases at hearing and Board Own Motion were available. Added fees in 2007 were 0.4 percent of total fees. Own motion fees are estimated.

Claimant attorney fees, 1987-2012

Year	Hearings ($ thousands)	Board ($ thousands)	CDA ($ thousands)	Reconsideration ($ thousands)
1987	$14,187	$226	-	-
1988	15,967	335	-	-
1989	15,953	656	-	-
1990	15,902	1,007	$900	$1
1991	13,796	905	6,429	277
1992	12,505	1,067	7,096	727
1993	11,145	1,165	6,658	858
1994	10,400	1,140	6,511	835
1995	10,859	826	7,315	880
1996	9,100	857	6,677	819
1997	8,518	753	5,999	675
1998	8,863	802	5,664	757
1999	8,537	612	5,908	756
2000	9,128	693	6,118	776
2001	8,540	612	6,115	826
2002	8,914	626	6,880	771
2003	8,989	721	6,540	810
	-------------------------->Series break #1			
2004	8,886	790	6,787	893
2005	9,490	762	6,784	976
2006	9,681	757	7,294	938
	-------------------------->Series break #2			
2007	9,647	746	7,692	814
2008	10,139	951	8,856	707
2009	11,295	778	9,129	670
2010	11,603	980	9,008	576
2011	10,382	900	9,200	494
2012	10,007	860	7,964	474

SB 369 in 1995 limited attorney fees in responsibility disputes, prohibited hearing-awarded fees for issues before the director, and limited fees for reversal of denials before hearing.

In early 1999, the board increased the maximum amount of fees that may be awarded out of increased disability awards, disputed claim settlements, and claim disposition agreements.

SB 620 in 2003 changed penalty fees from one-half of the penalty to fees proportional to the benefit. The maximum fee is $3,000.

HB 3345 increased maximum fees in responsibility and penalty disputes, as well as providing for fees in a few additional areas.

In 2012, 41 percent of all claimant attorney fees came from CDAs.

For information about series breaks, see comments in previous table.

Claimant attorney fees from lump-sum settlements, 1989-2012

Year	Hearing DCS ($ thousands)	Board DCS ($ thousands)	Lump sum ($ thousands)	Lump sum percentage
1989	$4,049	$98	$4,147	25.0%
1990	5,222	151	6,273	32.5%
1991	6,107	136	12,672	59.2%
1992	4,978	164	12,238	57.2%
1993	4,708	222	11,588	58.4%
1994	4,105	143	10,759	57.0%
1995	4,376	106	11,797	59.3%
1996	3,787	129	10,593	60.7%
1997	3,629	121	9,749	61.1%
1998	3,954	57	9,675	60.1%
1999	3,787	67	9,762	61.7%
2000	4,338	168	10,624	63.6%
2001	4,145	149	10,409	64.7%
2002	4,407	170	11,457	66.6%
2003	4,318	196	11,054	64.8%
2004	3,910	200	10,897	61.6%
2005	4,316	178	11,278	61.5%
2006	4,270	146	11,710	61.7%
2007	4,528	152	12,373	64.1%
2008	4,847	226	13,966	66.3%
2009	5,508	150	14,873	66.8%
2010	5,830	178	15,016	66.6%
2011	5,490	194	14,884	69.7%
2012	5,157	162	13,283	67.5%

Lump-sum attorney fees are from claim disposition agreements and disputed claim settlements. (CDA attorney fees are shown in the previous table.) Lump-sum fees increased from 25 percent of all attorney fees in 1989 (before CDAs) to 66 percent in 2002, a level reached again in 2008. In 2011 lump-sum fees were almost 70 percent of all claimant attorney fees. That number declined somewhat in 2012 but was still the second-highest recorded.

In 1989, DCSs accounted for 26 percent of all hearing fees. This percentage peaked in 2002 at 50 percent; it reached 50 percent again in 2010, and a record-high 53 percent in 2011.

Note: The 1989-1991 board DCS figures are estimates.

Maximum out-of-compensation attorney fees

Hearings	Prior to 2/1999	2/1999 - present
PTD	$4,600	$12,500
PPD	2,800	4,600
Time loss	1,050	1,500
DCSs	25% of the first $12,500, 10% of the remainder	25% of the first $17,500, 10% of the remainder

Board	1/1988 to 2/1999	2/1999 to present
PTD	$6,000	$16,300
PPD	3,800	6,000
Time loss	3,800	5,000
CDAs	25% of the first $12,500, 10% of the remainder	25% of the first $17,500, 10% of the remainder

PTD is permanent total disability. PPD is permanent partial disability. DCS is disputed claim settlement. CDA is claim disposition agreement.

For PTD, PPD, and time loss, attorney fees allowed are 25 percent of increased compensation award, subject to these limitations. Fees may exceed these limitations in extraordinary circumstances.

2012 Insurance and Self-insurance table updates

Workers' compensation premiums and rate changes, 1987-2012

Year	Total system written premiums ($ millions)	Annual change in written premium	Annual pure premium rate changes	Cumulative rate changes since 1990
1987	$677.0	-	14.5%	
1988	735.5	8.6%	0.0%	
1989	798.8	8.6%	5.2%	
1990	852.6	6.7%	6.2%	
1991	748.1	-12.3%	-12.2%	-12.2%
1992	786.1	5.1%	-11.0%	-21.9%
1993	739.5	-5.9%	-11.4%	-30.8%
1994	731.2	-1.1%	-4.3%	-33.7%
1995	750.3	2.6%	-3.2%	-35.9%
1996	743.0	-1.0%	-1.8%	-37.0%
1997	723.9	-2.6%	-10.5%	-43.6%
1998	664.0	-8.3%	-15.6%	-52.4%
1999	607.6	-8.5%	-4.8%	-54.7%
2000	615.5	1.3%	-2.2%	-55.7%
2001	637.0	3.5%	-3.7%	-57.3%
2002	728.0	14.3%	-0.1%	-57.4%
2003	758.4	4.2%	0.0%	-57.4%
2004	859.0	13.3%	0.0%	-57.4%
2005	907.5	5.6%	0.0%	-57.4%
2006	982.6	8.3%	0.0%	-57.4%
2007 *	1,192.9	6.8%	-2.1%	-58.3%
2008	945.7	-9.9%	-2.3%	-59.2%
2009	766.7	-18.9%	-5.9%	-61.6%
2010	729.1	-4.9%	-1.3%	-62.1%
2011	813.1	11.5%	-1.8%	-62.8%
2012	847.2	4.2%	1.9%	-62.1%

Total system written premiums exceeded $1 billion in 2007. During the most recent recession and its aftermath, premiums have fallen sharply. The $729.1 million in CY 2010 is 31 percent below the 2007 high. CY2011 on has shown increases to the TSWP.

Through 2011, workers' compensation pure premium rates have declined almost 13 percent since 2006 and more than 62 percent since 1990. There had not been an increase in the pure premium rate for the 21 years ending in 2011, although an increase of 1.9 percent was approved for 2012.

Notes: Although self-insured employers do not pay premiums, the department calculates a simulated premium for each self-insurer. Figures here include these simulated premiums. They also include large-deductible premium credits for private insurers.

* SAIF Corporation reported that its 2007 written premium amount was artificially inflated due to a policy system conversion, which now recognizes annual written premium at policy inception. SAIF estimated that this one-time adjustment inflated 2007's written premium by $143.8 million. This inflated figure is included in the total system written premium. It has been removed, however, from the calculation of the annual change in written premium in 2007 and 2008. This was done to better show the real change in premium.

Workers' compensation average premium rate ranking, 1986-2012

Year	Rate ranking	% of study median rate
1986	6th	137%
1988	8th	142%
1990	8th	149%
1992	22nd	107%
1994	32nd	85%
1996	34th	89%
1998	38th	85%
2000	34th	85%
2002	35th	85%
2004	42nd	79%
2006	42nd	79%
2008	39th	83%
2010	41st	83%
2012	39th	84%

Oregon's average premium rate ranking was the 39th highest in the nation in 2012. The average premium index was 84 percent of the national study median. Oregon's average premium has been between 79 percent and 85 percent of the national median in almost every study since 1994.

Note: The premium rate ranking is based on the manual rates in the 50 states, applied to Oregon's mix of occupations. The use of other occupational distributions may produce different rankings.

Earned large-deductible premium credits, 1996-2012

Year	Premium credits ($ millions)	% of private insurer written premium
1996	$0.6	0.2%
1997	9.3	2.5%
1998	16.2	4.6%
1999	24.4	7.5%
2000	20.9	6.8%
2001	37.7	12.0%
2002	54.8	16.8%
2003	54.4	16.8%
2004	50.8	14.3%
2005	60.3	16.9%
2006	79.8	20.1%
2007	96.8	21.0%
2008	87.8	22.0%
2009	75.7	23.8%
2010	63.6	23.6%
2011	82.3	26.2%
2012	79.5	25.7%

Earned large-deductible premium credits are credits on employers' workers' compensation premium. Participating employers repay insurers their claims costs up to the deductible amounts. The use of these credits grew rapidly through 2002 then stayed roughly the same through 2004. After 2004, the use showed rapid growth, peaking in dollar volume 2007. Although the amount of these credits dropped by 34 percent from 2008 to 2010, premium credits as a percentage of private insurer premium continued to increase, even as total premium has declined. In 2011, the dollar volume of credits saw a substantial increase of nearly 30 percent, while the share of private insurers' written premium increased to an all-time high of 26 percent in 2011. 2012 has seen a small decrease in both the dollar volume of credits and the percent share of private insurers' written premium.

Workers' compensation market share, by insurer type, 1995-2012

Year	SAIF	Private insurers	Self-insured employers
1995	33.2%	50.4%	16.3%
1996	32.6%	50.4%	17.0%
1997	30.9%	52.3%	16.8%
1998	31.0%	53.2%	15.8%
1999	31.4%	53.7%	14.9%
2000	35.7%	50.2%	14.0%
2001	37.2%	49.3%	13.5%
2002	41.7%	44.9%	13.4%
2003	42.5%	42.8%	14.7%
2004	44.3%	41.4%	14.3%
2005	46.1%	39.3%	14.6%
2006	45.8%	40.4%	13.9%
2007 *	42.4%	44.0%	13.6%
2008	42.6%	42.1%	15.2%
2009	40.8%	41.5%	17.7%
2010	44.9%	37.0%	18.1%
2011	44.9%	38.6%	16.5%
2012	47.2%	36.6%	16.2%

In 2012, as measured by total system written premiums, SAIF had 47.2 percent of the market. Private insurers' share was 36.6 percent, its lowest share since 1981. The largest private insurer, Liberty Northwest, had 5.8 percent of the market and 15.8 percent of the private insurer market, a substantial decrease from 2010.

* Note: SAIF Corporation reported that its 2007 written premium amount was artificially inflated due to a policy system conversion, which now recognizes annual written premium at policy inception. SAIF estimated that this one-time adjustment has inflated 2007's written premium by $143.8 million. This amount was removed from SAIF's premium in the computation of the 2007 market shares.

SAIF Corporation financial characteristics, 1995-2012

Year	Total system written premiums ($ millions)	Loss ratio	Expense loading factors	Dividends ($ millions)
1995	249.3	82.4	1.206	80.2
1996	242.2	125.6	1.200	50.1
1997	223.6	66.6	1.193	69.8
1998	205.7	40.6	1.130	121.1
1999	191.0	140.4	1.097	211.5
2000	220.0	166.2	1.103	159.4
2001	237.0	94.5	1.108	0.1
2002	303.4	108.9	1.129	-0.6
2003	322.0	109.5	1.149	0.2
2004	380.2	123.3	1.203	2.0
2005	418.3	65.8	1.204	0.0
2006	449.8	92.9	1.208	0.0
2007 *	588.9	86.4	1.211	60.0
2008	403.1	87.5	1.204	0.0
2009	312.9	88.6	1.201	0.0
2010	327.4	98.6	1.195	200.5
2011	365.2	65.5	1.197	150.0
2012	399.8	66.1	1.209	149.9

* SAIF's written premium grew by about 13 percent per year between 1999 and 2006. Starting with 2007, SAIF changed its DPW calculation method from arrears based to total estimated at policy inception. This caused a large one-time jump of $143.8 million, so the "true" premium in 2007 was about $445.1 million. After this adjustment, CY 2010 shows the first increase in written premium since 2006.

SAIF's loss ratio (incurred losses divided by earned premiums) was 65.5 percent in 2011.

SAIF's expense loading factor covers operating expenses, taxes, profit, and contingencies. This factor is multiplied by the pure premium rate to the employer's payroll to determine gross premium.

In 2010, SAIF paid more than $200 million in dividends. In 2011 and 2012 each, it was $150 million. (The 2002 negative dividend figure represents uncashed dividend checks credited back to SAIF.)

Private insurers' financial characteristics, 1995-2012

Year	Total system written premiums ($ millions)	Loss ratio	Expense loading factors	Dividends ($ millions)
1995	378.4	68.2	1.269	12.5
1996	374.8	66.8	1.207	10.3
1997	378.4	62.2	1.213	9.4
1998	353.6	71.3	1.232	10.3
1999	326.0	69.4	1.216	11.6
2000	309.1	78.4	1.238	10.3
2001	314.0	88.7	1.272	8.4
2002	327.0	66.7	1.349	6.0
2003	324.7	91.2	1.384	3.1
2004	355.7	88.0	1.382	2.6
2005	356.7	83.2	1.423	1.4
2006	396.7	81.1	1.413	2.2
2007	461.9	69.7	1.415	1.9
2008	398.5	71.0	1.397	1.1
2009	318.3	66.2	1.362	2.9
2010	269.9	109.1	1.363	1.1
2011	313.7	66.0	1.344	1.2
2012	310.1	50.1	1.339	0.6

Private insurers' written premium (including large-deductible premiums) was about $310 million in CY 2012. In CY 2010, it was 41 percent below the 2007 figure, and the lowest figure since 1984.

The loss ratio for all private insurers (incurred losses divided by earned premiums) was 109.1 percent in 2010. This was the first time the loss ratio had been above 100 since 1984. It has now dropped to a level below 2009.

Each private insurer develops an expense loading factor to cover operating expenses, taxes, profit, and contingencies. These factors are multiplied by the pure premium rate and applied to the employer's payroll to determine gross premium. The average 2012 factor was 1.339.

WC insurance plan (Assigned Risk Pool) characteristics, 1987-2012

Year	Covered employers	Pool premium ($ millions)	Percent of written premium
1987	1,935	$19.4	3.4%
1988	1,872	20.1	3.3%
1989	3,658	28.8	4.2%
1990	12,765	71.9	9.8%
1991	11,970	71.7	11.4%
1992	12,140	50.2	7.7%
1993	16,056	48.6	8.0%
1994	18,008	53.1	8.7%
1995	17,982	49.1	7.9%
1996	13,627	34.5	5.6%
1997	12,771	24.7	4.2%
1998	11,369	21.3	3.8%
1999	9,739	17.3	3.4%
2000	7,414	16.5	3.2%
2001	8,533	25.2	4.9%
2002	10,981	42.4	7.4%
2003	12,421	55.6	9.4%
2004	12,761	57.5	8.4%
2005	13,054	58.9	8.2%
2006	12,799	59.4	7.7%
2007	12,023	55.6	5.8%
2008	10,617	38.2	5.4%
2009	9,242	24.3	4.5%
2010	7,853	21.9	4.2%
2011	7,875	22.3	3.7%
2012	7,956	31.4	5.0%

After declining during the late 1990s, the assigned risk pool grew rapidly between 2000 and 2003, from 3 percent to 9 percent of the total premium. Although the number of employers in the pool stayed roughly constant for 2004 through 2007, pool premium, for the period, declined as a percentage of written premium. From 2008 to 2010, the number of covered employers decreased markedly, remaining largely stable through 2012, although pool premium and market share rose in 2012.