Minnesota
Workers' Compensation System Report, 2013

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LABOR & INDUSTRY
RESEARCH AND STATISTICS

Minnesota Workers' Compensation System Report, 2013

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Research and Statistics

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Executive summary

From the middle of the 1990s to the present, workers' compensation claim rates have declined nationwide. During the same period, benefits per claim, especially medical benefits, have increased more than wages. Indemnity benefits have risen less than medical benefits and have been largely stable relative to wages since the early 2000s. These same trends have occurred in Minnesota. A falling claim rate in Minnesota has counteracted increases in total benefits per claim, causing total benefits per $100 of payroll to be lower in 2013 than in 1997.

This report, part of an annual series, presents trend data beginning with 1997 about several aspects of Minnesota's workers' compensation system — claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

These are the report's major findings.[1]

- There were 4.6 paid claims per 100 full-time-equivalent workers in 2013, down 47 percent from 1997.
- The total cost of Minnesota's workers' compensation system was an estimated $1.62 billion for 2013, or $1.35 per $100 of payroll.
  - Total cost per $100 of payroll follows a multi-year cycle, in line with a nationwide insurance pricing cycle; however, it seems to show a long-term downward trend.
- In 2013, on a current-payment basis, the three largest components of total workers' compensation system cost were medical benefits (36 percent), insurer expenses (31 percent) and indemnity benefits other than vocational rehabilitation (29 percent).
- Pure premium rates for 2013 were down 32 percent from 1997, at their lowest level since that year.
- Adjusting for average wage growth, medical benefits per insured claim rose 97 percent from 1997 to 2012 while indemnity benefits per claim rose 43 percent. All of the increase for indemnity benefits occurred by 2003 and for medical benefits by 2008. The average 2011 workers' compensation claim cost $10,120 for medical and indemnity benefits combined (including vocational rehabilitation).
- Relative to total payroll, indemnity benefits were down 19 percent between 1997 and 2013, while medical benefits were down 2 percent; this reflects the net effect of a falling claim rate and higher benefits per claim. Medical and indemnity benefits (including vocational rehabilitation) amounted to $.83 per $100 of payroll for 2013.
  - By counteracting the increasing trend in benefits per claim, the falling claim rate has brought system cost per $100 of payroll to historically low levels.
- After adjusting for average wage growth, per paid indemnity claim:
  - total disability benefits (temporary total and permanent total disability benefits combined) rose 15 percent from 1997 to 2012;
  - temporary partial disability benefits fell 15 percent from 1997 to 2012;
  - permanent partial disability benefits fell 47 percent from 1997 to 2013; and
  - stipulated benefits rose 77 percent from 1997 to 2011 (stipulated benefits occur through claim settlements and may include indemnity, medical and vocational rehabilitation benefits). This happened partly because the percentage of

[1] See Glossary in Appendix A (p. 48). The time periods involved in these findings vary because of data availability and because, for statistics by injury year, the projected numbers may not be sufficiently stable for the most recent years.

paid indemnity claims with stipulated benefits rose from 17 percent to 24 percent from 1997 to 2010.

- In vocational rehabilitation:
  - the participation rate increased from 15 to 23 percent of paid indemnity claimants from 1997 to 2013; and
  - average service cost per participant was $8,830 for 2013; after adjusting for average wage growth, this was about the same as for 2000 and has been about the same since 2010.
- Vocational rehabilitation accounted for an estimated 2.7 percent of total workers' compensation system cost in 2013.
- Twenty-one percent of paid indemnity claims for 2012 had one or more disputes of any type, an increase from 16 percent for 1997.
  - The leading components of this increase were the rates of medical disputes (up 71 percent through 2011) and vocational rehabilitation disputes (up 52 percent through 2011).
  - Except for the claim petition rate, the overall dispute rate and its component rates seem to have leveled off since 2007 or 2008, depending on the dispute rate concerned.
  - The percentage of paid indemnity claims with claimant attorney involvement rose from 17 to 24 percent from 1997 to 2012.
- At the Department of Labor and Industry (DLI):
  - From 1999 to 2014, the certification rate for medical and vocational rehabilitation disputes combined dropped from 67 to 46 percent (Figure 5.5).
  - About 32 percent of certified medical disputes and 18 percent of certified rehabilitation disputes were referred to the Office of Administrative Hearings in 2014.
  - About 64 percent of the dispute resolution proceedings at DLI for 2012 through 2014 were administrative conferences; the remainder were mediations (Figure 5.9).
  - About 80 percent of resolutions at DLI for 2012 through 2014 were by agreement — most of these by informal intervention but a significant number (14 percent of DLI resolutions) by agreement via conference or mediation. The remaining 20 percent of resolutions at DLI were decision-and-orders.
- At the Office of Administrative Hearings (OAH):
  - The most frequent type of dispute resolution for 2012 through 2014 was an award on stipulation (6,210 a year, 59 percent of OAH resolutions). The next most common outcome was for the case to be stricken from the calendar or dismissed (12 percent). The least common was a findings-and-order (7 percent).
  - Awards on stipulation were the most common outcome for all dispute types at OAH except for discontinuance disputes initiated by a request for administrative conference. For these disputes, for 2012 through 2014, 48 percent were resolved by an administrative conference decision and another 41 percent were withdrawn.

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1

Introduction

From the middle of the 1990s to the present, workers' compensation claim rates have declined nationwide. During the same period, benefits per claim, especially medical benefits, have increased more than wages. Indemnity benefits have risen less than medical benefits and have been largely stable relative to wages since the early 2000s.[2] These same trends have occurred in Minnesota. A falling claim rate in Minnesota has counteracted increases in benefits per claim, causing total benefits per $100 of payroll to be lower in 2013 than in 1997.

This report, part of an annual series, presents trend data beginning with 1997 about several aspects of Minnesota's workers' compensation system — claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution.[3] Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

Chapter 2 presents overall claim, benefit and cost data. Chapter 3 provides more detailed data about indemnity (monetary) benefit trends. Chapters 4 and 5 provide statistics about vocational rehabilitation and about disputes and dispute resolution. *To understand the major findings at the beginning of each chapter, readers may need to refer to the background material immediately following the major findings in question.*

Appendix A presents a glossary. Appendix B summarizes portions of the 2000, 2008, 2011 and 2013 law changes relevant to trends in this report. Appendix C describes data sources and estimation procedures.

***Developed statistics* —** Many statistics in this report (from both the Department of Labor and Industry (DLI) and the insurance industry) are presented by injury year, insurance policy year or vocational rehabilitation plan-closure year.[4] An issue with such data is that the originally reported numbers for more recent years are not mature because of longer claims and reporting lags.[5] In this report, all injury year and policy year data is "developed" to a uniform maturity to produce statistics that are comparable over time. The technique uses "development factors" (projection factors) based on observed data for older claims.[6]

The injury year and policy year statistics that result from this technique are projections of what the actual numbers will be when all claims are complete and all data is reported. Therefore, the statistics for any given injury year (especially for more recent years) are subject to change when more recent data becomes available.

DLI periodically reviews the developed statistics to determine their stability over time and thus their suitability for publication. Through this process, DLI has determined that some of the developed statistics from its own data for the most recent injury years are not sufficiently stable for publication. As a result, several of the

[2] Department of Labor and Industry analysis of data in National Council on Compensation Insurance, "State of the Workers' Compensation Line," May 2014, at www.ncci.com/NCCIMain/IndustryInformation/ ResearchOutlook/Pages/default.aspx, "News from Annual Issues Symposium 2014."

[3] "Benefits" in this report refers to monetary benefits, medical benefits and vocational rehabilitation benefits. "Costs" refers to the combined costs of these benefits and other costs such as insurer expenses.

[4] Definitions in Appendix A. Some insurance data is by accident year, which is equivalent to injury year.

[5] Development occurs in vocational rehabilitation (VR) plan-closure year data because a claim may have more than one VR plan and the plan-closure year statistics are computed for all plans combined, categorized by the closure year of the last plan.

[6] See Appendix C for more detail.

trends from DLI data in this report extend only through 2011 or 2012.

Adjustment of cost data for wage growth — Several figures in the report present costs over time. As wages and prices grow, a given cost in dollar terms represents a progressively smaller economic burden from one year to the next. If the total cost of indemnity and medical benefits grows at the same rate as wages, there is no net change in cost as a percentage of total payroll. Therefore, all costs other than those expressed relative to payroll are adjusted for average wage growth. The adjusted trends reflect the extent to which cost growth exceeds (or falls short of) average wage growth.[7]

[7] See Appendix C for computational details.

2

Claims, benefits and costs: overview

This chapter presents overall indicators of the status and direction of Minnesota's workers' compensation system.

Major findings

- The total number of paid claims dropped 47 percent relative to the number of full-time-equivalent (FTE) workers from 1997 to 2013 (Figure 2.1).
- The total cost of Minnesota's workers' compensation system relative to payroll follows a multi-year cycle, but a comparison of similar points in the cycle suggests a long-term downward trend (Figure 2.2).
- In 2013, on a current-payment basis, the three largest components of total workers' compensation system cost were medical benefits (36 percent), insurer expenses (31 percent) and indemnity benefits other than vocational rehabilitation (29 percent) (Figure 2.3).
- Adjusting for average wage growth, medical benefits per insured claim rose 97 percent from 1997 to 2012 (the most recent year available) while indemnity benefits rose 43 percent. Medical benefits per insured claim have been stable since 2008 and indemnity benefits since 2003 (Figure 2.5).
- Relative to total payroll, indemnity benefits were down 19 percent between 1997 and 2013, while medical benefits were down 2 percent (Figure 2.7). These trends are the net result of a falling claim rate and higher benefits per claim.
- Pure premium rates for 2015 were down 32 percent from 1997 and 20 percent from 1998 (Figure 2.9).

Background

The following basic information is necessary for understanding the figures in this chapter. See the glossary in Appendix A for more detail.

Workers' compensation benefits and claim types

Workers' compensation provides three basic types of benefits.

- ***Monetary benefits*** compensate the injured or ill worker (or surviving dependents) for wage loss, permanent functional impairment or death. These benefits are often called ***"indemnity benefits."*** They are considered in detail in Chapter 3.
- ***Medical benefits*** consist of reasonable and necessary medical services and supplies related to the injury or illness.
- ***Vocational rehabilitation (VR) benefits*** consist of a variety of services to help eligible injured workers return to work. With very few exceptions, only workers receiving monetary benefits receive VR benefits. VR benefits are counted as indemnity benefits in insurance data but are counted separately in DLI data. They are considered in detail in Chapter 4.

Claims with indemnity benefits (including VR benefits in insurance data) are called ***indemnity claims****;* these claims typically have medical benefits also. The remainder of claims are called ***medical-only claims*** because they only have medical benefits.

Insurance arrangements

Employers cover themselves for workers' compensation in one of three ways. The most

common is to purchase insurance in the "voluntary market," so named because an insurer may choose whether to insure any particular employer. Employers unable to insure in the voluntary market may insure through the Assigned Risk Plan, the insurance program of last resort administered by the Minnesota Department of Commerce. Employers meeting certain financial requirements may self-insure.

Rate-setting

Minnesota is an open-rating state for workers' compensation, meaning rates are set by insurance companies rather than by a central authority. In determining their rates, insurance companies start with "pure premium rates" (also known as "advisory loss costs"). These rates represent expected losses (indemnity and medical) per $100 of payroll for some 600 payroll classifications. The Minnesota Workers' Compensation Insurers Association (MWCIA) — Minnesota's workers' compensation data service organization and rating bureau — calculates the pure premium rates every year from insurers' most recent pure premium and losses. Insurance companies add their own expenses to the pure premium rates and make other modifications in determining their own rates (which are filed with the Department of Commerce).

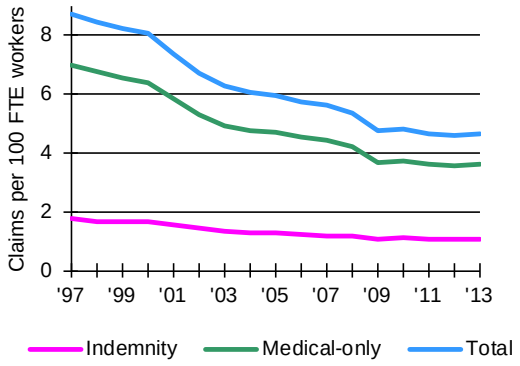
The pure premium rates are calculated from data for two to three years prior, which produces a lag between benefit trends and pure premium rate changes.

Claim rates

A starting point for understanding trends in the Minnesota workers' compensation system is the claim rate — the number of paid claims per 100 full-time-equivalent (FTE) workers. Claim rates declined almost continually from 1997 to 2011 but were steady from 2011 to 2013.

- In 2013, there were:
  - 1.06 paid indemnity claims per 100 FTE workers, down 36 percent from 2000;
  - 3.6 paid medical-only claims per 100 FTE workers, down 44 percent from 2000; and
  - 4.6 total paid claims per 100 FTE workers, down 42 percent from 2000.
- The overall paid claim rate for 2013 was 47 percent below the rate for 1997.
- Since 2009, indemnity claims have made up slightly less than 23 percent of all paid claims, while medical-only claims have constituted the remaining 77 percent. The indemnity claim percentage relative to total claims represents an increase from 20 percent for 1997.
- Since 1997, the total claim rate has followed a similar downward trend to Minnesota's total reportable case rate from the Survey of Occupational Injuries and Illnesses.[8]
- Because of the falling claim rate, the number of claims has fallen despite an increase in the number of covered workers. In 2012, there were 22,500 paid indemnity claims and 98,500 total paid claims, down 33 percent and 42 percent, respectively, from 1997.

Figure 2.1 Paid claims per 100 full-time-equivalent workers, injury years 1997-2013 [1]



Injury year	Indemnity claims	Medical-only claims	Total claims
1997	1.74	7.0	8.7
2000	1.66	6.4	8.0
2009	1.06	3.7	4.7
2010	1.09	3.7	4.8
2011	1.05	3.6	4.6
2012	1.04	3.6	4.6
2013	1.06	3.6	4.6

1. Developed statistics from DLI data and other sources (see Appendix C).

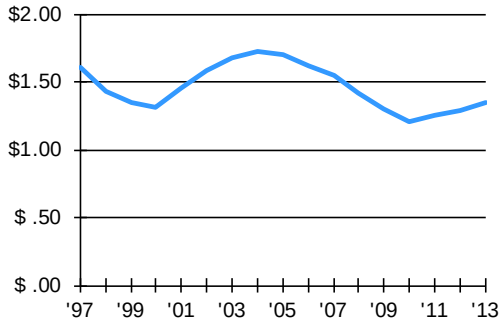
[8] This survey (the "SOII") is conducted jointly by state agencies and the U.S. Bureau of Labor Statistics. See www.dli.mn.gov/RS/DlisSaf1.asp for Minnesota injury and illness rates from the SOII. See the *Minnesota Workplace Safety Report* (www.dli.mn.gov/RS/WorkplaceSafety.asp) for a description of the SOII itself.

System cost

The total cost of Minnesota's workers' compensation system per $100 of payroll has followed a cycle since 1997, with low-points reached in 2000 and 2010 and a high-point in 2004. Despite the annual fluctuations, the long-term trend seems to be downward.

- The total cost of the system was an estimated $1.35 per $100 of payroll in 2013, an increase from the low-point reached in 2010.
- The total cost of workers' compensation in 2013 was an estimated $1.62 billion.
- These figures reflect benefits (indemnity, medical and vocational rehabilitation) plus other costs such as insurance brokerage, underwriting, claim adjustment, litigation, and taxes and assessments. They are computed primarily from actual premium for insured employers (adjusted for costs under deductible limits) and experience-modified pure premium for self-insured employers (see Appendix C).
- These figures partly reflect trends in the cost of benefits and other expenses; however, they also reflect a nationwide insurance pricing cycle, in which the ratio of premium to insurance losses varies over time.[9]
- The average system cost per $100 of payroll was $1.47 for 1999 to 2003 and $1.28 for 2009 to 2013 — comparable periods in the cycle; this suggests a long-term downward trend with a 13-percent decrease between the two periods 10 years apart.

Figure 2.2 System cost per $100 of payroll, 1997-2013 [1]



	Cost per $100 of payroll
1997	$1.61
2000	1.31
2004	1.72
2009 [2]	1.31
2010 [2]	1.21
2011 [2]	1.26
2012 [2]	1.29
2013 [2]	1.35

1. Data from several sources (see Appendix C). Includes insured and self-insured employers.
2. Subject to revision.

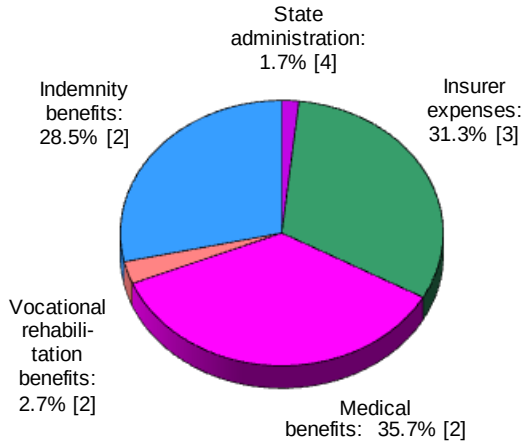
[9] One indicator of this pricing cycle is the nationwide ratio of employers' cost of workers' compensation insurance (primarily reflecting premium) to workers' compensation benefits paid, computed by the National Academy of Social Insurance (NASI). This ratio varied from 1.42 for 1993 to 1.22 for 1999, 1.59 for 2006, 1.24 for 2010 and 1.34 for 2012 (*Workers' compensation coverage, benefits, and costs, 2012*, NASI, August 2014, www.nasi.org/research/2014/report-workers-compensation-benefits-coverage-costs-2012). Relevant data also appears in National Council on Compensation Insurance, "News from Annual Issues Symposium 2015" ("2105 State of the Line," May 2015) and "Understanding What Drives the Underwriting Cycle," May 2014, at www.ncci.com/NCCIMain/IndustryInformation/ResearchOutlook/Pages/default.aspx. The latter also explores several theories about the causes of the underwriting cycle.

System cost components

The largest share of total workers' compensation system cost goes to medical benefits.

- In 2013, on a current-payment basis, medical benefits accounted for an estimated 36 percent of total system cost, followed by insurer expenses at 31 percent and indemnity benefits other than vocational rehabilitation at 29 percent.
- Total benefit payments accounted for 67 percent of total system cost.
- As shown in Figure 2.7, the medical share of total benefits has increased since 1997.
- As shown in Figure 3.10, state agency administrative cost has declined relative to payroll since 1997.

Figure 2.3 System cost components, 2013 [1]



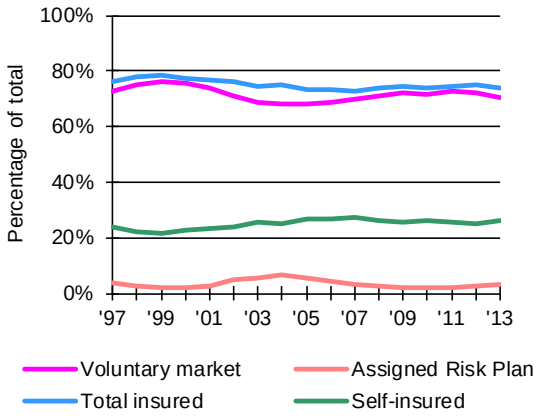
1. Estimated by DLI with data from several sources. These numbers are on a current-payment basis and therefore differ from others estimated on an injury year or policy year basis. Because these numbers follow a multi-year cycle, they are averaged over the most recent complete cycle (see Appendix C).
2. Indemnity and medical benefits include those reimbursed through DLI programs (including supplementary and second-injury benefits) and those paid through insurance guaranty entities (the Minnesota Insurance Guaranty Association and the Self-Insurers' Security Fund). Indemnity benefits include those claimant attorney costs that are paid out of indemnity benefits. Indemnity benefits here exclude vocational rehabilitation.
3. Includes underwriting, brokerage, claim adjustment, litigation, general operations, taxes, fees and profit. Litigation costs include defense attorney costs plus those claimant attorney costs that do not come out of indemnity benefits but are paid by the insurer. Excludes assessments on insurers and self-insurers because the benefits and state administration financed with those assessments are counted elsewhere in the figure.
4. Includes costs of workers' compensation functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the state share of the cost of Minnesota's OSHA program. Excludes costs of benefit payments reimbursed by the Special Compensation Fund (such as supplementary and second-injury benefits). Costs are net of fees for service.

Insurance arrangements

The voluntary market share of the workers' compensation insurance market is somewhat higher than the low-point reached in the mid-2000s.

- The voluntary market share of paid indemnity claims was about 71 percent in 2013, an increase from the low-point of 68 percent for 2005 but down from the 76-percent mark reached in 1999.
- The self-insured share, 26 percent for 2013, has ranged from 25 to 27 percent since 2003; its low-point was 22 percent for 1999.
- The Assigned Risk Plan share reached a low-point of 1.9 percent in 2010 before rising to 3.3 percent for 2013.
- These shifts are at least partly due to changes in insurance costs shown in Figure 2.2. Cost increases in the voluntary market tend to cause shifts from the voluntary market to both the Assigned Risk Plan and self-insurance, while cost decreases in the voluntary market tend to cause shifts in the opposite direction.
- These figures have generally followed similar trends to market-share percentages based on pure premium.[10]

Figure 2.4 Market shares of different insurance arrangements as measured by paid indemnity claims, injury years 1997-2013 [1]



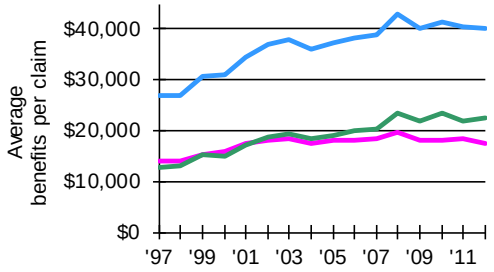
Injury year	Voluntary market	Assigned Risk Plan	Total insured	Self-insured
1997	72.7%	3.6%	76.3%	23.7%
1999	76.3	2.0	78.3	21.7
2004	68.4	6.4	74.7	25.3
2005	68.1	5.4	73.5	26.5
2007	70.0	3.0	73.0	27.0
2008	71.2	2.5	73.7	26.3
2009	72.1	2.1	74.2	25.8
2010	71.7	1.9	73.7	26.3
2011	72.5	2.1	74.6	25.4
2012	72.1	2.7	74.8	25.2
2013	70.5	3.3	73.8	26.2

1. Data from DLI.

[10] The pure premium figures used in this comparison are from the Minnesota Workers' Compensation Reinsurance Association.

Figure 2.5 Average indemnity and medical benefits per insured claim, adjusted for wage growth, policy years 1997-2012 [1]

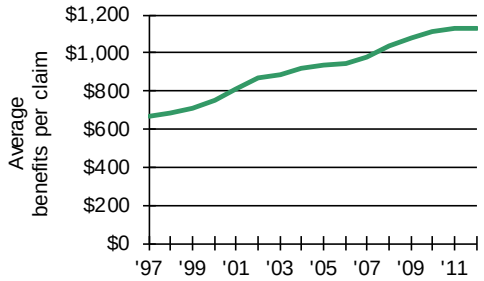
A: Indemnity claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$14,100	$12,700	$26,800
2003	18,500	19,500	38,000
2009	18,100	21,900	40,000
2010	18,000	23,300	41,400
2011	18,600	21,800	40,400
2012	17,600	22,600	40,200

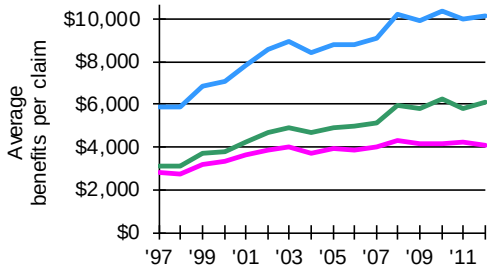
Indemnity [2] Medical Total

B: Medical-only claims



Policy year	Medical benefits	Total benefits
1997	$670	$670
2003	884	884
2009	1,078	1,078
2010	1,112	1,112
2011	1,130	1,130
2012	1,129	1,129

C: All claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$2,820	$3,080	$5,910
2003	4,000	4,910	8,910
2009	4,120	5,800	9,930
2010	4,150	6,230	10,380
2011	4,200	5,820	10,020
2012	4,050	6,070	10,120

Indemnity [2] Medical Total

1. Developed statistics from MWCIA data (see Appendix C). Includes the voluntary market and Assigned Risk Plan; excludes self-insured employers. Benefits are adjusted for average wage growth between the respective year and 2013. 2012 is the most recent year available.
2. Since these statistics are from insurance data, indemnity benefits include vocational rehabilitation benefits.

Benefits per claim

Adjusting for average wage growth, average medical benefits per insured claim rose rapidly between 1997 and 2003 and more slowly from 2003 to 2008, and were stable from 2008 to 2012. Average indemnity benefits rose from 1997 to 2003 but have been stable since then.

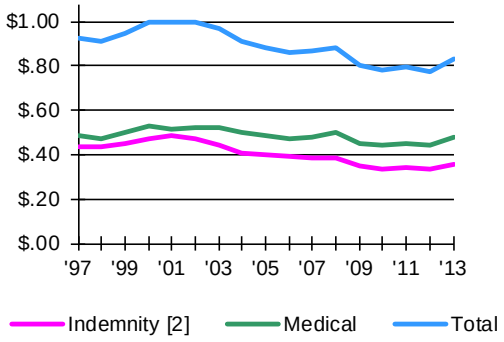
- For all claims combined, in 2012 relative to 2003:
  - average indemnity benefits were about the same (up 1 percent);
  - average medical benefits were up 24 percent; and
  - average total benefits were up 14 percent.
- For all claims combined, average medical benefits were about the same for 2012 as for 2008.
- For all claims combined, average medical benefits were 97 percent higher in 2012 than in 1997; average indemnity benefits were 43 percent higher; and average total benefits were 71 percent higher.

Benefits relative to payroll

Relative to total payroll, medical benefits were about the same in 2013 as in 1997, and indemnity benefits were significantly lower.

- Both indemnity and medical benefits rose relative to payroll from 1997 to 2000 or 2001, but fell thereafter.
- In 2013 compared to 1997, relative to payroll:
  - indemnity benefits were 19 percent lower;
  - medical benefits were 2 percent lower; and
  - total benefits were 10 percent lower.
- These changes are the net result of a decreasing claim rate (Figure 2.1) and higher indemnity and medical benefits per claim (Figure 2.5). The different trends in indemnity and medical benefits relative to payroll occur because medical benefits per claim have risen more than indemnity benefits per claim (Figure 2.5).

Figure 2.6 Benefits per $100 of payroll in the voluntary market, accident years 1997-2013 [1]



Accident year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$.44	$.49	$ .93
2000	.47	.53	1.00
2001	.48	.52	1.00
2002	.47	.52	1.00
2009	.35	.45	.80
2010	.34	.44	.78
2011	.34	.45	.79
2012	.33	.44	.77
2013	.35	.48	.83

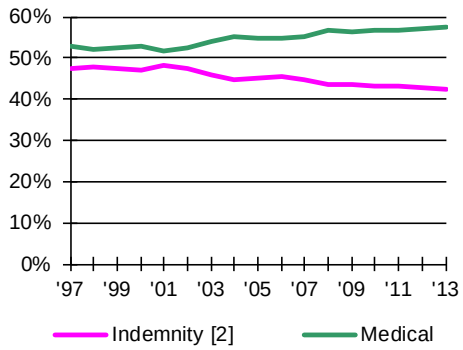
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan and those benefits paid through DLI programs (including supplementary and second-injury benefits).
2. Includes vocational rehabilitation benefits.

Indemnity and medical shares

The medical share of total benefits rose between 1997 and 2013. The increase occurred primarily during the middle part of the period.

- Reflecting the data in Figure 2.6:
  - medical benefits rose from a 53-percent share of total benefits in 1997 to 58 percent in 2013; and
  - indemnity benefits fell from 47 percent of total benefits to 42 percent during the same period.

Figure 2.7 Indemnity and medical benefit shares in the voluntary market, accident years 1997-2013 [1]



Accident year	Indemnity benefits [2]	Medical benefits
1997	47.3%	52.7%
2001	48.3	51.7
2009	43.6	56.4
2010	43.2	56.8
2011	43.3	56.7
2012	42.8	57.2
2013	42.4	57.6

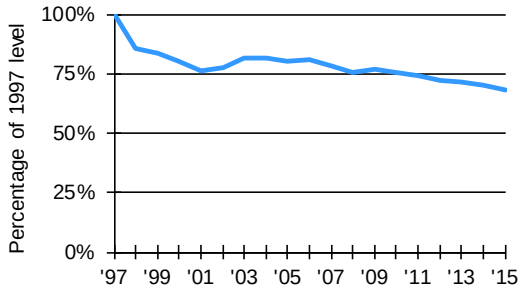
1. Note 1 in Figure 2.6 applies here.
2. Includes vocational rehabilitation benefits.

Pure premium rates

Pure premium rates have generally fallen since 1997.

- Pure premium rates for 2015 were the lowest since 1997. The 2015 rates were down 32 percent from 1997 and 20 percent from 1998.[11]
- Pure premium rates are ultimately driven by the trend in benefits relative to payroll (Figure 2.6). However, this occurs with a lag of two to three years because the pure premium rates for any period are derived from prior premium and loss experience.[12]
- Insurers in the voluntary market consider the pure premium rates, along with other factors, in determining their own rates, which in turn affect total system cost (Figure 2.2).

Figure 2.8 Average pure premium rate as percentage of 1997 level, 1997-2015 [1]



Effective year	Percentage of 1997
1997	100.0%
1998	85.7
2001	76.1
2003	81.7
2011	74.0
2012	72.0
2013	71.4
2014	70.0
2015	68.2

1. Data from the MWCIA. Pure premium rates represent expected indemnity and medical losses per $100 of covered payroll in the voluntary market. The MWCIA computes the pure premium rates for each year ("effective year") from insurers' most recent pure premium and losses (see Appendix A for details).

[11] A "percent change" means the proportionate change in the initial percentage, not the number of percentage points of change. For example, a change from 10 percent to either 5 or 15 percent is a 50-percent change.

[12] Changes in pure premium rates directly following law changes also include anticipated effects of those law changes estimated by the Minnesota Workers' Compensation Insurers Association.

3

Claims, benefits and costs: detail

This chapter presents additional data about claims, benefits and costs. Most of the data provides further detail about the indemnity claim and benefit information in Chapter 2. Some of the data relates to costs of special benefit programs and state agency administrative functions. Some (developed) statistics by injury year from DLI data are not given all the way through 2013 because the most recent years are not always sufficiently stable (see Chapter 1).

Major findings

- The average amount of time an injured worker received total disability benefits for injury year 2012 was 39 percent longer than for 1997 and about the same as for 2008; the average duration of temporary partial disability (TPD) showed relatively little change (Figure 3.3).

- After adjusting for average wage growth:

  - Stipulated benefits per paid indemnity claim rose 77 percent from 1997 to 2011 (Figure 3.8). This resulted from a 38-percent increase in the proportion of claims with stipulated benefits (Figure 3.2) and a 27-percent increase in the average amount of these benefits where they were paid (Figure 3.7).
  - Total disability benefits (temporary total and permanent total disability benefits combined) per paid indemnity claim rose 15 percent from 1997 to 2012 (Figure 3.8). This resulted from an increase in average total disability duration (Figure 3.3).
  - Temporary partial disability benefits per paid indemnity claim fell 15 percent from 1997 to 2012 (Figure 3.8).
  - Permanent partial disability benefits per paid indemnity claim fell 47 percent from 1997 to 2013 (Figure 3.8). This occurred because, under the fixed PPD benefit schedule, PPD benefits became smaller relative to rising wages.[13]

- State agency administrative costs in 2014 amounted to about 2.2 cents per $100 of covered payroll, down from 3.9 cents in 1997 (Figure 3.10).

Background

The following basic information is necessary for understanding the figures in this chapter. See the glossary in Appendix A for more detail.

Benefit types

- ***Temporary total disability (TTD)*** — A weekly wage-replacement benefit paid to an employee who is temporarily unable to work because of a work-related injury or illness, equal to two-thirds of pre-injury earnings subject to a weekly minimum and maximum and a duration limit. TTD ends when the employee returns to work (or when other events occur).

- ***Temporary partial disability (TPD)*** — A weekly wage-replacement benefit paid to an injured employee who has returned to work at less than his or her pre-injury earnings, generally equal to two-thirds of the difference between current earnings and pre-injury earnings subject to weekly maximum and duration provisions.

- ***Permanent partial disability (PPD)*** — A benefit that compensates for permanent functional impairment resulting from a work-related injury or illness. The benefit is based

[13] The PPD benefit increase in the 2000 law change (see Appendix B) had a relatively small effect on this overall trend.

on the employee's impairment rating and the total amount paid is unrelated to wages.

- ***Permanent total disability (PTD)*** — A weekly wage-replacement benefit paid to an employee who sustains one of the severe work-related injuries specified in law or who, because of a work-related injury or illness in combination with other factors, is permanently unable to secure gainful employment (subject to a permanent impairment rating threshold).

- ***Stipulated benefits*** — Indemnity, medical and/or vocational rehabilitation benefits included in a claim settlement — "stipulation for settlement" — among the parties to a claim. A stipulation usually occurs in a dispute, and stipulated benefits are usually paid in a lump sum.

- ***Total disability*** — The combination of TTD and PTD benefits. Most figures in this chapter — those presenting DLI data — use this category because the DLI data does not distinguish between TTD and PTD benefits.

Counting claims and benefits: insurance data and department data

The first figure in this chapter uses insurance data from the MWCIA; all other figures use DLI data.

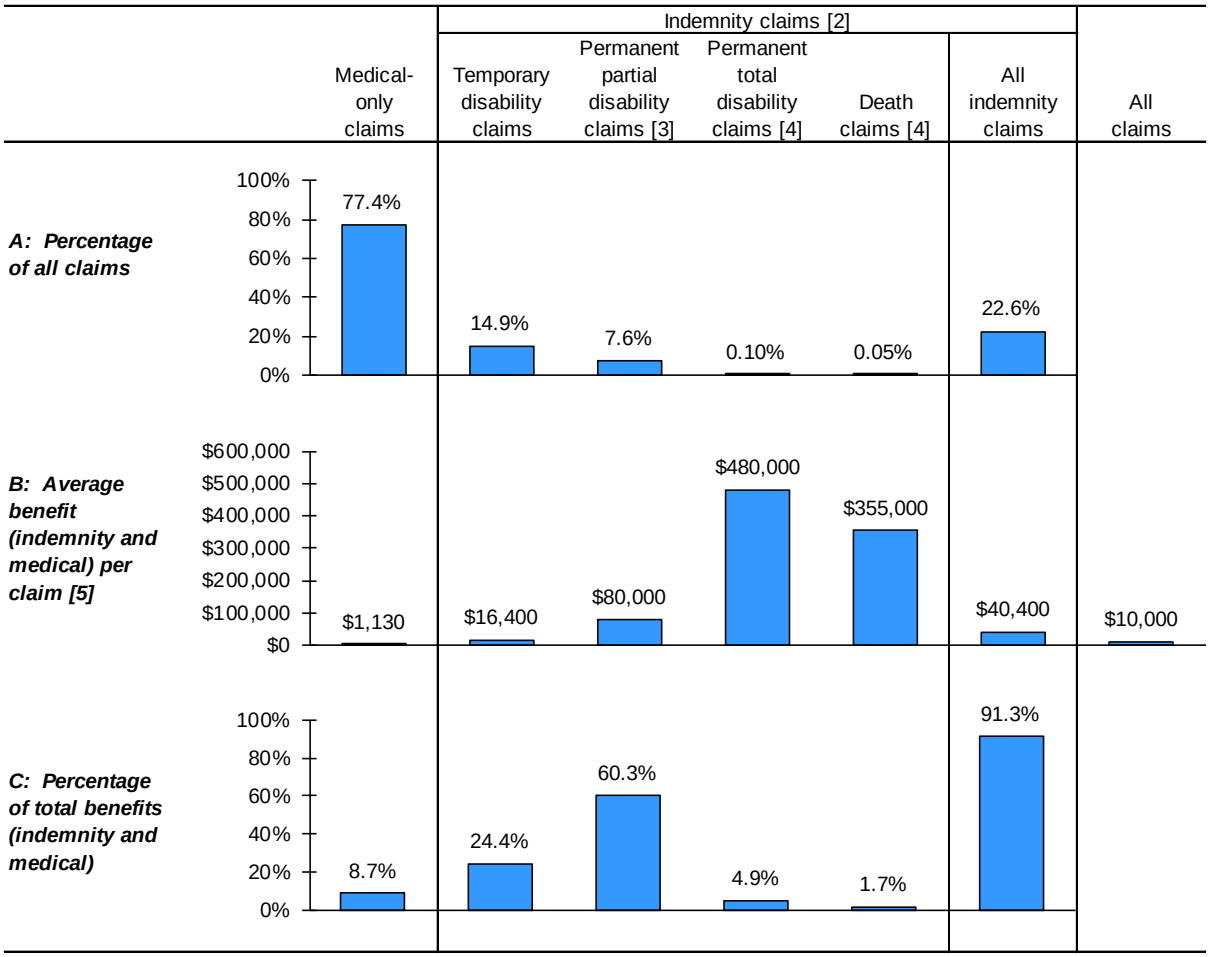
In the insurance data, claims and benefits are categorized by "claim type," defined according to the most severe type of benefit on the claim. In increasing severity, the benefit types are medical, temporary disability (TTD or TPD), PPD, PTD and death. For example, a claim with medical, TTD and PPD payments is a PPD claim. PPD claims also include claims with temporary disability benefits lasting more than one year and claims with stipulated settlements. In the insurance data, all benefits on a claim are counted in the one claim-type category into which the claim falls.

In the DLI data, by contrast with the insurance data, each claim may be counted in more than one category, depending on the types of benefits paid. For example, the same claim may be counted among claims with total disability benefits and among claims with PPD benefits.

Costs supported by Special Compensation Fund assessment

DLI, through its Special Compensation Fund (SCF), levies an annual assessment on insurers and self-insured employers to finance (1) costs in DLI, the Office of Administrative Hearings and other state agencies to administer the workers' compensation system and (2) certain benefits for which DLI is responsible. Primary among these benefits are ***supplementary benefits*** and ***second-injury benefits.*** Although these programs were eliminated in the 1990s, benefits must still be paid on prior claims (see Appendix A). The assessment (or benefits and administrative costs paid with the assessment) is included in total workers' compensation system cost (Figures 2.2 and 2.3).

Figure 3.1 Benefits by claim type for insured claims, policy year 2011 [1]



1. Developed statistics from MWCIA data (see Appendix C). 2011 is the most recent year available.
2. Indemnity claims consist of all claim types other than medical-only. These claims typically have medical as well as indemnity benefits.
3. PPD claims in the insurance data, and as shown here, include any claims with stipulated settlements or with temporary disability lasting more than 130 weeks, in addition to claims with permanent partial disability.
4. Because of large annual fluctuations, data for PTD and death claims is averaged over 2007 to 2011 (see Appendix C).
5. Benefit amounts in panel B are adjusted for overall wage growth between 2011 and 2013.

Benefits by claim type

Each claim type (in the insurance data) contributes to total benefits paid depending on its relative frequency and average benefit. PPD claims account for the majority of total benefits.

As indicated in the introduction to this chapter, in the insurance data, the benefits for each claim type include all types of benefits paid on that type of claim. PPD claims, for example, may include medical, TTD and TPD benefits in addition to PPD benefits.

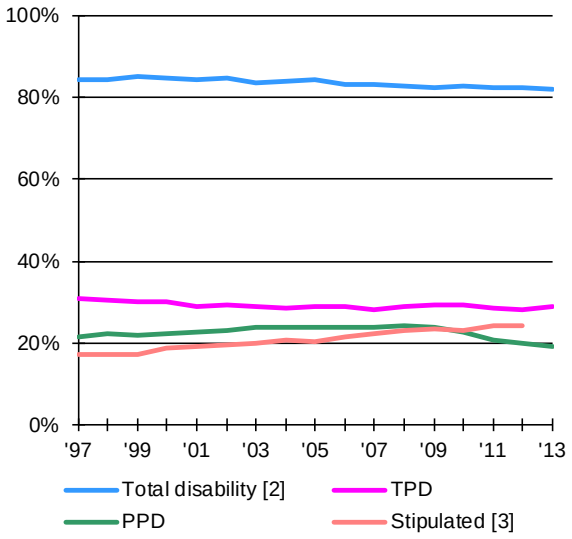
- PPD claims accounted for 60 percent of total benefits in 2011 (panel C in Figure 3.1) through a combination of moderately low frequency (panel A) and higher-than-average benefits per claim (panel B).
- Other claim types contributed smaller amounts to total benefits because of very low frequency (PTD and death claims) or relatively low average benefits (medical-only and temporary disability claims).
- Indemnity claims were 23 percent of all paid claims, but accounted for 91 percent of total benefits because they have far higher benefits on average than medical-only claims ($40,400 vs. $1,130 for 2011). Medical-only claims accounted for 77 percent of claims but only 9 percent of total benefits.

Claims by benefit type

Since 1997, the proportion of paid indemnity claims with stipulated benefits has increased significantly; the proportions of claims with other types of benefits have changed by smaller amounts.

- The percentage of claims with stipulated benefits rose from 1997 to 2011 and changed little in 2012. In proportionate terms, the increase for the overall period was 38 percent.[14] This is related to a similar increase in the dispute rate (Figure 5.1).
- The percentages of claims with total disability benefits and with TPD benefits fell somewhat from 1997 to 2013.
- The percentage of claims with PPD benefits rose gradually from 1997 to 2008 but fell thereafter, reaching a lower point in 2013 than in 1997.

Figure 3.2 Percentages of paid indemnity claims with selected types of benefits, injury years 1997-2013 [1]



Injury year	Total disabilty [2]	TPD	PPD	Stipu-lated [3]
1997	84.3%	30.9%	21.7%	17.4%
2008	82.8	29.1	24.1	23.2
2009	82.4	29.5	23.9	23.6
2010	83.0	29.2	22.5	23.2
2011	82.5	28.5	20.7	24.2
2012	82.3	28.2	19.9	24.1
2013	82.1	28.8	19.0	

1. Developed statistics from DLI data (see Appendix C). An indemnity claim may have more than one type of benefit paid. Therefore, the sum of the figures for the different benefit types is greater than 100 percent.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components. The percentages of claims with stipulated benefits are not shown for the two most recent injury years because those statistics are not yet sufficiently stable.

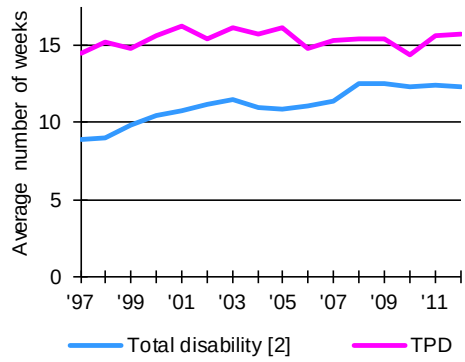
[14] See note 11 on p. 11.

Benefit duration

The average duration of total disability benefits rose significantly between 1997 and 2008, but was stable for the next four years; the duration of TPD showed little movement, other than annual fluctuation, from 1997 to 2012.

- Total disability duration averaged 12.3 weeks for 2012, 39 percent above 1997. Most of this increase had occurred by 2003, and all of it by 2008.
- TPD duration averaged 15.7 weeks for 2012, somewhat higher than in 1997.
- The increased total disability duration beginning with 2008 suggests an effect from the Great Recession.[15] TPD duration, however, does not show a correlation with the recession.

Figure 3.3 Average duration of wage-replacement benefits, injury years 1997-2012 [1]



Injury year	Total disability [2]	TPD
1997	8.9	14.5
2003	11.5	16.1
2008	12.5	15.4
2009	12.6	15.4
2010	12.3	14.4
2011	12.4	15.7
2012	12.3	15.7

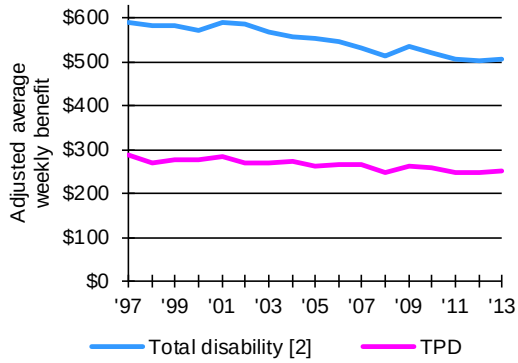
1. Developed statistics from DLI data (see Appendix C). Statistics are not shown for 2013 because they are not yet sufficiently stable.
2. Total disability includes TTD and PTD.

Weekly benefits

After adjusting for average wage growth, average weekly total disability and TPD benefits decreased between 1997 and 2013.

- Adjusted average weekly total disability and TPD benefits, respectively, were 14 and 13 percent lower in 2013 than in 1997.[16]

Figure 3.4 Average weekly wage-replacement benefits, adjusted for wage growth, injury years 1997-2013 [1]



Injury year	Total disability [2]	TPD
1997	$591	$288
2008	512	247
2009	533	263
2010	522	260
2011	506	249
2012	503	249
2013	506	251

1. Developed statistics from DLI data. Benefit amounts are adjusted for average wage growth between the respective year and 2013. See Appendix C.
2. Total disability includes TTD and PTD.

[15] For 2006 to 2011, Minnesota's annual average unemployment rate was (as a percentage, by year) 4.1, 4.7, 5.4, 8.0, 7.4 and 6.5; for the same years, total unemployment-insurance-covered employment was (in millions) 2.68, 2.69, 2.68, 2.57, 2.56 and 2.60. Data from the Minnesota Department of Employment and Economic Development (www.positivelyminnesota.com).

The limit on TTD duration was raised from 104 weeks to 130 weeks under a law change effective Oct. 1, 2008 (see Appendix B). DLI estimated this change would raise average TTD duration by 2.0 percent. Given that this provision took effect in the last quarter of 2008, this would have caused a 0.5-percent increase in duration from 2007 to 2008. This accounts for about 5 percent of the actual 10-percent increase in average total disability duration from 2007 to 2008.

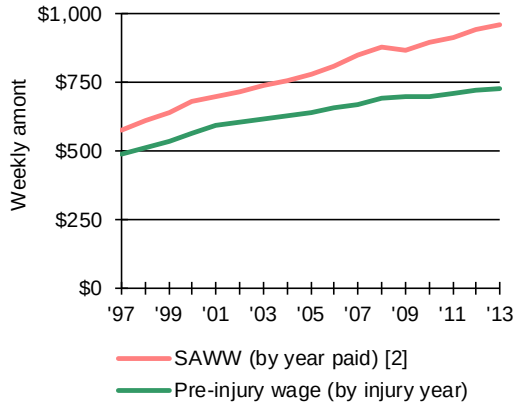
[16] *Unadjusted* average weekly benefits rose during the period examined, but less rapidly than the statewide average weekly wage, causing *adjusted* average weekly benefits to decline as shown here.

Growth of average pre-injury wage compared to statewide average weekly wage

The reported average pre-injury wage of injured workers (PIW) — the primary basis for average weekly benefits — rose more slowly than the statewide average weekly wage (SAWW) from 1997 to 2013.

- While the SAWW rose 66 percent over this period, the PIW rose 48 percent (Figure 3.5).
- The PIW is less than the SAWW because injuries are more common in lower-wage jobs.
- Because of the relatively slow rate of increase in the PIW, the PIW fell from 85 percent of the SAWW in 1997 to 76 percent in 2013 (Figure 3.6).
- Because average weekly benefits (Figure 3.4) are adjusted for growth in the SAWW, a change in the PIW relative to the SAWW will cause a change in these adjusted benefits, other things equal. The decrease in the PIW relative to the SAWW explains about 75 percent of the estimated decrease in adjusted average weekly benefits for total disability and 84 percent for TPD.

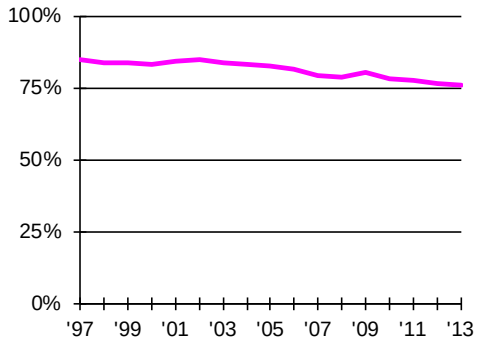
Figure 3.5 Statewide average weekly wage and average pre-injury wage, injury years 1997-2013 [1]



Injury year	SAWW (by year paid) [2]	Average pre-injury wage (by injury year)
1997	$579	$490
2005	782	644
2008	878	693
2013	961	727

1. Data from DLI.
2. The statewide average weekly wage (SAWW) is shown here by the year in which the wages were paid. This makes it comparable to the pre-injury wage, which is by year of injury. By contrast, as it is used in workers' compensation benefit adjustment, the effective SAWW for the 12-month period beginning Oct. 1 of each year reflects wages paid during the most recent calendar year.

Figure 3.6 Average pre-injury wage as percentage of statewide average weekly wage, 1997-2013 [1]



Injury year	APIW as pctg. of SAWW
1997	84.7%
2002	84.7
2011	77.6
2012	76.2
2013	75.6

1. Data from Figure 3.5.

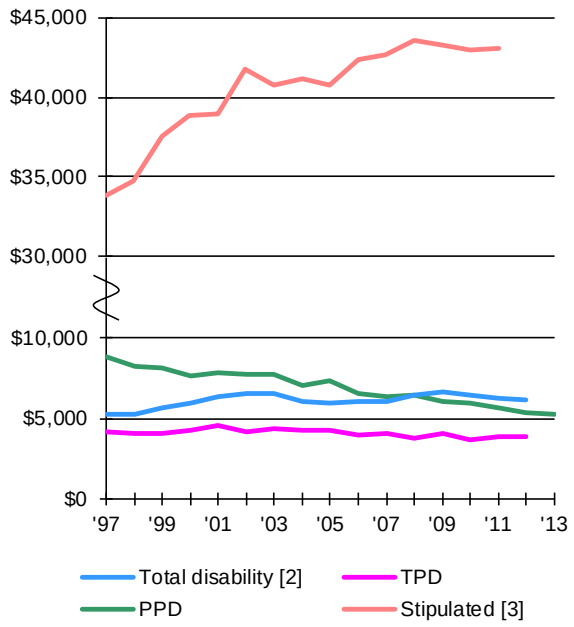
Average benefits by type

Adjusting for average wage growth, average benefits per paid indemnity claim showed widely varying trends depending on benefit type.

- After adjusting for average wage growth:
  - average total disability benefits rose 25 percent from 1997 to 2002 and changed little thereafter;
  - average TPD benefits fell 7 percent from 1997 to 2012;
  - average PPD benefits fell 40 percent from 1997 to 2014; and
  - average stipulated benefits rose 27 percent from 1997 to 2011.
- The trends in average total disability and TPD benefits are driven by the trends in average benefit duration and average weekly benefits.
  - Average total disability benefits increased between 1997 and 2002 because of rising duration (with average weekly benefits showing only small change) and were little-changed after 2002 because of opposing trends in duration and average weekly benefits (Figures 3.3 and 3.4).
  - The slightly falling trend in average TPD benefits occurred because of falling average weekly benefits with relatively little change in duration (Figures 3.3 and 3.4).
- Adjusted average PPD benefits have fallen nearly continually since 1997. This has occurred primarily because the PPD benefit schedule is fixed in statute, apart from legislated changes. Under the fixed schedule, PPD benefits become smaller relative to rising wages, which is reflected in adjusted average benefits. The only statutory increase during the period concerned was in the 2000 law change (see Appendix B), which produced a slight increase in average PPD benefits in 2001.[17]
- The large increase in average stipulated benefits is notable given the smaller increase in average total disability benefits and the decreases in TPD and PPD benefits. Stipulated benefits depend in part on the value of benefits the claimant might receive without a settlement.

[17] The average PPD rating, which also affects average PPD benefits, varied somewhat during the period and was somewhat lower in 2011 than in 1997 (6.3 vs. 6.7 percent).

Figure 3.7 Average benefit by type per claim with the given benefit type, adjusted for wage growth, injury years 1997-2013 [1]



Injury year	Total disability [2]	TPD	PPD	Stipulated [3]
1997	$5,240	$4,190	$8,790	$33,800
2009	6,700	4,050	6,060	43,270
2010	6,430	3,740	5,960	42,960
2011	6,260	3,900	5,710	43,070
2012	6,190	3,900	5,390	
2013			5,300	

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2013. Statistics for total disability, TPD and stipulated benefits are not shown for the most recent injury years because they are not yet sufficiently stable.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.

Since stipulated benefits may include medical and vocational rehabilitation (VR) benefits as well as indemnity benefits, and since VR benefits are relatively small, these trends raise the question whether settlements of some medical benefits may be playing a role in increasing stipulated benefits.[18]

[18] Under current DLI protocols, insurers do not separate the indemnity, medical and vocational rehabilitation components of stipulation awards in their reporting to DLI (see note 3 in Figure 3.7). Another consideration is that, as shown in Figure 5.1, while all dispute rates rose in varying degrees from 1997 to 2011, the medical request dispute rate rose significantly faster than the others. Settlements rarely

Benefits by type per indemnity claim

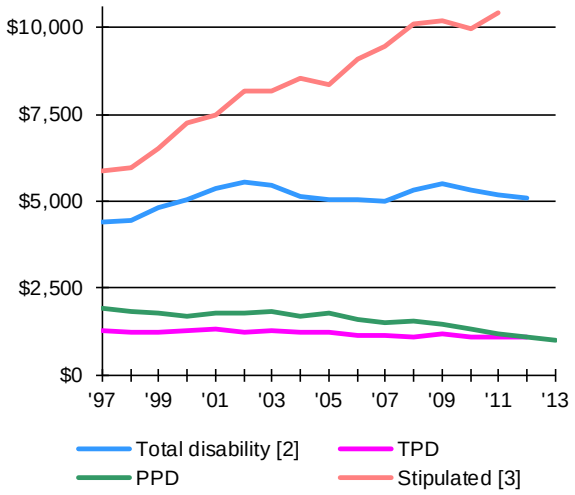
Adjusting for average wage growth, average benefits per paid indemnity claim showed widely different trends by benefit type.

Note: Figure 3.8 differs from Figure 3.7 in that it shows the average benefit of each type *per paid indemnity claim*, rather than *per claim with that type of benefit.* Figure 3.8 reflects the percentage of indemnity claims with each benefit type (Figure 3.2) and the average benefit amount per claim with that benefit type (Figure 3.7).

- After adjusting for average wage growth:
  - total disability benefits per indemnity claim rose 25 percent from 1997 to 2002 and fell somewhat thereafter, and in 2012 were 15 percent higher than in 1997;
  - TPD benefits per indemnity claim fell 15 percent from 1997 to 2012;
  - PPD benefits per indemnity claim fell 47 percent from 1997 to 2013; and
  - stipulated benefits per indemnity claim rose 77 percent from 1997 to 2011.
- The increase in total disability benefits per indemnity claim from 1997 to 2002 resulted from an increase in adjusted average total disability benefits per claim where these were paid (Figure 3.7), given the flat trend in the proportion of indemnity claims with these benefits for the same period (Figure 3.2).
- The decline in TPD benefits per indemnity claim is attributable to declines in the percentage of indemnity claims with these benefits (Figure 3.2) and in adjusted average TPD benefits where these were paid (Figure 3.7).
- The decline in average PPD benefits per indemnity claim resulted primarily from a decrease in adjusted average PPD benefits where these were paid (Figure 3.7) and to a lesser degree from a decrease in the percentage of claims with these benefits (Figure 3.2).
- The increase in stipulated benefits per indemnity claim resulted from an increase in the proportion of claims with these benefits (Figure 3.2) and an increase in adjusted average stipulated benefits where they were paid (Figure 3.7).

close out all medical benefits, but they often close out certain types of these benefits. In a sample of medical request disputes filed in 2003 and 2007, 21 percent of the 2003 disputes and 19 percent of the 2007 disputes ended with awards on stipulation. (These disputes were part of a larger dispute issue tracking study conducted by DLI Research and Statistics between 2006 and 2010. The 2003 percentage is reported in "Minnesota Workers' Compensation Dispute Issue Tracking Study: Report 1," May 2009, available at www.dli.mn.gov/RS/WcDispTrack.asp.)

Figure 3.8 Average benefit by type per paid indemnity claim, adjusted for wage growth, injury years 1997-2013 [1]



Injury year	Total disabilty [2]	TPD	PPD	Stipulated [3]
1997	$4,420	$1,300	$1,900	$5,880
2009	5,520	1,200	1,450	10,220
2010	5,330	1,090	1,340	9,950
2011	5,170	1,110	1,180	10,430
2012	5,090	1,100	1,080	
2013			1,010	

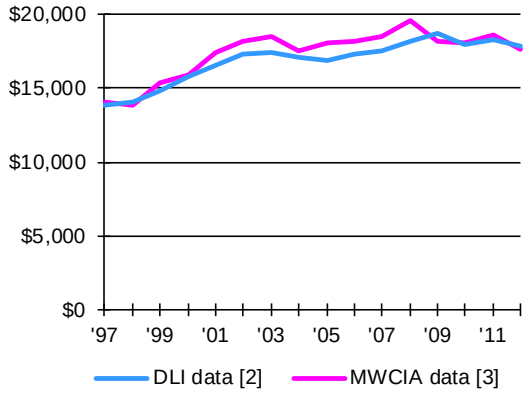
1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2013. Statistics for some benefit types are not shown for the most recent years because they are not yet sufficiently stable.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.

Indemnity benefits per claim, DLI and MWCIA data

As computed from DLI and MWCIA data, indemnity benefits per claim from the two sources follow each other closely.

- For about four years at the beginning and end of the 1997 to 2012 period, average indemnity benefits from the DLI and MWCIA data were nearly identical.
- It is uncertain why the two data sources were divergent from 2001 to 2008.
- The general agreement between the data sources lends credibility to both.

Figure 3.9 Average indemnity benefits per paid indemnity claim, adjusted for wage growth, DLI and MWCIA data, 1997-2012 [1]



	DLI data (by injury year) [2]	MWCIA data (by policy year) [3]
1997	$13,900	$14,100
2001	16,600	17,400
2003	17,400	18,500
2008	18,200	19,600
2009	18,700	18,100
2010	17,900	18,000
2011	18,300	18,600
2012	17,800	17,600

1. Benefit amounts are adjusted for average wage growth between the respective year and 2013. See Appendix C.
2. Includes insured and self-insured employers. In DLI reporting, benefits paid under a stipulation for settlement are not divided into indemnity and medical components. All benefits paid under a stipulation are included with indemnity benefits in the DLI data here. Indemnity benefits exclude vocational rehabilitation service costs in DLI reporting.
3. From Figure 2.5, Panel A. Includes insured employers only (including those in the Assigned Risk Plan). In MWCIA reporting, insurers are instructed to divide benefits paid under a stipulation for settlement into indemnity and medical components. Indemnity benefits include vocational rehabilitation service costs in MWCIA reporting.

Supplementary benefit and second-injury costs

DLI produces an annual projection of supplementary benefit and second-injury reimbursement costs as they would exist without future settlement activity. The total annual cost is projected to fall about 53 percent during the next 10 years and to disappear by 2052.

- The 2015 projected cost of $42 million consists of roughly $33 million for supplementary benefits and $9 million for second injuries.
- Without settlements, supplementary benefit claims are projected to continue until 2052 and second-injury claims until 2041.
- Claim settlements will reduce future projections of these liabilities. Settlements amounted to $2.8 million in fiscal year 2014.
- The total cost of supplementary and second-injury benefits for 2013, including settlements, amounted to 3.0 percent of total workers' compensation system cost.[19]

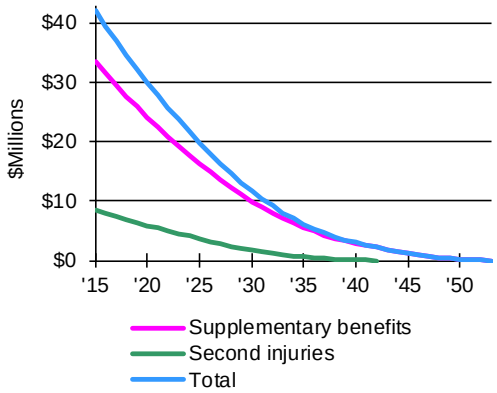
State agency administrative cost

State agency administrative cost has fallen as a proportion of workers' compensation covered payroll during the past several years.

- In fiscal year 2014, state agency administrative cost (see note 1 in Figure 3.11) came to 2.2 cents per $100 of payroll.
- Administrative cost for 2014 was about $27 million. As indicated in Figure 2.3, state administration accounts for about 1.7 percent of total workers' compensation system cost.

[19] This percentage was calculated with techniques similar to those for Figure 2.3 to reduce the effects of annual fluctuations in system cost.

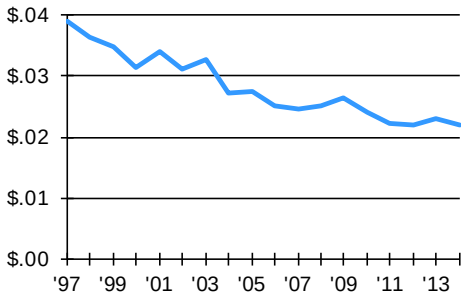
Figure 3.10 Projected cost of supplementary benefit and second-injury reimbursement claims, fiscal claim-receipt years 2015-2050 [1]



Fiscal year of claim receipt	Projected amount claimed ($millions)		
	Supple-mentary benefits	Second injuries	Total
2015	$33.4	$8.5	$41.9
2025	16.2	3.6	19.8
2030	9.9	1.7	11.7
2035	5.5	.6	6.1
2050	.2	.0	.2

1. Projected from DLI data, assuming no future settlement activity. See Appendix A for definitions.

Figure 3.11 Net state agency administrative cost per $100 of payroll, fiscal years 1997-2014 [1]



Fiscal year	State agency admin. cost per $100 of payroll
1997	$.039
2011	.022
2012	.022
2013	.023
2014	.022

1. Data from DLI, MWCIA and the Workers' Compensation Reinsurance Association. Includes costs of workers' compensation administrative functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the state share of the cost of Minnesota's OSHA program, beyond what is paid from revenues other than the Special Compensation Fund assessment. Estimated as described in Appendix C.

4

Vocational rehabilitation

This chapter provides data about vocational rehabilitation (VR) services in Minnesota's workers' compensation system.

Major findings

- Participation in vocational rehabilitation rose from 15 percent of paid indemnity claims for injury year 1997 to 24 percent for 2013 (Figure 4.1).
- After adjusting for average wage growth, the average cost of VR services for injury year 2013 ($8,830) was about the same as for 2000 and has been about the same since 2010 (Figure 4.3). VR services account for an estimated 2.7 percent of total workers' compensation system cost (Figure 2.3).
- The percentage of VR plans closed because of plan completion fell from 54 percent for plans closed in 2005 to 47 percent for 2013; during the same period, the percentage of closures resulting from claim settlement or agreement of the parties increased from 43 percent to 49 percent. A return to work is reported for most participants who complete their plans, but for only a minority of those who do not (Figure 4.7).
- The percentage of VR participants with a job reported at plan closure decreased from 65 percent for plan-closure year 2005 to 58 percent for 2013 (Figure 4.8).
- The return-to-work wage of VR participants varies widely relative to their pre-injury wage (Figure 4.10).
- For VR participants who returned to work at a different employer, the average return-to-work wage ratio (relative to the pre-injury wage) was 85 percent for plan-closure year 2013, an increase from 2005. The ratio for this group was relatively low for 2008 to 2010, suggesting an effect of the Great Recession. For those returning to the same employer, the average ratio was 97 percent for 2013, which has changed little since 2005 (Figure 4.11).

Background

The following basic information is necessary for understanding the figures in this chapter. See the glossary in Appendix A for more detail.

Vocational rehabilitation is the third type of workers' compensation benefit, supplementing medical and indemnity benefits. VR services are provided to injured workers who need help in returning to suitable gainful employment because of their injuries.[20]

VR services include:

- vocational evaluation;
- medical management;
- counseling;
- job analysis;
- job modification;
- job development;
- job placement;
- vocational testing;
- transferable skills analysis;
- job-seeking skills training;
- retraining; and
- arrangement of on-the-job training.

Except for retraining, these services are delivered by qualified rehabilitation consultants (QRCs) and job-placement vendors. These providers are registered with DLI and must follow professional conduct standards specified in Minnesota Rules.

[20] Minnesota Rules, part 5220.0100, subp. 34.

QRCs work mostly in private-sector VR firms, and may also provide services to non-workers' compensation clients. Some VR firms also have job-placement staff. Some QRCs are employed by insurers and self-insured employers. DLI's Vocational Rehabilitation unit provides VR services to injured workers whose claims are involved in primary liability or causation disputes; it may also provide VR services in non-contested cases.

QRCs determine whether injured workers are eligible for VR services, develop VR plans for those determined eligible and coordinate service delivery under those plans. Eligibility is determined in a VR consultation, which is typically done within certain timelines or if requested by the employee, employer or DLI.

Job-placement vendors help injured workers to secure suitable employment through a series of activities including teaching job-seeking skills and assisting with preparation of resumes, cover letters and job applications. Job-placement vendors also contact prospective employers to identify jobs, arrange interviews, discuss employment incentives and conduct labor market surveys.

VR plan costs are generated by hourly charges for services by QRCs and vendors and by the costs for certain services, such as retraining and vocational testing. Any annual changes in hourly charges through 2012 were limited to the lesser of the percent increase in the statewide average weekly wage (SAWW) or 2 percent. The changes to Minnesota's workers' compensation statute in 2013 increased the annual change in hourly charges to the lesser of the percent increase in the SAWW or 3 percent, effective Oct. 1, 2013.

The maximum hourly fee levels for QRCs and for job-development and -placement services, effective Oct. 1, 2013, through Sept. 30, 2014, were $99.47 and $75.51, respectively. These rates increased by 1.69 percent to $101.15 and $76.79, respectively, for Oct. 1, 2014, through Sept. 30, 2015.

The 2013 law changes also defined job-development services and limited these services to 20 hours a month for up to 13 weeks, or 26 weeks by agreement between the injured worker and employer or by order of DLI or the Office of Administrative Hearings. This limit is effective for employees injured on or after Oct. 1, 2013. Injured workers with earlier dates of injury have no limit on their job-development services.

Data sources and time period covered

The data in this chapter comes from VR documents filed with DLI for claims with VR activity. Injured workers may receive services from multiple VR service providers (at different times), each of which may file VR plans. The duration and cost of VR services reported in this chapter are the cumulative values from all plans involved with a particular claim. For brevity, combined plans are referred to simply as plans. The service outcomes are the outcomes of the most recent plan closure. Reported results may change in subsequent reports because of newer plan-closure filings.

The trend statistics in this chapter reported by injury year are developed as described in Appendix C, with a 10-year development period. Results reported by closure year that are developed use a seven-year period based on the year of the initial plan submission. This is described in more detail in Appendix C.

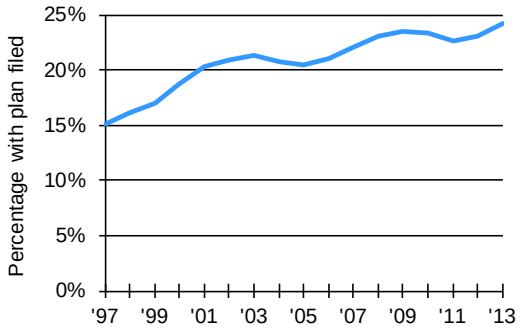
With the exception of the VR participation rate, the VR data only goes back to 1998.

Participation

VR participation increased substantially from 1997 to 2003.

- The VR participation rate — the percentage of paid indemnity claims with a VR plan filed — increased from 15 percent in 1997 to 24 percent in 2013.
- The participation rate has shown some annual fluctuation relative to the long-term trend, with an increase for the past two years.
- An estimated 5,400 workers injured in 2013 are expected to receive VR services (some of these people have not yet begun services).
- The increase in the VR participation rate between 2005 and 2009 coincides with the Great Recession; however, it is uncertain to what degree the recession has affected VR participation.[21]

Figure 4.1 Percentage of paid indemnity claims with a VR plan filed, injury years 1997-2013 [1]



Injury year	Percentage with plan
1997	15.1%
2009	23.4
2010	23.3
2011	22.6
2012	23.1
2013	24.2

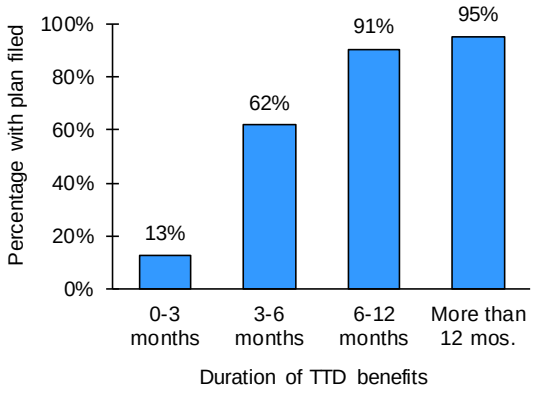
1. Developed statistics from DLI data (see Appendix C).

Participation and injury severity

VR participation varies with injury severity as measured by the amount of time the injured worker has been off the job and by the worker's degree of permanent partial disability.

- For paid indemnity claimants injured from 2010 to 2012:
  - VR participation ranged from 13 percent for workers with no more than three months of TTD benefits to 95 percent for workers with more than 12 months of TTD benefits; and
  - VR participation ranged from 18 percent for workers without PPD benefits to 78 percent for workers with PPD ratings of 20 percent or more (no figure shown).

Figure 4.2 Percentage of paid indemnity claims with a VR plan filed by TTD duration, injury years 2010-2012 combined [1]



1. Data from DLI.

[21] Since the statistics here are by year of injury, the recession could affect claim duration for workers injured before it began, and could therefore affect VR participation for those years.

Cost

Adjusted for average wage growth, the average cost of VR services peaked in 2007 but has fallen since then.

- The average cost of $8,800 for 2013 was 17 percent above 1998, 8 percent below the 2007 peak of $9,600, and about the same as in 2000.
- Median cost showed a similar pattern, peaking in 2008. The 2013 median of $5,420 was about the same as 2007.
- The total cost of VR services for injury year 2013 was an estimated $48 million. As shown in Figure 2.3, VR service costs account for an estimated 2.7 percent of total workers' compensation system cost.[22]
- Average VR service cost per indemnity claim (counting claims with and without plans) was $2,130 for 2013, an increase of 75 percent from 1998. Nearly all of this increase had taken place by 2003. These changes reflect the trends in the participation rate (Figure 4.1) and average service cost (Figure 4.3).
- Among plans closed in 2013, 78 percent of total cost was for QRC services other than job development and placement, 21 percent was for job development and placement (10 percent by QRCs, 11 percent by outside vendors) and less than 1 percent was for other items (including mileage, supplies and retraining tuition).

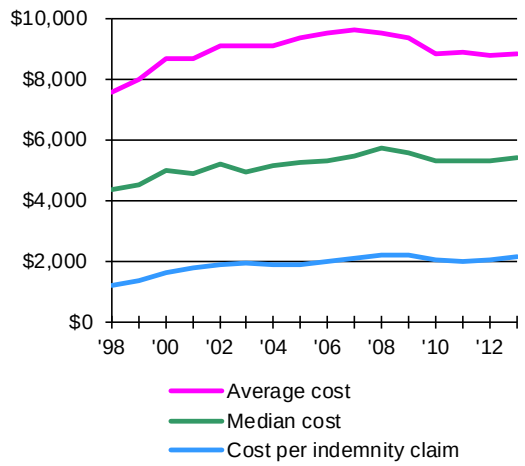
Cost and injury severity

VR service costs increase with injury severity as measured by PPD rating.

- For plan-closure years 2011 to 2013 combined, participants with higher PPD ratings had progressively higher VR costs. For PPD ratings of 15 percent or more, the average cost of VR services was more than double the cost for PPD ratings of 1 to 5 percent.

[22] The percentages in Figure 2.3 are calculated in a way that reduces the effects of annual fluctuations in system cost (see Appendix C).

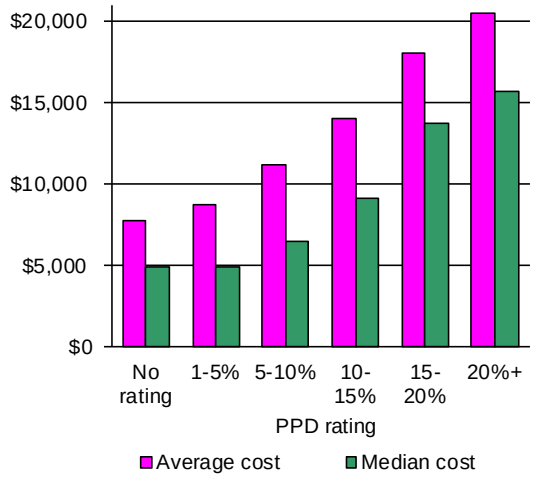
Figure 4.3 VR service costs, adjusted for wage growth, injury years 1998-2013 [1]



Injury year	Average cost	Median cost	Cost per indemnity claim
1998	$7,550	$4,360	$1,220
2000	8,650	4,970	1,620
2007	9,610	5,480	2,120
2008	9,510	5,710	2,190
2009	9,370	5,590	2,200
2010	8,820	5,290	2,060
2011	8,880	5,320	2,010
2012	8,760	5,330	2,020
2013	8,830	5,420	2,130

1. Developed statistics from DLI data. Costs are adjusted for average wage growth between the respective year and 2013. See Appendix C.

Figure 4.4 VR service cost by PPD rating, adjusted for wage growth, plan-closure years 2011-2013 combined [1]



1. Data from DLI. Costs are adjusted for average wage growth between the year of injury and 2013.

Timing of services

The success of VR is closely linked to prompt service provision. The average time from injury to the start of VR services decreased by two months from 1998 to 2013.

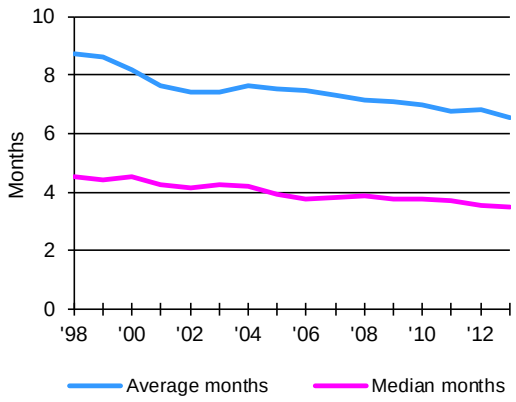
- The average time to the start of VR services was 6.5 months for injury year 2013, down 25 percent from 1998; the median time was 3.5 months for 2013, down 22 percent from 1998.
- Among plans closed in 2013, 41 percent of VR starts were within three months of the injury date and 69 percent were within six months.
- Among VR participants with plans closed in 2013, those who began services within three months of injury, as compared to those starting more than one year after their injury, had:
  - lower VR service costs by 25 percent ($8,400 vs. $11,230);
  - shorter service durations by 23 percent (12.7 months vs. 16.5 months); and
  - higher chances of returning to work (63 percent vs. 54 percent).

Service duration

VR service duration has shown little change since 2005.

- Average duration was an estimated 13.5 months for plan-closure year 2013; median duration was 9.4 months. These values were about the same as for 2008 and slightly higher than for 2005.
- As compared with the years prior to 2008, the relatively high duration rates for 2008 and later years suggest an effect of the Great Recession.
- Among plan closures in 2013, average service duration was shortest for participants who returned to work with their pre-injury employer (9.4 months); it was longest for those who went to a different employer (17.1 months) and nearly as long for workers who had their plans closed without returning to work (16.3 months).

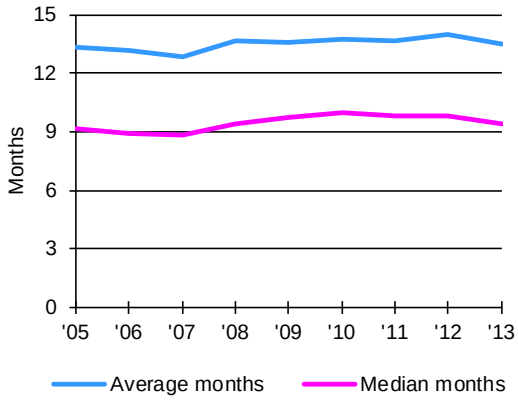
Figure 4.5 Time from injury to start of VR services, injury years 1998-2013 [1]



Injury year	Average months	Median months
1998	8.7	4.5
2009	7.1	3.8
2010	7.0	3.8
2011	6.8	3.7
2012	6.8	3.6
2013	6.5	3.5

1. Developed statistics from DLI data (see Appendix C).

Figure 4.6 VR service duration, plan-closure years 2005-2013 [1]



Plan-closure year	Average months	Median months
2005	13.3	9.2
2008	13.7	9.4
2009	13.6	9.7
2010	13.7	10.0
2011	13.7	9.8
2012	14.0	9.9
2013	13.5	9.4

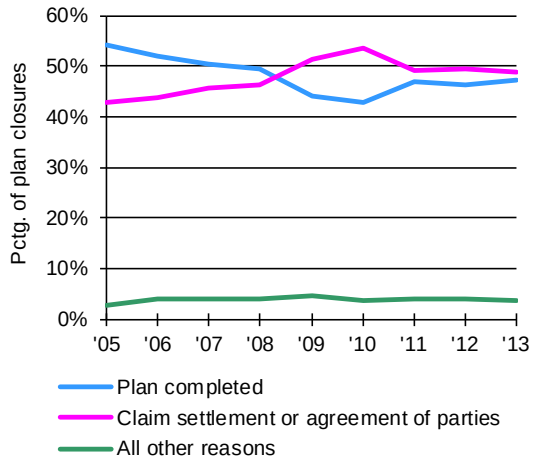
1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury year 1998, to be sufficiently mature. See Appendix C.

Reason for plan closure

The percentage of VR plans closed because of plan completion has fallen since 2005, while the percentage closed because of claim settlement or agreement of the parties has increased by almost the same amount.

- The proportion of VR plans closed because they were completed fell from 54 percent among plans closed in 2005 to 47 percent in 2013. During the same period, the proportion of plans closed by claim settlement or agreement of the parties grew from 43 percent to 49 percent.
  - ➢ Plan completions dropped to as low as 43 percent of closures in 2010, and have recovered to 47 percent of closures in 2013.
- The increased proportion of VR plans closed because of claim settlement or agreement of the parties is consistent with the increase in the percentage of paid indemnity claims with stipulated settlements (Figure 3.2).
- A return to work is reported for most participants who complete their plans (98 percent for 2013), but for only a minority of those who do not (whose plans close for any other reason) (22 percent). It is uncertain to what degree plan completion actually contributes to the participant's likelihood of having a job at plan closure.[23]
- Plan costs vary by reason for closure: for closures in 2013, costs averaged $5,930 for completed plans; $12,010 for plans closed by settlement or agreement; and $9,360 for plans closed for other reasons.[24]

Figure 4.7 Reason for plan closure, plan-closure years 2005-2013 [1]



Plan-closure year	Plan completed	Claim settlement or agreement of parties	All other reasons [2]
2005	54.2%	43.0%	2.9%
2008	49.4	46.5	4.1
2009	44.0	51.3	4.7
2010	42.8	53.6	3.6
2011	46.9	49.1	4.0
2012	46.4	49.4	4.1
2013	47.4	48.9	3.7

1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury year 1998, to be sufficiently mature. See Appendix C.
2. "All other reasons" includes closures due to decision-and-orders and, starting with forms filed after July 2005, closures due to inability to locate the employee, death of the employee or QRC withdrawal. Closures for these reasons through July 2005 were coded as due to decision-and-orders or agreement of the parties.

[23] Completing a plan may lead to job placement, or job placement may lead the QRC to deem the plan completed. Also, a return to work may be less likely to be reported if the plan closes for reasons other than completion (for example, claim settlement or agreement of the parties).

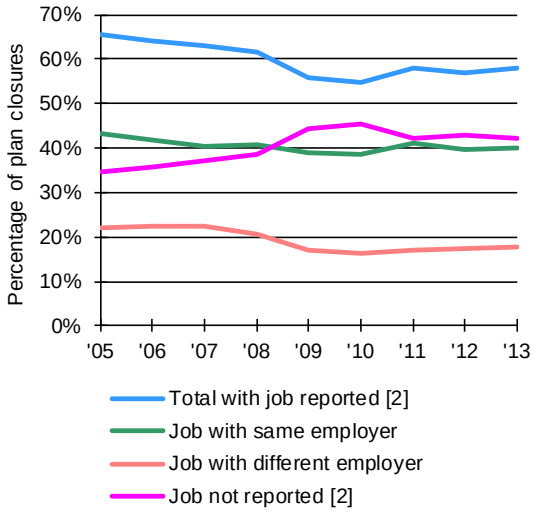
[24] Plan costs were adjusted to 2013 wage levels according to the worker's date of injury.

Return-to-work status

The goal of VR is to return injured workers to suitable gainful employment. Return to work is affected by many factors, including VR services, the job market, injury severity, availability of job modifications and claim litigation. The estimated percentage of VR participants with a job reported at plan closure fell between plan-closure years 2005 and 2013.[25]

- The estimated percentage of VR participants with a job reported at plan closure fell from 65 percent in 2005 to 59 percent in 2013. This decline had two components:
  - the percentage with a job at their pre-injury employer fell from 43 percent to 40 percent; and
  - the percentage with a job at a different employer fell from 22 percent to 19 percent.
- The percentage of participants with a job reported at plan closure almost exactly parallels the percentage of plans closed because of completion (Figure 4.7). This is expected since, as indicated on the previous page, a job is reported at closure for almost all who complete their plans but for only a minority of others. Again, the reason for the correlation between plan completion and having a job reported at plan closure is uncertain.[26]
- The percentage of participants with a job reported at plan closure reached a low-point, at 55 percent, for 2010 plan closures and recovered somewhat in the following years. This may be partly due to the Great Recession. This is uncertain, however, because of the previously described interplay among reported job placement, plan completion and plan closure by reason of claim settlement.
- For plan closures in 2013, the average cost of VR services for participants returning to work with their pre-injury employer ($5,020) was less than half the cost for those going to a different employer ($12,840) and for those not returning to work ($11,270).

Figure 4.8 Return-to-work status, plan-closure years 2005-2013 [1]



Plan-closure year	Job reported [2]			Job not reported [2]
	With same employer	With different employer	Total with job reported	
2005	43.2%	22.1%	65.4%	34.6%
2008	40.7	20.7	61.4	38.6
2009	38.8	17.0	55.8	44.2
2010	38.5	16.2	54.6	45.4
2011	41.0	16.9	57.9	42.1
2012	39.5	17.4	56.9	43.1
2013	40.1	17.9	58.0	42.0

1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury year 1998, to be sufficiently mature. See Appendix C.
2. See note 25 in text.

[25] The term "reported" is used to emphasize that the available information about whether the VR participant has a job at plan closure is what the QRC reports to DLI. Especially where the plan closes for reasons other than completion (for example, claim settlement), the participant may have a job without this being known and reported by the QRC.

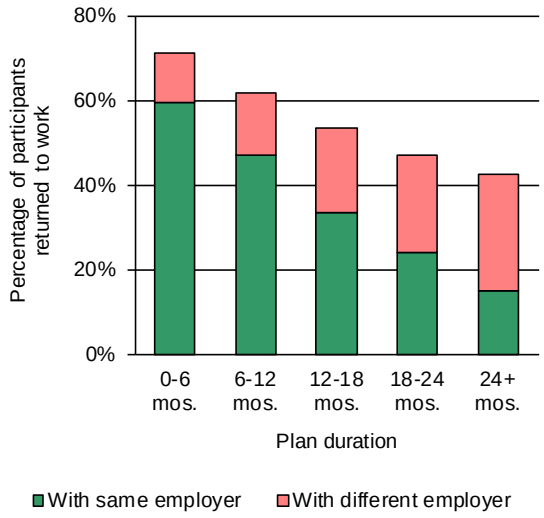
[26] See note 23.

Return-to-work status and plan duration

The percentage of VR participants who have returned to work at plan closure decreases with plan duration.

- For plan closures in 2011 to 2013 combined, the percentage of participants who returned to work ranged from 71 percent for plans lasting no more than six months to 42 percent for plans lasting 24 months or more.
- The percentage of participants returning to their pre-injury employer ranged from 60 percent for the shortest plans to 15 percent for the longest plans.
- The percentage of participants finding a job with a different employer ranged from 12 percent for the shortest plans to 28 percent for the longest plans.

Figure 4.9 Return-to-work status by plan duration, plan-closure years 2011-2013 combined [1]



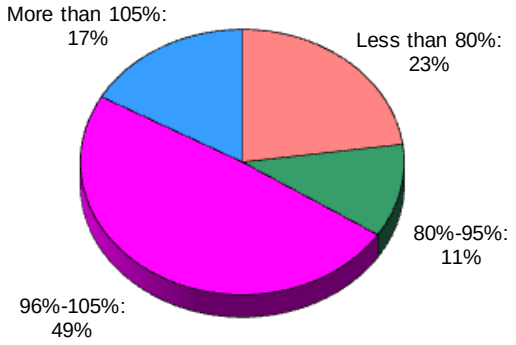
1. Data from DLI.

Return-to-work wages: distribution

For VR participants returning to work, the return-to-work wage on average is somewhat less than the pre-injury wage, but this varies widely.

- For plan closures in 2011 to 2013 combined, 66 percent of VR participants returning to work earned at least 96 percent of their pre-injury wage, but 23 percent earned less than 80 percent.
- Return-to-work wage experience varies widely with the amount of time worked in the pre-injury job. For plans closed in 2011 to 2013, 69 percent of the workers with more than five years of job tenure returned to a job with a wage of at least 96 percent of their pre-injury wage, compared with 60 percent of workers with less than three months of job tenure.
- Return-to-work wage experience also varies with plan duration. For 2011 to 2013 closures, the average return-to-work wage ratio was 98 percent for VR plans of less than 12 months of duration, 92 percent for plans between 12 and 18 months, but only 78 percent for plans with longer service durations.

Figure 4.10 Ratio of return-to-work wage to pre-injury wage for participants returning to work, plan-closure years 2011-2013 combined [1]



Average: 93%
Median: 100%

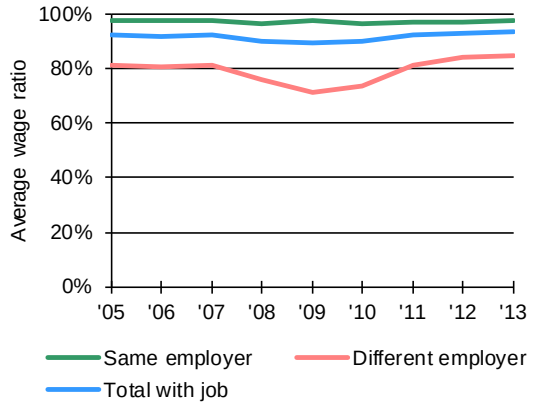
1. Data from DLI.

Return-to-work wages: trend

Among VR participants returning to work at plan completion, the ratio of the return-to-work wage to the pre-injury wage changed little between 2005 and 2013 for those returning to their pre-injury employer; for workers going to a different employer, the ratio declined in 2008 and 2009 but recovered in later years.

- For workers returning to their pre-injury employer, the average wage ratio stayed at about 97 percent.
- For workers going to a different employer, the wage ratio stood at 85 percent for closures in 2013; this was 4 percentage points higher than in 2005.
- The dip in the wage ratio for 2008 to 2010 for those going to a different employer suggests an effect of the Great Recession.

Figure 4.11 Average ratio of return-to-work wage to pre-injury wage by employer type, plan-closure years 2005-2013 [1]



Plan-closure year	Average ratio of return-to-work wage to pre-injury wage		
	Same employer	Different employer	Total with job
2005	97.8%	81.3%	92.5%
2008	96.7	76.0	89.8
2009	97.5	71.1	89.6
2010	96.4	73.5	90.0
2011	96.8	81.3	92.3
2012	96.9	84.2	93.0
2013	97.4	84.8	93.5

1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury year 1998, to be sufficiently mature. See Appendix C.

5

Disputes and dispute resolution

This chapter presents data about workers' compensation disputes and dispute resolution. Since statistics by year of injury are "developed" statistics,[27] in some instances they are not sufficiently stable for publication for the most recent injury years, and are therefore not reported in those instances. Statistics on a basis *other than* year of injury (for example, year of dispute certification decision) are presented through 2014 because such statistics are already mature and do not need to be "developed" (projected to full maturity).

Major findings

- The overall dispute rate increased from 15.5 percent of filed indemnity claims in 1997 to 20.5 percent for injury year 2012, a 32-percent increase.[28] Leading the way were the rates of medical disputes (up 69 percent through 2011) and vocational rehabilitation disputes (up 49 percent through 2011). With the exception of the claim petition rate, the overall dispute rate and its component rates seem to have leveled off since 2007 or 2008 (Figure 5.1).

- The percentage of paid indemnity claims with claimant attorney involvement rose from 16.9 percent for injury year 1997 to 23.8 percent for 2012, a 41-percent increase (Figure 5.2).[29]

- Total claimant attorney fees are estimated at $51 million for injury year 2012.[30] These fees account for an estimated 3.3 percent of total workers' compensation system cost.

- The rate of denial of filed indemnity claims was 13.5 percent for injury year 2012, down from 15.8 percent for 1997. This was 3.2 points (19 percent) below the peak in 2004, but 1.4 points (11 percent) above the low-point in 2010 (Figure 5.3).

- At DLI:

  - Between 1999 and 2014, the certification rate for medical and vocational rehabilitation disputes combined dropped from 67 to 46 percent (Figure 5.5).[31] For 2014, 48 percent of medical disputes and 40 percent of rehabilitation disputes were certified. Most noncertifications of medical and rehabilitation disputes occur because the issues have been resolved (Figure 5.6 and 5.7).
  - About 32 percent of certified medical disputes and 18 percent of certified rehabilitation disputes were referred to the Office of Administrative Hearings (OAH) in 2014 (Figure 5.8).
  - About 64 percent of the dispute resolution proceedings at DLI for 2012 to 2014 were administrative conferences; the remainder were mediations (Figure 5.9).
  - About 80 percent of resolutions at DLI for 2012 to 2014 were by agreement — most of these by informal intervention but a significant number (14 percent of DLI resolutions) by agreement via conference or mediation. The remaining 20 percent of resolutions at DLI were decision-and-orders.

- At OAH :

  - The most frequent type of dispute resolution for 2012 to 2014 was an award on stipulation, averaging 6,210 a year and

[27] See "Developed statistics" on p. 1.
[28] See note 11 on p. 11.
[29] A claimant attorney is deemed to be involved if there are claimant attorney fees of any type.
[30] See note 29.
[31] See description of DLI dispute certification process on p. 33.

accounting for 59 percent of OAH resolutions. The next most common outcome was for the case to be stricken from the proceeding calendar or dismissed (12 percent). The least common was a findings-and-order (7 percent) (Figure 5.13).

- Awards on stipulation were the most common outcome for all dispute types at OAH except for discontinuance disputes initiated by a request for administrative conference. For these disputes, for 2012 to 2014, 48 percent were resolved by an administrative conference decision and another 41 percent were withdrawn (Figure 5.14).

Background

The following basic information is necessary for understanding the figures in this chapter. See the glossary in Appendix A for more detail.

Types of disputes

Most disputes in Minnesota's workers' compensation system concern one or more of the three types of benefits and services the system provides:

- monetary benefits;
- medical services; and
- vocational rehabilitation services.

The injured worker and the insurer may disagree about whether the benefit or service should be provided, the level at which it should be provided or how long it should continue. Often, the disagreement is about whether the worker's claimed injury, medical condition or disability is work-related (see "primary liability" and "causation" in Appendix A). Disputes may also occur about payment for a service already provided. Payment disputes typically involve a medical or vocational rehabilitation provider and the insurer, and may also involve the injured worker.

These disputes are typically filed by the injured worker and dealt with by DLI and OAH in the following forms.

Claim petition disputes — Disputes about primary liability and monetary benefit issues are typically filed on a claim petition, which triggers a formal hearing or settlement conference at OAH. Some medical and vocational rehabilitation disputes are also filed on claim petitions.

Discontinuance disputes — Discontinuance disputes are disputes about the discontinuance of wage-loss benefits. They are most often initiated when the claimant requests an administrative conference (usually by phone) in response to the insurer's declared intention to discontinue temporary total or temporary partial benefits. These disputes may also be presented on the claimant's *Objection to Discontinuance* form or the insurer's petition to discontinue benefits, either of which leads to a hearing at OAH.

Medical request disputes — Medical disputes are usually filed on a *Medical Request* form, which triggers an administrative conference at DLI or OAH if DLI certifies the dispute.

Rehabilitation request disputes — Vocational rehabilitation disputes are usually filed on a *Rehabilitation Request* form, which leads to an administrative conference at DLI (or in some circumstances OAH) if DLI certifies the dispute.

Disputes also occur over other types of issues, such as attorney fees and the apportionment of liability among different employers, insurers and other payers (including the Special Compensation Fund).

Dispute resolution

Depending on the nature of the dispute, the form on which it is filed and the wishes of the parties, dispute resolution may be facilitated by a dispute-resolution specialist at DLI or by a judge at OAH. Administrative decisions from DLI or OAH can be appealed by requesting a *de novo* hearing at OAH; decisions from an OAH hearing can be appealed to the Workers' Compensation Court of Appeals and then to the Minnesota Supreme Court.

Dispute resolution at the Department of Labor and Industry

DLI carries out a variety of dispute-resolution activities.

Informal intervention — Through informal intervention, DLI provides information and

assistance to the claim parties and communicates with them to resolve potential and actual disputes at an early stage and/or determine whether a dispute should be certified (see below). Informal intervention is often initiated when a party, usually a claimant, medical provider or vocational rehabilitation provider, contacts DLI because they have had difficulty obtaining a workers' compensation benefit or service or payment for it. Resolution through informal intervention may occur before, during or after the dispute certification process.

Dispute certification — In a medical or vocational rehabilitation dispute, DLI must certify that a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services.[32] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

Mediation — If the parties agree to participate, a DLI specialist conducts a mediation to seek agreement on the issues. Any type of dispute is eligible. A DLI mediation agreement is usually recorded in a "mediation award," but may be incorporated into a stipulation for settlement and submitted to OAH for approval via an award on stipulation.

Administrative conference — DLI conducts administrative conferences on medical or vocational rehabilitation (VR) issues presented on a medical or rehabilitation request unless it has referred the issues to OAH or the issues have otherwise been resolved. DLI refers medical disputes involving more than $7,500 to OAH, and it may refer medical or VR disputes for other reasons.[33] The DLI specialist usually attempts to bring the parties to agreement during the conference. If agreement is not reached, the specialist issues a "decision-and-order." If agreement is reached, the specialist issues an "order on agreement." A party may appeal a DLI decision-and-order by requesting a *de novo* hearing at OAH.

Dispute resolution at the Office of Administrative Hearings

OAH performs the following dispute-resolution activities.

Mediation — If the parties agree to participate, OAH offers mediation to seek agreement on the issues. Any type of dispute is eligible. An OAH mediation agreement is usually recorded in a stipulation for settlement and submitted to an OAH judge for approval via an award on stipulation, but the agreement is sometimes recorded in a "mediation award" issued by an OAH judge.

Settlement conference — OAH conducts settlement conferences in litigated cases to achieve a negotiated settlement, where possible, without a formal hearing. If achieved, the settlement typically takes the form of a "stipulation for settlement." A stipulation for settlement is approved by an OAH judge; it may be incorporated into a mediation award or "award on stipulation," usually the latter.

Administrative conference — With some exceptions, OAH conducts administrative conferences on issues presented on a medical or rehabilitation request that have been referred from DLI (see above). In some cases, medical and rehabilitation request disputes referred from DLI are heard in a formal hearing (see below). OAH also conducts administrative conferences where requested by the claimant in a dispute about discontinuance of wage-loss benefits.[34] If agreement is not reached at the conference, the OAH judge issues a decision-and-order. A party may appeal an OAH decision-and-order by requesting a *de novo* formal hearing at OAH.

Formal hearing — OAH conducts formal hearings on disputes presented on claim petitions and other petitions where resolution through a settlement conference is not possible. OAH also conducts hearings on other issues, such as medical request disputes involving

[32] Minnesota Statutes §176.081, subd. 1(c).

[33] Minnesota Statutes §176.106. The 2005 Legislature increased the monetary limit on DLI jurisdiction in medical disputes from $1,500 to $7,500. The 2013 Legislature removed this limit for disputes over medical fees, effective May 17, 2013. DLI also refers medical disputes to OAH if surgery is involved, and it may refer medical or VR disputes if litigation is pending at OAH or the issues are unusually complex. Primary liability disputes are outside of administrative conference jurisdiction and must be filed on a claim petition, which leads to a settlement conference or hearing at OAH.

[34] Minnesota Statutes §176.239.

surgery; medical or rehabilitation request disputes that have complex legal issues or have been joined with other disputes by an order for consolidation; discontinuance disputes where the parties have requested a hearing; and disputes about miscellaneous issues such as attorney fees. OAH also conducts *de novo* hearings when a party files a request for hearing to appeal an administrative-conference decision-and-order from DLI or OAH. If the parties do not reach agreement, the judge issues a "findings-and-order."

Dispute resolution by the parties

Often, the parties in a dispute reach agreement outside of the dispute-resolution process at DLI or OAH, although this is often spurred by DLI or OAH initiatives, such as the scheduling of proceedings. Sometimes the party initiating a dispute or an appeal of a decision-and-order withdraws the dispute or the appeal. Sometimes the parties agree informally, sometimes without notifying DLI or OAH. Often they settle by means of a stipulation for settlement, which may be reached while the dispute is at DLI or OAH. The stipulation for settlement is usually incorporated into an award on stipulation issued by an OAH judge. An award on stipulation may occur in any type of dispute, but occurs most commonly in claim petition disputes.

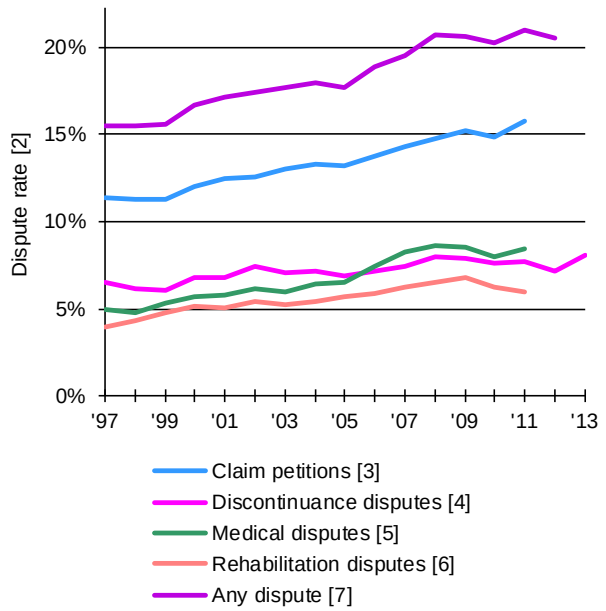
Dispute rates

The overall dispute rate showed a large increase from 1997 to 2012. The increase was most pronounced for the proportion of claims with medical requests.

- The overall dispute rate was 20.5 percent in 2012, 32 percent higher than in 1997.[35] From 1997 to 2011:[36]
  - the rate of claim petitions rose 4.4 percentage points (39 percent);
  - the rate of discontinuance disputes rose 1.2 points (18 percent);
  - the rate of medical disputes rose 3.4 points (69 percent); and
  - the rate of rehabilitation disputes rose 2.0 points (49 percent).[37]
- Except for the claim petition rate, dispute rates have leveled off in the past few years:
  - the rate of discontinuance disputes was about the same in 2013 as in 2008;
  - the rates of medical and rehabilitation disputes were about the same in 2011 as in 2007; and
  - the overall dispute rate was about the same in 2012 as in 2008.

[35] See note 11 on p. 11.
[36] See note 2 in Figure 5.1.
[37] The definition of medical and rehabilitation disputes is changed from prior reports. In prior reports, these disputes were defined as the filing of a medical or rehabilitation request (respectively). In the current report, these disputes include the filing of either a certification request (medical or rehabilitation, respectively) or a medical or rehabilitation request (respectively). This is based on the fact that the dispute certification process is triggered by either a certification request or a medical or rehabilitation request.

Figure 5.1 Incidence of disputes, injury years 1997-2013 [1]



Injury year	Dispute rate [2] Claim petitions [3]	Discontinuance disputes [4]	Medical disputes [5]	Rehabilitation disputes [6]	Any dispute [7]
1997	11.4%	6.5%	5.0%	4.0%	15.5%
1999	11.3	6.1	5.3	4.8	15.6
2007	14.3	7.5	8.3	6.2	19.5
2008	14.8	8.0	8.6	6.6	20.7
2009	15.2	7.9	8.5	6.8	20.7
2010	14.9	7.6	8.0	6.2	20.2
2011	15.8	7.7	8.4	6.0	21.0
2012		7.2			20.5
2013		8.1			

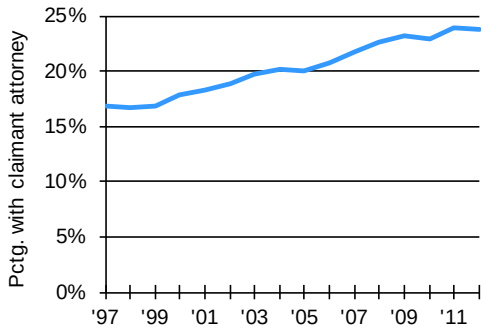
1. Developed statistics from DLI data (see Appendix C).
2. Some dispute rates are not shown for the most recent injury years because they are not yet sufficiently stable for those years.
3. Percentage of filed indemnity claims with at least one claim petition. (Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.)
4. Percentage of paid wage-loss claims with at least one discontinuance dispute.
5. Percentage of paid indemnity claims with at least one medical dispute certification request or medical request.
6. Percentage of paid indemnity claims with at least one rehabilitation dispute certification request or rehabilitation request.
7. Percentage of filed indemnity claims with at least one dispute of any type.

Claimant attorney involvement

Claimant attorney involvement has increased substantially since 1997.[38]

- The percentage of paid indemnity claims with claimant attorney involvement rose from 16.9 percent for injury year 1997 to a projected 23.8 percent for 2012.[39] This is a 41-percent increase.[40]
- This parallels a similar pattern in the dispute rate (Figure 5.1).
- Total claimant attorney fees are projected at $51 million for injury year 2012.[41] These fees account for an estimated 3.3 percent of total workers' compensation system cost.[42]

Figure 5.2 Percentage of paid indemnity claims with claimant attorney involvement, injury years 1997-2012 [1]



Injury year	Percentage with claimant attorney
1997	16.9%
2006	20.7
2007	21.8
2008	22.7
2009	23.1
2010	22.9
2011	23.9
2012	23.8

1. Developed statistics from DLI data (see Appendix C). A claimant attorney is deemed to be involved if claimant attorney fees of any type are reported. Statistics are not shown for 2013 because they are not yet sufficiently stable.

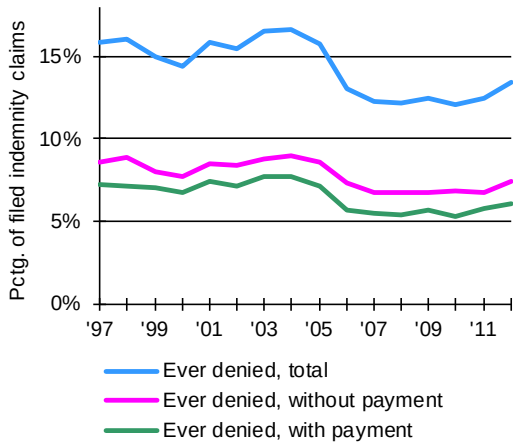
[38] DLI does not track defense attorney involvement.
[39] See note 1 in Figure 5.2.
[40] See note 11 on p. 11.
[41] All types of claimant attorney fees are counted here.
[42] This percentage was calculated with techniques similar to those for Figure 2.3 to reduce the effects of annual fluctuations in system cost.

Claim denials

Denials of primary liability are of interest because they frequently generate disputes. The denial rate was steady from 2007 to 2010, but rose between 2010 and 2012.

- The rate of denial of filed indemnity claims stood at 13.5 percent for 2012. This was 3.2 points (19 percent) below the peak in 2004, but 1.4 points (11 percent) above the low-point in 2010.
- Among filed indemnity claims with denials, 44 to 47 percent received payment from 1997 through 2012. These claims include cases denied but then paid and cases paid but then denied.
- The percentage of claims denied and without payment and the percentage denied but with payment both generally followed the same trend as the overall percentage ever denied.
- The decrease in the denial rate between 2004 and 2007 coincided with an enhancement in DLI's denial review process initiated in November 2005.[43]

Figure 5.3 Filed indemnity claim denial rates, injury years 1997-2012 [1]



Injury year	Percentage of filed indemnity claims ever denied: Without payment	With payment	Total	Pctg. of denied filed indemnity claims ever paid
1997	8.6%	7.2%	15.8%	45.7%
2000	7.7	6.7	14.5	46.4
2004	9.0	7.7	16.7	46.2
2006	7.3	5.7	13.0	43.8
2007	6.8	5.4	12.2	44.5
2008	6.8	5.4	12.2	44.5
2009	6.8	5.7	12.4	45.7
2010	6.8	5.3	12.1	43.6
2011	6.7	5.7	12.5	46.1
2012	7.4	6.0	13.5	44.8

1. Developed statistics from DLI data (see Appendix C). Filed indemnity claims are claims for indemnity benefits, including claims paid and claims never paid. Denied claims include claims denied and never paid, claims denied but eventually paid and claims initially paid but later denied. Statistics are not shown for 2013 because they are not yet sufficiently stable.

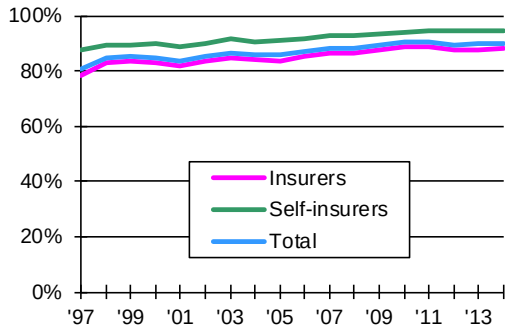
[43] In this enhancement, still in effect, DLI requires insurers to indicate their reasons for claim denials in a manner compliant with statute and rule. The pronounced decrease in the denial rate suggests insurers may be refraining from making some denials they otherwise would have made, believing those denials might not withstand DLI scrutiny. See "DLI Primary Liability Determination Review Process," in *COMPACT*, August 2006, available from DLI Research and Statistics, (651) 284-5025.

Prompt first action

Insurers must either begin payment on a wage-loss claim or deny the claim within 14 days of when the employer knows of the injury.[44] This "prompt first action" is important not only for the sake of the injured worker, but also because it makes disputes less likely. The prompt-first-action rate has increased since 1997.

- The fiscal year 2014 prompt-first-action rate was 90 percent, about 9 percentage points higher than 1997.
- The prompt-first-action rate is higher for self-insurers than for insurers.
- The rates for insurers and self-insurers have been fairly stable for the past four to five years.
- In compliance with statute[45] and to improve workers' compensation system performance, DLI publishes the annual *Prompt First Action Report*, which indicates the prompt-first-action rates of individual insurers, self-insurers and the overall system.

Figure 5.4 Percentage of lost-time claims with prompt first action, fiscal claim-receipt years 1997-2014 [1]



Fiscal year of claim receipt	Insurers	Self-insurers	Total
1997	78.5%	87.3%	80.7%
2010	88.9	94.2	90.3
2011	88.7	94.3	90.2
2012	87.6	94.6	89.4
2013	87.8	94.5	89.6
2014	87.9	94.3	89.6

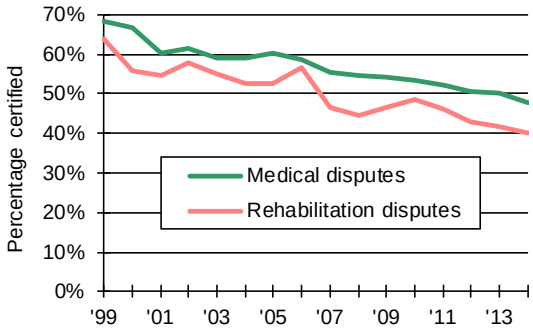
1. Computed from DLI data by DLI Compliance, Records and Training. See DLI Benefit Management and Resolution, *2014 Prompt First Action Report.* Fiscal claim-receipt year means the fiscal year in which DLI received the claim. Fiscal years are from July 1 through June 30; for example, July 1, 2013, through June 30, 2014, is fiscal year 2014.

Certification of medical and rehabilitation disputes at DLI

The percentages of medical and rehabilitation disputes certified at DLI have fallen substantially since 1999.

- From 1999 to 2014, the percentage certified fell from 68 percent to 48 percent for medical disputes and from 64 percent to 49 percent for rehabilitation disputes.
- The proportion of disputes certified was higher among medical disputes than among rehabilitation disputes for the period shown. For 2014, 48 percent of medical disputes were certified vs. 40 percent of rehabilitation disputes.

Figure 5.5 Percentage of disputes certified at the Department of Labor and Industry, 1999-2014 [1]



Year of certification decision	Percentage certified: Medical disputes	Rehabilitation disputes	Total
1999	68%	64%	67%
2010	53	48	52
2011	52	46	50
2012	51	43	48
2013	50	42	48
2014	48	40	46

1. Data from DLI. The dispute certification process is triggered by the filing of a dispute certification request or a medical or rehabilitation request. Disputes as counted here include the filing of a certification request or a medical or rehabilitation request. Data not available before 1999.

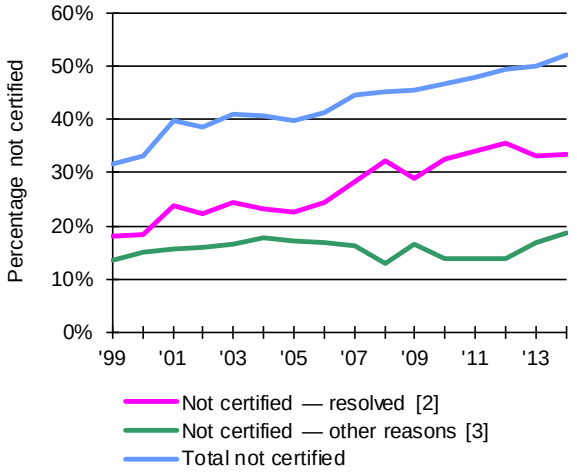
[44] Minnesota Statutes §176.221.
[45] Minnesota Statutes §176.223.

Reason for noncertification at DLI: medical disputes

Most of the increase in noncertification of medical disputes since 1999 has resulted from an increase in the percentage not certified because the issues were resolved.

- From 1999 to 2014, the percentage of medical disputes (see note 1 in Figure 5.6) not certified because the issues were resolved rose from 18 to 34 percent. These disputes accounted for 57 percent of noncertified medical disputes in 1999 and 64 percent in 2014.
- Over the same period, the percentage of medical disputes not certified for other reasons (see note 2 in Figure 5.6) rose from 14 to 19 percent. These disputes accounted for 43 percent of noncertified medical disputes in 1999 and 36 percent in 2014.
- Among noncertified medical disputes, the percentage not certified because the issues were resolved peaked in 2012 at 72 percent.

Figure 5.6 Reason for noncertification of medical disputes at the Department of Labor and Industry, 1999-2014 [1]



Year of certification decision	Reason not certified: Resolved [2] Pctg. of all medical disputes	Resolved [2] Pctg. of non-certified medical disputes	Other [3] Pctg. of all medical disputes	Other [3] Pctg. of non-certified medical disputes	Total not certified Pctg. of all medical disputes	Total not certified Pctg. of non-certified medical disputes
1999	18%	57%	14%	43%	32%	100%
2005	23	57	17	43	40	100
2010	33	70	14	30	47	100
2011	34	71	14	29	48	100
2012	35	72	14	28	49	100
2013	33	67	17	33	50	100
2014	34	64	19	36	52	100

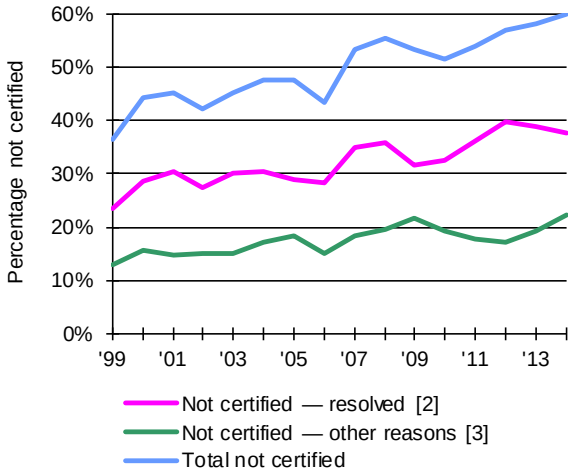
1. Data from DLI. The medical dispute certification process is triggered by the filing of a dispute certification request on medical issues or a medical request. Medical disputes as counted here include the filing of a certification request on medical issues or a medical request. Data not available before 1999.
2. The resolution here could be the result of efforts by a DLI specialist or of the insurer indicating that it intended from the start to pay for the services as requested.
3. Other reasons for noncertification include the following: insurer needs additional time or information to decide position; the same issues are already scheduled for a proceeding at DLI or OAH; the injured worker's claim is subject to the provisions of a collective bargaining "carve-out" agreement (Minnesota Statutes §176.1812) and an administrative conference is currently deemed unnecessary; or a medical issue hasn't previously been submitted to the internal dispute resolution procedure of a certified managed care plan.

Reason for noncertification at DLI: rehabilitation disputes

The increase in noncertification of rehabilitation disputes since 1999 has resulted about equally from increases in the percentage not certified because the issues were resolved and in the percentage not certified for other reasons.

- From 1999 to 2014, the percentage of rehabilitation disputes (see note 1 in Figure 5.7) not certified because the issues were resolved rose from 23 to 38 percent. These disputes accounted for 64 percent of noncertified rehabilitation disputes in 1999 and 63 percent in 2014.
- Over the same period, the percentage of rehabilitation disputes not certified for other reasons (see note 2 in Figure 5.7) rose from 13 to 22 percent. These disputes accounted for 36 percent of noncertified rehabilitation disputes in 1999 and 37 percent in 2014.
- Among noncertified rehabilitation disputes, the percentage not certified because the issues were resolved peaked in 2012 at 70 percent.

Figure 5.7 Reason for noncertification of rehabilitation disputes at the Department of Labor and Industry, 1999-2014 [1]



Year of certification decision	Reason not certified: Resolved [2] Pctg. of all rehab. disputes	Resolved [2] Pctg. of non-certified rehab. disputes	Other [3] Pctg. of all rehab. disputes	Other [3] Pctg. of non-certified rehab. disputes	Total not certified Pctg. of all rehab. disputes	Total not certified Pctg. of non-certified rehab. disputes
1999	23%	64%	13%	36%	36%	100%
2005	29	61	18	39	48	100
2010	32	63	19	37	52	100
2011	36	67	18	33	54	100
2012	40	70	17	30	57	100
2013	39	67	19	33	58	100
2014	38	63	22	37	60	100

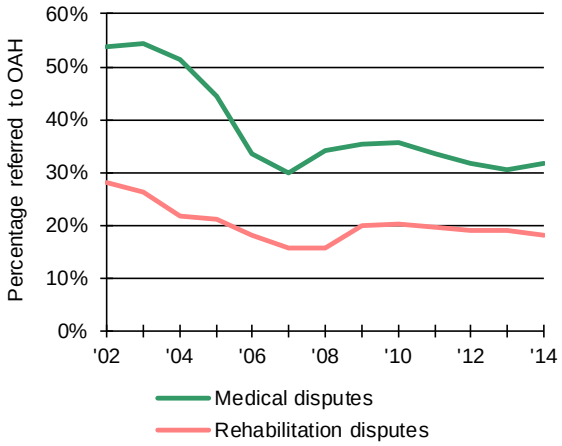
1. Data from DLI. The rehabilitation dispute certification process is triggered by the filing of a dispute certification request on rehabilitation issues or a rehabilitation request. Rehabilitation disputes as counted here include the filing of a certification request on rehabilitation issues or a rehabilitation request. Data not available before 1999.
2. The resolution here could be the result of efforts by a DLI specialist or of the insurer indicating that it intended from the start to pay for the services as requested.
3. Other reasons for noncertification include the following: insurer needs additional time or information to decide position; the same issues are already scheduled for a proceeding at DLI or OAH; the injured worker's claim is subject to the provisions of a collective bargaining "carve-out" agreement (Minnesota Statutes §176.1812) and an administrative conference is currently deemed unnecessary; or a medical issue hasn't previously been submitted to the internal dispute resolution procedure of a certified managed care plan.

DLI referrals to OAH

DLI referrals to OAH are far less frequent than in the early 2000s.

- The referral rate for medical disputes fell from 54 percent in 2002 to a low-point of 30 percent in 2007; the 32-percent rate for 2014 was somewhat higher than for 2007 and about the same as for 2006.
- The referral rate for rehabilitation disputes fell from 28 percent in 2002 to a low-point of 16 percent in 2007 and 2008; the 18-percent rate for 2014 was somewhat higher than for 2007 and 2008 and about the same as for 2006.
- The referral rate is higher for medical disputes than for rehabilitation disputes at least partly because two types of medical disputes are automatically referred: (1) those of more than $7,500 (unless they concern the amount of payment for services) and (2) surgery disputes.[46]

Figure 5.8 Percentage of DLI-certified disputes referred to the Office of Administrative Hearings, 2002-2014 [1]



	Percentage referred to OAH		
Year of certification decision	Certified medical disputes	Certified rehabilitation disputes	Total
2002	54%	28%	42%
2005	44	21	34
2006	33	18	27
2007	30	16	24
2008	34	16	27
2010	36	20	30
2011	34	20	28
2012	32	19	27
2013	31	19	26
2014	32	18	26

1. Data from DLI. Data not available before 2002.

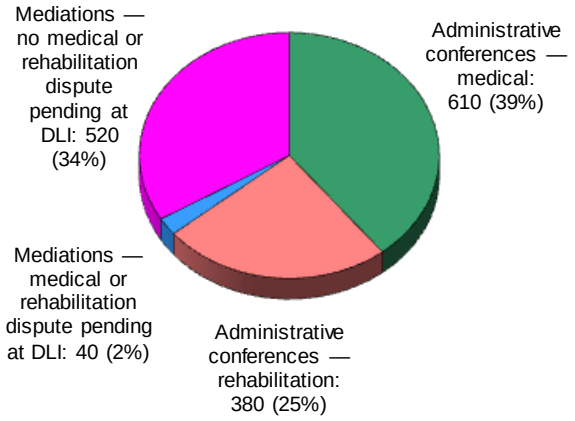
[46] See p. 33 and note 33.

Dispute resolution proceedings at DLI

Administrative conferences account for a majority of dispute resolution proceedings at DLI. With most DLI mediations, there are no medical or rehabilitation disputes pending at DLI.

- For 2012 to 2014, administrative conferences on medical issues accounted for 39 percent of DLI proceedings, while conferences on rehabilitation issues accounted for another 25 percent.
- Mediations accounted for the remaining 36 percent of DLI proceedings. With 94 percent of DLI mediations (or 34 percent of DLI proceedings), there were no medical or rehabilitation disputes pending at DLI. This is because most DLI mediations are on claim petition issues.[47]

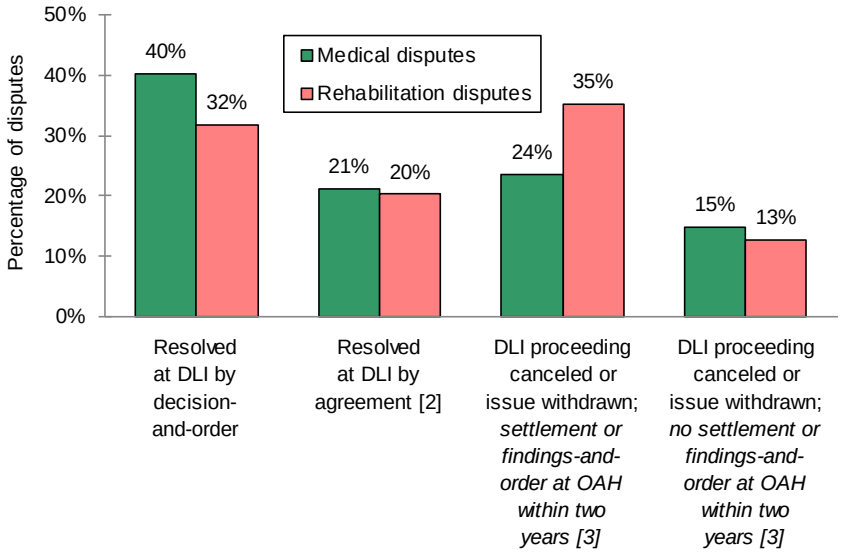
Figure 5.9 Mediations and administrative conferences at the Department of Labor and Industry, 2012-2014 average [1]



1. Data from DLI. Numbers rounded to nearest 10.

[47] This is the experience of the DLI ADR unit; the DLI data system does not track this information.

Figure 5.10 Outcomes of DLI-certified disputes not referred to the Office of Administrative Hearings, 2012-2014 combined [1]



1. Data from DLI.
2. Since this figure is limited to DLI-certified disputes not referred to OAH, it excludes most DLI mediation agreements — specifically, those on issues other than a medical or rehabilitation dispute at DLI (see Figure 5.9). The "agreement" category here includes (in declining order of frequency) instances of conference canceled because of prior issue resolution, conference held and issues resolved without DLI written agreement, conference held and issues resolved with DLI written agreement, mediation held and issues resolved without DLI written agreement, conference or mediation held with issues resolved with a DLI mediation award, and issues resolved prior to conference by DLI intervention. Where an agreement is reached without a DLI document, the agreement is often incorporated in an award on stipulation at OAH.
3. The canceled DLI proceeding may be an administrative conference or mediation. "Withdrawn" means the dispute was withdrawn at DLI (not necessarily OAH). This category also includes DLI mediations held with no agreement and cases where the dispute parties no longer respond to DLI communications. An OAH findings-and-order may occur in these disputes because they may be consolidated with other OAH disputes.

Outcomes of DLI-certified disputes not referred to OAH

Among DLI-certified medical and rehabilitation disputes that are not referred to OAH, a majority (only a slight majority for rehabilitation disputes) are resolved at DLI by decision-and-order or by mediation or other agreement.

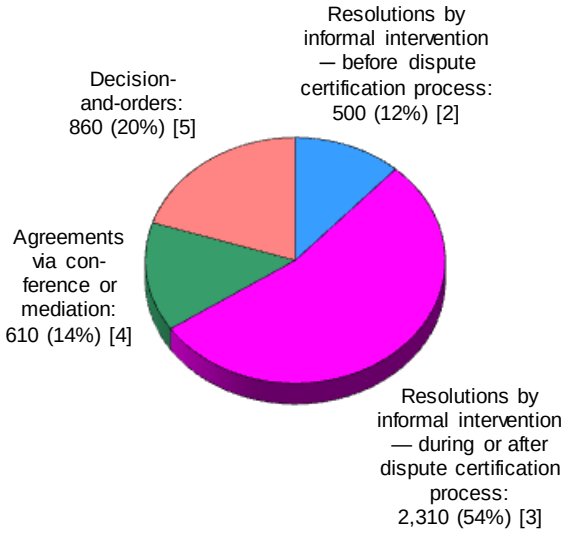
- For 2012 to 2014 combined:
  - 40 percent of medical disputes were resolved by DLI decision-and-order and another 21 percent by agreement at DLI (see note 2 in Figure 5.10); and
  - 32 percent of rehabilitation disputes were resolved by DLI decision-and-order and another 20 percent by agreement at DLI.
- For about 39 percent of medical disputes and 48 percent of rehabilitation disputes, the DLI outcome was a cancellation of a scheduled proceeding or withdrawal of the dispute. In a majority of these cases, there was a settlement (award on stipulation) or findings-and-order at OAH within two years. This was more likely for rehabilitation disputes (35 percent of all outcomes) than for medical disputes (24 percent).
- Overall, the main difference between medical and rehabilitation disputes was that rehabilitation disputes were less likely to be resolved by DLI decision-and-order and more likely to be resolved by settlement or findings-and-order (usually settlement) at OAH.

Resolutions at DLI

About 80 percent of dispute resolutions at DLI are by agreement, and most of these are through informal intervention.

- For 2012 to 2014 combined, 66 percent of DLI dispute resolutions were by informal intervention; most of these (54 percent of resolutions at DLI) were during or after the dispute certification process.
- Another 14 percent of DLI resolutions were agreements via conference or mediation.
- The remaining 20 percent took the form of decision-and-orders.

Figure 5.11 Total resolutions at the Department of Labor and Industry, 2012-2014 average [1]



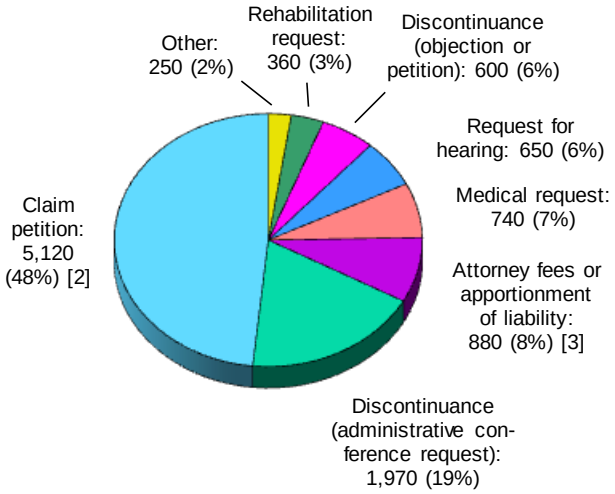
1. Data from DLI. Numbers rounded to nearest 10.
2. These resolutions are accomplished by a DLI specialist via phone, walk-in contact or correspondence before a dispute certification request or a medical or rehabilitation request has been submittted.
3. These resolutions are accomplished by a DLI specialist via phone, walk-in contact or correspondence after a dispute certification request and/or a medical or rehabilitation request has been submittted. If the resolution occurs during the dispute certification process, a dispute is not certified. If if occurs after that process, this means a dispute has been certified.
4. These include mediation awards and other agreements from conference or mediation. All DLI mediation agreements are counted here, including those on issues other than medical and rehabilitation disputes at DLI (see Figure 5.9).
5. Virtually all decision-and-orders are via administrative conference. Since 2004, nonconference decision-and-orders have numbered three or fewer a year.

Dispute types at OAH

Claim petitions are the most common dispute type at OAH, accounting for about half of disputes there.

- Claim petitions, numbering somewhat over 5,100 a year, accounted for 48 percent of OAH disputes for 2012 to 2014.
- Next most common were discontinuance disputes with 25 percent of the total, consisting of discontinuance disputes presented on an administrative conference request (19 percent) and on an objection to discontinuance or petition to discontinue benefits (6 percent).

Figure 5.12 Dispute types at the Office of Administrative Hearings, 2012-2014 average [1]



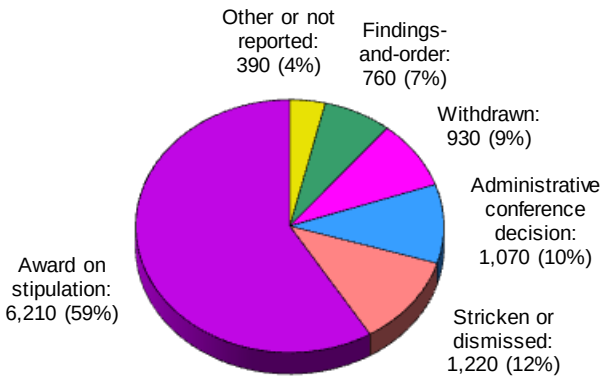
1. Data from DLI. Numbers rounded to nearest 10.
2. Includes general claim petitions and petitions for permanent total or dependents' benefits.
3. Also includes petitions by the Special Compensation Fund for reimbursement from uninsured employers. Attorney fee disputes are combined here with apportionment and reimbursement disputes because these do not directly involve benefits for the injured worker.

Dispute outcomes at OAH

A majority of disputes at OAH are resolved by an award on stipulation.

- Awards on stipulation, numbering somewhat over 6,200 a year, accounted for 59 percent of OAH dispute outcomes for 2012 to 2014.
- The next most common outcome was for the dispute to be stricken from a proceeding calendar or dismissed altogether.
- The third most common outcome is an administrative conference decision in a discontinuance dispute (where an administrative conference was requested) or a medical request or rehabilitation request dispute.
- For fiscal years 2011 to 2013, about 21 percent of findings-and-orders were appealed to the Workers' Compensation Court of Appeals.

Figure 5.13 Dispute outcomes at the Office of Administrative Hearings, 2012-2014 average [1]



1. Data from DLI. Numbers rounded to nearest 10.

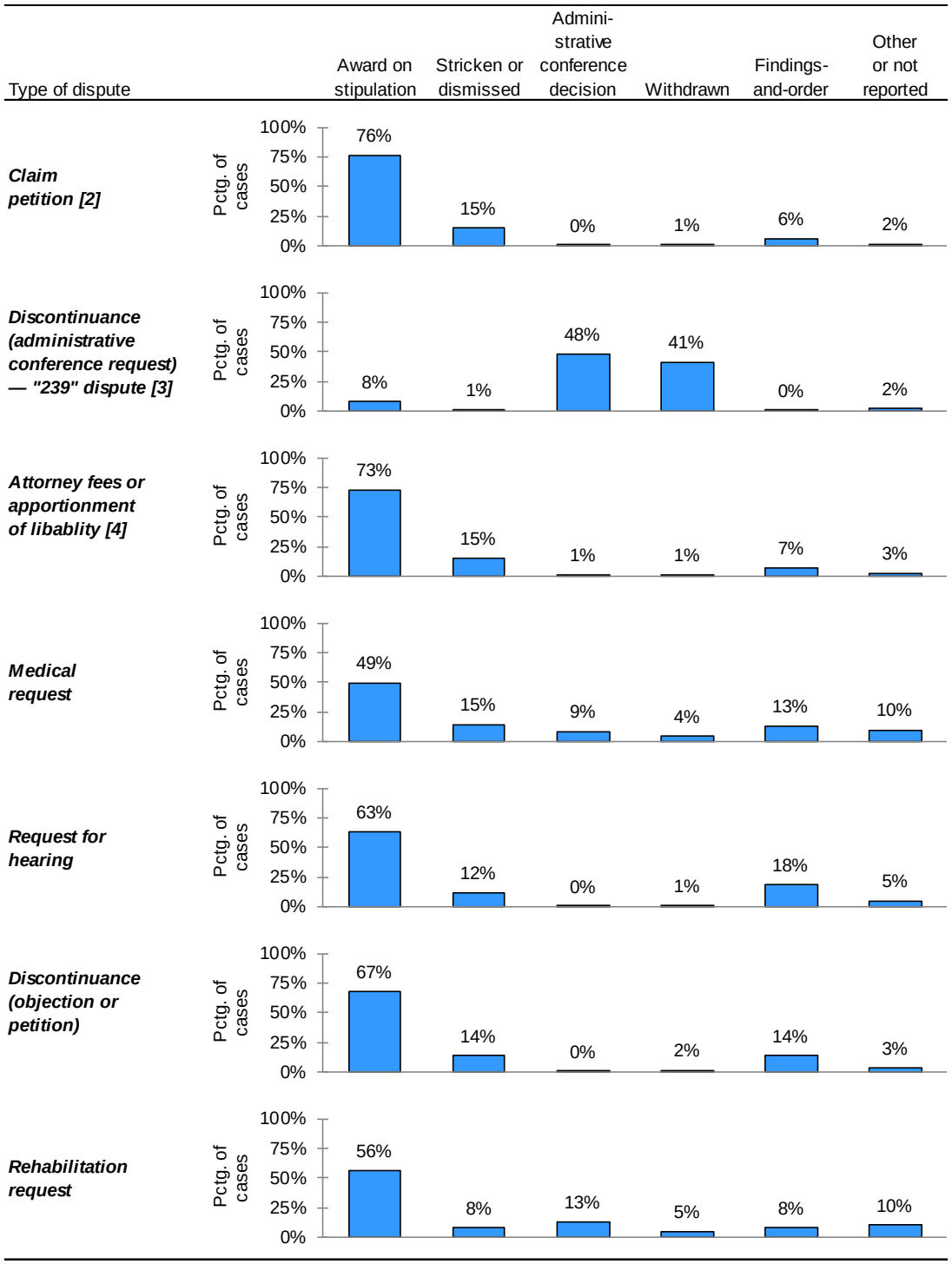
Dispute outcomes by dispute type at OAH

An award on stipulation was the most common dispute outcome for all OAH dispute types except discontinuance disputes initiated by an administrative conference request (".239" disputes[48]) (Figure 5.14).

- For 2012 to 2014 combined, for disputes other than .239 disputes, an award on stipulation was the outcome in 49 to 76 percent of the cases, the highest percentage being for claim petition disputes.
- For .239 disputes, the most common outcome was an administrative conference decision (48 percent of cases); 41 percent of these disputes were withdrawn.
- The dispute types most likely to have a findings-and-order were requests for hearing (18 percent), discontinuance disputes initiated by an objection to discontinuance or petition to discontinue benefits (14 percent) and medical requests.
  - ➢ The relatively low frequency of findings-and-orders in request-for-hearing disputes (18 percent vs. 63 for awards on stipulation) is notable given that a request for hearing is an appeal from an administrative conference decision in a medical or rehabilitation dispute.
  - ➢ Some medical requests at OAH have findings-and-orders because they are surgery disputes that have gone straight to hearing.
- Notably, claim petition disputes — which account for nearly half of OAH disputes as shown in Figure 5.12 — end with a findings-and-order only 6 percent of the time.

[48] These disputes are typically called ".239" disputes after their governing statute, Minnesota Statutes §176.239.

Figure 5.14 Dispute outcomes by type of dispute at the Office of Administrative Hearings, 2012-2014 average [1]



1. Data from DLI.
2. Includes general claim petitions and petitions for permanent total or dependents' benefits.
3. These disputes are typically called ".239" disputes after their governing statute, Minnesota Statutes §176.239.
4. Also includes petitions by the Special Compensation Fund for reimbursement from uninsured employers. Attorney fee disputes are combined here with apportionment and reimbursement disputes because these do not directly involve benefits for the injured worker.

Appendix A

Glossary

The following terms are used in this report.[49]

***Accident year* —** The year in which the accident or condition occurred giving rise to the injury or illness. In accident year data, all claims and costs are tied to the year in which the accident occurred. Accident year, used with insurance data, is equivalent to injury year, used with Department of Labor and Industry data.

***Administrative conference* —** An expedited, informal proceeding where parties present and discuss viewpoints in a dispute. With some exceptions, administrative conferences are conducted on medical and vocational rehabilitation disputes presented on a medical or rehabilitation request;[50] they are also conducted on disputes about discontinuance of wage-loss benefits presented by a claimant's request for administrative conference. Medical and rehabilitation conferences are conducted at either the Department of Labor and Industry (DLI) or the Office of Administrative Hearings (OAH) depending on whether DLI has referred the issues concerned to OAH.[51] Discontinuance conferences are conducted at OAH. If agreement is not achieved in the conference, the DLI specialist or OAH judge issues a "decision-and-order" which is binding unless appealed. If agreement is achieved, an "order on agreement" is issued. A party may appeal a DLI or OAH decision-and-order by requesting a *de novo* hearing at OAH.

***Assigned Risk Plan (ARP)* —** Minnesota's workers' compensation insurer of last resort, which insures employers unable to insure themselves in the voluntary market. The ARP is necessary because all non-exempt employers are required to have workers' compensation insurance or self-insure. The Department of Commerce operates the ARP through contracts with private companies for administrative services. The Department of Commerce sets the ARP premium rates, which are different from the voluntary market rates.

***Causation* —** The issue of whether the medical condition or disability for which the employee requests benefits or services was caused by an admitted injury (one for which the insurer or employer has admitted primary liability). An insurer denying benefits or services on the basis of causation is claiming the medical condition or disability in question did not arise from the admitted work injury.

***Claim petition* —** A form by which the injured worker contests a denial of primary liability or requests an award of indemnity, medical or rehabilitation benefits. In response to a claim petition, the Office of Administrative Hearings generally schedules a settlement conference or formal hearing.

***Cost-of-living adjustment* —** An annual adjustment of temporary total disability, temporary partial disability, permanent total disability or dependents' benefits computed from the annual change in the statewide average weekly wage (SAWW).[52] The percent adjustment is equal to the proportion by which the SAWW in effect at the time of the adjustment differs from the SAWW in effect one year earlier, not to exceed a statutory limit. For

[49] These definitions are only intended to help the reader understand the material presented in this report. They are not intended to be legally definitive or exhaustive.

[50] As indicated on pp. 33-34, some issues presented on a medical or rehabilitation request are heard in a formal hearing at the Office of Administrative Hearings rather than an administrative conference.

[51] See discussion of DLI administrative conferences on p. 33 (including note 33) for types of medical and vocational rehabilitation disputes referred to OAH.

[52] The SAWW is calculated according to Minnesota Statutes §176.011. The annual benefit adjustment is as provided in Minnesota Statutes §176.645.

injuries from Oct. 1, 1995, through Sept. 30, 2013, the cost-of-living adjustment was limited to 2 percent a year and was delayed until the fourth anniversary of the injury. For injuries on or after Oct. 1, 2013, the cost-of-living adjustment is limited to 3 percent a year and delayed until the third anniversary of the injury.

***Dependents' benefits* —** Benefits paid to dependents of a worker who has died from a work-related injury or illness. These benefits are equal to a percentage of the worker's gross pre-injury wage and are paid for a specified period of time, depending on the dependents concerned.

***Developed statistics* —** Estimates of the values of claim statistics (for example, number of claims, average claim cost, dispute rate, vocational rehabilitation participation rate) at a given claim maturity. Developed statistics are relevant for accident year, policy year, injury year and vocational rehabilitation (VR) plan-closure year data.[53] They are obtained by applying development factors, based on historical rates of development of the statistic in question, to tabulated numbers.

***Development* —** The change over time in a claim statistic (for example, number or cost of claims) for a particular accident year, policy year, injury year or vocational rehabilitation (VR) plan-closure year.[54] The reported numbers develop both because of the time necessary for claims to mature and, in the case of Department of Labor and Industry data, because of reporting lags.

***Discontinuance dispute* —** A dispute about the discontinuance of wage-loss benefits, most often initiated when the claimant requests an administrative conference (usually by phone) in response to the insurer's declared intention to discontinue temporary total or temporary partial benefits. The conference is conducted at the Office of Administrative Hearings (OAH). A discontinuance dispute may also be presented on the claimant's *Objection to Discontinuance* or the insurer's petition to discontinue benefits, either of which triggers a hearing at OAH.

***Discontinuance of wage-loss benefits* —** The insurer may propose to discontinue wage-loss benefits (temporary total, temporary partial or unadjudicated permanent total disability) if it believes one of the legal conditions for discontinuance have been met. See "Notice of Intention to Discontinue," "Request for Administrative Conference," "Objection to Discontinuance" and "petition to discontinue benefits."

***Dispute certification* —** A process required by statute in which, in a medical or rehabilitation dispute, the Department of Labor and Industry (DLI) must certify that a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services.[55] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

***Experience modification factor* —** A factor computed by an insurer to modify an employer's premium on the basis of the employer's recent loss experience relative to the overall experience for all employers in the same payroll class. For statistical reliability reasons, the "mod" more closely reflects the employer's own experience for larger employers than for smaller employers.

***Full-time-equivalent (FTE) covered employment* —** An estimate of the number of full-time employees who would work the same total number of hours during a year as the actual workers' compensation covered employees, some of whom work part-time or overtime. It is used in computing workers' compensation claims incidence rates.

***Hearing* —** A formal proceeding on a disputed issue or issues in a workers' compensation claim, conducted at the Office of Administrative Hearings (OAH). After the hearing, the judge issues a "findings-and-order" which is binding unless appealed to the Workers' Compensation Court of Appeals. OAH conducts formal hearings on disputes presented on claim petitions and other petitions where resolution through a settlement conference is not possible. OAH also conducts hearings on some discontinuance disputes (those presented on an

[53] See note 53.

[54] Development occurs in VR plan-closure year data because a claim may have more than one VR plan and the plan-closure year statistics are computed for all plans combined, categorized by the closure year of the last plan.

[55] Minnesota Statutes §176.081, subd. 1(c).

Objection to Discontinuance or a petition to discontinue benefits), disputes referred by the Department of Labor and Industry (DLI) because they do not seem amenable to less formal resolution, surgery disputes[56] and disputes about miscellaneous issues such as attorney fees. Finally, OAH conducts *de novo* formal hearings when requested by a party to an administrative-conference decision-and-order from DLI or OAH or a nonconference decision-and-order from DLI.

***Indemnity benefit* —** A benefit to the injured or ill worker or survivors to compensate for wage loss, functional impairment or death. Indemnity benefits include temporary total disability, temporary partial disability, permanent partial disability and permanent total disability benefits; supplementary benefits; dependents' benefits; and, in insurance industry accounting, vocational rehabilitation benefits.

***Indemnity claim* —** A claim with paid indemnity benefits. Most indemnity claims involve more than three days of total or partial disability, since this is the threshold for qualifying for temporary total or temporary partial disability benefits, which are paid on most of these claims. Indemnity claims typically include medical costs in addition to indemnity costs.

***Injury year* —** The year in which the injury occurred or the illness began. In injury year data, all claims, costs and other statistics are tied to the year in which the injury occurred. Injury year, used with Department of Labor and Industry data, is essentially equivalent to accident year, used with insurance data.

***Intervention* —** An instance in which the Department of Labor and Industry provides information or assistance to prevent a potential dispute from developing into an actual one, or communicates with the parties (outside of a conference or mediation) to resolve a dispute and/or determine whether a dispute should be certified. A dispute resolution through intervention may occur before, during or after the dispute certification process. (This is different from the intervention process in which an interested person or entity not originally involved in the dispute becomes a party to the dispute.)

***Mediation* —** A voluntary, informal proceeding to facilitate agreement among the parties in a dispute. A mediation occurs at the Department of Labor and Industry (DLI) or the Office of Administrative Hearings (OAH) when one party requests it and the others agree to participate. This often takes place after attempts at resolution by phone and correspondence have failed. If agreement is reached in a DLI mediation, the specialist formally records its terms in a "mediation award" or the parties incorporate the agreement into a stipulation for settlement and submit it to OAH for an award on stipulation. If agreement is reached in an OAH mediation, the parties usually file a stipulation for settlement which the OAH judge incorporates into an award on stipulation. However, sometimes an agreement from an OAH mediation is recorded in a mediation award issued by the OAH judge. Mediations also occur outside of DLI and OAH; when such a mediation produces agreement, the agreement is usually incorporated into a stipulation for settlement and submitted to OAH for an award on stipulation.

***Medical cost* —** The cost of medical services and supplies provided to the injured or ill worker, including payments to providers and certain reimbursements to the worker. Workers' compensation covers the costs of all reasonable and necessary medical services related to the injury or illness, subject to maximums established in law.

***Medical dispute* —** A dispute about a medical issue, such as choice of providers, nature and timing of treatments or appropriate payments to providers.

***Medical-only claim* —** A claim with paid medical costs and no indemnity benefits.

***Medical Request* —** A form by which a party to a medical dispute requests assistance from the Department of Labor and Industry (DLI) in resolving the dispute. The request may lead to mediation or other efforts toward informal resolution by DLI or to an administrative conference at DLI or the Office of Administrative Hearings (see administrative conference).

[56] Minnesota Rules, part 1420.2150, subp. 1 provides for expedited hearings on not-yet-provided-surgery issues.

Minnesota Workers' Compensation Insurers Association (MWCIA) — Minnesota's workers' compensation data service organization (DSO). State law specifies the duties of the DSO and the Department of Commerce designates the entity to be the DSO. Among other activities, the MWCIA collects data about claims, premium and losses from insurers, and annually produces pure premium rates.

Nonconference decision and order — A decision issued by the Department of Labor and Industry, without an administrative conference, in a dispute for which it has administrative conference authority (see "administrative conference"). The decision is binding unless a dispute party requests a formal hearing at the Office of Administrative Hearings.

Notice of Intention to Discontinue (NOID) — A form by which the insurer informs the worker of its intention to discontinue temporary total, temporary partial or unadjudicated permanent total disability benefits. In contrast with a petition to discontinue benefits, the NOID brings about benefit termination if the worker does not contest it.

Objection to Discontinuance — A form by which the injured worker requests a formal hearing to contest a discontinuance of wage-loss benefits (temporary total, temporary partial or permanent total disability) proposed by the insurer by means of a *Notice of Intention to Discontinue* or a petition to discontinue benefits. The hearing is conducted at the Office of Administrative Hearings.

Office of Administrative Hearings (OAH) — An executive branch body that conducts hearings in administrative law cases. One section is responsible for workers' compensation cases; it conducts administrative conferences, mediations, settlement conferences and hearings.

Permanent partial disability (PPD) — A benefit that compensates for permanent functional impairment resulting from a work-related injury or illness. The benefit is based on the worker's impairment rating, which is a percentage of whole-body impairment determined on the basis of health care providers' assessments according to a rating schedule in rules. The PPD benefit is calculated under a schedule specified in law, which assigns a benefit amount per rating point with higher ratings receiving proportionately higher benefits. The scheduled amounts per rating point were fixed for injuries from 1984 through September 2000, but were raised in the 2000 law change for injuries on or after Oct. 1, 2000. The PPD benefit is paid after temporary total disability (TTD) benefits have ended. For injuries from October 1995 through September 2000, it is paid at the same rate and intervals as TTD until the overall amount is exhausted. For injuries on or after Oct. 1, 2000, the PPD benefit may be paid in this manner or as a lump sum, computed with a discount rate not to exceed 5 percent.

Permanent total disability (PTD) — A wage-replacement benefit paid if the worker sustains a severe work-related injury specified in law or if the worker, because of a work-related injury or illness in combination with other factors, is permanently unable to secure gainful employment, provided that, for injuries on or after Oct. 1, 1995, the worker has a PPD rating of at least 13 to 17 percent, depending on age and education. The benefit is equal to two-thirds of the worker's gross pre-injury wage, subject to minimum and maximum weekly amounts, and is paid at the same intervals as wages were paid before the injury. For injuries on or after Oct. 1, 1995, benefits end at age 67 under a rebuttable presumption of retirement. Also for injuries on or after Oct. 1, 1995, weekly benefits are subject to a minimum of 65 percent of the statewide average weekly wage. The maximum weekly benefit amount is indicated in Appendix B. Cost-of-living adjustments are described in this appendix.

Petition to discontinue benefits — A document by which the insurer requests a formal hearing to allow a discontinuance of wage-loss benefits (temporary total disability, temporary partial disability or unadjudicated permanent total disability). The hearing is conducted at the Office of Administrative Hearings.

Policy year — The year of initiation of the insurance policy covering the accident or condition that caused the worker's injury or illness. In policy year data, all claims and costs are tied to the year in which the applicable policy took effect. Since policy periods often include portions of two calendar years, the data for a policy year includes claims and costs for

injuries occurring in two different calendar years.

***Primary liability* —** The overall liability of the insurer for any costs associated with an injury once the injury is determined to be compensable. An insurer may deny primary liability (deny the injury is compensable) if it has reason to believe the injury did not arise out of and in the course of employment or is not covered under Minnesota's workers' compensation law.

***Pure premium* —** A measure of expected losses, equal to the sum, over all insurance classes, of payroll times the class-specific pure premium rates, adjusted for individual employers' prior loss experience. It is different from (and somewhat lower than) the actual premium charged to employers, because actual premium includes other insurance company costs plus taxes and assessments.

***Pure premium rates* —** Rates of expected indemnity and medical losses a year per $100 of covered payroll, also referred to as "loss costs." Pure premium rates are determined annually by the Minnesota Workers' Compensation Insurers Association for approximately 560 insurance classes in the voluntary market. They are based on insurer "experience" and statutory benefit changes. "Experience" refers to actual losses relative to pure premium for the most recent report periods. The pure premium rates are published with documentation in the annual *Minnesota Ratemaking Report* subject to approval by the Department of Commerce.

***Rehabilitation Request* —** A form by which a party to a vocational rehabilitation dispute requests assistance from the Department of Labor and Industry (DLI) in resolving the dispute. The request may lead to mediation or other efforts toward informal resolution by DLI or to an administrative conference, usually at DLI but occasionally at the Office of Administrative Hearings (see administrative conference).

***Request for Administrative Conference* —** A form by which the injured worker requests an administrative conference to contest a discontinuance of wage-loss benefits (temporary total, temporary partial or permanent total disability) proposed by the insurer on the *Notice of Intention to Discontinue.* Requests for a discontinuance conference are usually done by phone.

***Reserves* —** Funds that an insurer or self-insurer sets aside to pay expected future claim costs.

***Second-injury claim* —** A claim for which the insurer (or self-insured employer) is entitled to reimbursement from the Special Compensation Fund because the injury was a subsequent (or "second") injury for the worker concerned. The 1992 law eliminated reimbursement (to insurers) of second-injury claims for subsequent injuries occurring on or after July 1, 1992.

***Self-insurance* —** A mode of workers' compensation insurance in which an employer or employer group insures itself or its members. To do so, the employer or employer group must meet financial requirements and be approved by the Department of Commerce.

***Settlement conference* —** A proceeding conducted at the Office of Administrative Hearings to achieve a negotiated settlement, where possible, without a formal hearing. If achieved, the settlement typically takes the form of a "stipulation for settlement" (see "stipulated benefits").

***Special Compensation Fund (SCF)* —** A fund within the Department of Labor and Industry (DLI) that pays, among other things, uninsured claims and reimburses insurers (including self-insured employers) for supplementary and second-injury benefit payments. (The supplementary-benefit and second-injury provisions only apply to older claims because they were eliminated by the law changes of 1995 and 1992, respectively.) The SCF also funds workers' compensation functions at DLI, the nonfederal portion of the cost of DLI's Minnesota OSHA compliance functions, the workers' compensation portion of the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and workers' compensation functions at the Department of Commerce. Revenues come primarily from an assessment on insurers (passed on to employers through a premium surcharge) and self-insured employers.

***Statewide average weekly wage (SAWW)* —** The average wage used by insurers and the Department of Labor and Industry to adjust

certain workers' compensation benefits. This report uses the SAWW to adjust average benefit amounts for different years so they are all expressed in constant (2012) wage dollars. The SAWW, from the Department of Employment and Economic Development, is the average weekly wage of nonfederal workers covered under unemployment insurance.

***Stipulated benefits* —** Indemnity and medical benefits specified in a "stipulation for settlement," which states the terms of settlement of a claim among the affected parties. A stipulation usually occurs in the context of a dispute, but not always. The stipulation may be reached independently by the parties or in a settlement conference or associated preparatory activities. A stipulation is approved by a judge at the Office of Administrative Hearings. It may be incorporated into a mediation award or an award on stipulation, usually the latter. The stipulation usually includes an agreement by the claimant to release the employer and insurer from future liability for the claim other than for medical treatment. Stipulated benefits are usually paid in a lump sum.

***Supplementary benefits* —** Additional benefits paid to certain workers receiving temporary total disability (TTD) or permanent total disability (PTD) benefits for injuries prior to October 1995. These benefits are equal to the difference between 65 percent of the statewide average weekly wage and the TTD or PTD benefit. The Special Compensation Fund reimburses insurers (and self-insured employers) for supplementary benefit payments. Supplementary benefits were repealed for injuries on or after Oct. 1, 1995.

***Temporary partial disability (TPD)* —** A wage-replacement benefit paid if the worker is employed with earnings that are reduced because of a work-related injury or illness. (The benefit is not payable for the first three calendar days of total or partial disability unless the disability lasts, continuously or intermittently, for at least 10 days.) The benefit is equal to two-thirds of the difference between the worker's gross pre-injury wage and his or her gross current wage, subject to a maximum weekly amount, and is paid at the same intervals as wages were paid before the injury. For injuries on or after Oct. 1, 1992, TPD benefits are limited to a total of 225 weeks and to the first 450 weeks after the injury (with an exception for approved retraining). The maximum weekly benefit amount is indicated in Appendix B. An additional limit is that the weekly TPD benefit plus the employee's weekly wage earned while receiving TPD benefits may not exceed 500 percent of the SAWW. Cost-of-living adjustments are described in this appendix.

***Temporary total disability (TTD)* —** A wage-replacement benefit paid if the worker is unable to work because of a work-related injury or illness. (The benefit is not payable for the first three calendar days of total or partial disability unless the disability lasts, continuously or intermittently, for at least 10 days.) The benefit is equal to two-thirds of the worker's gross pre-injury wage, subject to minimum and maximum weekly amounts, and is paid at the same intervals as wages were paid before the injury. Currently, TTD stops if the employee returns to work; the employee withdraws from the labor market; the employee fails to diligently search for work within his or her physical restrictions; the employee is released to work without physical restrictions from the injury; the employee refuses an appropriate offer of employment; 90 days have passed after the employee has reached maximum medical improvement or completed an approved retraining plan; or the employee fails to cooperate with an approved vocational rehabilitation plan or with certain procedures in the development of such a plan. TTD also stops, for injuries on or after Oct. 1, 1995, after 104 weeks of TTD have been paid, or for injuries on or after Oct. 1, 2008, after 130 weeks of TTD have been paid (with an exception for approved retraining). Minimum and maximum weekly benefit provisions are described in Appendix B. Cost-of-living adjustments are described in this appendix.

***Vocational rehabilitation (VR) dispute* —** A dispute about a VR issue, such as whether the employee should be evaluated for VR eligibility, whether he or she is eligible, whether certain VR plan provisions are appropriate or whether the employee is cooperating with the plan.

***Vocational rehabilitation (VR) plan* —** A plan for VR services developed by a qualified rehabilitation consultant (QRC) in consultation with the employee and the employer and/or insurer. The plan is developed after the QRC determines the injured worker to be eligible for

VR services. It is filed with the Department of Labor and Industry and provided to the affected parties. The plan indicates the vocational goal, the services necessary to achieve the goal and their expected duration and cost.

Voluntary market — The workers' compensation insurance market associated with policies issued voluntarily by insurers. Insurers may choose whether to insure a particular employer. See "Assigned Risk Plan."

Workers' Compensation Court of Appeals (WCCA) — An executive branch body that hears appeals of workers' compensation findings-and-orders from the Office of Administrative Hearings. WCCA decisions may be appealed to the Minnesota Supreme Court.

Workers' Compensation Reinsurance Association (WCRA) — A nonprofit entity created by law to provide reinsurance to workers' compensation insurers (including self-insurers) in Minnesota. Every workers' compensation insurer must purchase "excess of loss" reinsurance (reinsurance for losses above a specified limit per event) from the WCRA. Insurers may obtain other forms of reinsurance (such as aggregate coverage for total losses above a specified amount) through other means.

Written premium — The entire "bottom-line" premium for insurance policies initiated in a given year, regardless of when the premium comes due and is paid. Written premium is "bottom-line" in that it reflects all premium modifications in the pricing of the policies.

Appendix B

Workers' compensation law changes

Some workers' compensation law changes enacted since 1997 are relevant for this report. This appendix summarizes those law changes. Law changes that do not affect the trends in this report are not considered.

2000 law change

The following provisions took effect for injuries on or after Oct. 1, 2000.

Temporary total disability (TTD) minimum benefit — The minimum weekly TTD benefit was raised from $104 to $130, not to exceed the employee's pre-injury wage.

Temporary total disability (TTD), temporary partial disability (TPD) and permanent total disability (PTD) maximum benefit — The maximum weekly TTD, TPD and PTD benefit was raised from $615 to $750. (This maximum was raised again in 2008; see below.)

Permanent partial disability (PPD) benefits — Benefit amounts were raised for all impairment ratings. In addition, the PPD award may be paid as a lump sum, computed with a discount rate not to exceed 5 percent. Previously, PPD benefits were only payable in installments at the same interval and amount as the employee's temporary total disability (TTD) benefits.

Death cases — A $60,000 minimum total benefit was established for dependency benefits. In death cases with no dependents, a $60,000 payment to the estate of the deceased was established and the $25,000 payment to the Special Compensation Fund was eliminated. The burial allowance was increased from $7,500 to $15,000.

2005 law change

The following provision took effect for medical request disputes filed on or after May 26, 2005.

Jurisdiction in medical disputes — The monetary limit on DLI jurisdiction in medical disputes was raised from $1,500 to $7,500.

2008 law change

The following provisions took effect for injuries on or after Oct. 1, 2008.

Temporary total disability (TTD), temporary partial disability (TPD) and permanent total disability (PTD) maximum benefit — The maximum weekly TTD, TPD and PTD benefit was raised from $750 to $850.

Temporary total disability (TTD) duration limit — The limit on the total number of weeks of TTD benefits was raised from 104 to 130. (An exception to the duration limit is available for approved retraining.)

2011 law change

The following provisions took effect on Aug. 1, 2011.

Scheduling of proceedings at the Office of Administrative Hearings (OAH) — OAH must schedule a settlement conference to occur within 180 days of the filing of a claim petition, and within 45 days of the filing of a petition to discontinue benefits, objection to discontinuance or request for *de novo* hearing. If settlement is not reached, OAH must schedule a hearing to occur no more than 90 days after the scheduled settlement conference, or sooner if statute requires an expedited hearing on the issues concerned.

2013 law change

The following provision took effect for injuries on or after Oct. 1, 2013.

Cost-of-living adjustment of temporary total disability (TTD), temporary partial disability (TPD), permanent total disability (PTD) and dependents' benefits — The maximum annual adjustment was raised from 2 percent to 3 percent and the date of the first adjustment was moved from the fourth anniversary of the injury to the third anniversary.

The following provision took effect for medical request disputes filed on or after May 17, 2013.

Jurisdiction in medical disputes — The monetary limit on DLI jurisdiction in medical disputes does not apply where the dispute is about the amount of payment for medical services, articles or supplies.

Appendix C

Data sources and estimation procedures

This appendix describes data sources and estimation procedures for those figures where additional detail is needed. Two general procedures are used throughout the report: "development" of statistics to incorporate the effects of claim maturation beyond the most current data and adjustment of benefit and cost data for wage growth to achieve comparability over time. After a general description of these procedures, additional detail for individual figures is provided as necessary. See Appendix A for definitions of terms.

Developed statistics — Many statistics in this report are by accident year or policy year (insurance data) or by injury year or vocational rehabilitation (VR) plan-closure year (Department of Labor and Industry (DLI) data). For any given accident, policy, injury or VR plan-closure year, these statistics grow, or "develop," over time because of claim maturation and reporting lags.[57] This affects a range of statistics, including claims, costs, dispute rates, attorney fees and others. Statistics from the DLI database develop constantly as the data is updated from insurer reports received daily. With the insurance data, insurers submit annual reports to the Minnesota Workers' Compensation Insurers Association (MWCIA) giving updates about prior accident and policy years along with initial data about the most recent year. If the DLI and insurance statistics were reported without adjustment, time series data would give invalid comparisons because the statistics would be progressively less mature from one year to the next, especially for the most recent years.

The MWCIA uses a standard insurance industry technique to produce "developed statistics." In this technique, the reported numbers are adjusted to reflect expected development between the current report and future reports. The adjustment uses "development factors" derived from historical rates of growth (from one report to the next) in the statistic in question. The result is a series of statistics developed to a constant maturity, for example, to an "eighth-report" basis. The developed insurance statistics in this report were computed by DLI Research and Statistics using tabulated numbers and associated development factors from the MWCIA.

Research and Statistics has adapted this technique to DLI data. It tabulates statistics at regular intervals from the DLI database, computes development factors representing historical development for given injury years and then derives developed statistics by applying the development factors to the most recent tabulated statistics. For example, in Figure 2.1, the developed number of indemnity claims for injury year 2013 (in the numerator of the indemnity claim rate) is 22,500 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2013, 19,954, multiplied by the appropriate development factor, 1.128. In this manner, the annual numbers in any given time series are developed to a constant maturity.

The level of maturity depends on the length of history available on the statistics concerned. The DLI injury year statistics in Chapters 2 and 3 are at a 30-year maturity. In Chapter 4 (VR), the injury year statistics are at a 10-year maturity and the VR plan-closure statistics are at a seven-year maturity. In Chapter 5, the dispute rates by injury year are at 24-year maturity and the rates of attorney involvement and of claim denial by injury year are at 29-year maturity.

All developed statistics are estimates and are therefore revised each year in light of the most

[57] Development occurs in VR plan-closure year data because a claim may have more than one VR plan and the plan-closure year statistics are computed for all plans combined, categorized by the closure year of the last plan.

current data. DLI periodically reviews the developed statistics to determine their stability over time and thus their suitability for publication. Through this process, DLI has determined that some of the developed statistics from its own data for the most recent injury years are not sufficiently stable for publication. As a result, several of the trends from DLI data in this report extend only through 2011 or 2012.

Adjustment of cost data for wage growth — For reasons explained in Chapter 1, all costs in this report (except those expressed relative to payroll) are adjusted for average wage growth. The cost number for each year is multiplied by the ratio of the 2013 statewide average weekly wage (SAWW) to the SAWW for that year, using the SAWW reflecting wages paid during the respective year. Thus, the numbers for all years represent costs expressed in 2013 wage-dollars.

Figure 2.1 — The developed number of paid indemnity claims for each year is calculated from the DLI database. The annual number of medical-only claims is estimated by applying the ratio of medical-only to indemnity claims for insured employers to the total number of indemnity claims. (The ratio is unavailable for self-insured employers.) The MWCIA, through special tabulations, provides this ratio by injury year for compatibility with the injury-year indemnity claims numbers.

The number of full-time-equivalent (FTE) workers covered by workers' compensation is estimated as total nonfederal unemployment insurance (UI) covered employment from the Department of Employment and Economic Development (DEED) multiplied by average annual hours per employee (from the annual *Survey of Occupational Injuries and Illnesses,* conducted jointly by the U.S. Bureau of Labor Statistics and state labor departments) divided by 2,000 (annual hours per full-time worker).[58] Nonfederal UI-covered employment is used because there is no direct data about workers'-compensation-covered employment.

Figure 2.2 — For insured employers, total cost is computed as written premium adjusted for deductible credits, minus paid policy dividends. Written premium and paid dividends for the voluntary market are obtained from the Department of Commerce. Written premium for the Assigned Risk Plan (ARP) is obtained from AON Risk Services, the plan administrator. (There are no policy dividends in the ARP.)

Written premium is adjusted upward by the amount of premium credits granted with respect to policy deductibles to reflect that portion of cost for insured employers that falls below deductible limits. Deductible credit data through policy year 2012 is available from the MWCIA. The 2013 figure was estimated by applying the ratio of deductible credits to written premium for the prior two years to the 2013 premium figure. When the actual amount becomes available for 2013, that year's total cost figure will be revised.

For self-insured employers, the primary component of estimated total cost is pure premium from the Minnesota Workers' Compensation Reinsurance Association (WCRA). A second component is administrative cost, estimated as 10 percent of pure premium. The final component is the total assessment paid to the Special Compensation Fund (SCF), net of the portion used to pay claims from defaulted self-insurers, since this is already reflected in pure premium.

Total workers'-compensation-covered payroll is computed as the sum of insured payroll, from the MWCIA, and self-insured payroll, from the WCRA. Insured payroll was not yet available for 2013. This figure was extrapolated from actual figures using the trend in nonfederal UI-covered payroll (from DEED) and the trend in the relative insured and self-insured shares of total pure premium (from the WCRA).

Figure 2.3 — The percentages in this figure were derived from payment year data to avoid significant issues that would arise with injury year (or accident year) data.[59] A major issue is that both paid benefits and total system cost vary substantially from year to year, causing major

[58] Because of annual fluctuations caused by sampling variation, a smoothed version of the average-annual-hours trend is used.

[59] With injury year data, there would be a significant time-discounting issue in comparing benefits with written premium, because injury year benefits include projected payments to be made several years or sometimes decades after the injury. The ratio of discounted benefits to premium would be quite sensitive to the choice of discount rate, even within a reasonable range. This would be in addition to the issue of accurately projecting total injury year benefits in the first place.

variation in the ratio of the two. Therefore, the percentages in this figure were derived by averaging data over time.

Data about benefits and state agency administrative cost came from DLI, the Minnesota Workers' Compensation Insurers Association, the Minnesota Insurance Guaranty Association and the Minnesota Self-Insurers' Security Fund. Total system cost was calculated as indicated in connection with Figure 2.2. The percentage of cost going to insurer expenses was calculated as a residual as described below.

Because written premium — the primary element in system cost — relates to policies originating in a given year, it is paid during that year and the year following. Therefore, the ratio of benefits to system cost was computed using system cost for the year prior to the benefit payment year. An analysis of the data reveals that this ratio varies through approximately an 11-year cycle. To minimize annual fluctuation, an average over this cycle was used. To further reduce annual fluctuation, an average of averages was used, corresponding to the 11-year cycles ending with the most recent year and the prior two years. This yielded the ratio 67.0 percent as the ratio of total paid benefits to total system cost.

The indemnity, medical and vocational rehabilitation (VR) components of the 67.0 percent were then computed using the relative totals of these payments for 2013. VR benefits (counted separately here from indemnity benefits) are not directly available on a payment year basis, so a payment year version of these benefits was estimated from the injury year series used for Figure 4.3.

The portion of total system cost not accounted for by benefit payments, 33.0 percent, was then allocated between state agency administrative expenses and insurer expenses. State agency administrative expenses (using the same numbers as for Figure 3.10) were estimated to account for 1.7 percent of total system cost, leaving an estimated 31.3 percent attributable to insurance expenses (for insurers and self-insurers).

Figure 2.4 — Market-share percentages are taken from undeveloped counts of paid indemnity claims from the DLI database. Using undeveloped rather than developed claim counts has little effect on the percentages, because the number of indemnity claims develops at nearly the same rate for the different insurance arrangements.

Figure 2.5 — Claim and loss data is from the MWCIA's *2015 Minnesota Ratemaking Report*. This data comes from insurance company reports on claim and loss experience for individual policies for the voluntary market and the Assigned Risk Plan. The reported losses include paid losses plus case-specific reserves. Data is developed to an eighth-report basis using the development factors in the *Ratemaking Report*, which produces statistics at an average maturity of 8.5 years from the injury date; the statistics are then adjusted for average wage growth.

Figures 2.6 and 2.7 — Figures 2.6 and 2.7 are based on paid losses, because paid losses are more stable from year to year than are paid losses plus case reserves. The data is from financial reports to the MWCIA by voluntary market insurers only. Paid losses are developed to a uniform maturity of 18 years (an "18th-report basis") using development factors computed from year-to-year loss development data supplied by the MWCIA. Payroll data for Figure 2.7 is from insurer reports of policy experience.

Figure 3.1 — Statistics are derived in the same manner as for Figure 2.5, with one modification. Figure 3.1 presents data by claim type. For permanent total disability (PTD) and death cases, the number of claims and their average cost fluctuate widely from one policy year to the next because of small numbers of cases. Therefore, to produce more meaningful comparisons among claim types, PTD and death claims and losses were estimated by applying respective percentages of claims and losses (relative to the total) during the most recent three years to total claims and losses for 2011.

Figures 3.3 and 3.4 — Average benefit duration (Figure 3.3) is computed by dividing the average weekly benefit (Figure 3.4) into the average benefit per claim where it was paid (Figure 3.5) (using developed statistics). This method is used because of issues relating to relatively more frequent nonreporting of duration for longer claims.

Figure 3.11 — Administrative cost is computed to capture that portion of the workers' compensation assessment (see "Special Compensation Fund" in Appendix A) that pays for state administration. Consequently, administrative cost is computed as the total of costs other than workers' compensation benefits that are paid for by the assessment or other revenues with which it is combined, minus those other revenues.

Figure 4.6 through 4.8 and 4.11 — These figures are by vocational rehabilitation plan-closure year beginning with closure year 2005. Since the vocational rehabilitation data is only available beginning with plans filed in 1998, a uniform six-year window prior to each plan-closure year is used to make the statistics comparable across closure years.

Figure 5.2 — A modified procedure was used to compute the percentage of indemnity claims with claimant attorney fees. The procedure was similar to that described for the percentage of claims with stipulated benefits in connection with Figure 3.7 and was employed for the same reason.