

Minnesota Workers' Compensation System Report



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Executive summary

The 2026 Workers' Compensation System Report presents trend data from 2004 to the present regarding several aspects of Minnesota's workers' compensation system: (1) claims, benefits and costs; (2) vocational rehabilitation; and (3) disputes and dispute resolution. Its purpose is to use available statistics to describe the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

Note about the report timelines and trends

Statistics are computed using the most recently available data from various sources, which leads to different data years being presented for different measures. DLI statistics about claims, cost and indemnity benefits are displayed using 2024, the most recent injury-year, while some vocational rehabilitation statistics include data for 2025, the most recent plan-closure year. Claims resulting from injuries occurring in 2025 are still too recent to provide reliable measures of claim activity. Most of the statistics about dispute-resolution filings and timelines are displayed by the year the dispute was filed or by the year an action occurred and are presented through 2025. The report also includes statistics reported by policy year or fiscal year.

The report includes COVID-19 claims with injury dates during calendar-years 2020 through 2024 and filed through September 2025. Recent versions of this report presented two faces: one for the whole workers' compensation system, including COVID-19 claims; and the other excluding the COVID-19 claims, showing a pattern similar to prior years. Because the impact of COVID-19 claims on the system has significantly decreased since 2022, statistics for these claims are no longer reported separately in the current report.

In addition, in November 2020, DLI transitioned from a paper-based workers' compensation case management system to the Work Comp Campus online portal. In 2025, following an in-depth review of claim data, DLI discovered that Campus had initially undercounted indemnity payments for some claims due to data errors originating from Campus ETL (extract, transform and load) program functions. DLI's analysis identified more than 1,000 missing claims and approximately \$235 million in undercounted indemnity benefits in Campus. The corrected benefits are now included in this report. See [Part 1](#) for additional details on the corrections.

The following are the major findings of the report. The time periods involved in these findings vary because of data availability and because statistics by injury year are projected to full maturity. See Appendix A for details.

Part 2: Claims, benefits and costs – overview

- Relative to the number of full-time-equivalent (FTE) workers, the total number of paid claims dropped by 42%, indemnity claims by 32% and medical-only claims by 45% from 2004 to 2024. The total claim rate reached its lowest level in 2024 compared to any other reported year.
- Adjusting for average wage growth, indemnity benefits per claim were 16% higher and medical benefits per claim were 13% lower in 2023 than in 2004. 2023 is the most recent year available from MWCIA for this data. The average cost of a 2023 workers' compensation claim was \$13,780 for medical and indemnity benefits combined (including vocational rehabilitation).

- Indemnity benefits per \$100 of payroll were down 41%, while medical benefits per \$100 of payroll were down 54% between 2004 and 2024. Medical and indemnity benefits (including vocational rehabilitation) combined amounted to \$0.49 per \$100 of payroll for 2024.
- The 2026 average pure premium rate is down 44% from 2004.
- The total cost of the workers' compensation system in 2024 was an estimated \$1.70 billion, or \$0.83 per \$100 of payroll.
- Total system cost per \$100 of payroll follows a multi-year cycle in line with a nationwide insurance pricing cycle; however, extrapolating from comparable periods in the cycle indicates a decrease of 46% over 20 years.
- In 2024, on a current-payment basis, the three largest components of total workers' compensation system cost were insurer expenses (33%), medical benefits (32%) and indemnity benefits other than vocational rehabilitation (30%).

Part 3: Claims, benefits and costs – detail

The average benefit amount paid to workers receiving each type of indemnity benefit was examined, along with the average amounts paid to all workers with indemnity claims. This second analysis (benefits per paid indemnity claim) looked at the average amount of each type of indemnity benefit paid for all indemnity claims, including claims where workers did not receive that particular benefit. These averages were developed to ultimate maturity and adjusted for average wage growth.

- Total disability benefits (temporary total disability benefits and permanent total disability benefits combined) per indemnity claim increased 37% from 2004 to 2024.
- Temporary partial disability (TPD) benefits per indemnity claim decreased 27% from 2004 to 2024.
- Permanent partial disability (PPD) benefits per indemnity claim decreased 38% from 2004 to 2024.
- Settlement benefits per indemnity claim decreased 15% from 2004 to 2024.

Part 4: Vocational rehabilitation

- Participation in vocational rehabilitation rose from 21% of paid indemnity claims for injury-year 2004 to 24% for 2019, but decreased to 22% among indemnity claims for injuries in 2024.
- An estimated 4,435 workers will receive vocational rehabilitation services for their 2024 injuries and illnesses, a 9% decrease from 2023.
- After adjusting for average wage growth, the \$9,930 average cost of vocational rehabilitation services for injury-year 2024 was 20% below the 2008 peak of \$13,147.
- Vocational rehabilitation services accounted for an estimated 2.7% of total workers' compensation system cost for 2024.
- Fifty-seven percent of vocational rehabilitation participants reported a job at plan closure in 2025, down from 61% in 2024.

Part 5: Disputes and dispute resolution

- DLI received 7,238 dispute filings in 2025 among the four major dispute types – claim petitions, discontinuance disputes, and medical and rehabilitation requests for assistance. This was about 1,000 fewer disputes than in 2024.
- The denial rate for non-COVID-19 claims with 2024 injuries was 17.4%, which is slightly higher than the 17.0% rate in 2023. The denial rate of filed indemnity claims, with COVID-19 claims included, was 18.6% for 2024, below the 23.3% denial rate in 2023.
- Due largely to resolutions of disputes reached through DLI's Alternative Dispute Resolution (ADR) outreach, the proportion of disputes certified by the ADR staff members dropped from 60% to 51% for medical disputes and from 52% to 40% for vocational rehabilitation disputes between 2005 and 2025.
- In 2025, 86% of scheduled mediations were completed, while 24% of scheduled medical conferences and 25% of scheduled rehabilitation conferences were completed.
- For medical and rehabilitation requests for assistance received in 2025, the median days from the request to the first scheduled DLI conference date were 71 and 32 days, respectively. The time interval for medical requests for assistance has been increasing since 2013, with some fluctuations. The interval for rehabilitation requests for assistance was close to the intervals for recent years, reflecting DLI's response to the 2013 law change requiring that most rehabilitation conferences be scheduled within 21 days of the request.

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Part 1: Introduction

Nationwide, workers' compensation claim rates have declined since 2004. During the same period, indemnity claim costs have increased at about the same rate as wages, but wage growth has outpaced indemnity claim costs in recent years, possibly exerting upward pressure on indemnity benefits.¹ In Minnesota, both indemnity and medical benefits per \$100 of payroll were substantially lower in 2024 than in 2004 due to a falling claim rate counteracting the increases in total benefits per claim relative to wages.

This report, part of an annual series, presents trend data regarding several aspects of Minnesota's workers' compensation system: (1) claims, benefits and costs; (2) vocational rehabilitation; and (3) disputes and dispute resolution. "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. Like other reports in the series, this report presents data from the most recently available 20-year window. Its purpose is to use available statistics to describe the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

Report layout

The report is organized into four topic parts. Part 2 presents overall claim, benefit and cost data. Part 3 provides more detailed data about indemnity (monetary) benefit trends. Part 4 provides statistics about vocational rehabilitation. Part 5 deals with disputes and dispute resolution. To understand the major findings at the beginning of each part, readers may need to refer to the background material immediately following the major findings in each part.

Appendix A presents a glossary. Appendix B includes portions of the 2000, 2008, 2011, 2013, 2018 and 2020 through 2024 law changes relevant to trends in this report. Appendix C describes data sources, development techniques and estimation procedures.

Corrections to indemnity claim and benefit data in Work Comp Campus

The Department of Labor and Industry's (DLI) Work Comp Campus database, which replaced an older database (Informix), was launched in November 2020 to support workers' compensation claims data reporting and extraction. Campus contains injury data submitted by insurers as well as derived indemnity benefit tables that maintain running benefit totals and sub benefit totals at the claim level.

In 2025, the Business Technology Office (BTO) and Research and Data Analytics (RDA) conducted an in-depth evaluation of the Campus ETL (extract, transform and load) process. The evaluation showed that certain ETL program functions were generating data errors, resulting in inaccurate indemnity benefits data for some claims. In response, RDA and BTO produced corrected indemnity data tables derived directly from the original electronic data interchange (EDI) submissions, before they were manipulated by Campus ETL procedures.

This comparative analysis of the corrected and existing Campus indemnity benefit tables resulted in benefit corrections for approximately 9% of claims and identified more than 1,000 previously missing claims, primarily temporary total disability claims, and approximately \$235 million in undercounted indemnity benefits (out of a

total of \$3.5 billion paid since the launch of Campus in late 2020). The discrepancies varied by benefit type, with permanent total disability benefits undercounted by more than \$93 million (a 14.7% difference), and temporary total disability benefits undercounted by more than \$81 million (a 7.7% difference), relative to what was originally reported in Campus.

Benefit duration statistics were also updated based on the analysis, with 8% of claims with wage replacement benefits affected. Among those claims, temporary total disability duration was found to be understated by an average of 0.4 weeks to 1.4 weeks for injury years 2020 through 2024. Overall, the corrected temporary total disability duration was approximately one week higher than the uncorrected duration. Temporary partial disability duration was also understated by an average of 0.5 weeks to 0.8 weeks over the same period.

These corrections allowed RDA to provide more accurate data for the 2026 Workers' Compensation System Report and other workers' compensation-related analyses. The current System Report incorporates these corrected numbers (claims with injuries after December 2024 will appear in subsequent reports). While the total undercounting of benefits in Campus is substantial, its impact on the System Report is less pronounced. This is because the adjusted amounts are spread across multiple years, and this report relies primarily on averages rather than total amounts, making it less sensitive to the undercounted totals. However, the effects of these corrections are still evident, particularly for the benefit types most affected, such as temporary total disability benefits.

Figure 1.1 shows the undercounted totals by year of injury and benefit type. Injuries for injury years 2015-2019 and before 2015 are grouped separately. The undercounted benefits for those years occurred because, although the injuries predate Campus, the benefits were paid after the switch to Campus. Permanent and temporary total disability benefits are combined as total disability benefits since they are reported together in the System Report.

Figure 1.1. Total benefits undercounted in Campus by benefit type and injury year

Injury year	Fatalities	Total disability	Temporary partial	Permanent partial	Settlements
Before 2015	\$ 9,441,947	\$102,385,311	\$ 3,512,053	\$ 8,996,330	\$ 9,404,728
2015-2019	\$ 1,801,442	\$ 10,583,125	\$ 2,551,420	\$ 1,570,303	\$ 6,034,951
2020	\$ 408,305	\$ 11,064,444	\$ 1,367,703	\$ 770,161	\$ 2,992,677
2021	\$ 325,349	\$ 6,692,409	\$ 888,283	\$ 369,786	\$ 835,074
2022	\$ 269,842	\$ 8,921,448	\$ 958,488	\$ 559,243	\$ 1,392,939
2023	\$ 380,169	\$ 11,776,504	\$ 1,385,343	\$ 250,272	\$ 1,880,895
2024	\$ 81,364	\$ 18,398,106	\$ 913,934	\$ 197,861	\$ 772,568
2025-2026	\$ 0	\$ 4,955,190	\$ 192,054	\$ 26,490	\$ 125,200
Total	\$ 12,708,418	\$174,776,537	\$ 11,769,278	\$ 12,740,446	\$ 23,439,032

Source: Data from DLI Campus database.

Impact of COVID-19

This report shows the effect of COVID-19 on claims for injuries from 2020 to 2024, and the effects on benefits and costs through September 2025. COVID-19 had both direct and indirect effects on the workers' compensation system: direct effects because of the influx of COVID-19 claims, indirect effects because of the interruption to the economy and changes in the composition of employment with respect to industry, occupation and remote work.

Minnesota also had a COVID-19 presumption that established certain employees who contracted COVID-19 were presumed to have an occupational disease covered by Minnesota workers' compensation law. The presumption was effective for employees who contracted COVID-19 between April 8, 2020, and Dec. 31, 2021, and between Feb. 3, 2022, and Jan. 13, 2023. The presumption enabled many first responders, corrections workers and health care workers to receive workers' compensation benefits. See Appendix B for details.

Although the pandemic had a significant impact on overall claims benefits, costs and developed statistics from 2020 to 2022, reported COVID-19 claims have significantly declined from their peak in 2022 when over 18,000 claims were filed to over 500 claims in 2024 (see Figure 1.2). COVID-19 claims accounted for only 2% of paid indemnity claims in 2024, compared to 32% in 2022. Therefore, while COVID-19 claims are included in this report, they are not broken out separately due to their diminishing impact on overall claim and benefit trends.

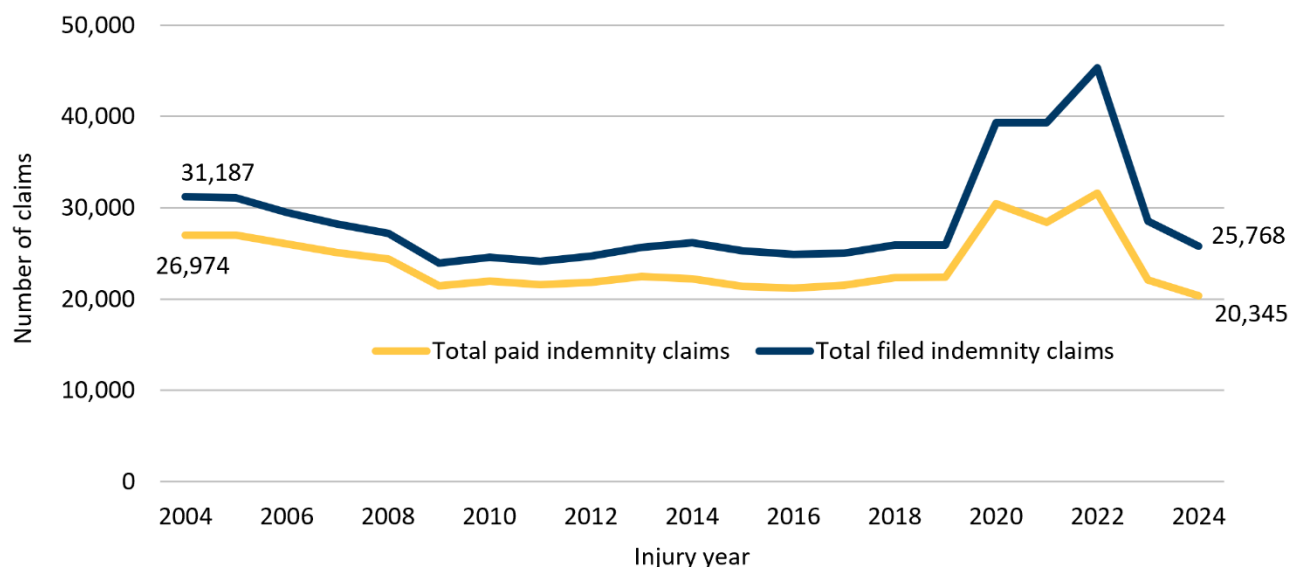
Figure 1.2 Filed and paid COVID-19 claims

Injury year	Filed Covid-19 claims	Paid Covid-19 claims
2020	16,842	11,612
2021	12,038	7,074
2022	18,121	10,166
2023	2,173	1,032
2024	581	338

Source: Data from DLI Campus database.

As shown in Figure 1.3, following an increase between 2020 and 2022, both filed and paid indemnity claims are returning to their pre-pandemic trends. Filed indemnity claims include all cases in which the worker missed more than three calendar days of work due to injury, even if the request for indemnity benefits was ultimately denied. Paid indemnity claims include any claim in which the injured worker received any type of benefit payment, including claims paid through settlement after an initial denial.

Figure 1.3. Filed and paid indemnity claims



Source: Data from DLI Campus database.

Developed statistics

Many statistics in this report, from both DLI and the insurance industry, are presented by injury-year (also referred to as “accident year” in the insurance data), insurance policy-year or vocational rehabilitation plan-closure year. See Appendix A for details. The timeframe presented varies across data elements; however, the report presents the most recent data available for each statistic.

An issue with injury-year and policy-year data is the originally reported numbers for more recent years are not mature because of longer claims and reporting lags. 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. Development occurs in vocational rehabilitation plan-closure-year data because a claim may have more than one vocational rehabilitation plan and the plan-closure-year statistics are computed for all plans combined, categorized by the closure year of the last plan. See Appendix C for more detail about the claim development techniques for the injury-year, policy-year and plan-closure-year data.

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. So, the developed statistics for any given injury-year, especially for more recent years, are subject to change when more recent data becomes available.

Computing developed statistics for COVID-19 indemnity claims cannot be done with a high level of confidence, because these claims are unlikely to follow the pattern of non-COVID claims from previous years. Therefore, claims development estimates were calculated only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims.

Adjustment of cost data for wage growth

Some figures in this report present average or median costs per claim or per vocational rehabilitation plan 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 per claim or per vocational rehabilitation plan are adjusted for average wage growth. The adjusted trends reflect the extent to which cost growth per claim or per vocational rehabilitation plan exceeds or falls short of average wage growth.



Part 2: Claims, benefits and costs – overview

This part of the report presents overall indicators of the status and direction of Minnesota’s workers’ compensation system. It uses the most recently available data from various sources, including the Minnesota Workers’ Compensation Insurers Association (MWCI), Minnesota Workers’ Compensation Reinsurance Association (WCRA), the Minnesota Department of Commerce and the Minnesota Department of Labor and Industry (DLI), which leads to different data years being presented for different measures.

The estimates for workers’ compensation claims for injury-years 2020 through 2022 were strongly affected by the COVID-19 pandemic, which led to an influx of COVID-19 claims, lower numbers of claims for other injuries and illnesses, and a reduction in employment.² In 2023 and 2024, with the decline in COVID-19 claims and the sunset of the COVID-19 presumption, trends started to return to pre-pandemic levels. Due to the significant decline in the number of COVID-19 claims, statistics for COVID-19 and non-COVID-19 claims are no longer shown separately in the current report.

Major findings

- Relative to the number of full-time-equivalent (FTE) workers, the total number of paid claims dropped by 42%, indemnity claims by 32% and medical-only claims by 45% from 2004 to 2024. The total claim rate reached its lowest level in 2024 compared to any other reported year (Figure 2.1).
- Adjusting for average wage growth, indemnity benefits per claim were 16% higher and medical benefits per claim were 13% lower in 2023 than in 2004 (Figure 2.3; most recent data available is for 2023).
- Indemnity benefits per \$100 of payroll were down 41%, while medical benefits per \$100 of payroll were down 54% between 2004 and 2024 (Figure 2.4).
 - By counteracting the increase in *unadjusted* benefits per claim, the falling claim rate has brought benefits per \$100 of payroll to historically low levels, which affected pure premium rates and system cost per \$100 of payroll.
- The 2026 average pure premium rate is down 44% from 2004 (Figure 2.6).
- The total cost of Minnesota’s workers’ compensation system relative to payroll follows a multi-year cycle. A comparison of similar points in the cycle indicates a long-term decrease that extrapolates to 46% over a 20-year period (Figure 2.7).
- In 2024, on a current-payment basis, the three largest components of total workers’ compensation system cost were insurer expenses (33%), medical benefits (32%) and indemnity benefits other than vocational rehabilitation (30%) (Figure 2.8).
- Claim rate, benefits per \$100 of payroll, pure premium rates and system cost per \$100 of payroll all decreased at roughly 2% to 3% per year during the past 20 years (Figure 2.9).

Background

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

Workers' compensation benefits and claim types

Workers' compensation provides three basic types of benefits: monetary, medical and vocational rehabilitation.

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 Part 3.

Medical benefits consist of reasonable and necessary medical services and supplies related to the injury or illness.³

Vocational rehabilitation 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 these services. Vocational rehabilitation benefits are counted as indemnity benefits in insurance data, but are counted separately in DLI data. They are considered in detail in Part 4.

Claims with indemnity benefits (including vocational rehabilitation 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

Minnesota requires all employers to have workers' compensation insurance coverage unless a specific statutory exemption applies. Employers are covered 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 Department of Commerce. Self-insurance is allowed for employers and employer groups that meet the financial requirements in Minnesota Statutes, Chapter 79A, administered by the Department of Commerce.

Rate setting

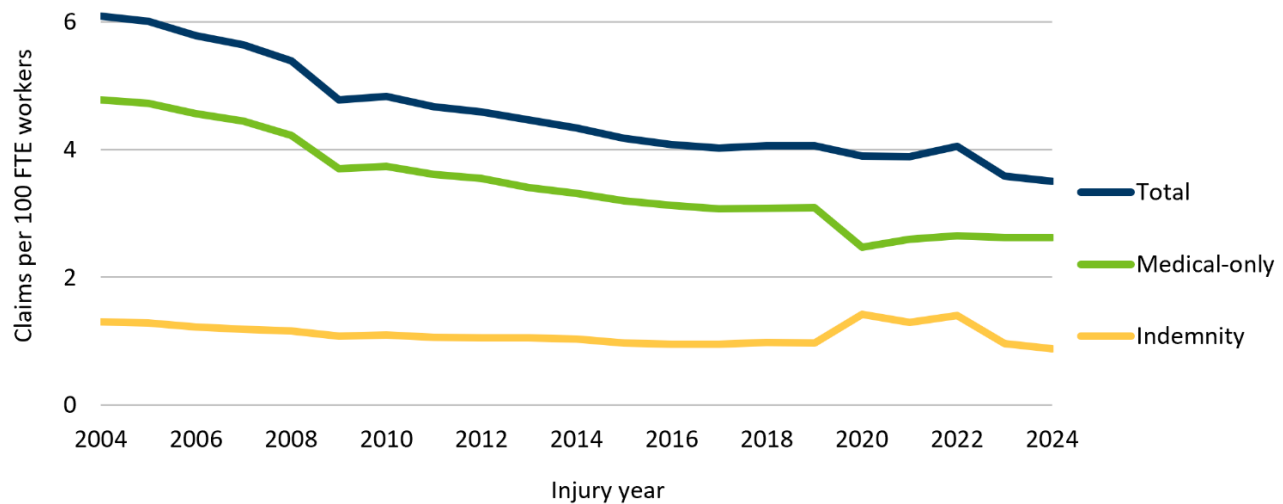
Minnesota is an open-rating state for workers' compensation, meaning rates are set by insurance companies rather than by a central authority. In determining their rates, insurance companies start with "pure premium rates" (also known as "advisory loss costs"). These rates represent expected losses (indemnity and medical) per \$100 of payroll for some 600 payroll classifications. MWCIA — Minnesota's workers' compensation data service organization and rating bureau — annually calculates the pure premium rates for the next year from insurers' most recent pure premium (computed from prior pure premium rates and payroll) and indemnity and medical losses.⁴ 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). In response to legislative and regulatory activity, MWCIA made significant changes to its calculation of advisory pure premium base rates effective Jan. 1, 2023. The advisory rates now include the elements of trend, development to ultimate losses and loss adjustment expenses in the pure premium base rates it provides to the industry.

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 FTE workers. Except for a rise in the indemnity claim rate from 2020 to 2022 because of the influx of COVID-19 claims, claim rates declined nearly continually for the past 20 years (Figure 2.1). In 2024, the total claim rate reached its lowest level compared to any other reported year.

- In 2024, there were:
 - 0.9 paid indemnity claims per 100 FTE workers, down 32% from 1.3 in 2004.
 - 2.6 paid medical-only claims per 100 FTE workers, down 45% from 4.8 in 2004.
 - 3.5 total paid claims per 100 FTE workers, down 42% from 6.1 in 2004.
- The rates of indemnity, medical-only and total claims were relatively stable from 2016 through 2019, but were affected by COVID-19 from 2020 to 2022. The 2023 and 2024 estimates show that the impact of the pandemic on the indemnity claim rate has dissipated. In 2024, the estimated indemnity claim rate fell slightly below its pre-pandemic level, while the medical-only claim rate remained similar to its pandemic level.⁵
- From 2009 to 2019, indemnity claims made up 23% to 24% of all paid claims, with medical-only claims constituting the remaining 76% to 77%. From 2020 to 2022, indemnity claims constituted about 35% of all paid claims on average due to the influx of COVID-19 claims. With the decline in COVID-19 claims, the indemnity claim share went down to 27% in 2023 and 25% in 2024. COVID-19 claims accounted for only 2% of indemnity claims in 2024, compared to an average of 32% from 2020 to 2022.⁶
- Since 2004, the total claim rate has followed a downward trend similar to Minnesota's total reportable case rate from the Survey of Occupational Injuries and Illnesses.
- Because of the falling claim rate, the total number of paid claims has fallen since 2004 despite the increase in the number of covered workers.
 - There were an estimated 80,700 total paid claims in 2024, down 36% from 2004.
 - Of the 20,300 paid indemnity claims in 2024, approximately 340 were COVID-19 claims.⁷
- The falling claim rate has led to decreases in benefits per \$100 of payroll (Figure 2.4) and workers' compensation system cost per \$100 of payroll (Figure 2.7).

Figure 2.1. Paid claims per 100 full-time-equivalent workers

Injury year	Indemnity claims	Medical-only claims	Total claims
2004	1.3	4.8	6.1
2019	1.0	3.1	4.1
2020	1.4	2.5	3.9
2021	1.3	2.6	3.9
2022	1.4	2.6	4.0
2023	1.0	2.6	3.6
2024	0.9	2.6	3.5

Source: Developed statistics from DLI Campus database and MWCIA data (see Appendix C).

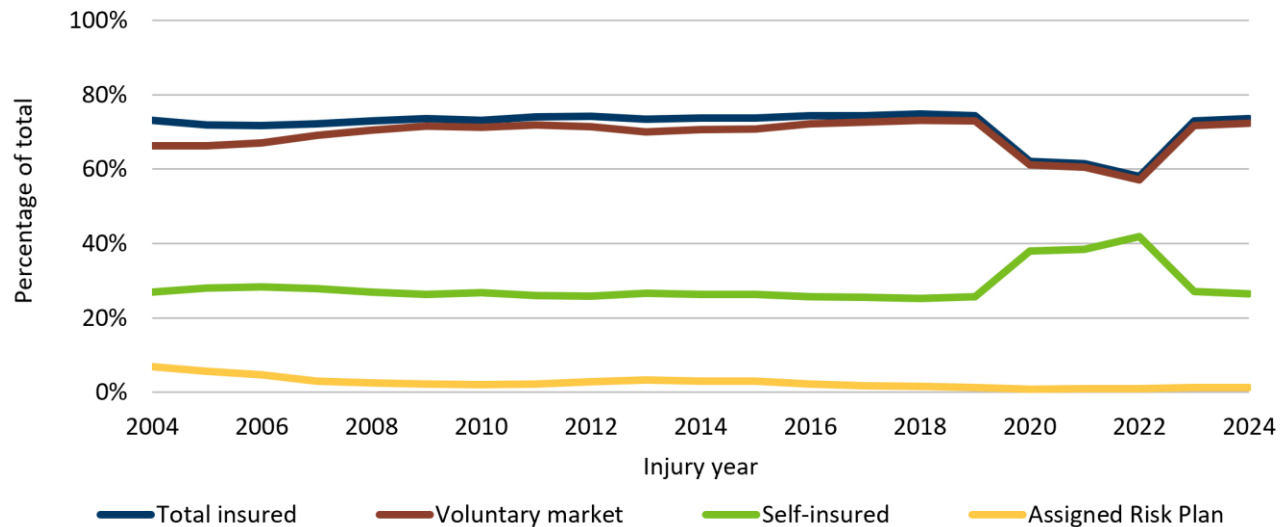
Insurance arrangements

Measured by the share of paid indemnity claims, the voluntary market share of the workers' compensation insurance market increased above the low point reached during the pandemic. The 2020 through 2022 estimates were affected by the COVID-19 pandemic. The pandemic caused a significant shift in data trends among paid indemnity claims from the voluntary market to self-insurance, as many of the workers covered by the COVID-19 presumption – first responders, corrections workers and health care workers – had self-insured employers. In 2023 and 2024, with the decline in COVID-19 claims and the sunset of the COVID-19 presumption, trends started to shift back to pre-pandemic levels.

- Following a decrease from 2020 to 2022, the voluntary market share of all paid indemnity claims reached 72% in 2024. This was slightly below the 73% mark in 2019, and above the 66% mark in 2004 (Figure 2.2).
- The self-insured share of all paid indemnity claims was 26% in 2024 – slightly above the 2019 mark. While the self-insured share typically ranged from 25% to 28% since 2004, it had shown a large increase between 2020 and 2022 during the pandemic period.

- The Assigned Risk Plan share of all paid indemnity claims was 1.3% in 2024 – the same as in 2019. The Assigned Risk Plan share has generally ranged from 1% to 3%, but had reached a high point of 6.8% in 2004 and a low point of 0.9% in 2020.
- These shifts, in the long term, are at least partly due to changes in insurance costs shown in Figure 2.7.

Figure 2.2. Distribution of paid indemnity claims by insurance type



Injury year	Voluntary market	Assigned Risk Plan	Total insured	Self-insured
2004	66.2%	6.8%	73.0%	27.0%
2019	73.0	1.3	74.3	25.7
2020	61.2	0.9	62.0	38.0
2021	60.5	1.0	61.5	38.5
2022	57.1	0.9	58.1	41.9
2023	71.7	1.2	72.9	27.1
2024	72.3	1.3	73.6	26.4

Source: Data from DLI Campus database.

Benefits per claim

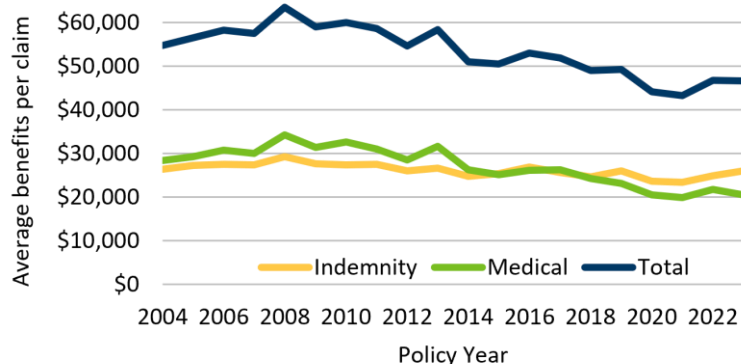
The statistics presented in Figure 2.3 include developed statistics from MWCIA (see Appendix C). Latest year available for this data is policy-year 2023. All insurance data from MWCIA include the voluntary market and Assigned Risk Plan, but exclude self-insured employers. Indemnity benefits include vocational rehabilitation benefits. Benefits are adjusted for average wage growth between the respective year and 2024.

- Adjusted for average wage growth, for all claims, from 2004 to 2023 (Figure 2.3, Panel C):
 - average indemnity benefits per insured claim increased by 16%;
 - average medical benefits per insured claim decreased by 13%;
 - there was no net change in average total benefits per insured claim.
- Indemnity and medical benefits per claim started to increase in 2022 after decreasing during the pandemic period; part of the reason for this decrease during the pandemic could be because COVID-19 claims had smaller indemnity and medical costs.⁸

- Statutory changes since 2016 concerning medical-service reimbursement and indemnity benefits have also affected the benefit trends displayed in Figures 2.3 and 2.4. (For details about all of these changes, see Appendix B.)
- The benefits per claim shown in Figure 2.3 have a direct effect on benefits per \$100 of payroll (Figure 2.4) and, thereby, on workers' compensation system cost per \$100 of payroll (Figure 2.7).

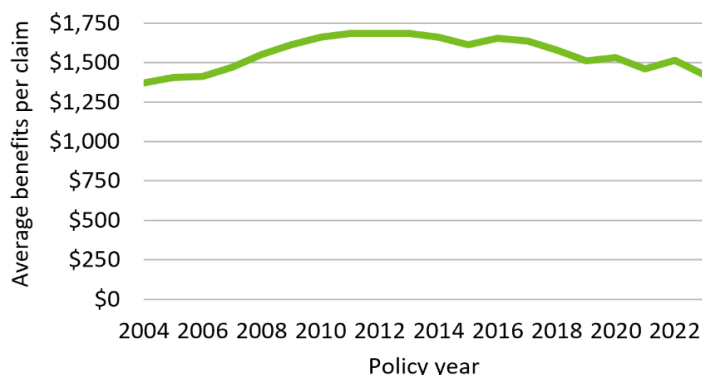
Figure 2.3. Average indemnity and medical benefits per insured claim, adjusted for average wage growth

A: Indemnity claims



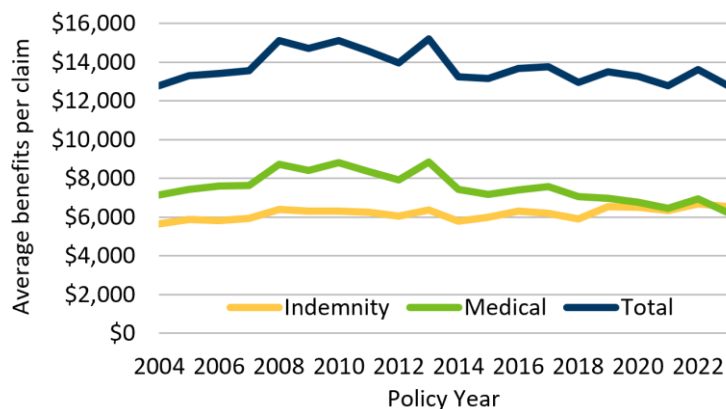
Policy year	Indemnity benefits	Medical benefits	Total benefits
2004	\$26,370	\$28,400	\$54,770
2019	26,060	23,200	49,260
2020	23,620	20,510	44,130
2021	23,460	19,870	43,330
2022	24,960	21,800	46,760
2023	26,100	20,610	46,700

B: Medical-only claims



Policy year	Medical benefits	Total benefits
2004	\$1,370	\$1,370
2019	1,510	1,510
2020	1,530	1,530
2021	1,460	1,460
2022	1,510	1,510
2023	1,420	1,420

C: All claims



Policy year	Indemnity benefits	Medical benefits	Total benefits
2004	\$5,640	\$7,150	\$12,790
2019	6,550	6,960	13,510
2020	6,510	6,760	13,260
2021	6,350	6,440	12,790
2022	6,680	6,940	13,620
2023	6,550	6,240	12,780

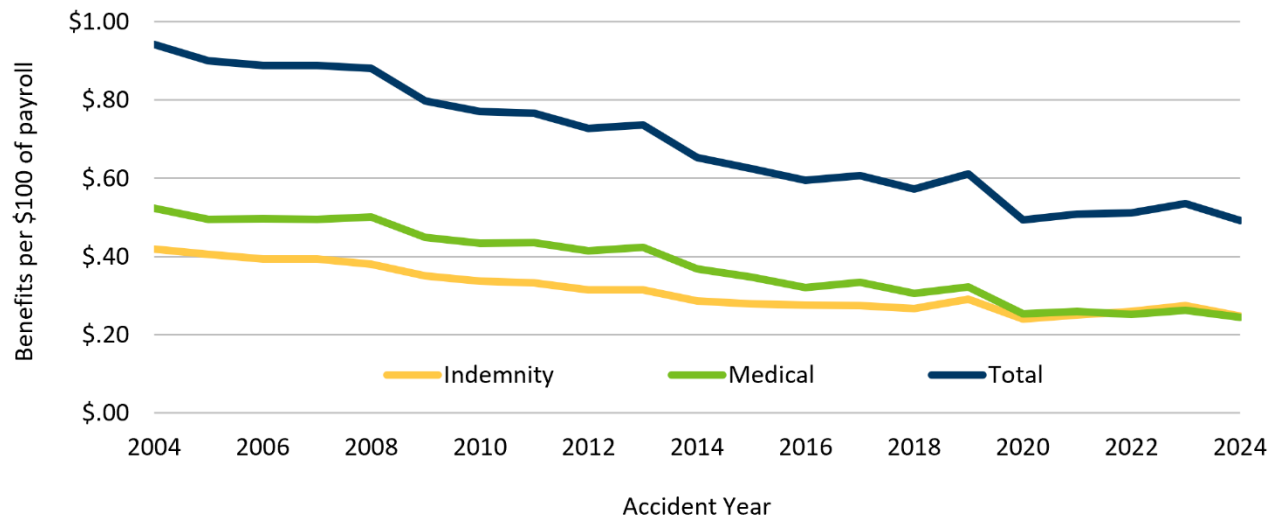
Source: Developed statistics from MWCIA data. Benefits are adjusted for average wage growth between the respective year and 2024.

Benefits relative to payroll

The statistics presented in Figure 2.4 include developed statistics from MWCIA. Relative to total payroll, indemnity and medical benefits were substantially lower in 2024 than in 2004, despite fluctuations in the past few years due to effects of the pandemic (Figure 2.4).

- In 2024 as compared to 2004, relative to payroll:
 - indemnity benefits were 41% lower;
 - medical benefits were 53% lower; and
 - total benefits were 48% lower.
- The falling benefits per \$100 of payroll have a direct downward effect on pure premium rates (Figure 2.6) and, thereby, on workers' compensation system cost per \$100 of payroll (Figure 2.7).

Figure 2.4. Benefits per \$100 of payroll in the voluntary market



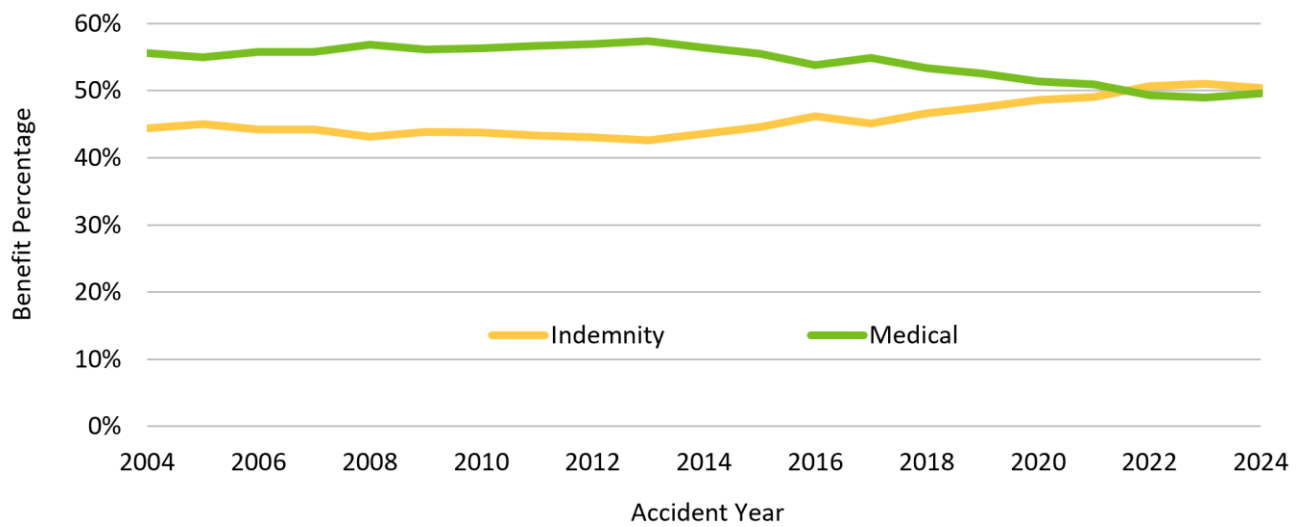
Accident year	Indemnity benefits	Medical benefits	Total benefits
2004	\$.42	\$.52	\$.94
2019	.29	.32	.61
2020	.24	.25	.49
2021	.25	.26	.51
2022	.26	.25	.51
2023	.27	.26	.54
2024	.25	.24	.49

Source: Developed statistics from MWCIA data.

Indemnity and medical shares of total benefits

Statistics presented in Figure 2.5 include developed statistics from MWCIA.

- Medical benefits decreased from 56% of total benefits in 2004 to 50% by 2024.
- Indemnity benefits increased from 44% of total benefits in 2004 to 50% by 2024.⁹

Figure 2.5. Indemnity and medical benefit percentages in the voluntary market

Accident year	Indemnity benefits	Medical benefits
2004	44.4%	55.6%
2013	42.6	57.4
2019	47.5	52.5
2020	48.6	51.4
2021	49.1	50.9
2022	50.6	49.4
2023	51.1	48.9
2024	50.4	49.6

Source: Developed statistics from MWCIA data.

Pure premium rates

Pure premium rates have decreased substantially since 2004. In response to legislative and regulatory activity, MWCIA made significant changes to its calculation of advisory pure premium base rates, which went into effect Jan. 1, 2023. Under the revised statute and rules, advisory pure premium base rates now include the elements of trend, development to ultimate losses and loss adjustment expenses. Prior to 2023, these elements were excluded from the rates published by MWCIA. Therefore, it is difficult to directly compare the pure premium base rates published prior to 2023 to the new rates.

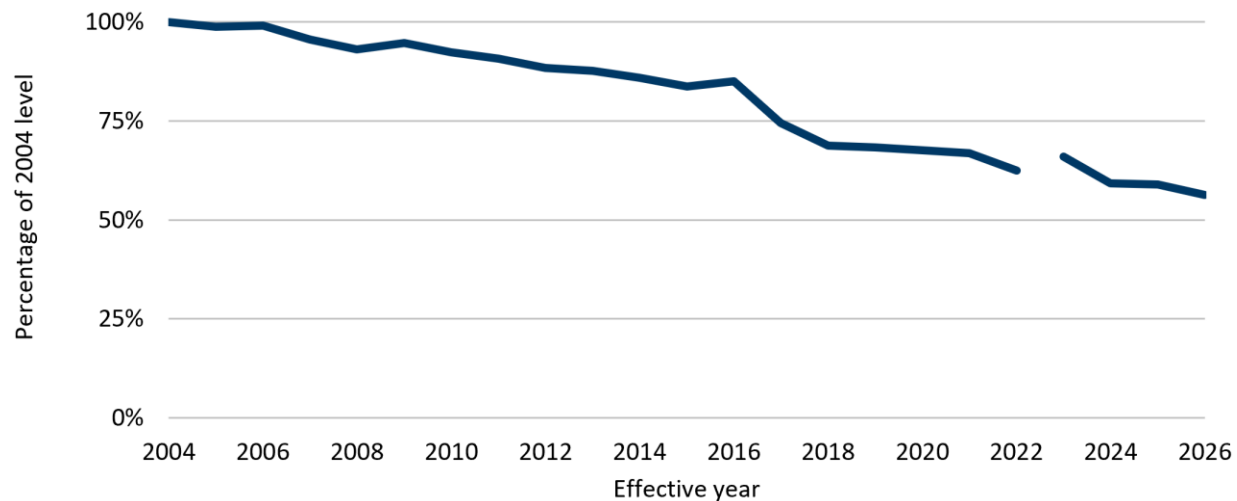
Before 2023, insurance companies could apply their own adjustments for trend, ultimate loss development and loss adjustment expenses into their rate multipliers filed with the Department of Commerce. MWCIA anticipates insurance companies will decrease their cost multipliers, resulting in no effect on premiums.¹⁰

With the new elements included in the advisory pure premiums:

- The 2026 MWCIA pure premium base rate change (effective Jan. 1, 2026) is -4.6%.
- The 2026 average pure premium rate is down 44% from 2004. The rate fell 34% from 2016 to 2026.¹¹
- Pure premium rates, determined by MWCIA, are ultimately driven by the trend in benefits relative to payroll (Figure 2.4). 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, affects total system cost (Figure 2.7).

Figure 2.6. Average pure premium rate as percentage of 2004



Effective year	Percentage of 2004
2004	100.0%
2016	85.1
2019	68.3
2020	67.6
2021	66.8
2022	62.5
2023	66.0
2024	59.2
2025	58.9
2026	56.2

Source: Data from MWCIA. Pure premium rates represent expected indemnity and medical losses per \$100 of covered payroll in the voluntary market. The rate changes from 2023 to 2026 indicated with the line break in this figure include the new elements of trend, loss development to ultimate and loss adjustment expenses.

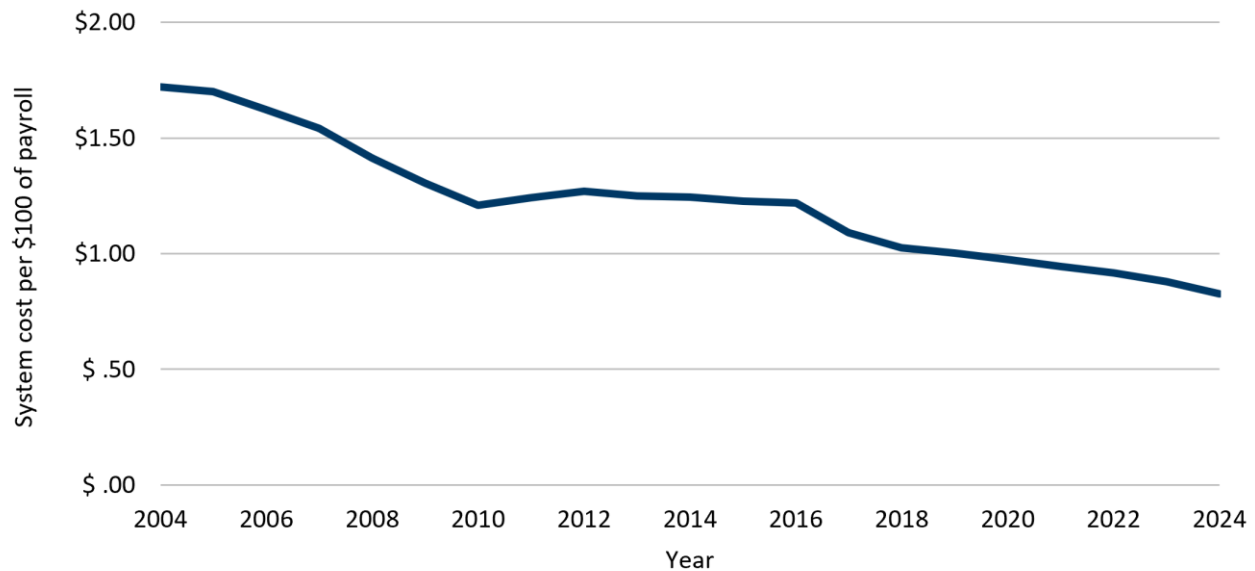
System cost

The total cost of Minnesota's workers' compensation system per \$100 of payroll follows a cycle of about 10 years, with alternating low and high points. Amid the annual fluctuations, the long-term trend is downward.

- The total cost of the workers' compensation system in 2024 was an estimated \$1.70 billion, or \$0.83 per \$100 of payroll.
- These figures reflect benefits (indemnity, medical and vocational rehabilitation) plus other costs, such as insurance brokerage, underwriting, claim adjustment, litigation, 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 pure premium rates (Figure 2.6) and in insurance expenses relative to payroll; however, they also reflect a nationwide insurance pricing cycle, in which the ratio of premium to insurance losses varies over time.¹³

- The average system cost per \$100 of payroll was \$1.38 for 2005 to 2014, and \$1.01 for 2015 to 2024 — two comparable cycles 10 years apart; this indicates a long-term downward trend with a 27% decrease between the two cycles. Extrapolated to 20 years, this would be a 46% decrease.¹⁴ This is close to the average pure premium rate decrease of 44% for 2004 to 2026, which is expected because insurers use the pure premium rates as the starting point for determining their filed premium rates.

Figure 2.7. System cost per \$100 of payroll



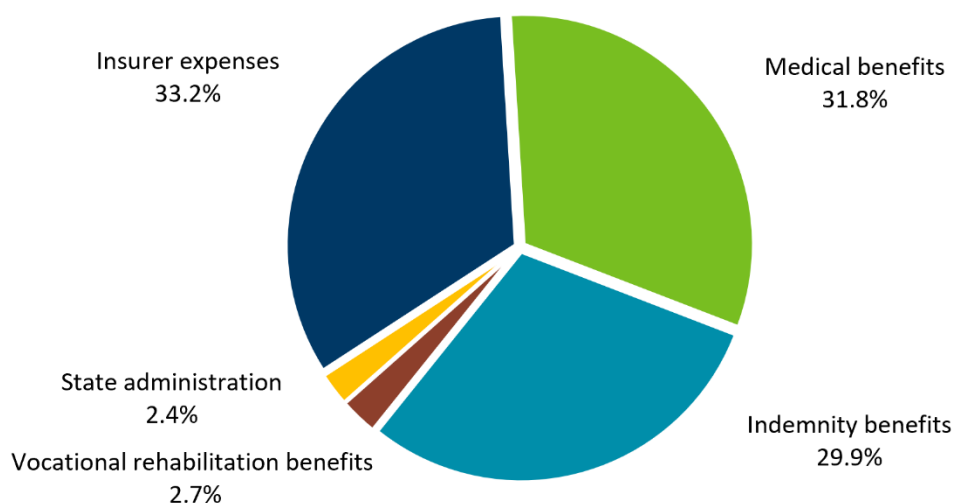
	Cost per \$100 of payroll
2004	\$1.72
2010	1.21
2012	1.27
2019	1.00
2020	.98
2021	.95
2022	.92
2023	.88
2024	.83

Source: Estimated by DLI with data from the Department of Commerce, WCRA and other sources (see Appendix C). Includes insured and self-insured employers. 2020-2024 is subject to revision as data gets updated.

System cost components

Insurer expenses represented the largest share of total workers' compensation system cost in 2024.

- In 2024, on a current-payment basis, the three largest components of total workers' compensation system cost were insurer expenses (33%), medical benefits (32%) and indemnity benefits other than vocational rehabilitation (30%).¹⁵ Vocational rehabilitation benefits accounted for an estimated 2.7% and state administration 2.4% of total system cost.
- Total benefit payments (including indemnity, medical and vocational rehabilitation components) accounted for 64.4% of total system cost in 2024.
- As shown in Figure 2.5, the indemnity and medical shares of total benefits have varied over time.¹⁶

Figure 2.8. System cost components, 2024

Source: Estimated with data from several sources. Data about benefits and state agency administrative cost came from the MWICIA, the Minnesota Insurance Guaranty Association, the Minnesota Self-Insurers' Security Fund and DLI. Total system cost was calculated as indicated for Figure 2.7. The percentage of cost going to insurer expenses was calculated as a residual as described in Appendix C. These numbers are on a current-payment basis and 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).

Note: 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. Insurer expenses include 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. Insurer expenses exclude assessments on insurers and self-insurers because the benefits and state administration financed with those assessments are counted elsewhere in the figure. State administration includes costs of workers' compensation functions in DLI, the Court 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; it 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.

Annual rates of change in key measures

The key measures presented in this part of the report are related to each other: benefits per \$100 of payroll depend on the total paid claim rate and average benefits per claim (as adjusted for wage growth); and the average pure premium rate and system cost per \$100 of payroll depend on benefits per \$100 of payroll. Figure 2.9 summarizes these relationships by presenting average annual rates of change for these key measures of the workers' compensation system.

- Combining the rates of change in the claim rate and benefits per claim (adjusted for average wage growth) gives an average annual rate of change of -2.6%. This is somewhat close to the average annual rate of change in benefits per \$100 of payroll of -3.1%. This relationship is only approximate because the three measures have different data sources (see note 3 in Figure 2.9).
- The rate of change in the average pure premium rate (-2.6%) is somewhat less (in absolute terms) than the rate of change in benefits per \$100 of payroll (-3.1%). An exact match is not expected because of

different data sources and the fact that the pure premium rates reflect the computational methodology of MWCIA in addition to actual loss experience.

- The rate of change in system cost per \$100 of payroll (-3.1%) is closer to the rate of change in benefits per \$100 of payroll (-3.1%) than to the rate of change in the average pure premium rate (-2.6%). Exact correspondence is not expected because of differences in the measures (see note 6 in Figure 2.9).
- The average annual rate of change is computed from the average value for the beginning period to the average value for the ending period. The number of years used in computing the rate of change is from the mid-point of the beginning period to the mid-point of the ending period.

Figure 2.9. Annual rates of change in key measures

Measure	Beginning period	Ending period	Average annual rate of change
1. Total claim rate	2004-2006	2022-2024	-2.6%
2. Total benefits per total claim	2004-2006	2021-2023	-0.0%
3. Combined change in total claim rate and total benefits per total claim			-2.6%
4. Total benefits per \$100 of payroll	2004-2006	2022-2024	-3.1%
5. Average pure premium rate	2004-2006	2024-2026	-2.6%
6. System cost per \$100 of payroll	2005-2014	2015-2024	-3.1%

1. From Figure 2.1.
2. From Panel C of Figure 2.3. Adjusted for average wage growth.
3. $(1 + -2.6\%) \times (1 + -0.0\%) - 1 = -2.6\%$. Since the growth in benefits per claim used in this calculation is adjusted for average wage growth, the combined average annual change of -2.6% can be viewed as an expectation regarding the rate of change in total benefits per \$100 of payroll (line 4). The exact relationship is this: claims per 100 FTE workers (claim rate, line 1) $\times$ (benefits per claim $\div$ wages per worker) (wage-adjusted benefits per total claim, line 2) = benefits per \$100 of payroll (line 4). This relationship is only approximate in the actual data because the three measures have different data sources.
4. From Figure 2.4. See note 3.
5. From Figure 2.6. MWCIA has computed the pure premium rate change every year by comparing historical pure premium (computed by applying historical pure premium rates to payroll) to total claim costs (or “benefits”). It is expected, in the long run, the pure premium rates will change at about the same rate as benefits per \$100 of payroll (line 4). This relationship is only approximate because the two measures have different data sources and because the pure premium rates reflect MWCIA’s computational methodology in addition to actual loss experience. The measure of pure premium rate change used in this report now takes into account the new elements of trend, loss development to ultimate and loss adjustment expenses, which are included in the 2023-2026 MWCIA pure premium rate changes, as impacted by new legislation.
6. From Figure 2.7. Because system cost per \$100 of payroll follows an approximately 10-year cycle, the beginning and ending periods for this measure are 10 years apart. Also, because of the variability of the cyclical pattern from one cycle to the next, the averages are taken over all 10 years in each cycle. System cost is primarily a premium-based number and individual insurers use the pure premium rates as the starting point in establishing their own premium rates each year. It is expected, in the long run, system cost per \$100 of payroll will change at about the same rate as the average pure premium rate. This relationship is only approximate because the two measures have different data sources, system cost reflects insurer pricing behavior and includes self-insured employers, while the average pure premium rate does not.



Part 3: Claims, benefits and costs – detail

This part presents additional information about workers' compensation claims, benefits and costs. Most of the statistics provide further detail about the indemnity claim and benefit information in Part 2. Some of the reported results relate to costs associated with special benefit programs and state agency administrative functions. Most of the trend statistics presented are by the year of the worker's injury or illness and are developed to a uniform maturity as described in more detail in Appendix C. Other statistics in this part are reported by policy year or fiscal year.

Claims development means values reported for earlier years have been updated in this report. Additionally, the benefit data corrections discussed in [Part 1](#) may have caused changes to values reported in previous System Reports. The 2020 through 2024 data is presented for all claims, including COVID-19 claims. Due to the significant decline in the number of COVID-19 claims, statistics for these claims are no longer shown separately in the current report.

Major findings

- The average amount of time an injured worker received total disability benefits was 33% longer in 2024 than in 2004. The average duration of temporary partial disability (TPD) was 12% shorter in 2024 than in 2004 (Figure 3.3).
- After adjusting for average wage growth, the following was found.
 - Total disability benefits per indemnity claim increased 37% from 2004 to 2024.
 - TPD benefits per indemnity claim decreased 27% from 2004 to 2024.
 - PPD benefits per indemnity claim decreased 38% from 2004 to 2024.
 - Settlement benefits per indemnity claim decreased 15% from 2004 to 2024.
- Department of Labor and Industry (DLI) values for indemnity benefits per paid indemnity claim and per \$100 of payroll closely follow their counterparts computed from Minnesota Workers' Compensation Insurers Association (MWCIA) data (Figures 3.10 and 3.11).
- The Special Compensation Fund assessment rate fell from 27.4% of paid indemnity benefits in 2004 to 11.9% in 2026 (Figure 3.14). This reflects decreasing liabilities under the supplementary and second-injury benefit programs and other factors (Figure 3.12).

Background

The following basic information is necessary for understanding the figures in this part. 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 certain 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 their pre-injury earnings, generally equal to two-thirds of the difference between current earnings and pre-injury earnings and 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 on an impairment rating from 0% to 100%. The benefit amount is derived by multiplying the impairment rating by a statutory benefit amount per rating point that increases for higher ratings. The total benefit is unrelated to pre-injury earnings.

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).

Settlements — indemnity, medical and vocational rehabilitation benefits included in a claim settlement, a stipulation for settlement, agreed to by the parties to a claim and including the injured worker's contingent attorney fees. A settlement usually occurs when there is a dispute and settlement benefits are usually paid in a lump sum.

Total disability — the combination of TTD and PTD benefits. Most figures in this part use this category because DLI data does not fully distinguish between TTD and PTD benefits.

Counting claims and benefits: Insurance data and DLI data

The first figure in this part uses insurance data from MWCIA for policy year 2022, which is the most recent year available. Two figures (3.10 and 3.11) present DLI and MWCIA data side by side; all other figures use DLI data. See Appendix C for more detail on developed statistics.

MWCIA does not include claims from self-insured employers. It includes data on insured employers from the voluntary market only (including those in the Assigned Risk Plan). In MWCIA reporting, insurers are instructed to divide settlement benefits into indemnity and medical components. Indemnity benefits in MWCIA reporting include vocational rehabilitation service costs.

MWCIA categorizes claims and benefits 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 130 weeks and claims with settlements. In MWCIA insurance data, all benefits on a claim are counted in the one claim-type category into which the claim falls.

In DLI data, by contrast, 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.

DLI data include insured and self-insured employers. In DLI reporting, benefits paid under a stipulation for settlement are not divided into indemnity and medical components. Consequently, all settlement benefits are included with indemnity benefits in the DLI data. Indemnity benefits in DLI reporting exclude vocational rehabilitation service costs.

Benefit amounts in the current report are adjusted for average wage growth between the respective year and 2024.

How COVID-19 has affected developed estimates

COVID-19 indemnity claims are unlike non-COVID-19 claims. Nearly all the COVID-19 claims, as of this reporting period, are of short duration and involve only total disability benefits. Claims development computations involve using the patterns of claims duration and cost change from previous years to estimate their ultimate values. Computing developed statistics for COVID-19 indemnity claims cannot be done with a high level of confidence because these claims are relatively new and are unlikely to follow the pattern of non-COVID claims from previous years. Therefore, claims development estimates were calculated only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims.

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 costs at DLI, the Court of Administrative Hearings (CAH), the Workers' Compensation Court of Appeals (WCCA) and other state agencies to administer the workers' compensation system, and certain benefits for which DLI is responsible.

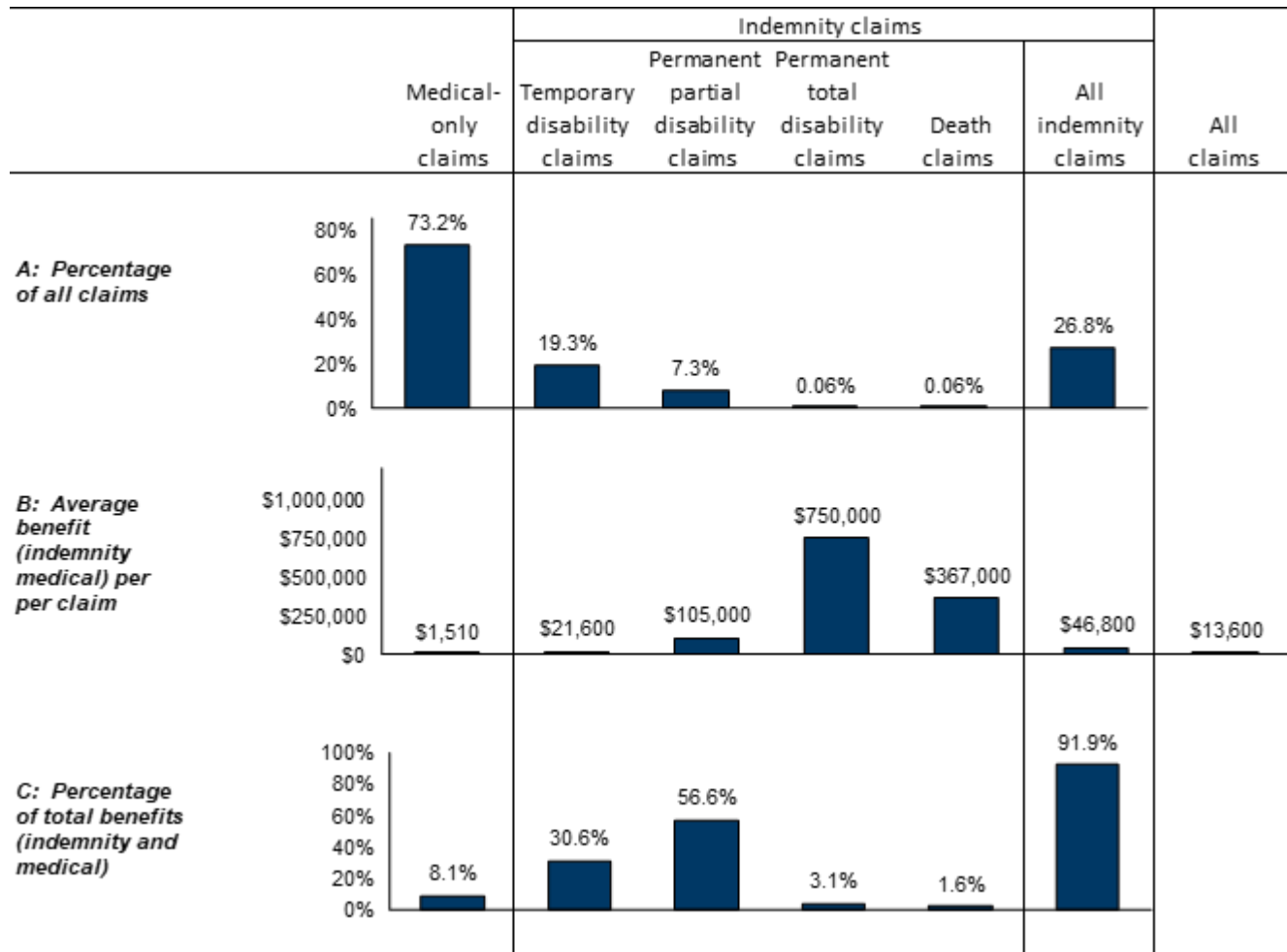
DLI is responsible for supplementary benefits and second-injury benefits. Although these benefits were eliminated in the 1990s, SCF reimburses insurers (including self-insured employers) for supplementary and second-injury benefit payments on claims that continue to be eligible (see Appendix A). The assessment (or benefits and administrative costs paid with the assessment) is included in total workers' compensation system cost (Figures 2.7 and 2.8).

Benefits by claim type

In the insurance data, PPD claims account for the majority of total benefits paid. Each claim type contributes to total benefits paid depending on its relative frequency and average benefit. In addition, 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, TPD and vocational rehabilitation benefits, in addition to PPD benefits.

Figure 3.1 presents developed statistics from MWCIA for policy-year 2022 and include some COVID-19 claims.

- PPD claims accounted for 57% of total benefits in 2022 (panel C in Figure 3.1) through a combination of moderately low frequency (panel A) and substantially higher 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 27% of all paid claims but accounted for 92% of total benefits because they have far higher benefits, on average, than medical-only claims (\$46,800 versus \$1,510 for 2022). Medical-only claims accounted for 73% of claims, but only 8% of total benefits.

Figure 3.1. Benefits by claim type for insured claims from MWCIA, policy-year 2022

Source: Developed statistics from MWCIA data.

Note: Indemnity claims consist of all claim types other than medical-only. These claims typically have both indemnity and medical benefits. PPD claims in MWCIA data include any claims with settlements or with temporary disability lasting more than 130 weeks, in addition to claims with PPD. Because of large annual fluctuations, data for PTD and death claims is averaged from 2018 to 2022. Benefit amounts in panel B are adjusted for overall wage growth between 2022 and 2024.

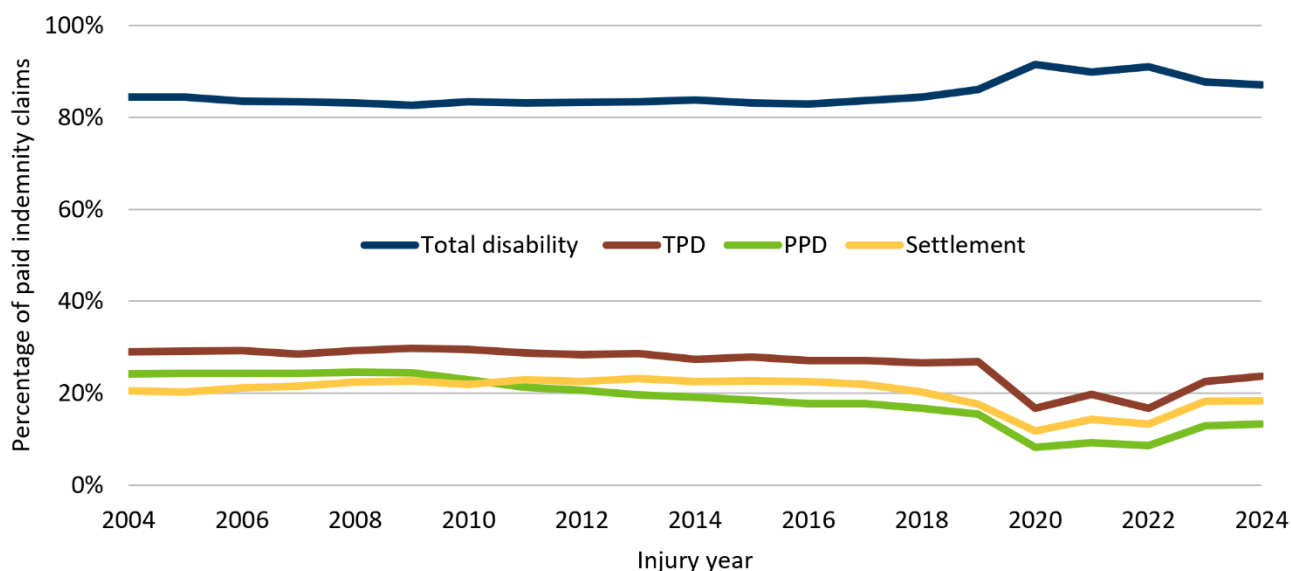
Claims by benefit type

The majority of paid indemnity claims receive total disability benefits (TTD and PTD benefits). Less than one-third of paid indemnity claims receive PPD, TPD or settlement benefits. (Figure 3.2)

- In 2024, 87% of all paid indemnity claims received total disability benefits. The proportion receiving the other benefit types was 24% for TPD benefits, 18% for settlement benefits and 13% for PPD benefits. An indemnity claim may have more than one type of benefit paid; therefore, the sum of the percentages for the different benefit types is greater than 100%.
- All four benefit types showed temporary fluctuations during the COVID-19 period. From 2020 to 2022, the proportion of claims with total disability benefits increased due to the influx of COVID-19 claims that mostly received only total disability benefits, while all other benefits fell. Only a small number of COVID-19 paid indemnity claims had settlement payments. In 2023 and 2024, trends returned to pre-pandemic levels, as the number of COVID-19 claims decreased.

- Aside from the fluctuations during the COVID-19 period, the following long-term trends were observed.
 - The percentage of claims with total disability benefits remained relatively stable, with minimal yearly variation. From 2004 to 2024, this share increased by 3%.
 - The percentage of claims with TPD benefits fell gradually over the period, decreasing 18% from 2004 to 2024.
 - The percentage of claims paid PPD benefits declined 45% from 2004 to 2024.
 - The percentage of claims with settlement payments changed little from 2004 to 2017, but has fluctuated since, with a 9% overall decline from 2018 to 2024.

Figure 3.2. Percentages of paid indemnity claims with selected types of benefits



Injury year	Total disability	TPD	PPD	Settlement
2004	84.4%	29.0%	24.2%	20.6%
2017	83.6	27.2	17.7	21.9
2019	86.1	26.9	15.4	17.6
2020	91.5	16.7	8.3	11.8
2021	89.8	19.7	9.2	14.4
2022	91.0	16.8	8.6	13.4
2023	87.6	22.6	13.0	18.3
2024	87.1	23.6	13.3	18.3

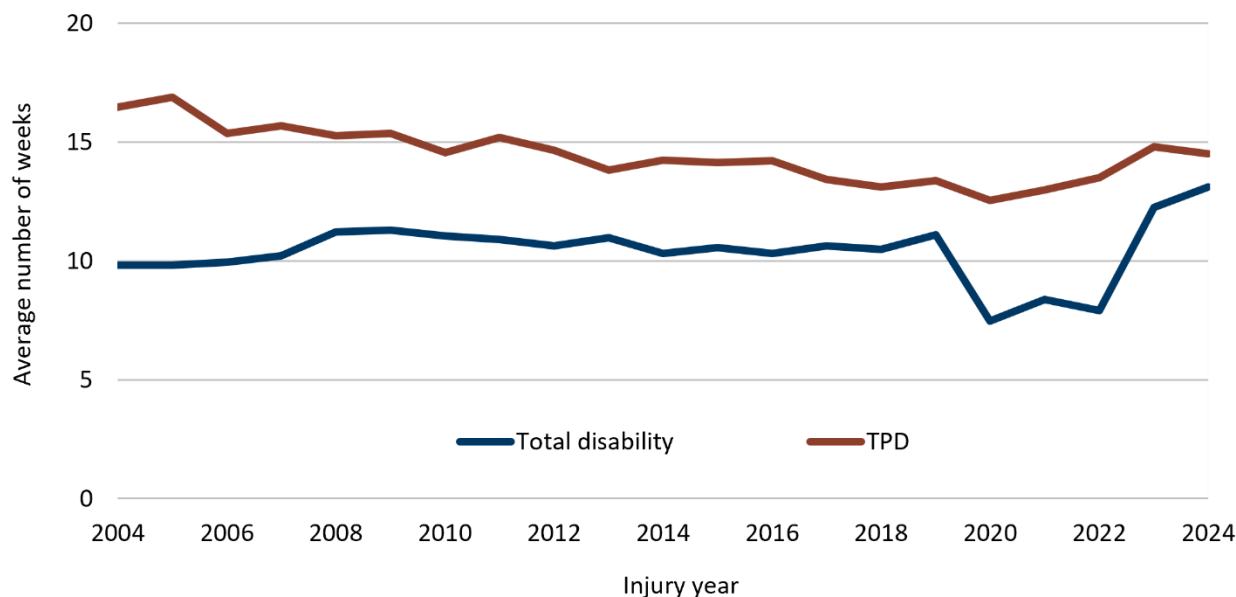
Source: Developed statistics from DLI Campus database (see Appendix C).

Benefit duration

- In 2024, the estimated average duration of total disability benefits was 13.1 weeks – up from 12.2 weeks in 2023. Total disability duration in 2024 was 33% higher than in 2004 and 18% higher than in 2019. It decreased from 2020 to 2022 due to the significantly shorter average benefit duration of COVID-19 claims, but increased above pre-pandemic levels in 2023 and 2024.
- The estimated TPD duration averaged 14.5 weeks in 2024 – slightly below the 2023 value of 14.8 weeks. TPD duration in 2024 was 12% lower than in 2004, but 8% higher than in 2019.

- Both total disability and TPD durations were also affected by the data corrections discussed in [Part 1](#), which showed that wage-replacement benefit durations had been previously understated. This may partially explain the higher duration averages for 2023–2025 injury years. Moreover, both DLI and [WCRI](#) previously found increases in average benefit durations in the post-pandemic era, particularly for TTD duration. Generally, values for the most recent years are subject to revision as more complete data becomes available.

Figure 3.3. Average duration of wage-replacement benefits in weeks

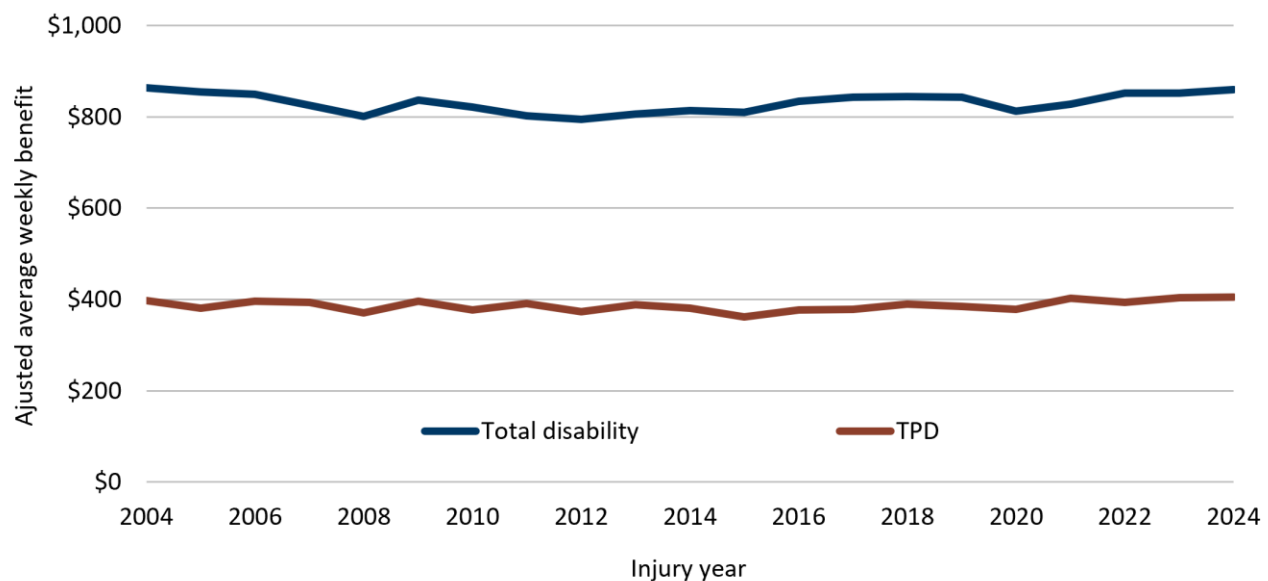


Injury year	Average weeks	
	Total disability	TPD
2004	9.8	16.5
2019	11.1	13.4
2020	7.5	12.5
2021	8.4	13.0
2022	7.9	13.5
2023	12.2	14.8
2024	13.1	14.5

Source: Developed statistics from DLI Campus database.

Weekly benefit payments

- After adjusting for average wage growth, weekly total disability benefits were estimated to average \$859 for workers with 2024 claims. These benefits decreased between 2004 and 2020 with annual fluctuations, but increased 6% between 2020 and 2024. This increase can be attributed to several factors, including higher wages of workers with COVID-19 claims during the pandemic and the statutory increases in the minimum and maximum TTD rates, which took effect in Oct. 2021 and 2024. See Appendix B for details about these law changes.¹⁷ The benefit data corrections discussed in [Part 1](#) may have also caused changes to values reported in previous System Reports.
- Wage-adjusted weekly TPD benefits were estimated to average \$405 for workers with 2024 claims. These benefits declined between 2004 and 2015, but steadily increased from 2015 to 2024, with minor annual fluctuations.

Figure 3.4. Average weekly wage-replacement benefits, adjusted for wage growth

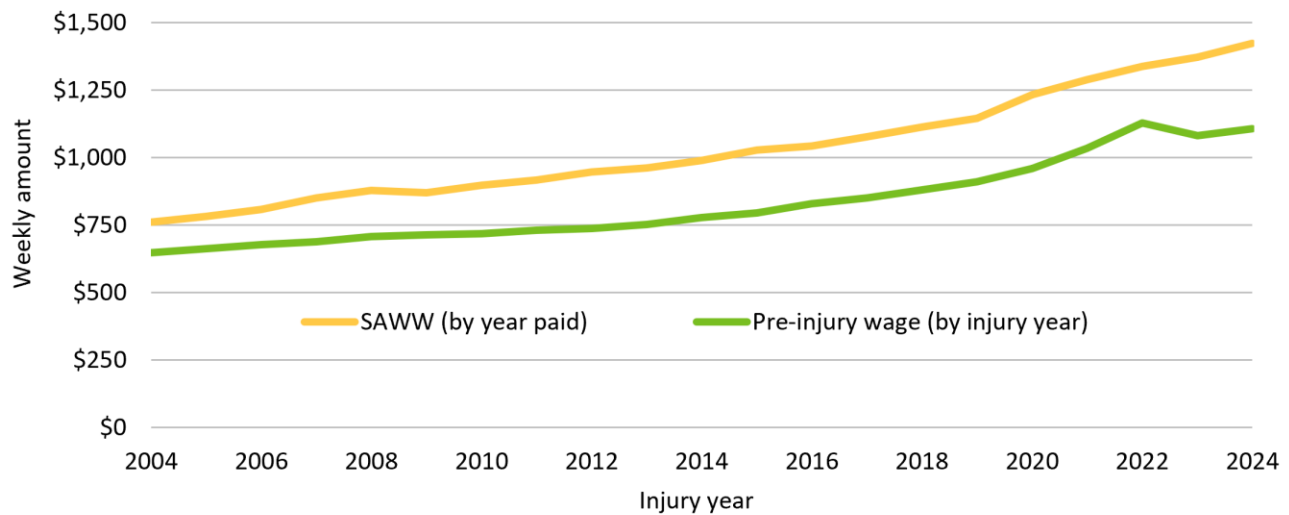
Injury year	Total	
	disability	TPD
2004	\$863	\$398
2019	843	384
2020	812	379
2021	828	402
2022	851	394
2023	852	404
2024	859	405

Source: Developed statistics from DLI Campus database.

Growth of average pre-injury wage in comparison with statewide average weekly wage

The pre-injury wage of injured workers is the primary basis for weekly wage-replacement benefits. Examining the trend in pre-injury wages relative to the statewide average weekly wage (SAWW) helps to understand the trends in adjusted average weekly benefits in Figure 3.4.

- The average pre-injury wage of injured workers (APIW) rose more slowly than the SAWW from 2004 to 2024. While the SAWW rose 87%, the APIW rose 71% during this period (Figure 3.5). APIW is typically less than the SAWW because workplace injuries resulting in paid claims are more common in lower-wage jobs.
 - However, from 2020 to 2022, APIW growth (18%) outpaced SAWW growth (9%). The faster growth in the APIW was largely fueled by labor market changes and the increase in COVID-19 claims in the pandemic period. Many workers included in the COVID-19 presumption had higher wages compared with all other workers.
- Because of its relatively slow rate of increase, the APIW fell from 85% of the SAWW in 2004 to 78% in 2024.¹⁸ The average weekly benefits (Figure 3.4) are adjusted for growth in the SAWW; therefore, a change in the APIW relative to the SAWW will cause a change in these adjusted benefits.¹⁹

Figure 3.5. Statewide average weekly wage and average pre-injury wage

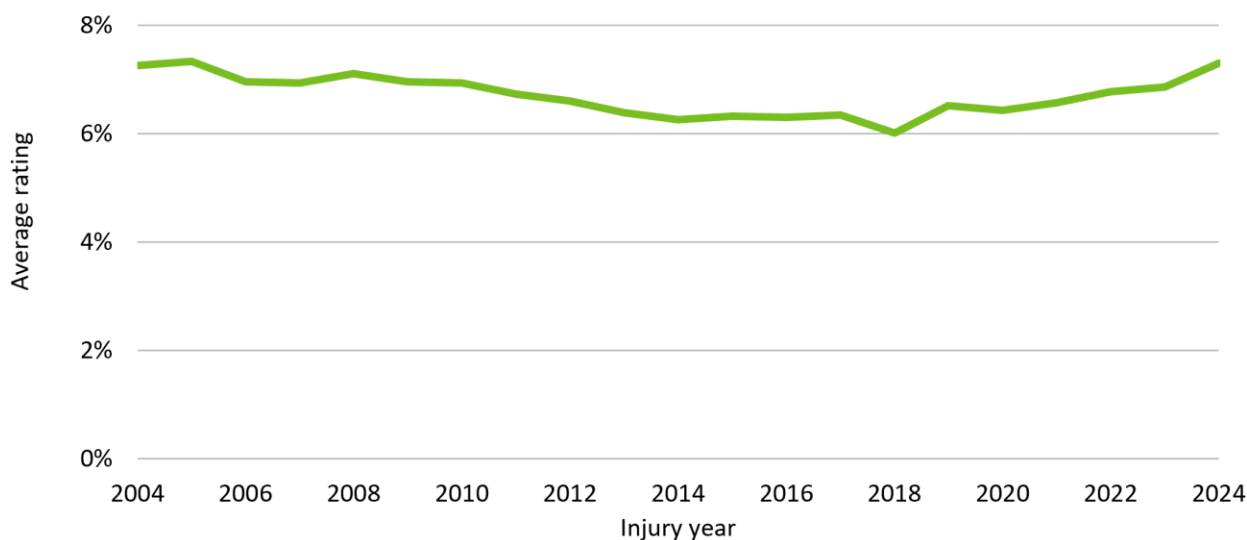
Injury year	SAWW (by year paid)	APIW (by injury year)	APIW as pctg. of SAWW
2004	\$759	\$647	85.2%
2019	1,144	909	79.4
2020	1,232	958	77.8
2021	1,287	1,033	80.3
2022	1,337	1,128	84.4
2023	1,372	1,081	78.8
2024	1,423	1,106	77.7

Source: Data from DLI. The 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 prior calendar year.

Average permanent partial disability rating

The trend in the average PPD rating helps to explain the trend in average PPD benefits in Figure 3.8. PPD ratings are reported for injured workers who receive PPD benefits and for some workers whose PPD benefits are determined and paid through the settlement process; however, PPD ratings are not reported for many workers with settlements, usually because the PPD rating itself is in dispute.

- The estimated average PPD impairment rating was 7.3% in injury-year 2024 – the same as in 2004. The rating decreased from 2004 to 2018, but increased after 2018.
- By itself, a change in the average rating would affect average PPD benefits because the PPD benefit is calculated as the rating times a statutorily specified benefit amount per rating point.²⁰

Figure 3.6. Average permanent partial disability rating

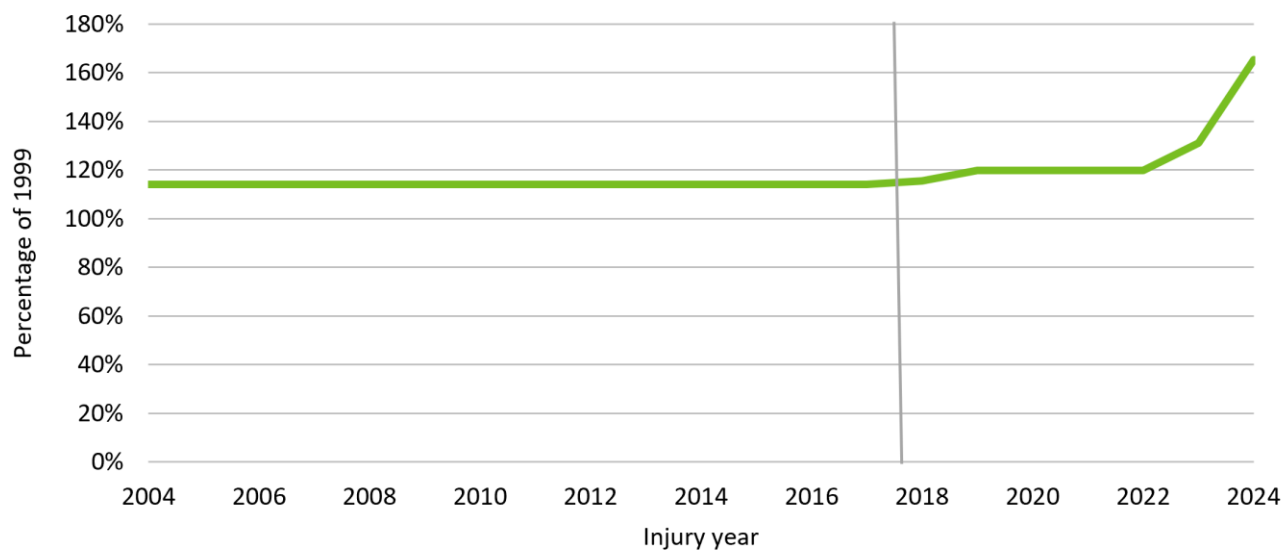
Injury year	Average PPD rating
2004	7.3%
2018	6.0
2019	6.5
2020	6.4
2021	6.6
2022	6.8
2023	6.9
2024	7.3

Source: Developed statistics from DLI Campus database.

Average level of permanent partial disability benefit schedule

The trend in average PPD benefits in Figure 3.8 is also partly explained by the trend in the level of the PPD benefit schedule. This benefit schedule is fixed in statute but has been raised in 2000, 2018 and 2023. These schedule increases affect the benefits paid to workers injured on or after the effective date of the increase.

- The PPD benefit schedule was raised in October 2000 by an estimated 14.1% and in October 2018 by 5%.
- The benefit schedule was increased again in 2023, with the largest increase (45%) applied to impairment ratings below 20.50. Approximately 95% of injured individuals with impairment ratings fall under this threshold. Overall, DLI estimates these changes result in a weighted increase of about 38% to the PPD benefit schedule.
- As a result of these changes, the benefit schedule was higher by an estimated 51.2% for injury-year 2024 than for injury-year 2004.

Figure 3.7. Average level of permanent partial disability benefit schedule as percentage of 1999 schedule

Injury year	Pctg. of 1999
2004	114.1%
2018	115.5
2019	119.8
2020	119.8
2021	119.8
2022	119.8
2023	131.2
2024	165.3

Note: The increase in 2019 reflects the 2018 law change that raised PPD benefits by a uniform 5% throughout the benefit schedule, effective for injuries on or after Oct. 1, 2018. Thus, one quarter of the 5% increase is assumed to be felt for injury-year 2018. The law change effective October 2023 raised the PPD benefits by an estimated 38%; one quarter of this increase (about 9.5%) is assumed to be felt for injury-year 2023 and the full effect is assumed to be felt for injury-year 2024.

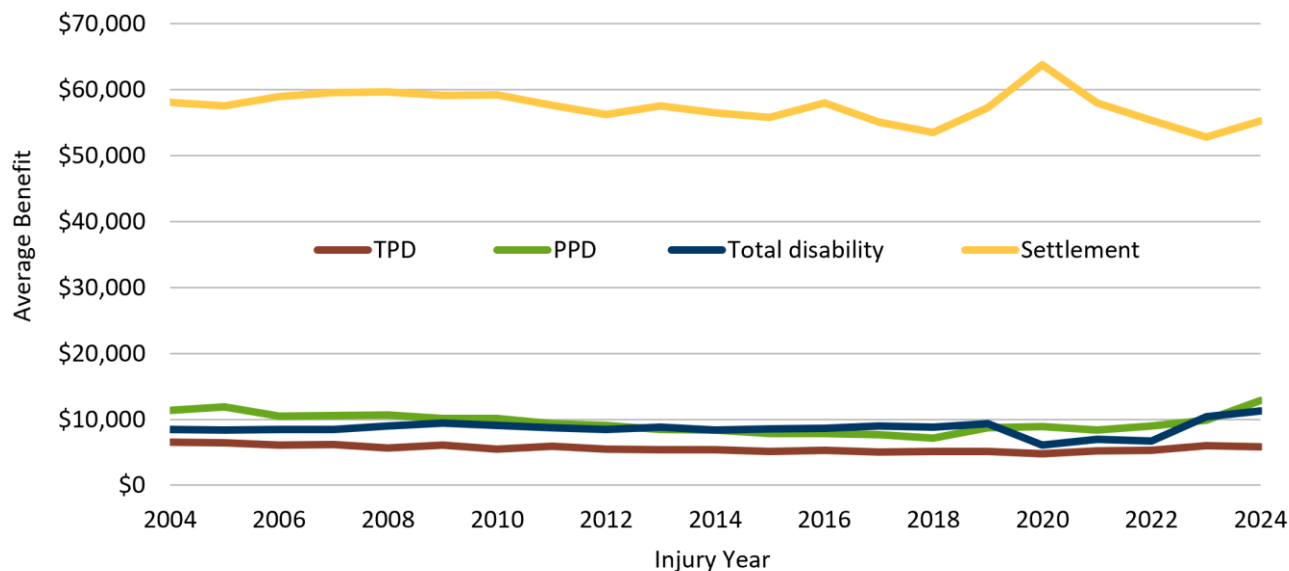
Average benefits by type

An indemnity claim may have more than one type of benefit paid. When paid, settlement payments are far higher on average than total disability, TPD and PPD benefits (Figure 3.8). After adjusting for average wage growth, average benefits of different types have moved in widely divergent ways. These are all developed statistics; reported values for recent years, especially for 2020 through 2024 claims, are subject to change as the claims mature. The benefit data corrections discussed in [Part 1](#) may have also caused changes to values reported in previous System Reports.

- In injury-year 2024, settlement benefits adjusted for wage growth averaged about \$55,290 per claim. Total disability benefits averaged about \$11,260, TPD benefits \$5,860, and PPD benefits \$12,870.
- With respect to trends in average benefits, the following was found.
 - Average total disability benefits increased 33% from 2004 to 2024, matching the 33% increase in total disability duration. These benefits were largely stable from 2004 to 2019 because of opposing trends in benefit duration and average weekly benefits, but fluctuated more after 2019 (Figures 3.3 and 3.4). From 2019 to 2022, there was an overall 28% decline, which was

driven largely by the short average benefit duration of COVID-19 claims. However, with the large decline in COVID-19 claims (which had lower benefits), average total disability benefits increased 67% from 2022 to 2024.

- This recent growth was also driven by several other factors: (1) Favorable labor market conditions led to higher wages for many workers in the post-pandemic era.²¹ (2) Effective October 2021, the minimum TTD rate changed to 20% of the maximum TTD rate, and effective October 2024, the maximum TTD rate increased from 102% to 108% of the SAWW. These changes allowed more injured workers to receive higher benefits. For instance, DLI estimated that the share of workers receiving the minimum weekly benefit increased from 3% of non-COVID-19 TTD claims in 2021 to 8% in 2023.
- Average TPD benefits decreased 10% from 2004 to 2024. These benefits decreased 20% between 2004 and 2021, followed by a 10% increase from 2022 to 2024. The trends in average TPD benefits are driven largely by the trends in average benefit duration and average weekly benefits.
- Average PPD benefits increased 13% from 2004 to 2024. These benefits fell nearly continually (37%) from 2004 to 2018, but increased between 2018 and 2024 (79%), with much of this increase occurring in 2024. The decrease in average PPD benefits from 2004 to 2018 occurred primarily because the statutory PPD benefit schedule did not change (Figure 3.7), while the SAWW increased by 47% during that period (Figure 3.5). Under the mostly fixed schedule, PPD benefits become smaller relative to rising wages, which is reflected in falling adjusted average benefits. The PPD benefit schedule was updated in 2018 and 2023. The increase in average PPD benefits from 2018 to 2024 corresponds to the increase in the average PPD rating and the PPD benefit schedule after 2018.²²
- Average settlement benefits decreased 5% from 2004 to 2024, with some annual fluctuations.²³ These benefits decreased 8% from 2004 to 2018. While there was a 19% increase from 2018 to 2020, it was followed by a 13% decrease from 2020 to 2024.²⁴

Figure 3.8. Average benefit by type *per claim with that benefit type*, adjusted for wage growth

Injury year	Total disability	TPD	PPD	Settlement
2004	\$8,490	\$6,550	\$11,390	\$58,050
2019	9,350	5,140	8,760	57,250
2020	6,070	4,750	8,930	63,740
2021	6,930	5,230	8,400	57,970
2022	6,730	5,320	9,010	55,350
2023	10,440	5,980	9,840	52,770
2024	11,260	5,860	12,870	55,290

Source: Developed statistics from DLI Campus database.

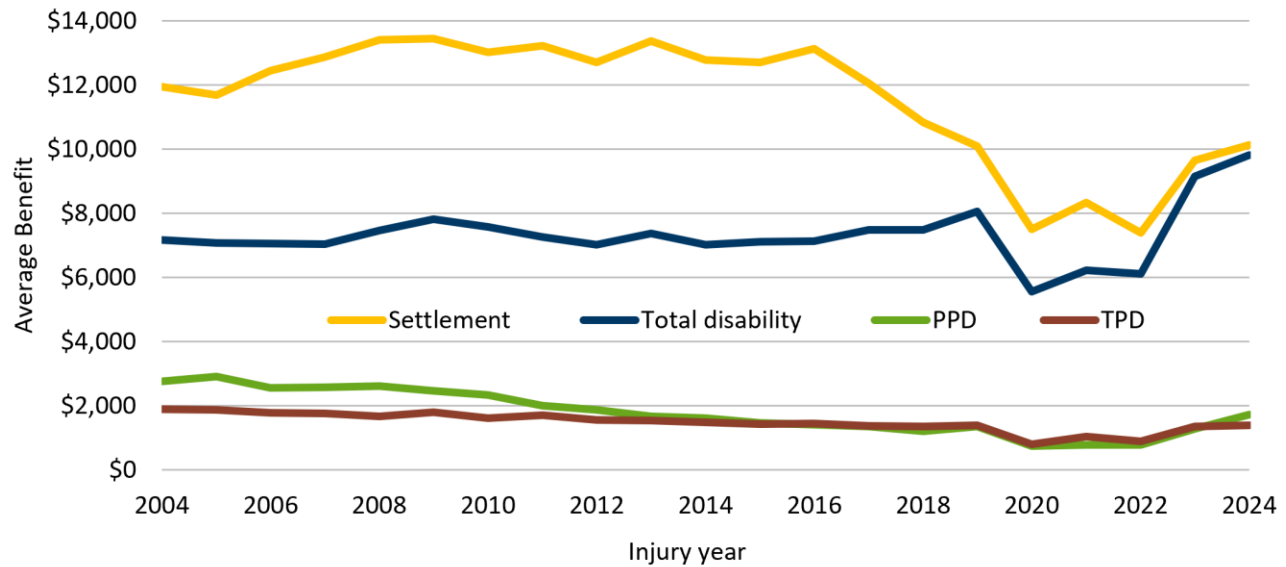
Benefits by type per indemnity claim

Per paid indemnity claim, settlement benefits are far higher than total disability, TPD or PPD benefits (Figure 3.9). With respect to trends, after adjusting for average wage growth, average benefits per paid indemnity claim followed widely divergent paths. Because these are all developed statistics, reported values for recent years, especially for 2020 through 2024 claims, are subject to change as the claims mature. The benefit data corrections discussed in [Part 1](#) may have also caused changes to values reported in previous System Reports.

Figure 3.9 differs from Figure 3.8 in that it shows the average benefit of each type per paid indemnity claim rather than per claim with that type of benefit. Figure 3.9 reflects the percentage of indemnity claims with each benefit type (Figure 3.2) and Figure 3.8 shows the average benefit amount per claim with that benefit type. For example, the \$10,140 average settlement benefits per paid indemnity claim for 2024 (Figure 3.9) is about equal to the percentage of indemnity claims with settlement benefits (18.3%, Figure 3.2) multiplied by the average settlement benefit where paid (\$55,290, Figure 3.8).

- The table presented in Figure 3.9 provides the average indemnity benefits for all 2020 through 2024 indemnity claims, including COVID-19 claims. The decrease in average values for all benefit types during the pandemic years was due to the low average benefits paid to COVID-19 claims. The low average benefits paid to workers with COVID-19 claims was the result of the relatively brief nature of the course of the illness for most workers.

- With respect to trends, after adjusting for average wage growth, the following was found.
 - Total disability benefits per indemnity claim increased 37% from 2004 to 2024. These benefits were relatively stable from 2004 to 2019, which reflected a stable trend in the proportion of claims with these benefits (Figure 3.2) and a small net change in the average amount of these benefits where they were paid (Figure 3.8). Total disability benefits per indemnity claim decreased from 2019 to 2022 due to the pandemic, but increased above pre-pandemic levels in 2023 and 2024. This increase could be attributable to the decline in COVID-19 claims with low average benefits as well as the statutory increases in the minimum and maximum TTD rates in 2021 and 2024.
 - TPD benefits per indemnity claim decreased 27% from 2004 to 2024. These benefits decreased from 2019 to 2022 due to the pandemic, but increased to pre-pandemic levels in 2024. The long-term 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 3.8).
 - PPD benefits per indemnity claim decreased 38% from 2004 to 2024. These benefits decreased 43% from 2019 to 2022, but started to increase after 2022, reaching above pre-pandemic levels in 2024. The long-term decline in average PPD benefits per indemnity claim occurred primarily because PPD benefits became smaller relative to rising wages under the mostly fixed PPD benefit schedule. Other factors included a decline in the adjusted average PPD benefits where they were paid (Figure 3.8), the percentage of claims with PPD benefits (Figure 3.2) and the average PPD impairment rating (Figure 3.6). This decline was somewhat offset by the increases in statutory PPD benefit levels in 2018 and 2023.
 - Settlement benefits per indemnity claim decreased 15% from 2004 to 2024. While these benefits rose 10% from 2004 to 2016, they declined 23% from 2016 to 2024, with annual fluctuations. This corresponds to the decline in the percentage of indemnity claims with these benefits (Figure 3.2) and the fluctuations in the average settlement benefits where these were paid (Figure 3.8) after 2016. There was a stronger decline in 2020 through 2022, because only a handful of COVID-19 paid indemnity claims involved settlement benefits. In 2024, settlement benefits rose back to pre-pandemic levels.

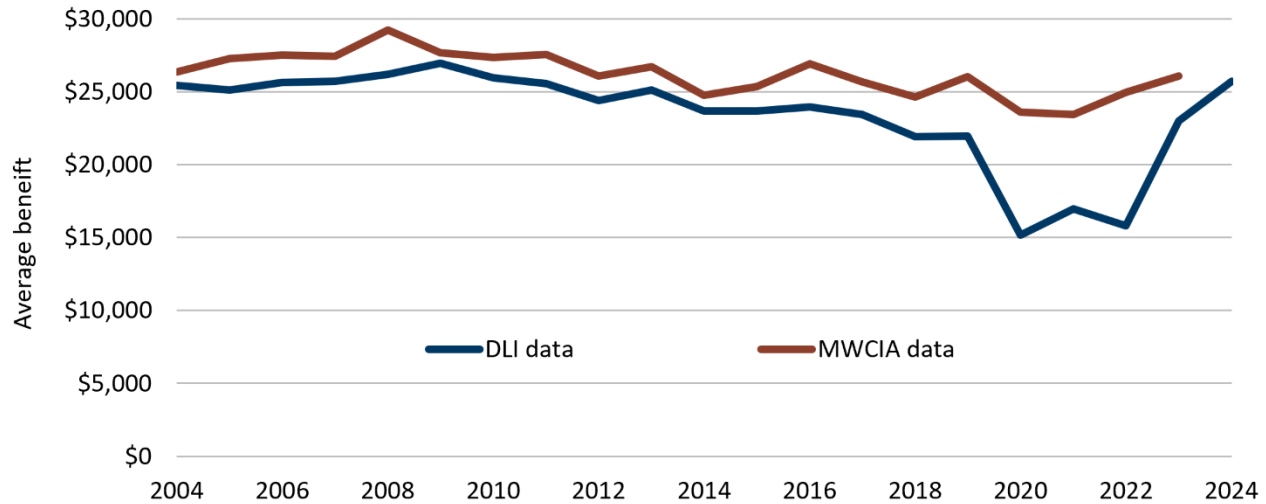
Figure 3.9. Average benefit by type per paid indemnity claim, adjusted for wage growth

Source: Developed statistics from DLI Campus database.

Indemnity benefits per claim, DLI and MWCIA data

As computed from DLI and MWCIA data, indemnity benefits per claim (adjusted for wage growth) from these two sources follow each other closely.

- From 2004 through 2023, the MWCIA amount has exceeded the DLI amount. This is largely because MWCIA includes vocational rehabilitation benefits while DLI does not.²⁵
- Both data sources show a generally stable trend in wage-adjusted indemnity benefits per indemnity claim since 2004, with some yearly fluctuations. The large decrease in DLI data from 2019 to 2022 reflects the changes in indemnity claims during the pandemic, as wage-adjusted indemnity benefits per indemnity claim decreased from \$21,950 in 2019 to \$15,810 in 2022. However, this amount rose to \$23,020 in 2023 and \$25,720 in 2024, as the number of COVID-19 claims declined. Recent statutory indemnity benefit changes may have also led to an increase in average indemnity benefits in this period.
- It is uncertain why the MWCIA figure seems to fluctuate more than the DLI figure. One possible explanation is the MWCIA figure is based on payments plus claim-specific reserves, while the DLI figure is based on payments alone.²⁶

Figure 3.10. Average indemnity benefits per paid indemnity claim, adjusted for wage growth, DLI and MWCIA data

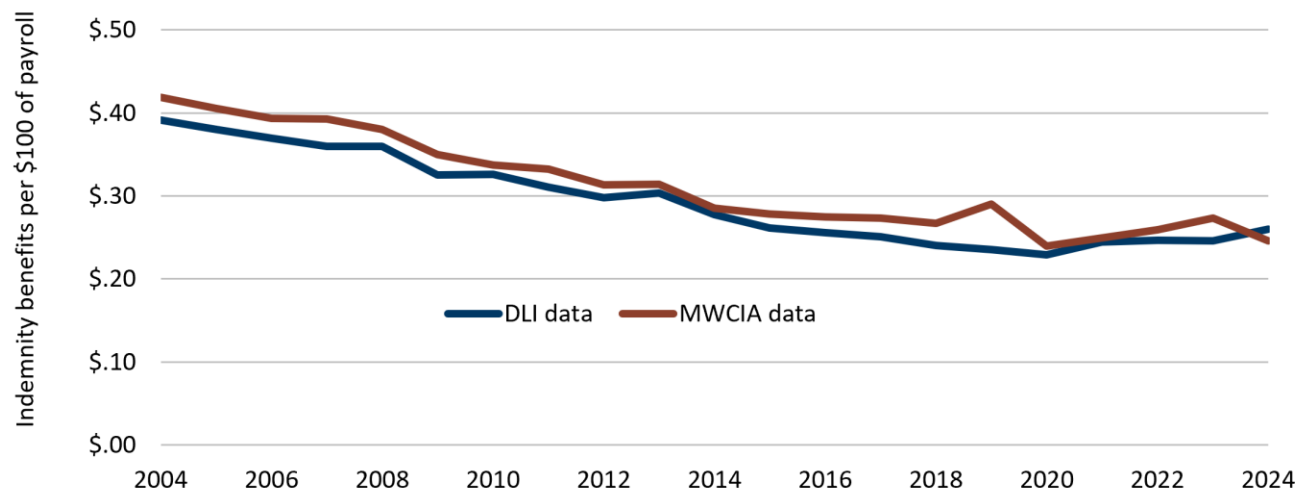
	DLI data (by injury year)	MWCIA data (by policy year)
2004	\$25,460	\$26,370
2019	21,950	26,060
2020	15,170	23,620
2021	16,990	23,460
2022	15,810	24,960
2023	23,020	26,100
2024	25,720	

Source: Developed statistics from DLI Campus database and MWCIA data (Figure 2.3, Panel A; not yet available for 2024).

Indemnity benefits per \$100 of payroll, DLI and MWCIA data

As computed from DLI and MWCIA data, indemnity benefits per \$100 of payroll from the two sources follow each other closely.

- Since 2004, the DLI figure has averaged about 94% of the MWCIA figure.
- As with average indemnity benefits per paid indemnity claim (Figure 3.10), much of the difference between the DLI and MWCIA numbers is because the MWCIA figure includes vocational rehabilitation service costs while the DLI number does not.²⁷

Figure 3.11. Indemnity benefits per \$100 of payroll, DLI and MWCIA data

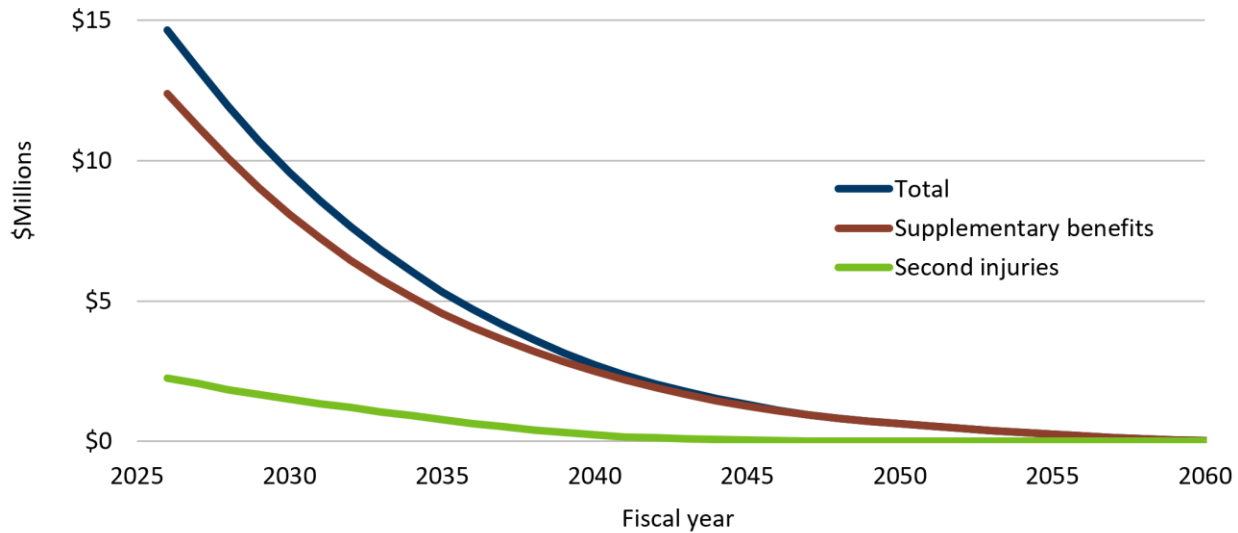
Injury year	DLI data	MWCIA data
2004	\$0.39	\$0.42
2019	.24	.29
2020	.23	.24
2021	.24	.25
2022	.25	.26
2023	.25	.27
2024	.26	.25

Source: Developed statistics from DLI Campus database and MWCIA data; payroll data from several sources (see Appendix C).

Supplementary and second-injury benefit costs

DLI produces an annual projection of supplementary benefit and second-injury benefit reimbursement costs as they would exist without future settlement activity. The total annual cost is projected to fall by 68% during the next 10 years and to disappear by 2060.

- The 2026 projected cost of \$14.6 million consists of roughly \$12.4 million for supplementary benefits and \$2.2 million for second-injury benefits.
- Without settlements, supplementary benefit claims are projected to continue until 2060 and second-injury benefit claims until 2045. Claim settlements will reduce future projections of these liabilities. In fiscal-year 2025, supplementary benefit and second injury settlements amounted to a total of \$1.18 million.

Figure 3.12. Projected cost of supplementary and second-injury reimbursement claims

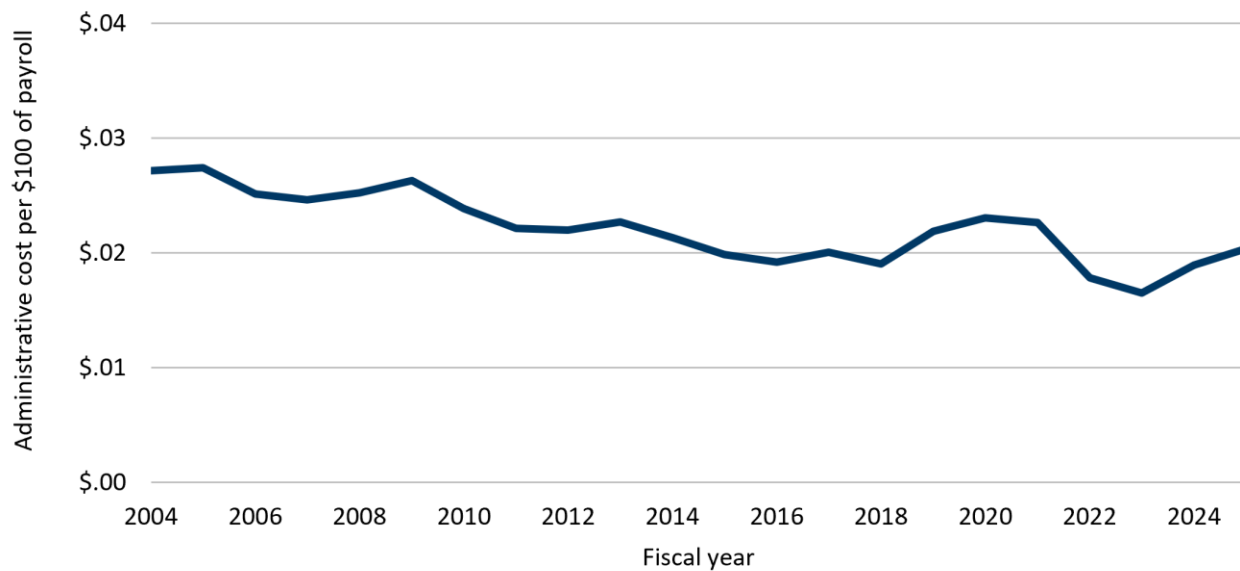
Fiscal year of claim receipt	Projected amount claimed (\$millions)		
	Supplementary benefits	Second injuries	Total
2026	\$12.4	\$2.2	\$14.6
2027	11.2	2.1	13.3
2030	8.1	1.5	9.6
2035	4.6	.8	5.3
2050	.6	.0	.6

Source: Projected from data from DLI Campus database.

State agency administrative cost

State agency administrative cost paid out of the workers' compensation assessment has fallen as a proportion of workers' compensation covered payroll.

- In fiscal-year 2025, state agency administrative cost (see note 1 in Figure 3.13) was 2.0 cents per \$100 of payroll, down 25% from 2004.
- The main factor in the decline of administrative cost relative to covered payroll over time has been the steady increase in payroll itself, as administrative cost has been relatively stable during the past two decades.
- The increase in administrative cost from 2019 to 2021 primarily reflected the expenditure for the Workers' Compensation Modernization Program, or Work Comp Campus.²⁸
- Administrative cost for fiscal-year 2025 was \$42.6 million. As indicated in Figure 2.8, state administration accounted for about 2.4% of total workers' compensation system cost in 2024.

Figure 3.13. Net state agency administrative cost per \$100 of payroll

Fiscal year	State agency admin. cost per \$100 of payroll
2004	\$0.027
2018	.019
2019	.022
2020	.023
2021	.023
2022	.018
2023	.016
2024	.019
2025	.020

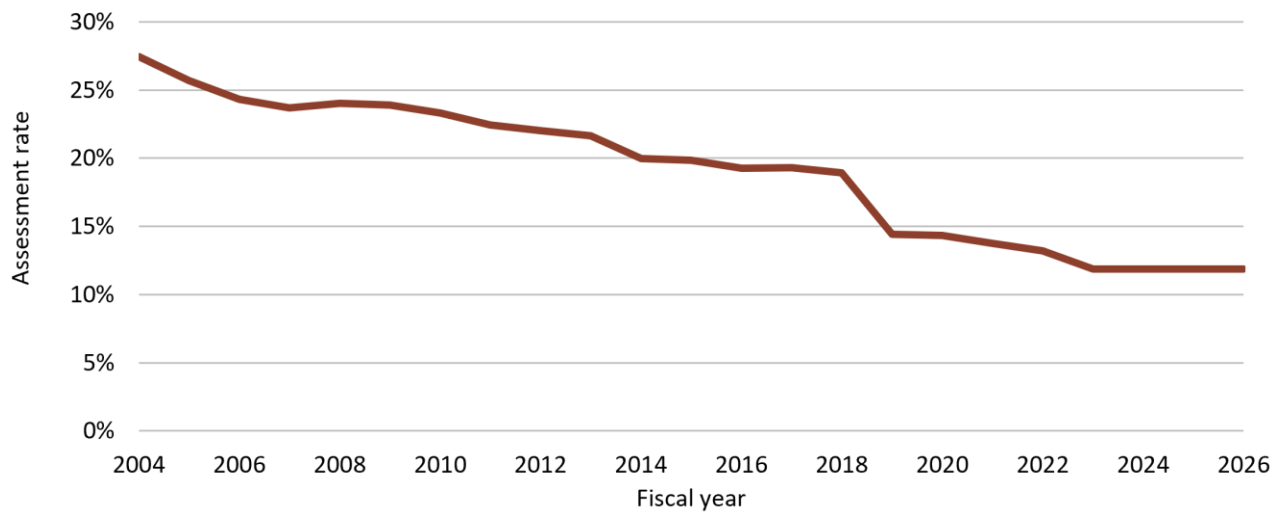
Source: Data from DLI, MWCIA and WCRA. Includes costs of workers' compensation administrative functions in DLI, the Court of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the state share of the cost of the Minnesota OSHA program, beyond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

Special Compensation Fund assessment rate

The state agency administrative cost is funded through an assessment on insurers and self-insured employers. The total assessment amount is calculated as the assessment rate multiplied by the amount of paid indemnity benefits.

- The assessment rate fell from 27.4% for 2004 to 11.9% for 2026. Primarily, this reflects the continuing decreases in supplementary benefit and second-injury benefit reimbursement costs (Figure 3.12) and, to a lesser degree, the decreasing trend in state agency administrative costs relative to total covered payroll (Figure 3.13).
- The sharp decrease in the assessment rate for fiscal-year 2019 primarily reflects an increase in the reported assessment base rather than a decrease in the assessment itself. The increase in the base reflects some insurers erroneously including medical benefits in their reported base, which is supposed to include paid indemnity benefits only.²⁹

- At its highest, the assessment rate was 31% for fiscal-years 1988 through 1992, before the period shown in Figure 3.14.

Figure 3.14. Special Compensation Fund assessment rate

Fiscal year assessment is due	Assessment rate
2004	27.4%
2018	18.9
2019	14.4
2020	14.4
2021	13.7
2022	13.2
2023	11.9
2024	11.9
2025	11.9
2026	11.9

Source: Data from DLI.

Note: Beginning with assessments due in fiscal-year 2004, DLI determines the total assessment amount to be collected and then allocates this amount between insurers and self-insurers (as groups) according to their relative shares of total indemnity benefits paid. The insurer share is then allocated among insurers according to their pure premium and the self-insurer share is allocated among self-insurers according to their paid indemnity benefits. The assessment rate shown here for 2004 and later years is the total assessment divided by total indemnity benefits paid.



Part 4: Vocational rehabilitation

This section of the report provides information about vocational rehabilitation services in Minnesota's workers' compensation system. Some of the statistics are presented by the year of the worker's injury or illness; others are presented by the year of the vocational rehabilitation plan closure, the period from Oct. 1 through Sept. 30 of the indicated year. The economic effects of the COVID-19 pandemic affected results for many workers receiving these services during 2020, 2021 and 2022.

Major findings

- Participation in vocational rehabilitation rose from 21% of paid indemnity claims for injury-year 2004 to 24% for 2019, but decreased to 22% among indemnity claims for workers injured in 2024 (Figure 4.1).
 - There was a 9% decrease in the estimated number of workers who have or will receive vocational rehabilitation services for their 2024 injuries and illnesses (4,435) compared with the number for 2023 injuries and illnesses (4,864).
- After adjusting for average wage growth, the \$9,930 estimated average cost of vocational rehabilitation services for injury-year 2024 was 20% below the 2008 peak of \$13,150 (Figure 4.4).
- Vocational rehabilitation services accounted for an estimated 2.7% of total workers' compensation system cost for 2024 (Figure 2.8).
- The average time from injury to the start of vocational rehabilitation services fell from 8.2 months for injury-year 2004 to 5.5 months for 2024 (Figure 4.8).
- The estimated average service duration decreased from 15.0 months for plans closed in 2012 to 12.3 months in 2025 (Figure 4.9). This is the shortest average duration during the 2007 through 2025 period.
- The proportion of plans closed with completion of services fluctuated between 51% and 45% from 2019 to 2025, while the proportion of plans closed by settlement varied between 33% and 26% (Figure 4.10).
- The percentage of vocational rehabilitation participants with a reported job at plan closure dropped from 62% in 2019 to 57% in 2020; it increased to 61% of workers employed at plan closure in 2023 but decreased to 57% in 2025 (Figure 4.13).
 - Forty-two percent of vocational rehabilitation participants returned to work with their pre-injury employer in 2025, just below the prior 10-year average of 43%.
 - Sixteen percent of vocational rehabilitation participants worked for a new employer at plan closure in 2025, just below the prior 10-year average of 17%.
- During the 2023 through 2025 closure years, 80% of the workers returned to a job with a wage at least 95% of their pre-injury wage (Figure 4.16).
- For vocational rehabilitation participants who returned to work at a different employer in closure-year 2025, the average ratio of the return-to-work wage to the pre-injury wage was 91%, an increase from 76% in 2009 (Figure 4.17). For workers returning to the same employer, the average ratio was 99%.

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 indemnity and medical benefits. Vocational rehabilitation services are provided to injured workers who need help in returning to suitable gainful employment because of their injuries.³⁰

Vocational rehabilitation services include the following:

- rehabilitation eligibility consultation;
- medical management;
- coordination of return to work at the pre-injury job;
- job modification;
- job-seeking skills training;
- job development;
- job placement;
- transferable skills analysis;
- vocational testing;
- labor market survey;
- vocational counseling and guidance; and
- retraining and on-the-job training.

These services are delivered or facilitated by qualified rehabilitation consultants (QRCs) and registered placement vendors. These providers are registered with Department of Labor and Industry (DLI) and must follow professional conduct standards specified in Minnesota Rules. QRCs determine worker eligibility for vocational rehabilitation services, develop plans for those determined eligible and coordinate service delivery under those plans.

Ninety-six percent of QRCs work in private-sector vocational rehabilitation firms and may also provide services outside of workers' compensation. Some vocational rehabilitation firms also have job-placement staff members. DLI's Vocational Rehabilitation unit (VRU) provides services primarily to injured workers whose claims are involved in primary liability (causation) disputes and further liability disputes (when there is a dispute about claim closure); it may also provide services in non-contested cases.

Registered placement vendors are approved to provide job-development and job-placement services under an approved vocational rehabilitation plan. They 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. Placement vendors also contact prospective employers to identify jobs, arrange interviews, discuss employment incentives and conduct labor market surveys.

The vocational rehabilitation eligibility process typically begins when the insurer files a disability status report (DSR) to notify DLI it is referring the injured worker to a QRC for a consultation or requesting a waiver of services. The insurer is required to file the DSR within 14 days of becoming aware that temporary total disability is likely to exceed 13 weeks, 90 days after the injury if the employee has not returned to work or 14 days after

receiving a consultation request from the employee. Although the insurer typically refers the employee for a consultation via the DSR, the employee or employer may request a consultation and DLI can also order a consultation. A QRC in DLI's VRU may also provide a consultation if the insurer denies the employee's injury or condition is work-related and the employee has disputed the denial.

A QRC conducts a consultation with the employee to determine if the employee is eligible to receive services. A vocational rehabilitation plan is developed if the QRC determines the employee is qualified and would benefit from such services.

Vocational rehabilitation plan costs reported to DLI include charges for services by QRCs and vendors and direct costs of certain other services, such as vocational testing. Vocational rehabilitation plan costs also include the costs of planning and facilitating other services, such as functional capacity evaluations, technical or academic skills improvement, retraining and on-the-job training. The direct costs of these other services, such as tuition, have traditionally been paid directly by the insurer and not reported by QRCs as a plan cost to DLI.

Annual changes in hourly vocational rehabilitation service charges through 2012 were limited to the lesser of the percentage increase in the statewide average weekly wage (SAWW) or 2%. The 2013 workers' compensation law change increased the annual change in hourly charges to the lesser of the percentage increase in the SAWW or 3%, effective Oct. 1, 2013. The maximum hourly fee levels for QRCs and for job-development and job-placement service providers, effective Oct. 1, 2024, through Sept. 30, 2025, were \$126.19 and \$101.06, respectively.

The 2013 law change also defined job-development services and limited these services: to 20 hours a month for up to 13 weeks; to 26 weeks by agreement between the injured worker and employer; or by order of DLI or the Court of Administrative Hearings (CAH). This limit is effective for employees injured on or after Oct. 1, 2013. Neither DLI nor CAH can order more than 26 weeks of job-development services, although the insurer can agree to pay for additional weeks of service. Injured workers with earlier dates of injury have no limit on their job-development services.

Rule amendments effective Sept. 24, 2018, eliminated the \$10 an hour fee reduction for lengthy and costly vocational rehabilitation plans and adjusted the hourly rate to maintain cost neutrality. The rule change also increased the amount of professional time QRCs can work with injured workers to enhance the job search process to six hours a month. This includes in-person meetings with the worker and any placement vendor to determine job goals, review why the current job search has been unsuccessful and set strategies to overcome obstacles to employment.

Data sources and time period covered

The data in this chapter comes from vocational rehabilitation documents and Work Comp Campus data entries filed with DLI for claims with vocational rehabilitation activity. Injured workers may receive services from multiple vocational rehabilitation service providers (at different times), each of which may file vocational rehabilitation plans. The duration and cost of 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.

The trend statistics in this chapter reported by injury-year or plan-closure year are developed (projected) to a uniform maturity as described in Appendix C. The most recent injury-year estimates are for 2024. Vocational rehabilitation plan-closure years cover plan closures in the period from Oct. 1 through Sept. 30 of the indicated year. Among the claims in plan-closure year 2025, 44% had injuries in 2024 and 29% had injuries in 2023.

Eligibility

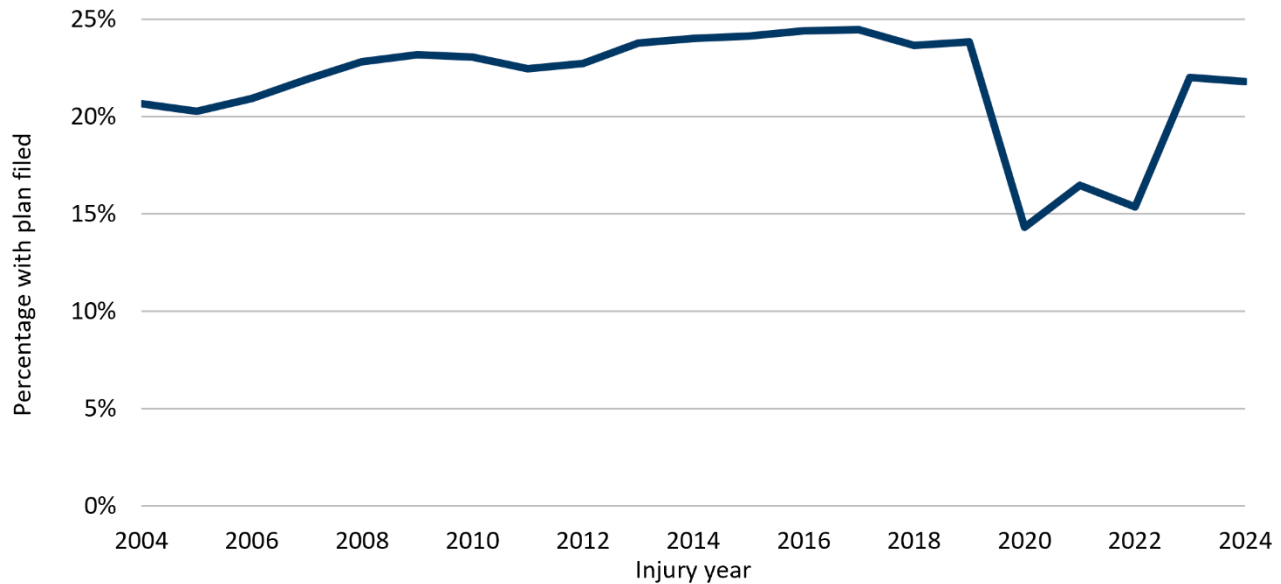
Vocational rehabilitation eligibility is determined at a vocational rehabilitation consultation between the injured worker and a QRC. Following the consultation, the QRC files a Rehabilitation Consultation Report, indicating whether the worker is eligible or not eligible for vocational rehabilitation services. The QRC can also indicate that the parties agree to provide vocational rehabilitation services regardless of the statutory eligibility of the injured worker.

- For workers with injuries in 2024 who had a vocational rehabilitation consultation, 84% were found eligible for services, 11% were given eligibility by agreement of the parties and 2% were determined not to be eligible. These percentages were largely unchanged from the results for workers injured in 2023.

Participation

Vocational rehabilitation participation is measured by the utilization rate, which is the percentage of estimated number of workers with indemnity claims for injuries during a calendar year who had (or will have) a vocational rehabilitation plan filed. The utilization rate is a developed statistic, meaning estimates are made for recent years based on the utilization pattern of previous years. The utilization rate remained between 20% and 25% from 2004 to 2019 and dropped below 20% from 2020 through 2022, while increasing to 22% beginning in 2023 (Figure 4.1).

- A projected 4,435 of the estimated 20,345 workers with indemnity claims for injury-year 2024 are expected to receive vocational rehabilitation services, 22% of the claims, similar to the previous year, and seven percentage points higher than the 2022 rate, when 15% of the 31,567 workers with indemnity claims are estimated to have received vocational rehabilitation services. The primary factor driving the decline in the vocational rehabilitation participation rates from 2020 to 2022 was the influx of COVID-19 claims beginning in 2020. The participation rate dropped during this period because of the short duration of COVID-19 indemnity claims, most of which had a disability duration of two weeks or fewer. Few of these workers required vocational rehabilitation services to return to work. Workers with COVID-19 indemnity claims accounted for 2% of estimated indemnity claims in 2024, but none of the 2024 claims with vocational rehabilitation services were COVID-19 claims.

Figure 4.1 Percentage of indemnity claims with a vocational rehabilitation plan filed

Injury year	Percentage with plan
2004	20.7%
2011	24.5
2020	14.3
2021	16.5
2022	15.3
2023	22.0
2024	21.8

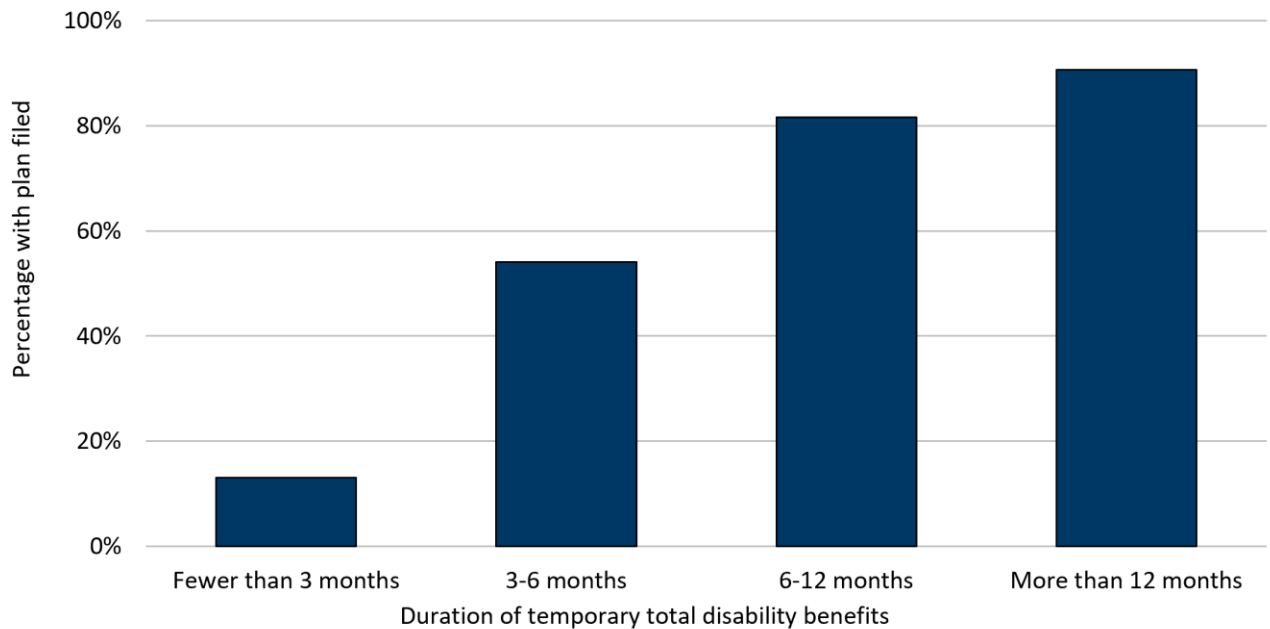
Source: Developed statistics from DLI Campus database (see Appendix C).

Participation and injury severity

The vocational rehabilitation participation rate increased with the amount of time injured workers have been away from work and by the worker's degree of permanent partial disability (PPD). Some workers may receive a settlement instead of a PPD rating when the degree of impairment is in dispute. For workers with indemnity claims closed between October 2023 and September 2025, the following was found.

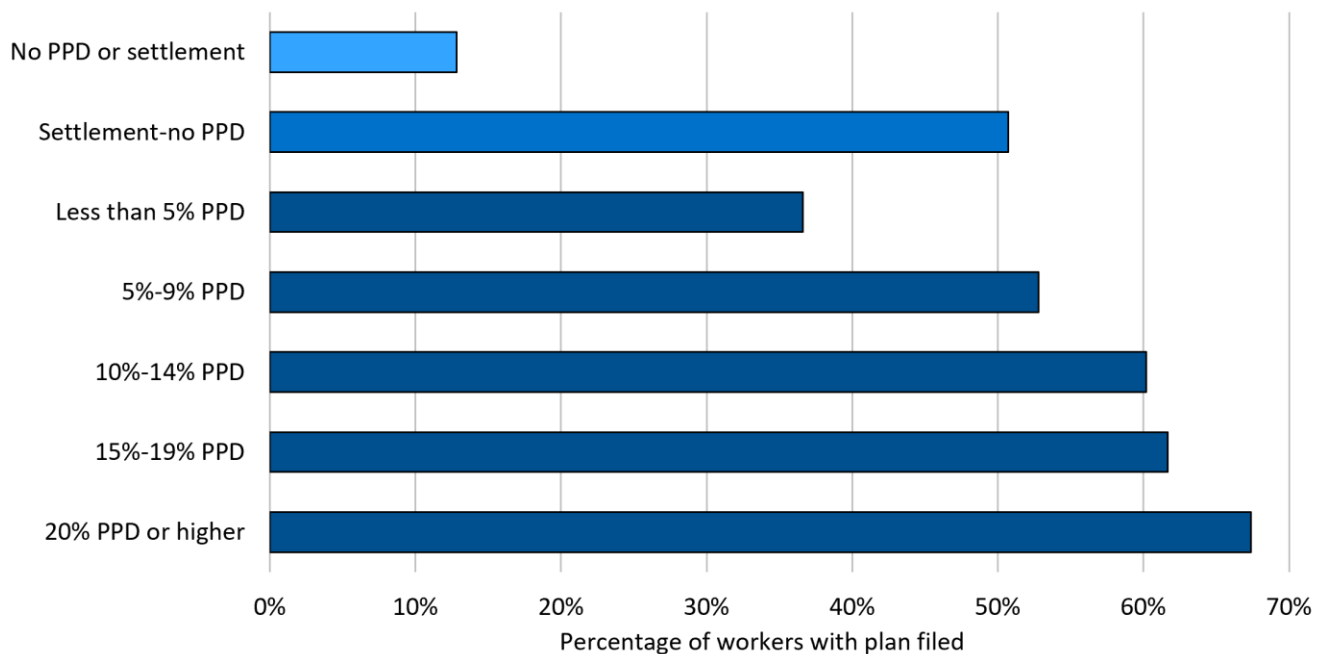
- The vocational rehabilitation participation rate went from a low of 13% for workers with three months or fewer of temporary total disability (TTD) benefits to a high of 91% for workers with more than 12 months of TTD benefits (Figure 4.2).
- Vocational rehabilitation participation ranged from 13% for workers without PPD benefits (and no settlement agreement) to 67% for workers with PPD ratings of 20% or more (Figure 4.3).³¹ Vocational rehabilitation participation was 51% for workers with a settlement and no PPD benefits.
- For workers with both a PPD rating and a settlement, the vocational rehabilitation participation rate was 67% (not shown in Figure 4.3).

Figure 4.2. Percentage of paid indemnity claims with a VR plan filed by TTD duration, claim-closure years 2023-2025 combined



Source: Data from DLI Campus database. Statistics by claim-closure year exclude injuries prior to 1998. Claim-closure years start in October and end in September of the indicated year.

Figure 4.3. Percentage of paid indemnity claims with a VR plan filed by permanent partial disability and settlement status, claim-closure years 2023-2025 combined



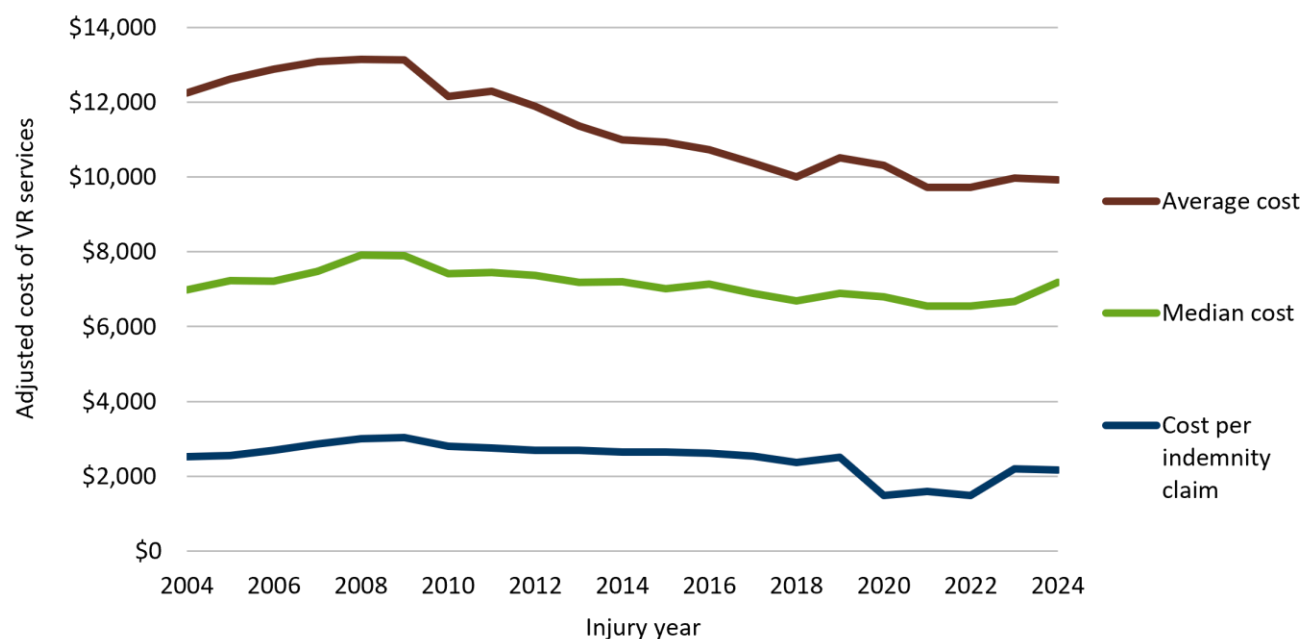
Source: Data from DLI Campus database. Claim-closure years start in October and end in September of the indicated year.

Cost of vocational rehabilitation services

Adjusted for wage growth, the average cost of vocational rehabilitation services peaked in 2008 but has fallen since then (Figure 4.4).³² These cost figures are estimates developed to 10 years of maturity.

- The adjusted average cost of \$9,930 for 2024 was similar to the 2023 adjusted average cost and 24% below the adjusted average cost peak of \$13,150 in 2008. The average cost had been steadily decreasing since that peak, although it has remained stable since 2021 with minor fluctuations.
- The adjusted median cost of \$7,180 for 2024 was 8% higher than the 2023 adjusted median cost and 9% below the median peak of \$7,910 in 2008.
- The average costs for recent years are about 50% higher than the median costs because a small percentage of injured workers have vocational rehabilitation services of more than \$30,000. This raises the average cost, while the median is more representative of typical claims with vocational rehabilitation services. Among plans closed between October 2023 and September 2025, 5% had adjusted costs higher than \$30,000.
- The total cost of vocational rehabilitation services for injury-year 2024 is estimated at \$44.1 million. This is a 9% decrease from the adjusted 2023 estimate of \$48.5 million. As shown in Figure 2.8, vocational rehabilitation accounts for an estimated 2.7% of total workers' compensation system cost for payment-year 2024.
- Estimated adjusted vocational rehabilitation service cost per indemnity claim (counting claims with and without plans) was \$2,170 for injury year 2024. This value is 14% below the value of \$2,500 in 2019. For injury years 2020-2023, cost per indemnity claim was affected by the large number of workers with COVID-19 indemnity claims who returned to work within two weeks of their illness date. COVID-19 has no impact on the 2024 cost per indemnity claim.

Figure 4.4. Vocational rehabilitation service costs, adjusted for wage growth



Injury year	Average cost	Median cost	Cost per indemnity claim
2004	\$12,250	\$ 6,980	\$ 2,530
2008	13,150	7,910	3,000
2019	10,520	6,890	2,500
2020	10,310	6,790	1,480
2021	9,730	6,550	1,600
2022	9,730	6,550	1,490
2023	9,970	6,670	2,190
2024	9,930	7,180	2,170

Source: Developed statistics from DLI Campus database. Costs are adjusted for average wage growth between the respective year and 2024.

Cost by service type

For plans closed in closure-year 2025 (October 2024 through September 2025), 93% of total vocational rehabilitation cost was for services provided by QRCs and QRC firms, and 7% was for services provided by placement vendor firms.

Figure 4.5 shows the average, median and total unadjusted costs for closure-year 2025 plans by service or expense type. Costs can be divided into consultation, plan services and administrative costs and expenses. Plan services include services by QRCs, QRC firms and placement vendors. The table shows unadjusted dollar values for the reported plan costs and service or expense types.

- Median costs are much lower than the average costs because a few plans with very high costs affect the mean value while the median is more representative of typical plan costs.
- Plan services by QRCs and placement vendors accounted for 60% of total plan costs. The medical management services subgroup accounted for 70% of the plan service costs. This subgroup includes medical management, functional capacity evaluation and work hardening or adjustment.
- The placement subgroup, which includes job-seeking skills training, job development, job placement and job placement follow-up, accounted for 16% of plan services in 2025, similar to the previous year. Only 25% of the plans included placement subgroup services.

Figure 4.5. Vocational rehabilitation cost by service or expense type group, plan-closure year 2025

Service/expense type	Average	Median	Sum	Percentage of total costs
Consultation	\$ 910	\$ 790	\$ 3,724,000	8%
Plan services	6,510	3,870	26,627,620	60%
Administrative, legal and expenses	3,340	2,170	13,691,960	31%
Total plan costs	10,750	7,140	44,044,050	100%

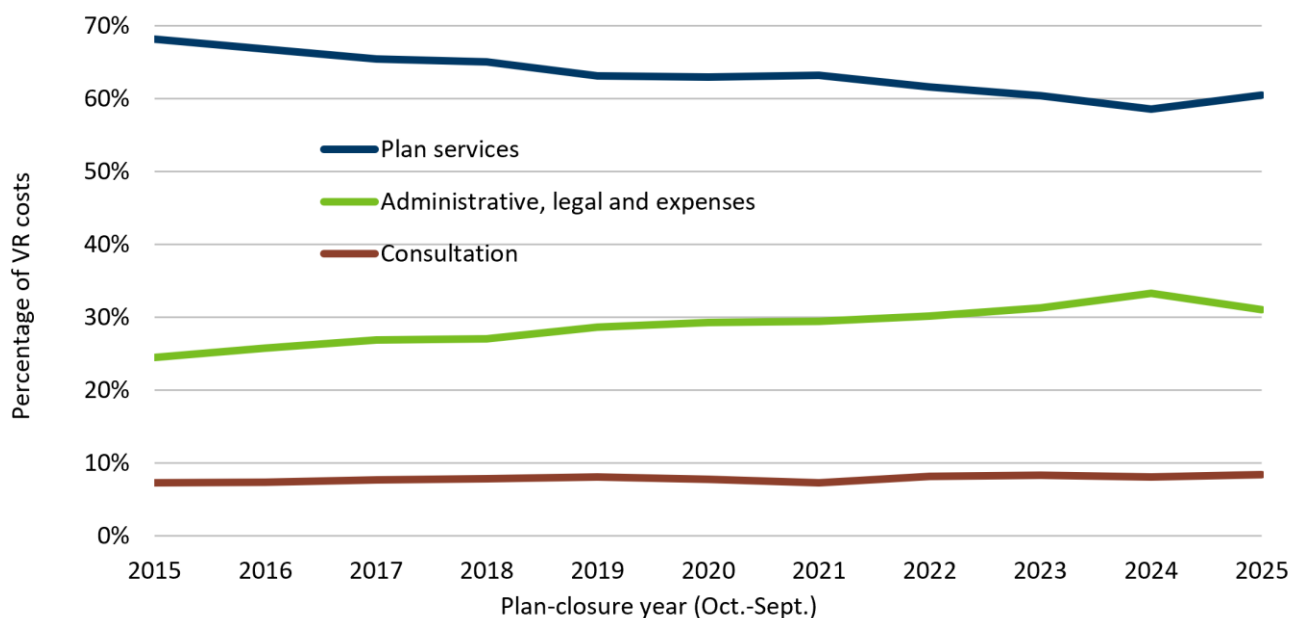
Source: Data from DLI Campus database.

- As a percentage of total cost for vocational rehabilitation services, plan services decreased by 8 percentage points between closure-years 2015 and 2025 (Figure 4.6).
- Administrative costs and expenses, which include administrative costs, legal expenses – such as preparation for and attendance at conferences and hearings – and other expenses, increased by 6

percentage points during the period mentioned above, while consultation costs have remained nearly constant. As shown in Figure 4.6, these changes have been gradual over the entire period.

- Within these cost groups, some subgroups have different trends. Costs for the medical management subgroup increased from 55% of plan services in closure-year 2015 to 70% in closure-year 2025. During this period, placement subgroup service costs decreased from 27% to 16% of all plan services.
 - This placement service cost decrease was driven mainly by decreased use of placement services, from 36% of 2015 plan closures to 25% of 2025 closures. The decreased placement use was most pronounced among plans closed by settlement, which saw placement services decrease from 47% of the 2015 closures to 28% of the 2025 closures.

Figure 4.6. Percentage of vocational rehabilitation costs by expense type group



Source: Data from DLI Campus database.

Cost and injury severity

Vocational rehabilitation plan costs increased with injury severity as measured by PPD rating, reflecting increases in service contact hours and differences in the types of services provided.

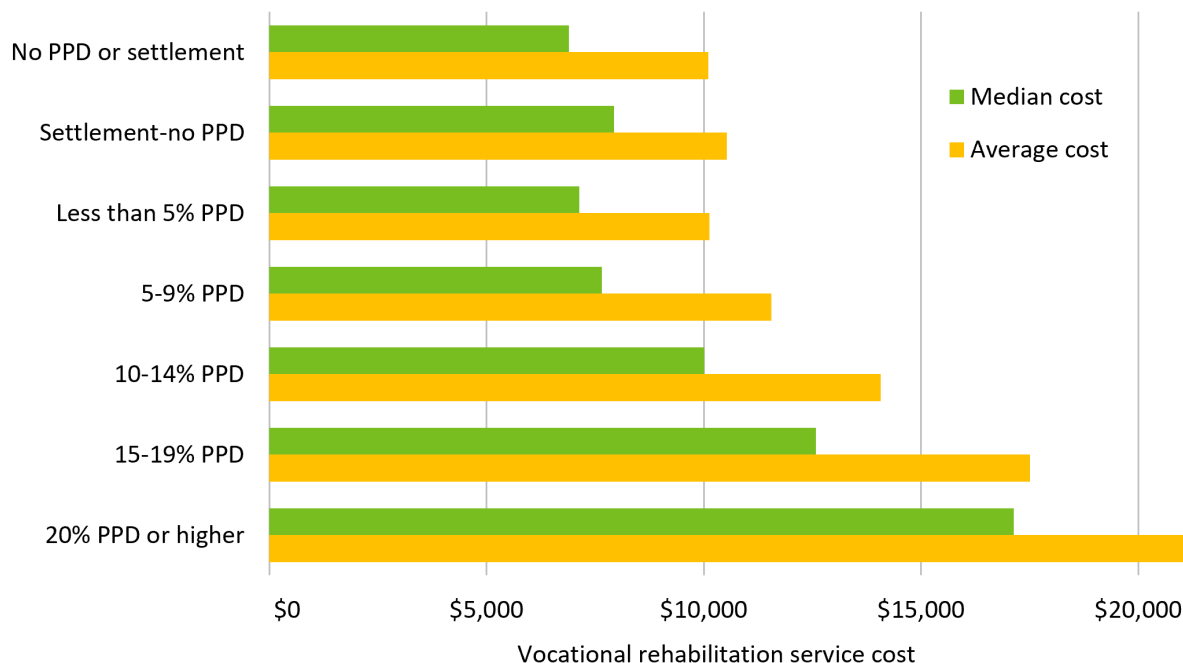
- For plan-closure years 2023 to 2025, vocational rehabilitation costs increased for workers with higher PPD ratings (Figure 4.7). For workers with PPD ratings of 20% or more, the median cost of vocational rehabilitation services was more than double the cost for workers with PPD ratings of 5% or less.
- For workers with a settlement but no reported PPD payments, the median vocational rehabilitation plan cost was similar to the median plan cost for workers with PPD ratings of 5% to 9%.

Timing of services

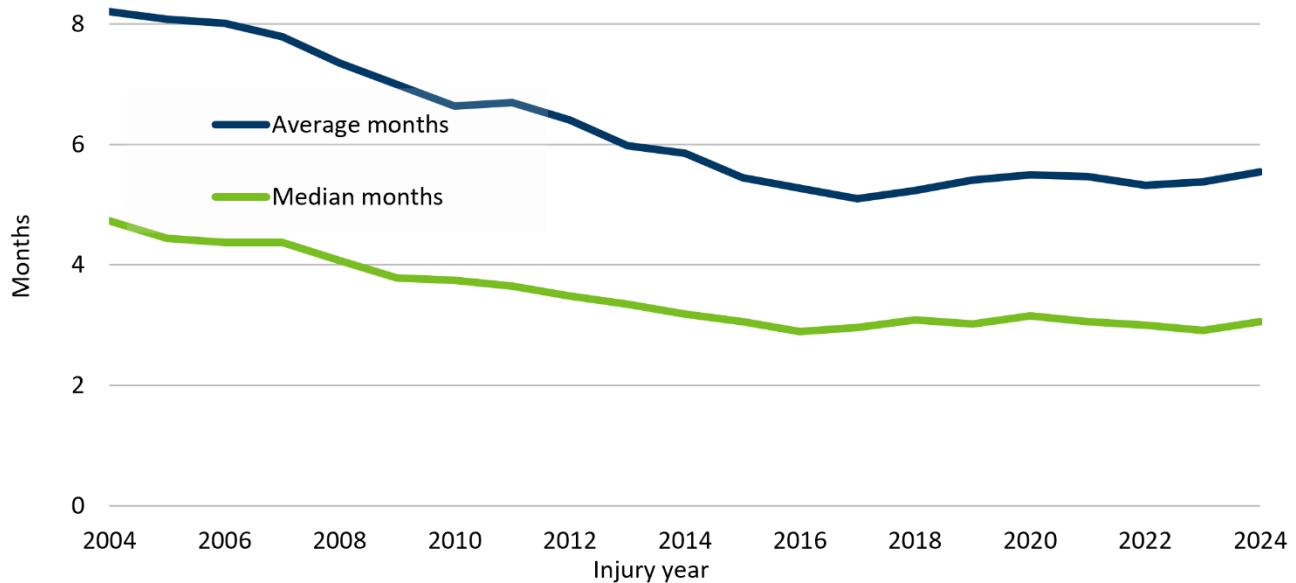
Prompt service provision is closely linked to successful vocational rehabilitation outcomes. The average time from injury to the start of vocational rehabilitation services has decreased by nearly three months since 2004. The rehabilitation consultation is considered the start of vocational rehabilitation services for this measure.

- The estimated average time from the date of injury to the start of vocational rehabilitation services was 5.5 months for injury-year 2024, similar to the 2020 average and down 32% from 2004 (Figure 4.8). The estimated median time from the injury to the start of services was 3.1 months for 2024, indicating that half of the workers provided vocational rehabilitation received consultations within approximately 90 days of the start of their work disability.
- Among plans closed in closure-year 2025, 45% of plans started services within three months of injury and 69% started within six months.
- Among vocational rehabilitation participants with plans closed in 2025, those who began services within three months of injury, as compared to those starting more than a year after their injury, had:
 - 21% shorter median service durations (8.4 months versus 10.7 months); and better chances of returning to work at plan closure (58% versus 55%).

Figure 4.7. Vocational rehabilitation service cost by PPD rating and settlement status, plan-closure years 2023-2025 combined



Source: Data from DLI Campus database. Costs are not adjusted for average wage growth. Plan-closure years start in October and end in September of the indicated year. The upper range of each category extends to all values up to the next category's start value.

Figure 4.8. Months from injury to start of vocational rehabilitation services

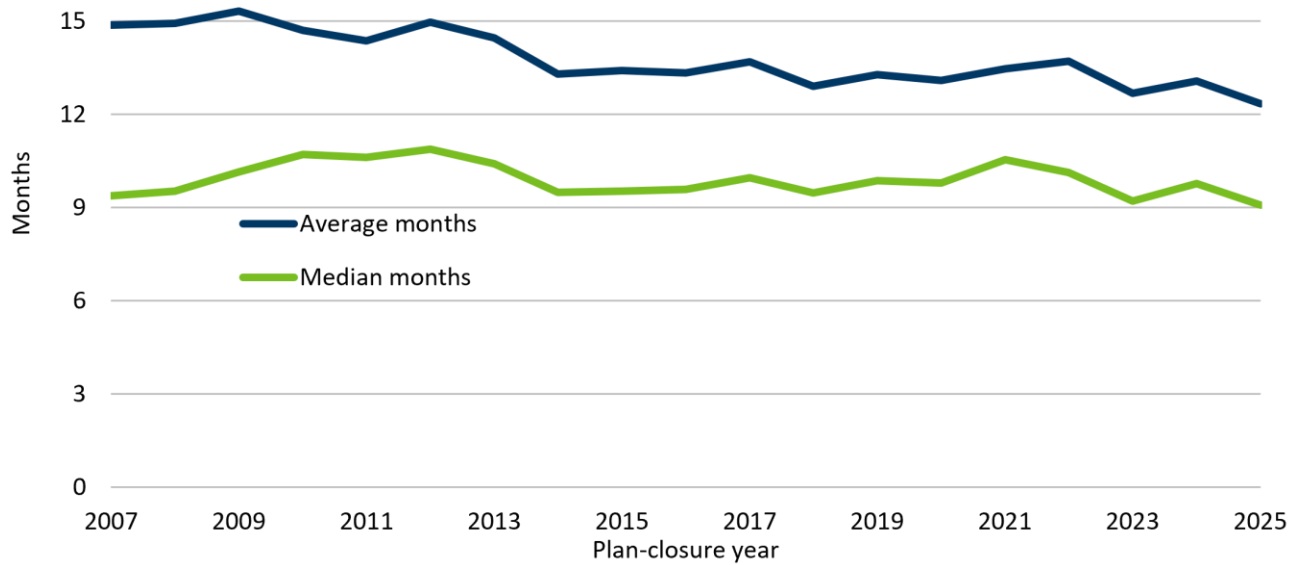
Injury year	Average months	Median months
2004	8.2	4.7
2020	5.5	3.2
2023	5.4	2.9
2024	5.5	3.1

Source: Developed statistics from DLI Campus database (see Appendix C).

Service duration

Average vocational rehabilitation service duration for plans closed in 2025 — measured by the time between the initial consultation and plan closure — has dropped by almost a month and a half since closure-year 2022 and by two and a half months since 2012.

- The estimated average service decreased from 15.3 months in 2009 to 12.3 months in 2025 (Figure 4.9). This is the shortest average duration during the 2013 through 2025 period. The estimated median service duration of 9.1 months for closure-year 2025 is the shortest median duration during the period included in figure 4.9.
- Among plans closed in 2025, median service duration was: 7.2 months for workers who returned to work with their pre-injury employer, an 11% increase from 2024; 12 months for workers who went to a different employer, a 7% increase from 2024; and 11.5 months for workers whose plans closed without a reported return to work, a 9% decrease from 2024.

Figure 4.9. Vocational rehabilitation service duration

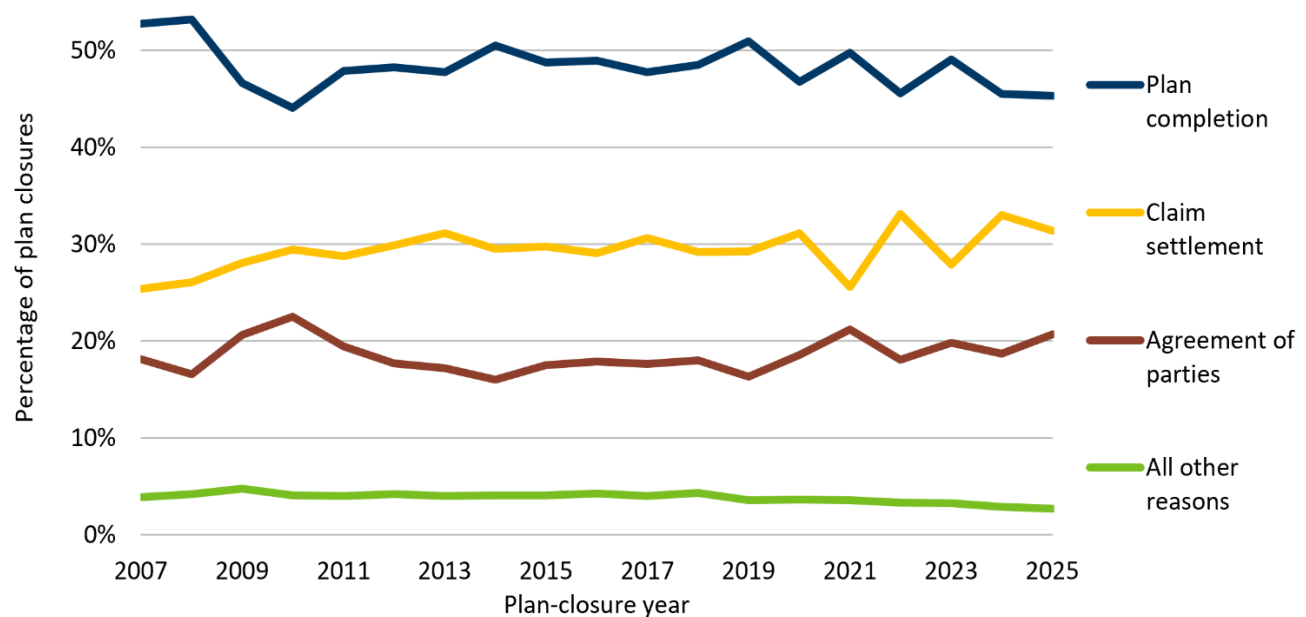
Plan-closure year	Average months	Median months
2007	14.9	9.4
2012	15.0	10.9
2023	12.7	9.2
2024	13.1	9.8
2025	12.3	9.1

Source: Developed statistics from DLI Campus database. Plan-closure years start in October and end in September of the indicated year. See Appendix C.

Reason for plan closure

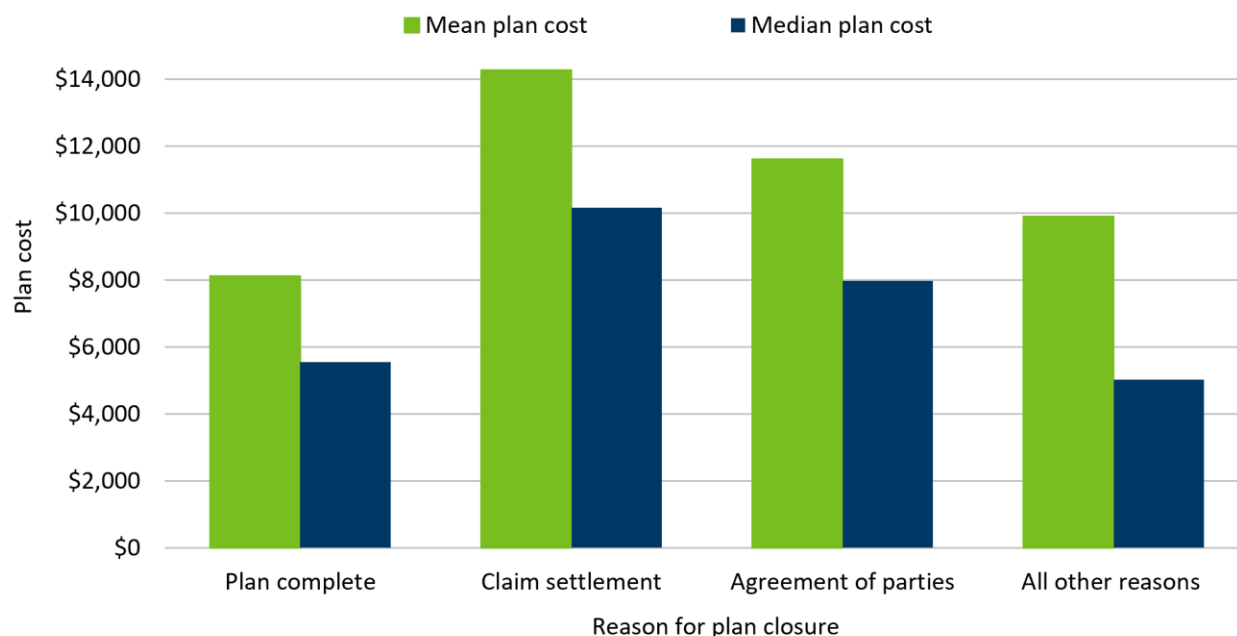
While the trends for plan-closure reasons have stabilized since closure-year 2011, estimated results for completions in 2020 and later have been fluctuating from year to year.

- The proportion of plans closed with completion of services remained between 45% and 51% from 2019 to 2025, while the proportion of plans closed by settlement varied between 26% and 33% (Figure 4.10).
- The proportion of plans closed by agreement of the parties moved opposite to the trend in settlements from 2020 to 2025.
- A return to work was reported for 98% of workers with completed plans and for 23% of workers whose plans closed for any other reason.

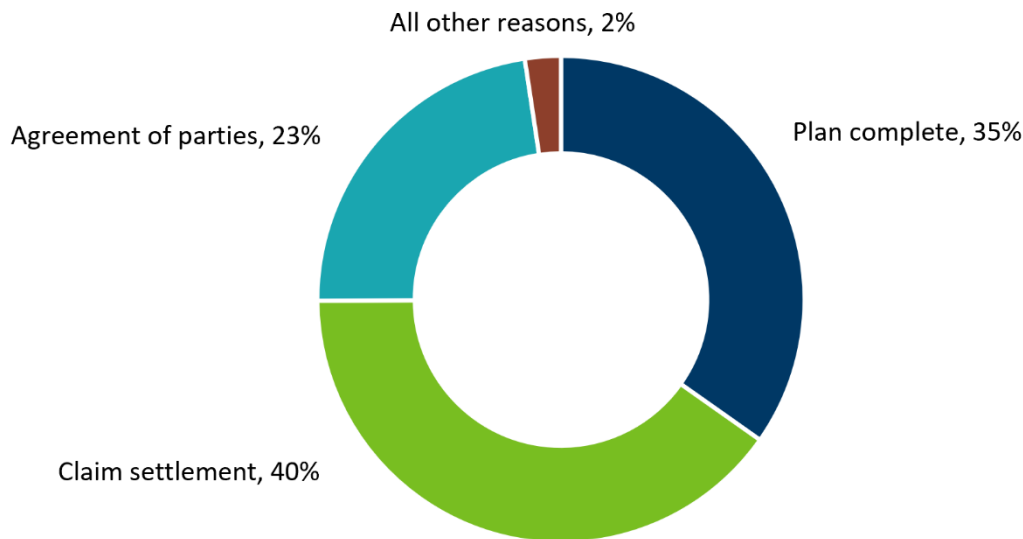
Figure 4.10. Reason for plan closure

Source: Developed statistics from DLI Campus database. Plan-closure years start in October and end in September of the indicated year. "All other reasons" includes closures due to decision-and-orders and, starting with forms filed after July 2005, closures due to the inability to locate the employee, death of the employee or QRC withdrawal.

- Plan costs vary by reason for closure (Figure 4.11). For 2025 closures, the highest median plan costs were for plans closed with a settlement (\$10,150) and the lowest were plans closed for other reasons (\$5,035). Closures by plan completion had second lowest median plan cost (\$5,543).
- The distribution of total plan costs by reason for plan closure shows that plans closing because of claim settlement accounted for 40% of the total cost for plans closed in 2025 plan-closure year (Figure 4.12). Plans closing with a plan completion accounted for 35% of total plan cost.

Figure 4.11. Plan cost by reason for plan closure, plan-closure year 2025

Source: Data from DLI Campus database. Plan costs are not adjusted for average wage growth. Plan-closure year 2025 started Oct. 1, 2024, and ended Sept. 30, 2025.

Figure 4.12. Distribution of total plan cost by reason for plan closure, plan-closure year 2025

Source: Data from DLI Campus database. Plan costs were not adjusted. Plan-closure year 2025 started Oct. 1, 2024, and ended Sept. 30, 2025.

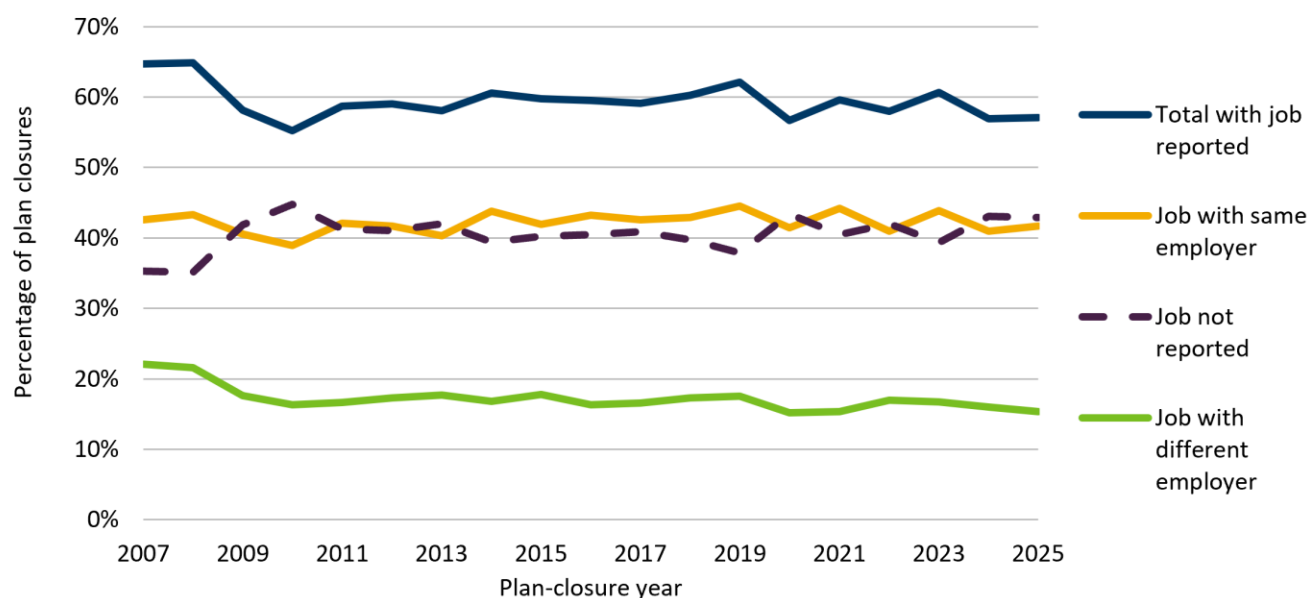
Return-to-work status

The goal of vocational rehabilitation is to return injured workers to a job related to the employee's former employment or to a job in another work area that produces an economic status as close as possible to what the employee would have enjoyed without disability. Returning to work is affected by many factors, including

vocational rehabilitation services, job availability with the pre-injury employer, the job market, injury severity, worker job skills and education, availability of job modifications and claim litigation.

- The estimated percentage of vocational rehabilitation participants with a job at plan closure in 2025 was slightly higher than in 2024 and two percentage points lower than 2023. This decrease was primarily driven by a decline in participants returning to the same employer and a slight decrease in those returning to a different employer (Figure 4.13).
- For plan closures in 2025, the median cost of vocational rehabilitation services for participants returning to work with their pre-injury employer (\$5,383) was 57% of the vocational rehabilitation cost of workers going to a different employer (\$9,434) and 64% of the cost for workers not returning to work at plan closure (\$8,461).

Figure 4.13. Return-to-work status



Plan-closure year	Job with same employer	Job with different employer	Total with job reported	Job not reported
2007	42.6%	22.1%	64.7%	35.3%
2012	41.7	17.3	59.0	41.0
2023	43.9	16.8	60.6	39.4
2024	41.0	16.0	56.9	43.1
2025	41.7	15.4	57.1	42.9

Source: Developed statistics from DLI Campus database. Plan-closure years start in October and end in September of the indicated year.

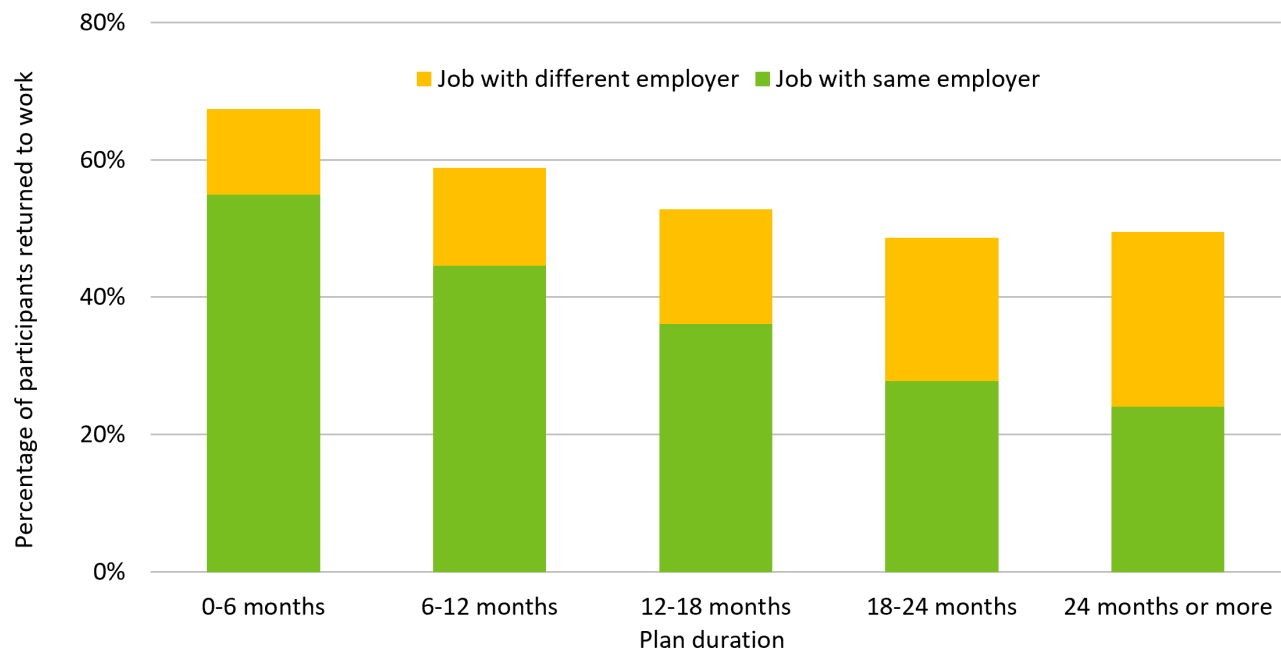
Return-to-work status and plan duration

The percentage of vocational rehabilitation participants with a reported return to work decreases with plan duration (Figure 4.14).

- For plan closures in 2023 to 2025 combined, the percentage of workers with a reported return to work ranged from 67% for plans lasting no more than six months to 50% for plans lasting 24 months or longer.
- The percentage of workers returning to their pre-injury employer was 55% for the shortest plans and 24% for the longest plans.

- The percentage of workers finding a job with a different employer was 13% for the shortest plans and 26% for the longest plans.

Figure 4.14. Return-to-work status by plan duration, plan-closure years 2023-2025 combined



Source: Data from DLI Campus database. Plan-closure years start in October and end in September of the indicated year.

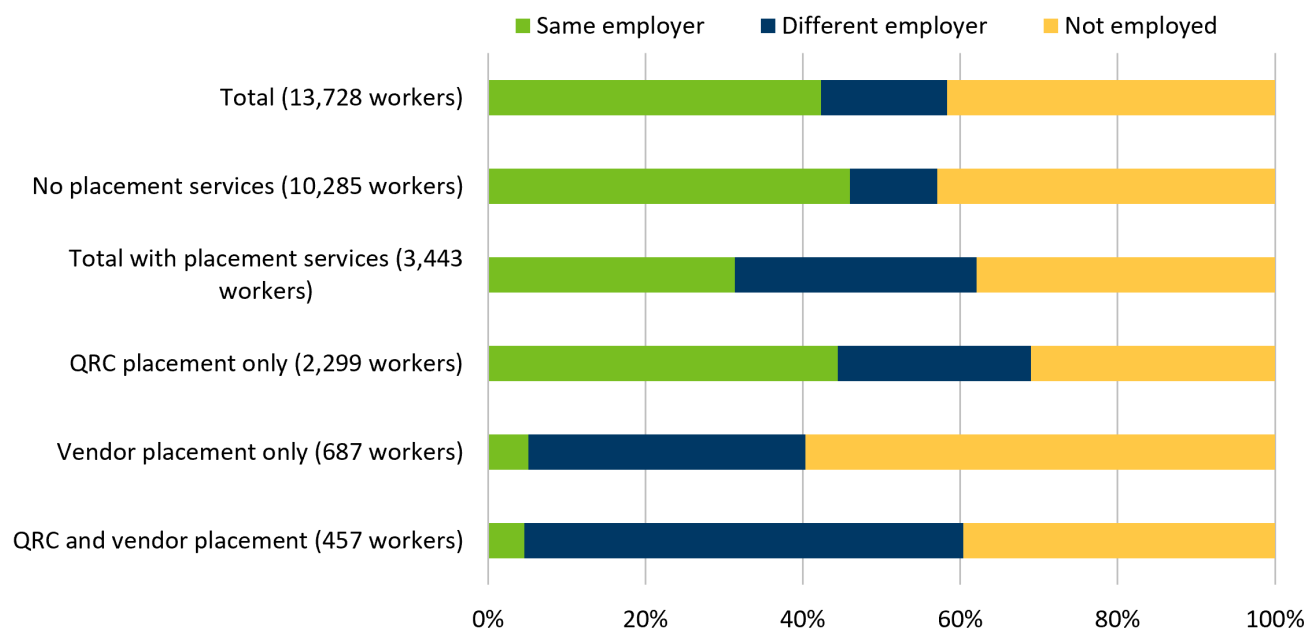
Return-to-work status and placement services

The placement services subgroup includes job-seeking skills training, job development, job placement and job placement follow-up. QRCs provide these services to help injured workers return to their pre-injury employer and QRC firm job placement staff members and placement vendors provide these services to help injured workers find work with a different employer. Twenty-five percent of the workers with plans closed between October 2023 and September 2025 received services in the placement subgroup.

Figure 4.15 shows 31% of the workers receiving placement services returned to work with a different employer, compared with 11% among workers not receiving job placement services. Among the workers with placement services, 31% returned to work with their pre-injury employer. However, there are noticeable differences in the return-to-work outcomes among the different placement service providers.

- As expected, more workers receiving placement services only from QRC firms returned to the pre-injury employer than to a new employer. In contrast, less than 10% of the workers receiving placement services from vendors returned to their pre-injury employer.
- While 35% of the workers receiving placement services only from vendors found employment with a different employer, 60% of the workers were not employed at plan closure. This was primarily due to the closure of 82% of these plans by settlement or agreement.
- Workers receiving placement services from both QRC firms and placement vendors had the highest rate of placement with a new employer, 56%.

Figure 4.15. Return-to-work outcomes by placement services provider type, plan-closure years 2023-2025 combined



Source: Data from DLI Campus database. Plan-closure years start in October and end in September of the indicated year.

Return-to-work wages

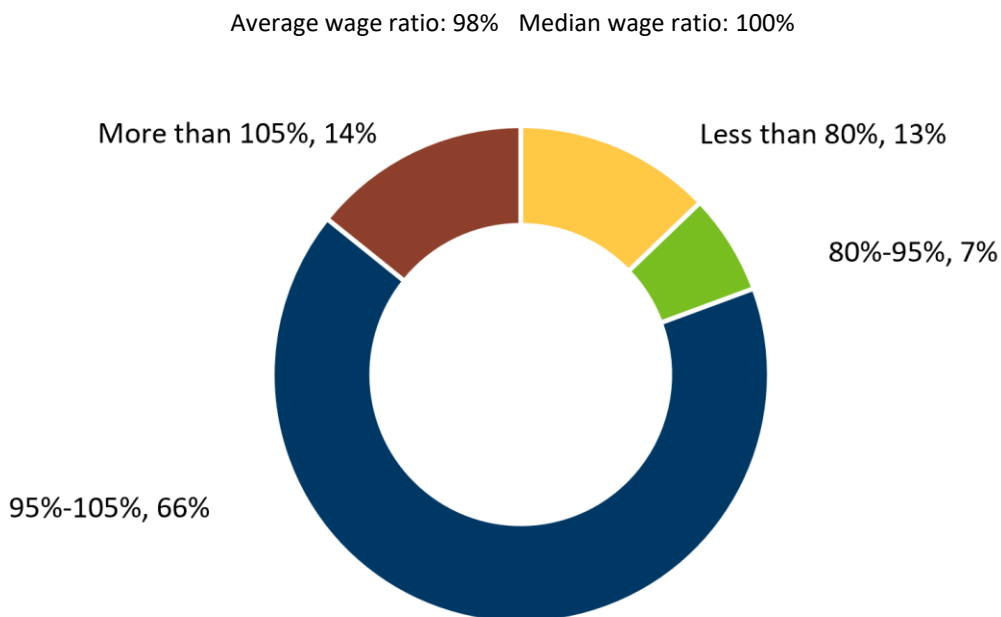
Distribution

For vocational rehabilitation participants returning to work, the return-to-work wage, on average, is nearly the same as the pre-injury wage, but this varies widely (Figure 4.16).

- Among workers returning to work with plans closed in 2023 to 2025, their median pre-injury wage was \$1,045 and their median return-to-work wage was \$995.
- For plan closures in 2023 to 2025, 80% of participants returning to work earned more than 95% of their pre-injury wage, but 13% earned less than 80% of their pre-injury wage.
- Return-to-work wage recovery was related to injury severity as measured by PPD rating. For plan closures in closure-years 2023 to 2025, workers without a PPD payment or a settlement agreement³³ had an average wage ratio of 99% of their pre-injury wage, while workers with PPD ratings of 15% or higher who returned to work had an average wage ratio of 92%.
- Average return-to-work wage rates also vary with plan duration. For 2023 to 2025 closures, the average return-to-work wage ratio was 99% for vocational rehabilitation plans with durations of 18 months or less, and 94% for plans between 18 and 24 months.
- The percentage of workers returning to wages of less than 80% of their pre-injury wage was also dependent on workers' pre-injury wage. For 2023 to 2025 closures, only 1.4% of the workers earning \$400 or less reported return-to-work wages of less than 80% and the percentage increased to 31% among workers earning more than \$1,500 weekly.

- Conversely, the percentage of workers returning to wages of 105% or higher of their pre-injury wage was also dependent on workers' pre-injury wage. For 2023 to 2025 closures, only 6% of the workers earning more than \$1,500 weekly reported return-to-work wages of at least 105% of their pre-injury wage and the percentage increased to 20% among workers earning \$500 weekly or less.

Figure 4.16. Ratio of return-to-work wage to pre-injury wage for participants returning to work, plan-closure years 2023-2025 combined



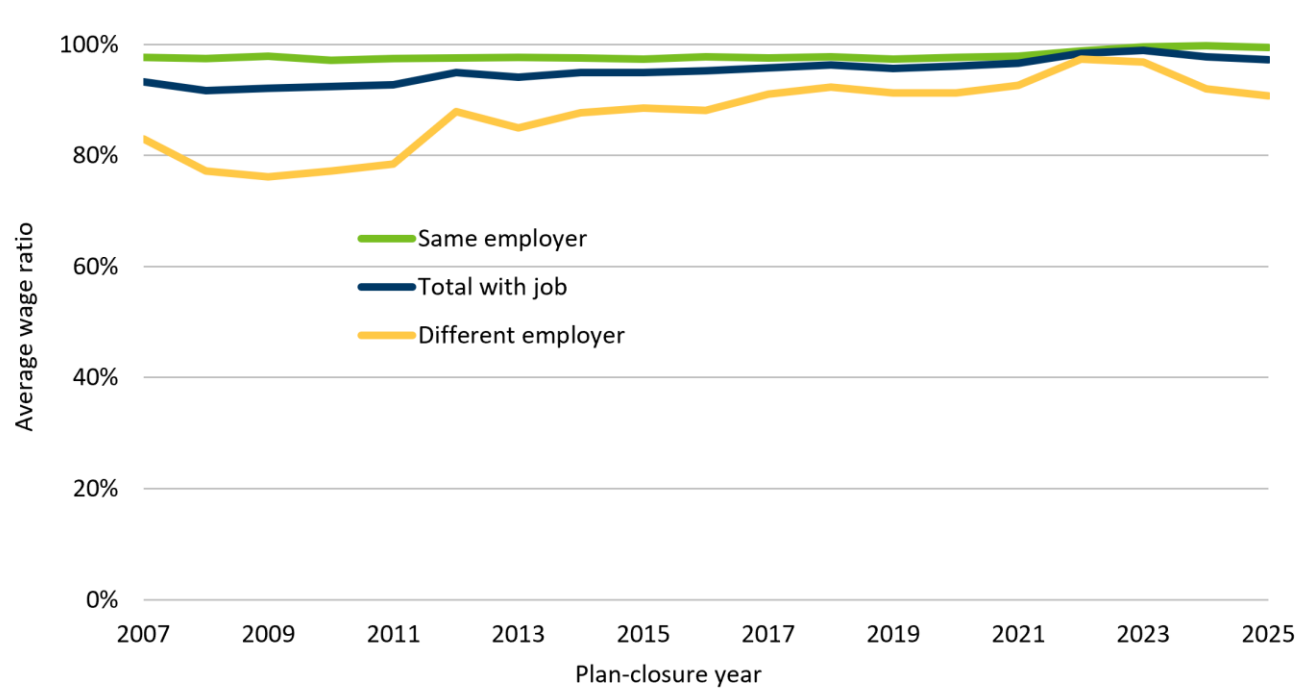
Source: Data from DLI Campus database. Plan-closure years start in October and end in September of the indicated year.

Return-to-work wages: Trend

Among vocational rehabilitation participants returning to work at plan completion, the ratio of the return-to-work wage to the pre-injury wage changed little between 2007 and 2025 for those returning to their pre-injury employer (Figure 4.17). For workers going to a different employer, the ratio declined in 2008 and 2009, but recovered in later years to nearly the same ratio as workers returning to the same employer.

- For workers returning to their pre-injury employer, the average wage ratio was between 97% and 100% from 2007 to 2025.
- For workers going to a different employer, the wage ratio was 90% for closures in 2025; this was 15 percentage points higher than the low point of 76% reached in 2009, 1% lower than in 2024 and 6% lower than in 2023.
- The decline in the wage ratio for workers returning to work beginning in closure-years 2023 and later may reflect less demand for workers following the post-pandemic period of unusually tight labor market dynamics.³⁴

Figure 4.17. Average ratio of return-to-work wage to pre-injury wage by employer type



Plan-closure year	Same employer	Different employer	Total with job
2007	97.6%	83.0%	93.3%
2010	97.2	77.2	92.4
2022	98.8	97.4	98.4
2024	99.7	92.0	97.7
2025	99.4	90.7	97.2

Source: Developed statistics from DLI Campus database. Plan-closure years start in October and end in September of the indicated year. See Appendix C.



Part 5: Dispute resolution

This part of the report presents statistics about dispute filings for all claims and for dispute-resolution activities at the Department of Labor and Industry (DLI).

Some statistics in this part are by year of injury, these are usually “developed” statistics. Statistics about dispute-resolution filings and timelines are displayed by the year the dispute was filed. Some statistics are by the year an action occurred and are presented through 2025.

Major findings

- DLI received 7,238 dispute filings in 2025 among the four major dispute types – claim petitions, discontinuance disputes, and medical and rehabilitation requests for assistance. This was about 1,000 fewer disputes than in 2024.
- The denial rate for non-COVID-19 claims with 2024 injuries was 17.4%, which is slightly higher than the 17.0 rate in 2023 (Figure 5.4).
- Due largely to resolutions of disputes reached through DLI’s Alternative Dispute Resolution (ADR) outreach, between 2005 and 2025, the proportion of disputes certified by DLI’s ADR staff members dropped from 60% to 51% for medical disputes and from 52% to 40% for vocational rehabilitation disputes (Figure 5.5). A majority of noncertifications for medical and rehabilitation disputes occurred because the issues were resolved (Figures 5.6 and 5.7).
- In 2025, 86% of scheduled mediations were completed, while 24% of scheduled medical conferences and 25% of scheduled rehabilitation conferences were completed (Figure 5.12).
- For medical and rehabilitation requests for assistance received in 2025, the median days from the request to the first scheduled DLI conference date were 71 and 32 days, respectively. The time interval for medical requests for assistance has been increasing since 2013, with some fluctuations. The interval for rehabilitation requests for assistance was close to the intervals for recent years, reflecting DLI’s response to the 2013 law change requiring that most rehabilitation conferences be scheduled within 21 days of the request (Figure 5.10). When a rehabilitation conference is scheduled past the 21st day, it is typically to accommodate the schedules of the participating attorneys.

Background

The following basic information is necessary for understanding the figures in this part. 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 handled by DLI and the Court of Administrative Hearings (CAH) in the following ways.

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 CAH. Some medical and vocational rehabilitation disputes are also filed on claim petitions.

Discontinuance disputes: Disputes about the discontinuance of wage-loss benefits are most often initiated when the worker 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 *Employee's Objection to Discontinuance* form or the insurer's petition to discontinue benefits, either of which leads to a hearing at CAH.

Medical request for assistance disputes: These disputes are usually filed on a request for assistance form, which triggers an administrative conference at DLI or CAH if DLI certifies the dispute.

Rehabilitation request for assistance disputes: These disputes are usually filed on a request for assistance form, which leads to an administrative conference at DLI (or in some circumstances CAH) if DLI certifies the dispute.

Disputes also occur about 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 activities and proceedings

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 compensation judge at CAH. Administrative decisions from DLI or CAH can be appealed by requesting a *de novo* hearing at CAH; decisions from a CAH hearing can be appealed to the Workers' Compensation Court of Appeals and then to the Minnesota Supreme Court.

Dispute resolution at DLI

DLI carries out a variety of dispute-resolution activities.

Informal intervention: Through informal communication efforts, DLI provides information and assistance to the claim parties and helps them to attempt to resolve potential and actual disputes at an early stage and to determine whether a dispute should be certified (see below). Informal intervention is often initiated when a party, usually a worker, 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 DLI efforts may occur before, during or after the dispute-certification process.

Dispute certification: In a medical or vocational rehabilitation dispute, DLI must certify a dispute exists and informal intervention did not resolve the dispute before an attorney may charge for services.³⁵ The certification process is triggered by either a certification request or request for assistance (medical or rehabilitation). 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 about the issues. Any type of dispute is eligible. A DLI mediation agreement is usually incorporated into a stipulation for settlement and submitted to CAH for approval via an award on stipulation; occasionally, the mediation agreement is recorded in a mediation award issued by DLI.

Administrative conference: DLI conducts administrative conferences about medical or vocational rehabilitation issues presented on request for assistance form unless it has referred the issues to CAH or the issues have otherwise been resolved. DLI refers medical disputes other than those about fee levels to CAH if they involve more than \$7,500 at the time of dispute filing and it may refer medical or vocational rehabilitation disputes for other reasons.³⁶ The DLI specialist usually attempts to bring the parties to agreement during the conference. If agreement is reached, the specialist issues an order on agreement. If agreement is not reached, the specialist issues a decision and order. A party may appeal a DLI decision-and-order or order on agreement by requesting a *de novo* hearing at CAH.

Dispute resolution at CAH

CAH also carries out a variety of dispute-resolution activities.

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

Settlement conference: CAH 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 reviewed by a CAH judge; it may be incorporated into a mediation award or award on stipulation, usually the latter.

Administrative conference: With some exceptions, CAH conducts administrative conferences about 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). CAH also conducts administrative conferences when requested by the worker in a dispute about discontinuance of wage-loss benefits.³⁷ If agreement is not reached at the conference, the CAH judge issues a decision-and-order. A party may appeal a CAH decision-and-order by requesting a *de novo* formal hearing at CAH.

Formal hearing: CAH conducts formal hearings about disputes presented on claim petitions and other petitions where resolution through a settlement conference is not possible. CAH also conducts hearings about other issues, such as: medical request disputes involving 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. CAH also conducts *de novo* hearings when a party files a request for hearing to appeal an administrative conference decision-and-order from DLI or CAH. 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 CAH, although this is often spurred by DLI or CAH initiatives, such as outreach to the parties and the scheduling of litigation 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. Disputes often

settle by means of a stipulation for settlement, which may be reached while the dispute is being litigated at DLI or CAH. If approved by a compensation judge, an award on stipulation is issued. An award on stipulation may occur in any type of dispute, but occurs most commonly in claim petition disputes.

Dispute resolution in the Union Construction Workers' Compensation Program

The 1995 workers' compensation law change authorized employers and employees, through collective bargaining agreements, to establish certain obligations and procedures relating to workers' compensation in their workplaces.³⁸ These obligations and procedures may include alternative dispute-resolution. If a collective bargaining agreement meets conditions in the law, the agreement must be recognized as valid and binding by DLI, CAH, the Workers' Compensation Court of Appeals (WCCA) and the Minnesota Supreme Court. The Union Construction Workers' Compensation Program (UCWCP) was created under this process and has been operating since 1997; it includes alternative dispute-resolution as one of its features.

The UCWCP aims to provide efficient and non-adversarial dispute resolution, quality medical and rehabilitative care, prompt payment of appropriate indemnity benefits³⁹, and prompt and safe return to union work, with the goal of minimizing losses for employers and employees.

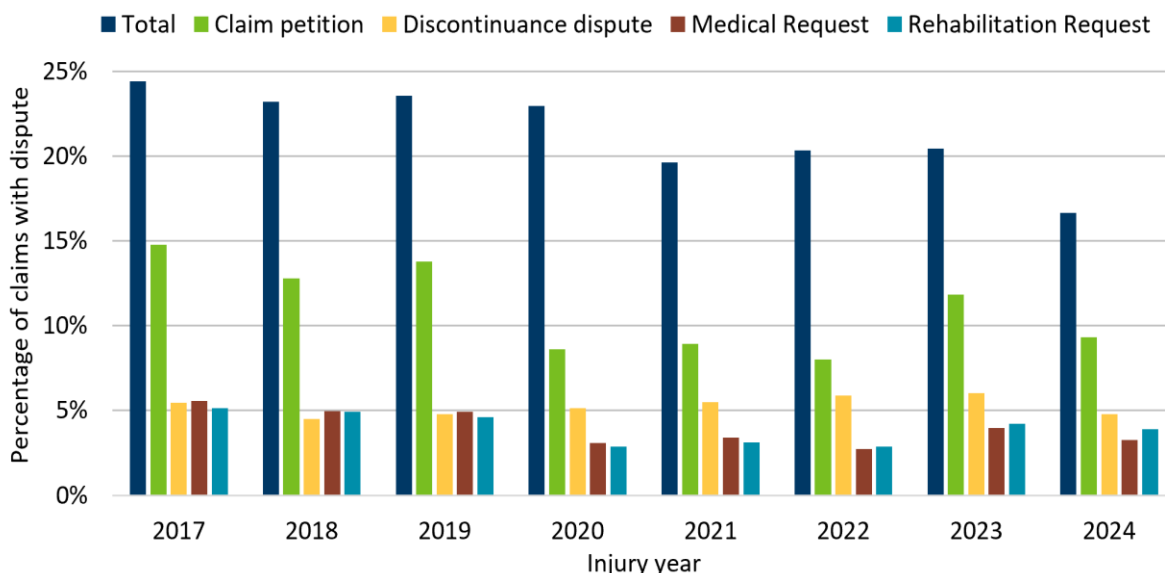
The UCWCP dispute-resolution process features four steps: intervention, facilitation, mediation and arbitration. An arbitrator's decision is binding but may be appealed to WCCA. Other features of UCWCP are an exclusive medical provider network, an exclusive rehabilitation consultant network and a neutral medical examiner panel. UCWCP provides an annual report to DLI concerning its dispute-resolution activities.

During calendar-year 2025, UCWCP resolved 59 intervention cases. Six disputes went to facilitation and all six reached full agreement. Among the 39 disputes using mediation, 34 reached full agreement and one reached partial agreement, while four did not reach agreement. None used arbitration.

Dispute filings and rates

While editions of this report published prior to 2022 have included developed estimates, a combination of factors create uncertainty about these values and estimates of ultimate dispute rates would be too unreliable to publish. At this time, it is uncertain how much of the changes in the reported measures are due to: changes in the dispute-resolution activity itself; variations in the number of filed claims; changes to how disputes are filed and recorded; or database changes at CAH and DLI and the communication between the database systems.

The undeveloped dispute rates (Figure 5.1) almost always show a decreasing trend because of decreasing claim maturity. Claim petitions accounted for between 57% to 66% of disputes since 2020. There were few disputes associated with COVID-19 claims from injury-years 2020 through 2023 (Figure 5.2).⁴⁰ This is because the average claim duration for COVID-19 claims was short (Figure 3.3), particularly relative to the time needed to schedule and hold conferences. Moreover, there was a significant decline in COVID-19 claims from 2022 to 2024 as infection rates declined.

Figure 5.1. Percentage of indemnity claims with filed disputes

Source: Data from DLI Campus database. Percentages are not developed to a constant maturity. Claim petitions are a percentage of all filed indemnity claims. All other disputes values are percentages of paid indemnity claims. Displayed values do not include COVID-19 claims.

Figure 5.2. Dispute filing by COVID-19 status

Injury year	Number of disputes		Dispute rate	
	COVID-19 claims	Non-COVID-19 claims	COVID-19 claims	Non-COVID-19 claims
2020	148	4,212	1.3%	22.9%
2021	57	4,557	0.8%	22.1%
2022	48	4,638	0.5%	22.4%
2023	4	4,312	0.4%	21.5%
2024	0	2,911	0.0%	16.1%

Source: Data from DLI Campus database. The number of disputes filed by Dec. 31, 2025, for workers injured in 2020 through 2024. Dispute rates are per indemnity claim.

Even without the ability to develop dispute activity, examination of dispute filings by filing year provides insights into dispute activity. The number of dispute filings for the four major types of disputes combined — claim petitions, discontinuance disputes, medical requests and rehabilitation requests — decreased by 11% from 2019 to 2025.

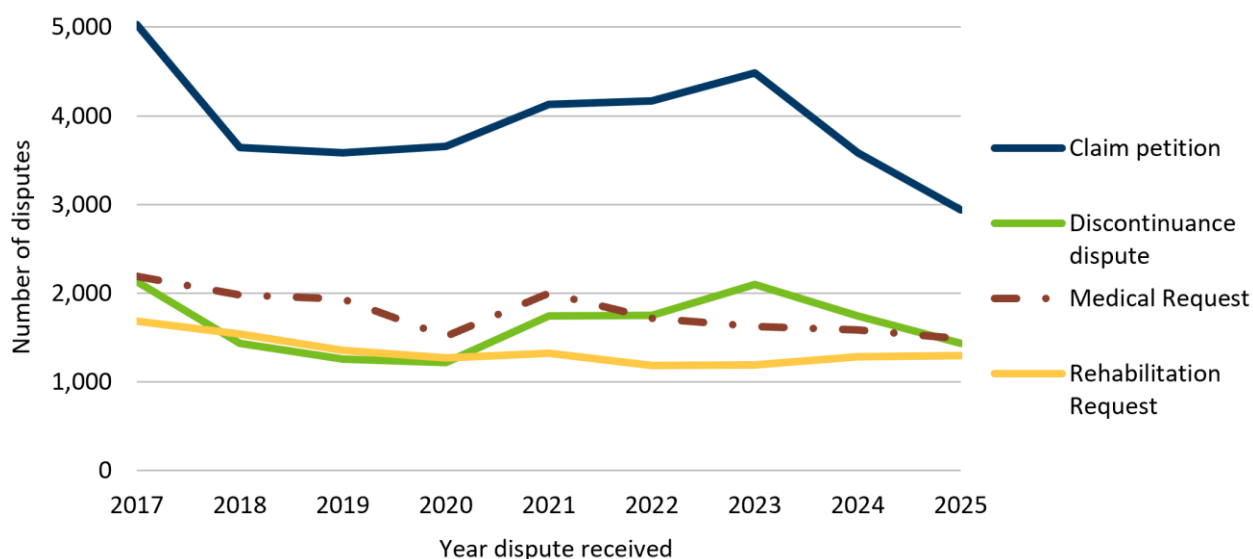
The number of claim petition filings in the DLI claims database increased 25% from 2019 to 2023 but has since decreased by 34% (approximately 1,500 filings). The onset of the COVID-19 pandemic in 2020 did not appear to substantially affect claim petition filings (Figure 5.3).

Discontinuance disputes increased by 66% from 2019 to 2023 (approximately 800 filings) but have decreased by 32% since 2023. Recent review of the dispute data revealed that many discontinuance dispute claims were not included in previous System Reports because of document miscategorization.

The number of medical dispute requests has been steadily decreasing since 2017, except in 2021 when requests temporarily increased before resuming their decline in 2022. Since 2022, filings have decreased by 14%.

The number of rehabilitation dispute requests decreased by 9% from 2019 to 2023 but has since increased by 9%.

Figure 5.3. Number of dispute filings and requests by type



Source: Data from DLI Campus database.

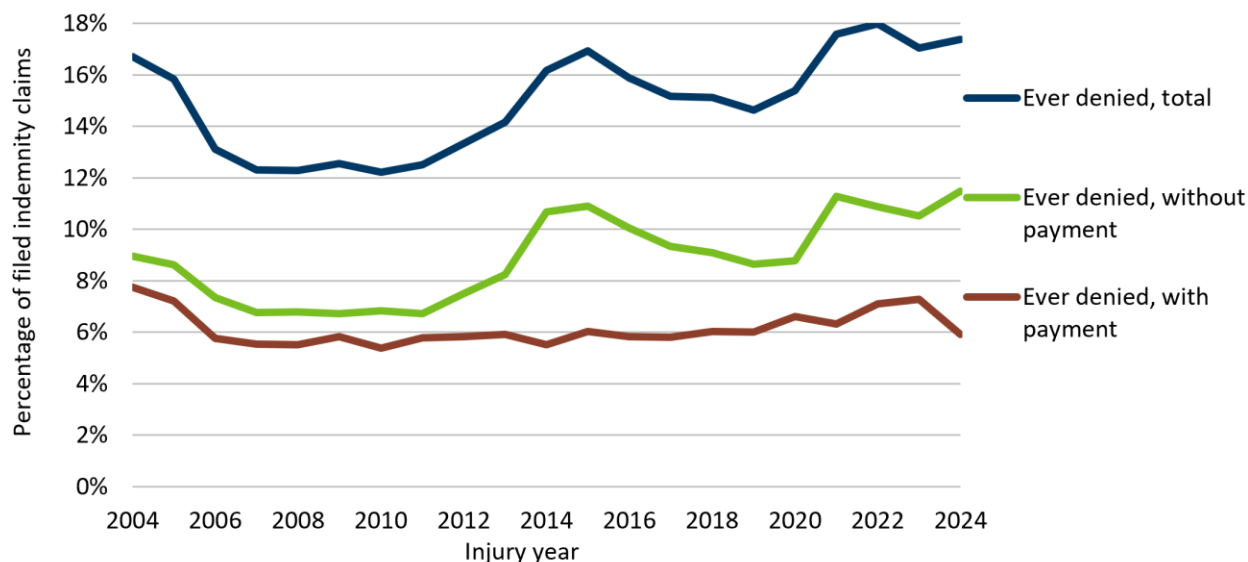
Denial of primary liability

When an employer or insurer takes the position that the claimed injury is not covered for workers' compensation benefits, that is a denial of primary liability.

COVID-19 claims have affected the 2020 through 2023 denial rates (see the table in Figure 5.4).⁴¹ However, the number of COVID-19 claims filed continued to decline, decreasing from about 2,000 claims in 2023 to 600 claims in 2024. The denial rate for non-COVID-19 claims was 17.4% in 2024, about half a percentage point higher than 2023, though rates for most recent years are always subject to revision.

The chart in Figure 5.4 excludes COVID-19 claims while the accompanying table includes denial rates with and without COVID-19 claims. Six percent of non-COVID-19 claims with a denial had an indemnity benefit payment in 2024, down from seven percent in 2023. None of the denied COVID-19 claims in 2024 had an indemnity payment.

Figure 5.4. Denial rates for non-COVID-19 filed indemnity claims



Percentage of filed indemnity claims ever denied				
Injury year	Without payment	With payment	Total	Pctg. of denied filed indemnity claims ever paid
2015	10.9%	6.0%	16.9%	35.6%
2019	8.6%	6.0%	14.6%	41.0%
2020	16.9%	5.1%	22.0%	22.8%
2021	22.2%	5.6%	27.9%	20.2%
2022	24.4%	5.5%	29.9%	18.2%
2023	16.1%	7.3%	23.3%	31.2%
2024	12.6%	6.0%	18.6%	32.3%

Source: Developed statistics from DLI Campus database (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.

Dispute certification

The certification process is triggered by the filing of a dispute certification request for medical or rehabilitation issues or a medical or rehabilitation request (if a dispute certification request was not filed).

In 2025, DLI's Alternative Dispute Resolution (ADR) staff members made certification decisions on 736 medical dispute filings and 515 rehabilitation dispute filings.

The percentage of medical and rehabilitation requests certified as disputes declined through 2017 but increased between 2018 and 2021 (Figure 5.5). Since 2021, medical requests have leveled off, while rehabilitation requests have been decreasing since 2022.

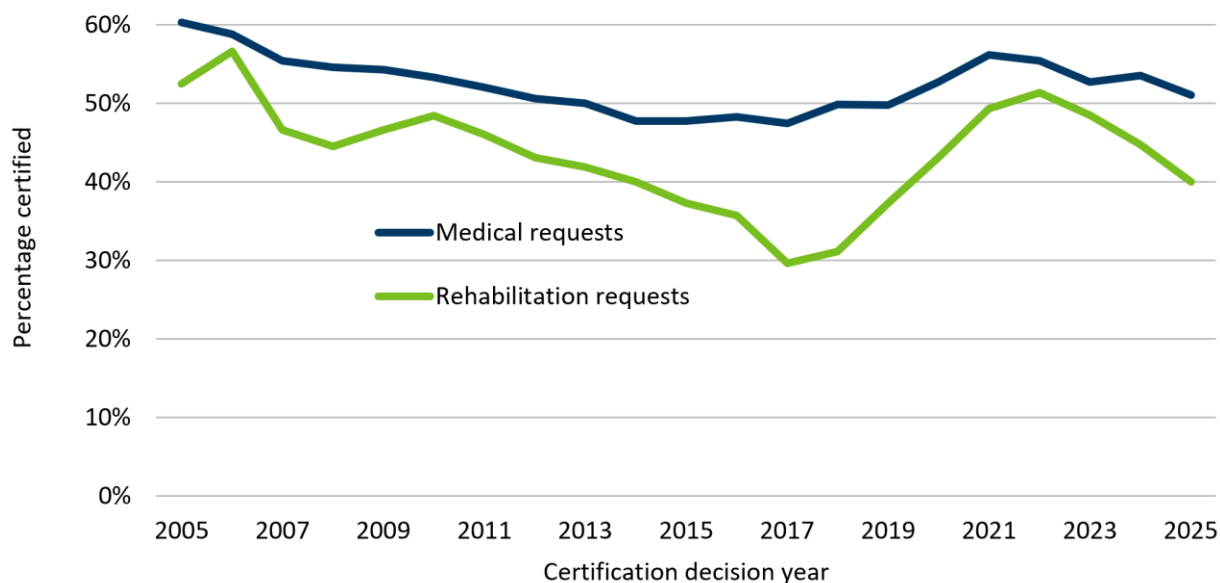
Between 2005 and 2017, the percentage of medical disputes certified decreased from 60% to 47%. The percentage of medical disputes certified has increased since 2017 to 54% in 2024 but fell to 51% in 2025. Among rehabilitation requests, the percentage certified decreased from 52% in 2005 to 30% in 2017, then increased to 45% in 2024 before decreasing to 40% in 2025.

The increase in noncertification of medical disputes since 2005 resulted entirely from an increase in the percentage not certified because the issues were resolved (Figure 5.6). In 2025, 68% of medical requests

not certified were resolved by ADR intervention during the certification process. Most of the noncertified medical requests were resolved by ADR intervention.

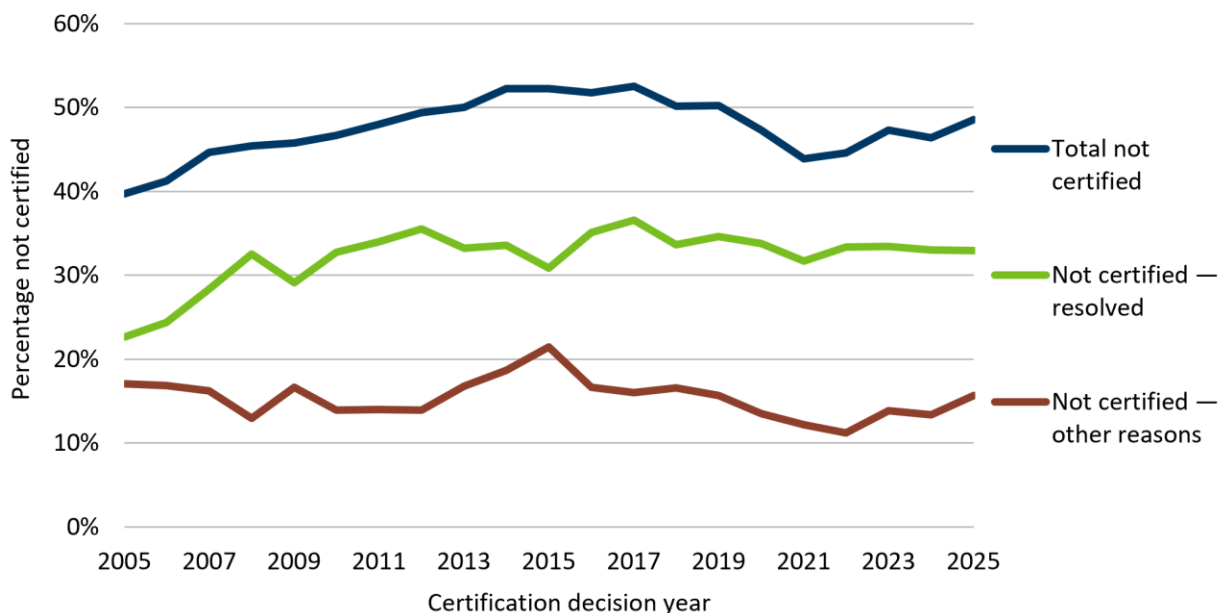
In contrast with medical disputes, the increase in noncertification of rehabilitation disputes between 2006 and 2016 resulted from increases in both the percentage not certified due to resolved issues and the percentage not certified for other reasons (Figure 5.7). The percentage of noncertified rehabilitation requests resolved by intervention during the certification process dipped from 60% in 2018 to 55% in 2020. Since then, it has steadily increased, reaching 69% in 2025.

Figure 5.5. Percentage of medical and rehabilitation requests for assistance certified



Source: Data from DLI Campus database.

Figure 5.6. Noncertification of medical disputes

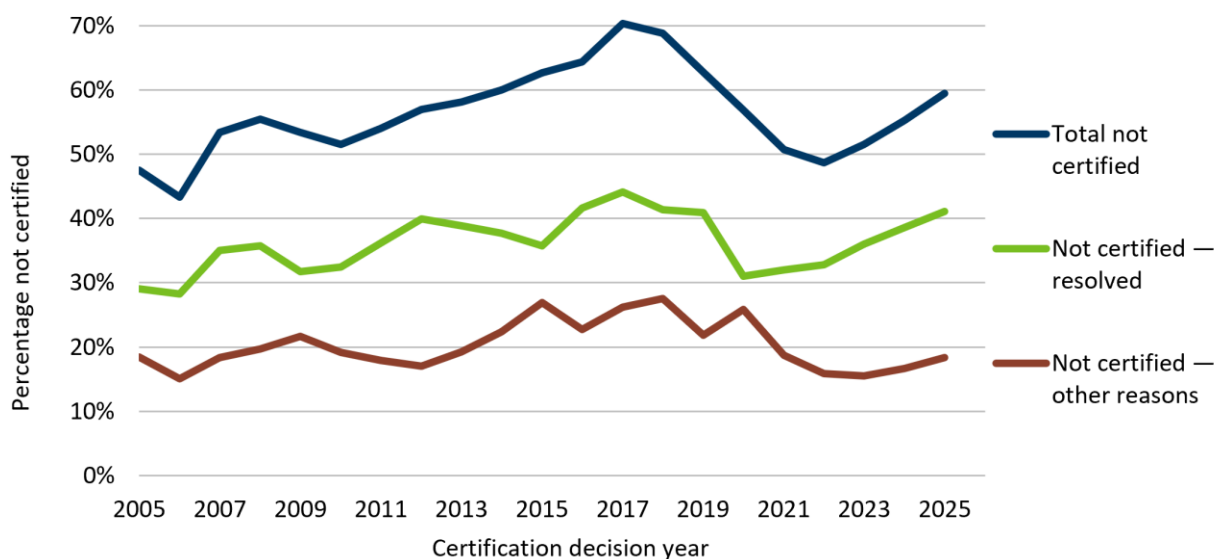


Source: Data from DLI Campus database.

Note: The resolution here could be the result of efforts by an ADR staff member or of the insurer indicating it intended from the start to approve or to pay for the services as requested. Other reasons include: the insurer needs additional time or information

to decide its position; the same issues are already scheduled for a proceeding at DLI or CAH; the injured claim is subject to the provisions of a collective bargaining "carve-out" agreement (Minn. Stat. § 176.1812) and an administrative conference is currently deemed unnecessary; or a medical issue has not previously been submitted to the internal dispute-resolution procedure of a certified managed care plan.

Figure 5.7. Noncertification of rehabilitation disputes



Source: Data from DLI Campus database.

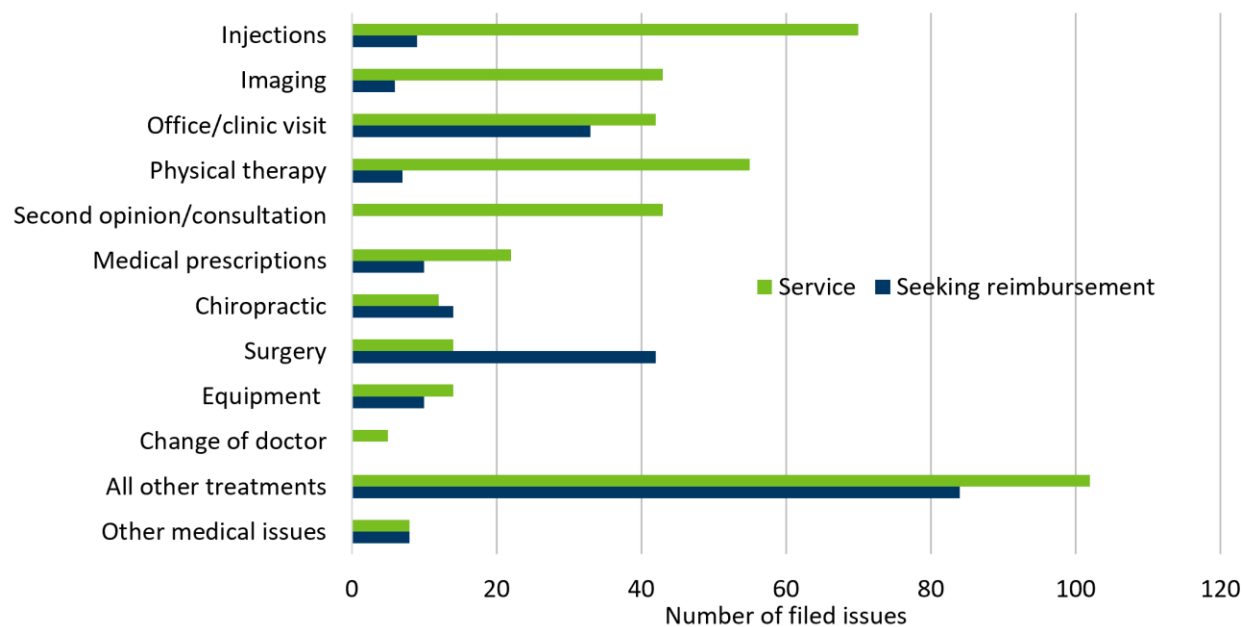
Note: The resolution here could be the result of efforts by a DLI specialist or of the insurer indicating it intended from the start to approve or to pay for the services as requested. Other reasons include: the insurer needs additional time or information to decide its position; the same issues are already scheduled for a proceeding at DLI or CAH; or the injured worker's claim is subject to the provisions of a collective bargaining "carve-out" agreement (Minn. Stat. § 176.1812) and an administrative conference is currently deemed unnecessary.

Dispute issues at DLI

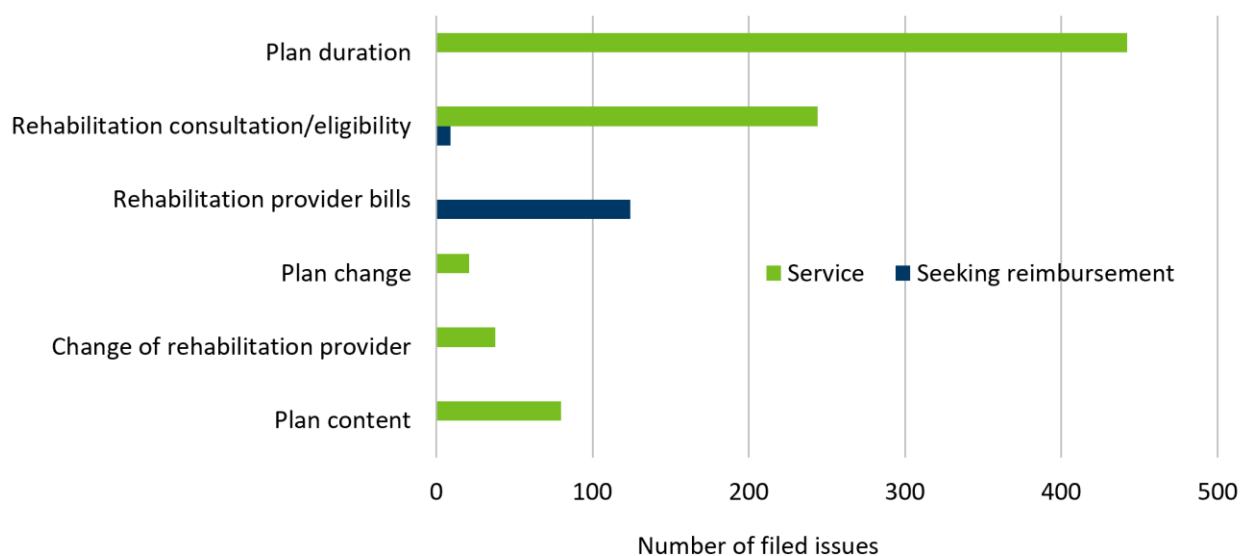
Disputes can include multiple issues on each request. Figure 5.8 shows the distribution of medical issues for disputes filed in 2025; Figure 5.9 shows the distribution for rehabilitation issues. The issues are classified into those seeking a service and those concerning payment for services already provided.

Injections were the most common medical issue. Imaging, office visits and physical therapy were the other top medical service requests, while office or clinic visits and surgery were the most common reimbursement issues.

Majority of the rehabilitation issues, 86%, were service-related; almost all reimbursement issues involved rehabilitation provider bills, with no further breakdown available about the services involved. The most common rehabilitation service issues were disputes about plan duration followed by consultation and eligibility for services.

Figure 5.8. Medical issues at DLI administrative conferences, disputes filed in 2025

Source: Data from DLI Campus database.

Figure 5.9. Rehabilitation issues at DLI administrative conferences, disputes filed in 2025

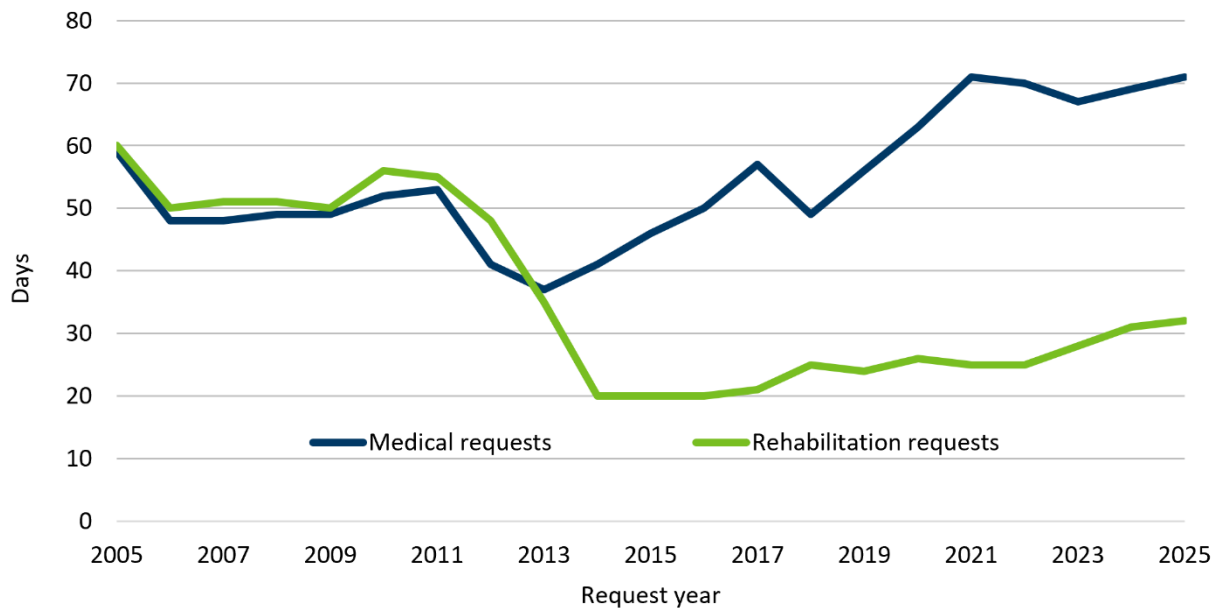
Source: Data from Campus database.

Time to first conference for medical and rehabilitation requests at DLI

The time from medical and rehabilitation requests to the first scheduled conference at DLI have diverged in recent years (Figure 5.10). For medical requests, the median time to the first scheduled conference dropped from 59 days in 2005 to 37 days in 2013, and then increased to 71 days in 2025. For rehabilitation requests, the median time to the first scheduled conference dropped from 60 days in 2005 to 20 days in 2014, and increased to 32 days in 2025. These changes were in response to the 2013 law change (see Appendix B) requiring rehabilitation conferences to take place within 21 days of the

request (unless the only issue is the amount of payment for services already provided or there is good cause). Giving priority to scheduling rehabilitation conferences delayed the timing of medical conferences.

Figure 5.10. Median days from dispute filing to first scheduled conference at DLI



Year request received	Median days from request to first scheduled conference	
	Medical requests	Rehabilitation requests
2005	59	60
2013	37	35
2017	57	21
2019	56	24
2020	63	26
2021	71	25
2022	70	25
2023	67	28
2024	69	31
2025	71	32

Source: Data from Campus database.

Dispute proceedings at DLI

DLI ADR schedules and conducts administrative conferences for certified disputes and for mediations. DLI mediations can be about claim petition issues and medical and rehabilitation disputes pending at DLI.

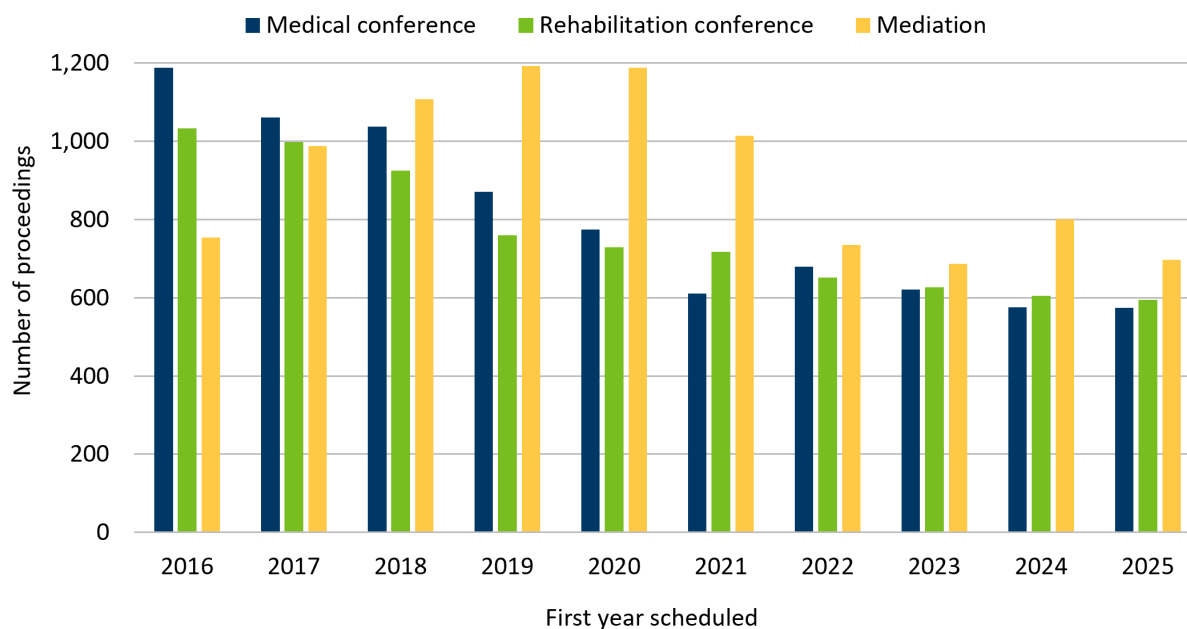
Scheduled proceedings

Figure 5.11 presents the trend in the number of scheduled proceedings at DLI. Since 2016, the number of medical and rehabilitation conferences has steadily declined. Over the same period, mediations increased from 754 in 2016 to nearly 1,200 in 2019. Beginning in 2021, however, the number of

mediations decreased, reaching 686 in 2023. Mediations rose again to 800 in 2024 before declining to approximately 700 in 2025.

Mediations increased from 25% of the scheduled conferences in 2016 to 44% in 2020, falling to 37% in 2025. In 2021, the number of rehabilitation conferences scheduled surpassed the number of medical conferences but the two have been nearly identical since 2023.

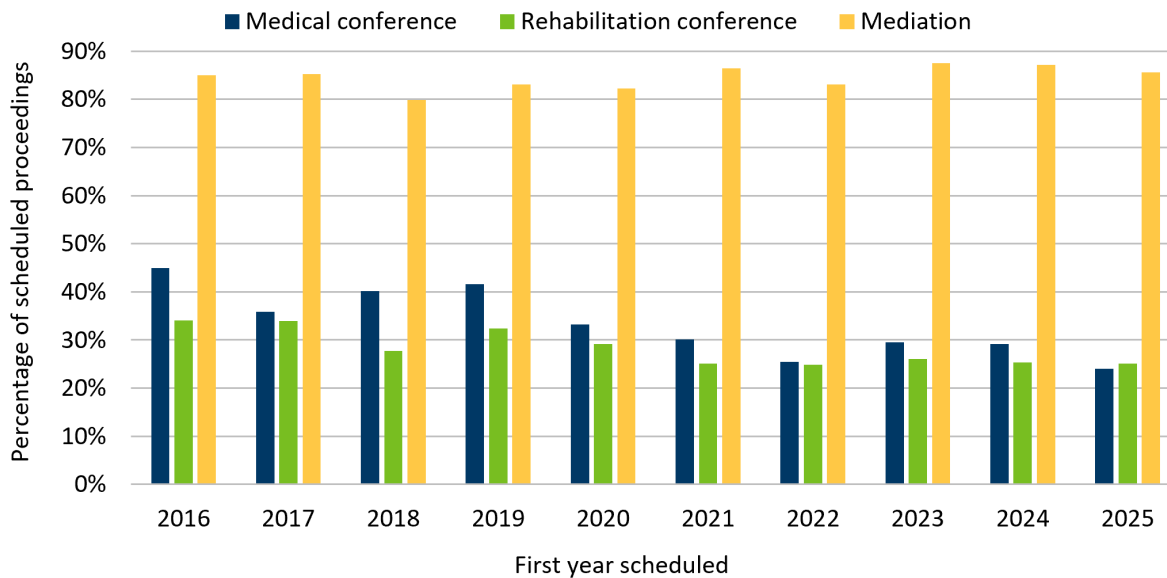
Figure 5.11. Scheduled proceedings at DLI



Source: Data from DLI Campus database. The first year scheduled is used because a proceeding can be rescheduled into another year.

Proceedings

More than half of the scheduled medical and rehabilitation conferences did not take place, often due to resolution of the disputes without the need for a conference. From 2016 to 2025, the percentage of scheduled mediations conducted remained consistently at or above 80% (Figure 5.12). This is expected because mediations are specifically requested by the parties. Some of the disputes originally scheduled as conferences became mediations either at the request of the parties or encouragement by the arbitrator. The number of DLI proceedings that were held increased from 1,526 in 2016 to 1,598 in 2019. Proceedings declined to 883 in 2025.

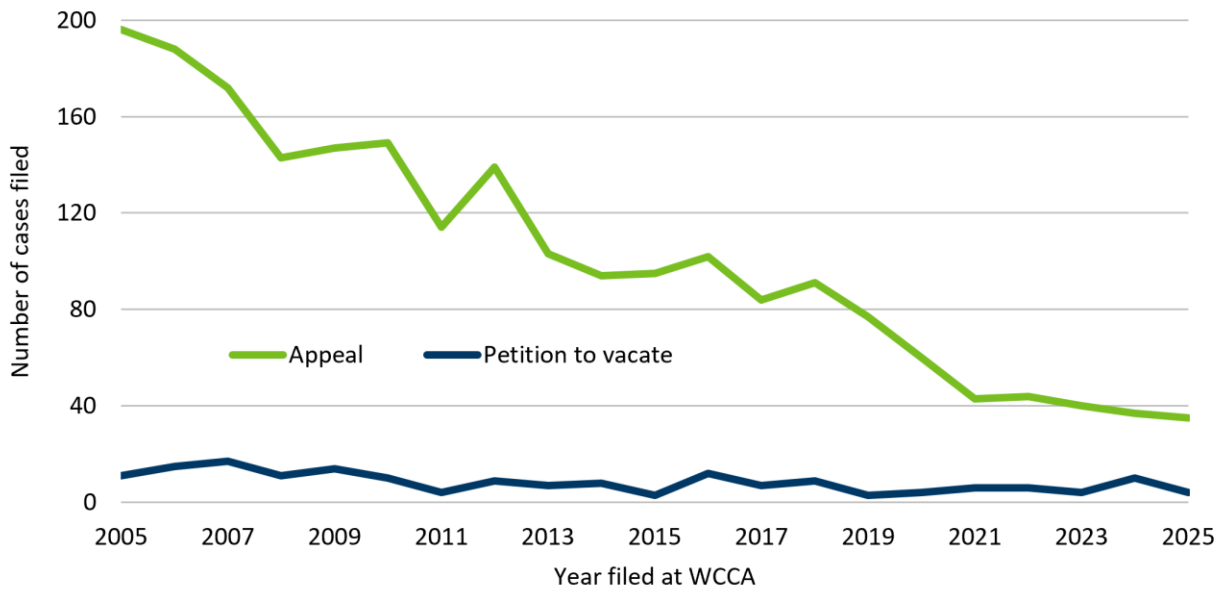
Figure 5.12. Percentage of DLI scheduled proceedings completed

Source: Data from DLI Campus database. The first year scheduled is used because a proceeding can be rescheduled into another year.

Workers' Compensation Court of Appeals activity

The Workers' Compensation Court of Appeals has exclusive statewide authority to review workers' compensation cases decided by compensation judges at CAH and certain cases decided by DLI's Workers' Compensation Division. A panel of three or five judges decides each appeal. A written decision must be issued within 90 days after a case has been assigned to a panel. The judges review the evidentiary record created at the initial hearing, preside over oral arguments, conduct legal research, decide the legal and factual issues appealed by the parties, and issue written orders, decisions and memoranda. Decisions are written to inform the parties and the public of the basis for the court's decisions and to create a body of law interpreting and applying Minnesota workers' compensation laws. Decisions of WCCA are appealable directly to the Minnesota Supreme Court.

Figure 5.13 shows the number of cases filed at WCCA from 2005 through 2025 and the reason for filing. The number of filed cases has been trending downward, declining from 207 cases in 2005 to 39 cases in 2025. Overall, the decline is driven primarily by fewer appeals, while petitions to vacate have remained relatively stable, ranging from three to 17 filings since 2005.

Figure 5.13. Number of WCCA cases filed and case type by year filed

Source: Data from DLI Campus database.

The median number of days from WCCA filing to the argument date was 111 days for WCCA decisions filed in 2025, with a median of 85 days from the argument date to the decision filing date. The median number of days from WCCA filing to the WCCA decision was 185 days for 2025 decisions. This number has been stable since 2021.

Appendix A

Glossary

The following terms are used in this report. 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.

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 for medical and vocational rehabilitation disputes presented on a medical or rehabilitation request; they are also conducted for 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 Court of Administrative Hearings (CAH) depending on whether DLI has referred the issues concerned to CAH. See the discussion of DLI administrative conferences in Part 5 for types of medical and vocational rehabilitation disputes referred to CAH. Discontinuance conferences are conducted at CAH. If agreement is achieved at the conference, an order on agreement is issued, which is binding unless appealed. If agreement is not achieved, the DLI specialist or CAH judge issues a decision-and-order, also binding unless appealed. A party may appeal a DLI or CAH decision-and-order or order on agreement by requesting a *de novo* hearing at CAH.

Ambulatory Surgical Center Payment System (ASCPS) — Minnesota's payment system for workers' compensation ambulatory surgical center facility services provided on or after Oct. 1, 2018. It is based on Medicare's ASCPS. Payment depends on the procedures performed and, under statute, is the lesser of 320% of Medicare or the usual and customary charge of all services, supplies and implantable devices provided.

Assigned Risk Plan (ARP) — Minnesota's workers' compensation insurance plan of last resort, for those employers unable to obtain insurance 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 than 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 benefits or, in some cases, medical or rehabilitation benefits. In response to a claim petition, the Court 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). The SAWW is calculated according to Minnesota Statutes § 176.011. The annual benefit adjustment is as provided in Minn. Stat. § 176.645. 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 injuries from Oct. 1, 1995, through Sept. 30, 2013, the cost-of-living adjustment was limited to 2% 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% a year and delayed until the third anniversary of the injury.

Court of Administrative Hearings (CAH) — 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.

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, 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 plan-closure year data. They are obtained by applying development factors, based on historical rates of development of the statistic in question, to tabulated numbers. Development occurs in vocational rehabilitation plan-closure year data because a claim may have more than one vocational rehabilitation plan and the plan-closure year statistics are computed for all plans combined, categorized by the closure year of the last plan.

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 plan-closure year. The reported numbers develop both because of the time necessary for claims to mature and, in the case of some Department of Labor and Industry data, because of reporting lags.

Diagnosis-related group (DRG) payment system — Minnesota's payment system for workers' compensation hospital inpatient facility services, effective for services provided on or after Jan. 1, 2016. It is based on Medicare's Inpatient Prospective Payment System (IPPS). In the IPPS, a hospitalization is categorized — by principal diagnosis and primary treatment performed — into a DRG and payment is determined mainly from the DRG. For hospitals that are not Medicare-designated Critical Access Hospitals, Minnesota's DRG system provides for payment at 200% of the Medicare level, not to exceed the charged amount, or 75% of charges in catastrophic (high-cost) cases. As of Oct. 1, 2025, the threshold for catastrophic cases was total charges of \$330,993. For Critical Access Hospitals, payment is 100% of charges.

Under the DRG payment system, a set of requirements regarding bill payment and denial takes effect when certain conditions are met. These conditions are: the hospital submits its charges to the insurer electronically; a DRG applies to the hospitalization; and the total charges in the case are less than the threshold for payment under the catastrophic provision. When these conditions are met, the insurer: must not require an itemization of charges or additional documentation to support a bill; and must, within 30 days of receipt, either pay the bill (with no reductions based on line-item review) or deny the entire bill on the basis that the condition for which the person is in the hospital is not work-related or that the hospitalization is not reasonably required. Under certain conditions, the insurer may do a post-payment audit with line-item review.

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 disability benefits. The conference is conducted at the Court of Administrative Hearings (CAH). A discontinuance dispute may also be presented on the *Employee's Objection to Discontinuance* form or the insurer's petition to discontinue benefits, either of which triggers a hearing at CAH.

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 has been met. See *Notice of Intention to Discontinue*, *Employee's Request for Administrative Conference*, *Employee's Objection to Discontinuance* and *Petition to Discontinue Benefits* in this glossary.

Dispute certification — a process required by statute in which, in a medical or rehabilitation dispute, the Department of Labor and Industry (DLI) must certify a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services (Minn. Stat. § 176.081, subd. 1(c)). 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.

Employee's Objection to Discontinuance — a form the injured worker uses to request 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 Workers' Compensation Benefits* form or a petition to discontinue benefits. The hearing is conducted at the Court of Administrative Hearings.

Employee's 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 Workers' Compensation Benefits* form. Requests for a discontinuance conference are usually done by phone.

Experience modification factor — a factor computed by an insurer to modify an employer's premium based on 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 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 about a disputed issue or issues in a workers' compensation claim, conducted at the Court of Administrative Hearings (CAH). After the hearing, the judge issues a findings-and-order, which is binding unless appealed to the Workers' Compensation Court of Appeals. CAH conducts formal hearings about disputes presented on claim petitions and other petitions where resolution through a settlement conference is not possible. CAH also conducts hearings about some discontinuance disputes (those presented on an *Employee's Objection to Discontinuance* form 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, disputes about proposed surgery and disputes about miscellaneous issues, such as attorney fees (Minnesota Rules part 1420.2150, subpart 1, provides for expedited hearings on not-yet-provided-surgery issues). Finally, CAH conducts *de novo*

formal hearings when requested by a party to an administrative conference decision-and-order from DLI or CAH or a nonconference decision-and-order from DLI.

Hospital Outpatient Fee Schedule (HOFS) — Minnesota's payment system for certain workers' compensation hospital outpatient facility services, effective for services provided on or after Oct. 1, 2018. It is based primarily on those portions of Medicare's Outpatient Prospective Payment System that relate to major surgical procedures and emergency department (ED) visits. For cases with major procedures, payment is based on the procedure regardless of other services provided. For cases with ED or clinic visits and no major procedures, payment is based on the ED or clinic visit and other services provided. Under statute, the Department of Labor and Industry has determined payment levels, separately for small and large hospitals (those with up to 100 beds and more than 100 beds, respectively), relative to Medicare to produce the same overall payment amounts as under the prior system.

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 the 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 or determine whether a dispute should be certified. Dispute resolution through intervention may occur before, during or after the dispute certification process. Note that this is different from the statutory intervention process in Minnesota Statutes § 176.361 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 Court of Administrative Hearings (CAH) (or with a private mediator) when one party requests it and the others agree to participate, and 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 CAH for an award on stipulation. If agreement is reached in an CAH mediation, the parties usually file a stipulation for settlement that the CAH judge incorporates into an award on stipulation. However, sometimes an agreement from an CAH mediation is recorded in a mediation award issued by the CAH judge. Mediations also occur outside of DLI and CAH; when such a mediation produces agreement, the agreement is usually incorporated into a stipulation for settlement and submitted to CAH 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 provider, the 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 Court of Administrative Hearings (see "Administrative conference" in this glossary).

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, 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" in this glossary). The decision is binding unless a dispute party requests a formal hearing at the Court of Administrative Hearings.

Notice of Intention to Discontinue Workers' Compensation Benefits (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.

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, in the 2018 law change for injuries on or after Oct. 1, 2018, and in the 2023 law change for injuries on or after Oct. 1, 2023. 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%.

Permanent total disability — 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 permanent partial disability rating of at least 13% to 17%, 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, weekly benefits are subject to a minimum of 65% of the statewide average weekly wage. The maximum weekly benefit amount is indicated in Appendix B. For injuries from Oct. 1, 1995, to Sept. 30, 2018, benefits end at age 67 under a rebuttable presumption

of retirement. For injuries on or after Oct. 1, 2018, benefits end at age 72 or, if the injury is after age 67, after five years of benefits have been paid. 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 Court 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 when 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 indemnity and medical losses, equal to the sum, over all insurance classes, of payroll multiplied by 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 (MWICIA) 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 Court of Administrative Hearings (see "Administrative conference").

Reserves — funds 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 or self-insured employers 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 benefits — workers' compensation 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. It may be incorporated into a mediation

award or a stipulation for settlement, usually the latter, which is approved by a judge at the Court of Administrative Hearings. 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. Settlement benefits are usually paid in a lump sum.

Settlement conference — a proceeding conducted at the Court 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 “Settlement benefits” above).

Special Compensation Fund (SCF) — a fund within the Department of Labor and Industry (DLI) that pays, among other things, uninsured claims and reimburses insurers and self-insured employers for supplementary and second-injury benefit payments (the supplementary and second-injury benefit provisions only apply to older claims because they were eliminated by the law changes of 1995 and 1992, respectively). 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 Court 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 (2024) wage dollars. The SAWW, determined by the Department of Employment and Economic Development, is the average weekly wage of nonfederal workers covered under unemployment insurance.

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% 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 gross current wage, subject to a maximum weekly amount, and is paid at the same intervals as wages were paid before the injury. An additional limit is that the weekly TPD benefit plus the employee's weekly wage earned while receiving TPD benefits may not exceed 500% of the statewide average weekly wage. For injuries from Oct. 1, 1992, through Sept. 30, 2018, 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). For injuries on or after Oct. 1, 2018, benefits are limited to a total of 275 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. 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 is released to work without physical restrictions from the injury; the employee withdraws from the labor market; the employee fails to diligently search for work within his or her physical restrictions; 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 dispute — a dispute about a vocational rehabilitation issue, such as whether the employee should be evaluated for eligibility, whether the employee is eligible, whether certain plan provisions are appropriate or whether the employee is cooperating with the plan.

Vocational rehabilitation plan — a plan for vocational rehabilitation 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 vocational rehabilitation 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" in this glossary.

Workers' Compensation Court of Appeals (WCCA) — an executive branch body that hears appeals of workers' compensation findings-and-orders from the Court 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 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 2000 are relevant for this report. This appendix summarizes those law changes. Law changes that do not significantly 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 and 2013 (see below).

Permanent partial disability (PPD) benefits: Benefit amounts were raised for all impairment ratings. At the time, the Department of Labor and Industry estimated this would increase overall PPD benefits by 14%. In addition, the PPD award may be paid as a lump sum, computed with a discount rate not to exceed 5%. Previously, PPD benefits were only payable in installments at the same interval and amount as the employee's temporary total disability 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 Department of Labor and Industry 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. This maximum was raised again in 2013 (see below).

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 Aug. 1, 2011.

Scheduling of proceedings at the Court of Administrative Hearings (CAH): CAH 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 a settlement is not reached, CAH must schedule a hearing to occur no more than 90 days after the scheduled settlement conference or sooner if statute requires an expedited hearing about the issues concerned.

2013 law change

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

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 \$850 to 102% of the statewide average weekly wage (SAWW). The SAWW in effect for injuries in each year beginning Oct. 1 is the SAWW reflecting wages paid during the year ending the prior Dec. 31.

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% to 3% and the date of the first adjustment was moved from the fourth anniversary of the injury to the third anniversary.

Post-traumatic stress disorder (PTSD): Work-related PTSD is compensable as the only mental impairment not associated with a physical injury. PTSD must be diagnosed by a licensed psychiatrist or psychologist.

Contingent claimant attorney fees: The maximum contingent claimant attorney fee is 20% of the first \$130,000 of compensation awarded to the injured worker, with a cap of \$26,000 in contingent fees. Previously, the maximum was 25% of the first \$4,000 of compensation and 20% of the next \$60,000, with a cap of \$13,000 in contingent fees.

Scheduling of administrative conferences in rehabilitation disputes: In rehabilitation request disputes, except where the dispute is about payment for services already provided or there is good cause, an administrative conference must be scheduled to occur within 21 days of when the request was received.

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.

2015 law change

The following provision took effect for inpatient hospital services provided on or after Jan. 1, 2016.

Diagnosis-related Group (DRG) system for hospital inpatient services: Minnesota changed its system for paying for workers' compensation hospital inpatient facility services from a charge-based system to one based on Medicare's Inpatient Prospective Payment System (IPPS). This system is often called a DRG system because payment is based primarily on the diagnosis-related group, which categorizes the major diagnosis and principal procedures performed. For non-catastrophic cases at non-Critical-Access Hospitals, the payment is 200% of the Medicare level, not to exceed the charged amount. DLI estimated that in its first year, the new system reduced inpatient hospital cost by 9% to 16%, total medical cost by 1.3% to 2.3% and total workers' compensation

system cost by 0.5% to 0.8% relative to what they would otherwise have been (See DLI, *Minnesota Workers' Compensation DRG Evaluation Report*, January 2018, pp. 24-27).

Minnesota's DRG statute also has a set of provisions regarding bill payment and denial. See Appendix A for details.

2018 law change

The following provisions took effect for injuries on or after Oct. 1, 2018.

Temporary partial disability (TPD) duration limit: The maximum duration of TPD benefits was raised from 225 to 275 weeks, not to extend beyond 450 weeks after injury.

Permanent partial disability (PPD) benefit schedule: The PPD benefit schedule was raised by a uniform 5% for all impairment ratings.

Retirement age for permanent total disability (PTD) benefits: The PTD "retirement age," at which PTD benefits cease, was raised from 65 to 67 years or the point where five years of those benefits have been paid, whichever is later. In addition, the provision allowing the injured worker to rebut the presumption of retirement (and consequent benefit cessation) was removed. DLI estimated these three benefit increases would raise total indemnity cost by 2.0% and total workers' compensation system cost by 0.6% relative to what they otherwise would have been.

The following provisions took effect for dates of injury on or after Jan. 1, 2019.

Post-traumatic stress disorder (PTSD): Certain employees who are diagnosed with PTSD are presumed to have a work-related occupational disease. Workers in the following occupations are covered by this rebuttable presumption:

- licensed peace officer;
- firefighter;
- paramedic, emergency medical technician and licensed nurse employed to provide emergency medical services outside of a medical facility;
- public safety dispatcher;
- correctional officer and security counselor employed by the state or a political subdivision at a corrections, detention or secure treatment facility;
- sheriff or full-time deputy sheriff of any county; and
- member of the Minnesota State Patrol.

Ambulatory Surgical Center Payment System (ASCPS): Payment for ambulatory surgical center (ASC) facility services was set at the lesser of 320% of Medicare or the usual and customary charge of all services, supplies and implantable devices provided. DLI estimated this would reduce payments to ASCs by 20%, total medical cost by 2.1% and total workers' compensation system cost by 0.7% relative to what they otherwise would have been. See DLI's *Evaluation of the impact of the Minnesota workers' compensation Ambulatory Surgical Center Payment System (ASCPS)*, January 2021.

Hospital Outpatient Fee Schedule (HOFS): Payment for certain hospital outpatient facility services was changed to be based on portions of Medicare's Outpatient Prospective Payment System (OPPS) that relate to major surgical procedures and emergency department visits. As provided by statute, DLI set the payment levels under the new system, separately for small and large hospitals (those with up to 100 beds and with more than 100

beds, respectively), so estimated outpatient payments would be the same under the old and new systems. See Appendix A for details.

2020-2022 law change

2020 and 2022 COVID-19 related law: On April 8, 2020, a new law stated certain employees who contract COVID-19 are presumed to have an occupational disease covered by the Minnesota workers' compensation law. The law originally sunset May 1, 2021, but was extended to sunset Dec. 31, 2021. It was then revived and reenacted on Feb. 3, 2022, with a new sunset of Jan. 13, 2023. Employees are entitled to the presumption if they contract COVID-19 while employed in one of these occupations:

- licensed peace officer, firefighter, paramedic or emergency medical technician;
- nurse or health care worker, correctional officer or security counselor employed by the state or a political subdivision (such as a city or county) at a corrections, detention or secure treatment facility;
- health care provider, nurse or assistive employee employed in a health care, home care or long-term care setting, with direct COVID-19 patient care or ancillary work in COVID-19 patient units; or
- a person required to provide childcare to children of first responders and health care workers under Gov. Tim Walz's Executive Orders 20-02 and 20-19.

Temporary total disability (TTD) minimum benefit: Effective Oct. 1, 2021, the minimum TTD weekly compensation rate was changed to 20% of the maximum weekly compensation payable or the employee's actual weekly wage, whichever is less.

2023 law change

Article 1, Workers' compensation self-insurance: Amends chapter 79A regarding procedures at the Department of Commerce related to bankruptcy of a self-insurer.

Article 2, System efficiencies: Amends chapter 176 to generate greater efficiencies in the workers' compensation system. This article has 10 sections, including provisions for certifying disputes at the Department of Labor and Industry and outlining a charge structure for copies of electronic medical records.

Article 3, Permanent partial disability schedule: Amends the permanent partial disability schedule in chapter 176, resulting in a weighted 38% to the permanent partial impairment ratings schedule used to calculate payments to injured workers with permanent impairments. The amendment also requires the Workers' Compensation Advisory Council in 2026 and every other year thereafter to consider the adequacy of compensation for permanent impairment.

Article 4, Hospital outpatient fee schedule (HOFS): Amends chapter 176 to provide for reductions to the hospital outpatient fee schedule over a period of three years. The reduction mandates 3% cuts in 2023 and 2024 and 4% cut in 2025, culminating in an overall 10% reduction to the HOFS conversion factors. It repeals the provision describing the criteria that must be met for the reductions to occur.

2024 law change

Temporary total disability (TTD): Updates the percentage calculation for maximum weekly compensation for temporary total disability benefits from 102% of the statewide average weekly wage the preceding year to 108%.

Limitation of fees: Updates the maximum dollar limit for contingent attorney fees from 20% of the first \$130,000 of compensation awarded to the employee to 20% of the first \$275,000, which increases the limit from \$26,000 to \$55,000. It clarifies that attorneys who are claiming legal fees for representing an employee file their statement of attorney fees with the Court of Administrative Hearings.

Weekly wage: Provides that the average weekly wage of an employee in agricultural employment fewer than 30 days in a calendar year, and who is regularly employed by two or more employers, is either the agricultural wages at five times the employee's daily wage or based only on the employee's other employment, whichever is higher.



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 in many places in 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 plan-closure year (Department of Labor and Industry (DLI) data). For any given accident, policy, injury or vocational rehabilitation plan-closure year, these statistics grow, or “develop,” over time because of claim maturation and reporting lags. Development occurs in vocational rehabilitation plan-closure-year data because a claim may have more than one vocational rehabilitation plan and the plan-closure-year statistics are computed for all plans combined, categorized by the closure year of the last plan.

Development affects a range of statistics, including claims, costs, 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, trend 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.

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 a “tenth-report” basis. The developed insurance statistics in this report were computed by DLI Research and Data Analytics using tabulated numbers and associated development factors from MWCIA. Research and Data Analytics 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. In this manner, the annual numbers in any given time series are developed to a uniform maturity.

The level of maturity to which the numbers in a time series are developed depends on the length of history available on the statistics concerned. The DLI injury-year statistics in Parts 2 and 3 are at a 35-year maturity. In Part 4, the injury-year statistics are at a 10-year maturity and the vocational rehabilitation plan-closure year statistics are at a seven-year maturity. In Part 5, the rate of claim denial by injury-year is at 35-year maturity.

Therefore, all developed statistics are estimates and are revised each year using updated data. DLI periodically reviews the developed statistics to determine their stability over time and their suitability for publication. However, to show the impact of COVID-19 in recent years, which was a destabilizing factor, DLI decided to publish statistics for the most recent years in this report.

COVID-19 and developed statistics: In the past few years, computing developed statistics for COVID-19 indemnity claims could not be done with a high level of confidence because these claims did not follow the pattern of non-COVID-19 claims from previous years. Therefore, claims development estimates were calculated only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims. However, as the impact of COVID-19 claims on the workers' compensation system has significantly decreased since 2022, DLI no longer reports the COVID-19 and non-COVID claims separately in the current and subsequent reports.

Adjustment of cost data for wage growth: For reasons explained in Part 1, all costs in this report that are expressed per claim or per vocational rehabilitation plan are adjusted for average wage growth. The cost number for each year is multiplied by the ratio of the 2024 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 2024 wage-dollars.

Data quality: Another factor that might affect the stability of published estimates for recent years is limitations of data reporting. The estimates presented in this report are dependent on the accuracy of data submitted by insurers and other stakeholders to DLI. External parties are still becoming familiar with filing workers' compensation documents in the Work Comp Campus online portal deployed in late 2020, and DLI is continually working to improve data quality and reporting in Campus. While Research and Data Analytics takes rigorous measures to clean and validate the reported statistics, incorrect or missing data submissions can still affect the estimates produced for this report. Data quality challenges can be caused by electronic data interchange problems, external parties' misfiling of data, data quality checks, or extract, transform and load issues. Data errors could result in misidentification of payment data within Campus and potentially underestimate a range of reported statistics, including settlement payments, claim counts, attorney fees and other estimates. These estimates will be updated as DLI continues to monitor the reported data to ensure data reporting meets the necessary standards and compliance requirements.

Figure 2.1: The developed number of non-COVID-19 paid indemnity claims for injury-year 2024 (in the numerator of the indemnity claim rate) is 20,000 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2025, 18,051 for non-COVID-19 claims, multiplied by the appropriate development factor, 1.108. In this manner, the non-COVID-19 numbers are developed to a uniform maturity. The reported, non-developed number of COVID-19 paid indemnity claims – 338 – is then added to the developed non-COVID-19 number to get the combined total number of paid indemnity claims, which is 20,300 (rounded to the nearest hundred) for injury-year 2024. For reasons explained in Part 1, COVID-19 claims are not developed.

The number of full-time-equivalent 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). Because of annual fluctuations caused by sampling variation, a smoothed version of the average-annual-hours trend is used. Nonfederal UI-covered employment is used because there is no direct data about workers' compensation-covered employment.

Figure 2.2: 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 2.3: Claim and loss data is from supplementary tables to MWCI's 2026 *Minnesota Ratemaking Report*. This data comes from insurance company reports about 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 a 10th-report basis using the development factors in the *Minnesota Ratemaking Report*, which produces statistics at an average maturity of 10.5 years from the injury date; the statistics are then adjusted for average wage growth.

Figures 2.4 and 2.5: These figures 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 MWCI by voluntary market insurers only. Paid losses are developed to a uniform maturity of 30 years (a "30th-report basis") using development factors computed from year-to-year loss development data supplied by MWCI. Payroll data for Figure 2.4 is from insurer reports of policy experience.

Figure 2.6: The pure premium rate data comes from MWCI's *Minnesota Ratemaking Reports* for the years shown. Beginning with 2016, MWCI has expressed the losses in the pure premium rates at progressively higher levels of maturity. In the *Minnesota Ratemaking Reports* for those years, MWCI indicates the component of change in the pure premium rates that is attributable to this progressively higher maturity level. This component is a positive number because it reflects an increasing maturity level over the period in question. In Figure 2.6, this component is removed from the pure premium rates to produce a uniform maturity level over time.

Figure 2.7: 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 2023 is available from MWCI. The 2024 deductible credit figure was estimated by applying the ratio of deductible credits to written premium for the prior two years to the 2024 premium figure. When the actual amount becomes available for 2023, 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% of pure premium. The final component is the total assessment paid to the Special Compensation Fund, net of the portion used to pay claims from defaulted self-insurers, because this is already reflected in pure premium.

Total workers' compensation covered payroll is computed as the sum of insured payroll, from MWCI, and self-insured payroll, from WCRA. Insured payroll was not yet available for 2024. 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 WCRA).

Figure 2.8: 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. A major issue is that both paid benefits and total system cost (primarily the latter) vary substantially from year to year, causing major variation in the ratio of the two. 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. Therefore, the percentages in this figure were derived by averaging data over time.

Data about benefits and state agency administrative cost came from DLI, MWCI, the Minnesota Insurance Guaranty Association and the Minnesota Self-Insurers' Security Fund. Total system cost was calculated as indicated in connection with Figure 2.7. 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 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 64.4% as the ratio of total paid benefits to total system cost.

The indemnity, medical and vocational rehabilitation components of the 64.4% were then computed using the relative totals of these payments for 2024. Vocational rehabilitation 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, 35.6%, was then allocated between state agency administrative expenses and insurer expenses. State agency administrative expenses (using the same numbers as for Figure 3.14) were estimated to account for 2.4% of total system cost, leaving an estimated 33.2% attributable to insurance expenses (for insurers and self-insurers).

Figure 3.1: Statistics are derived in the same manner as for Figure 2.3, 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 five years to total claims and losses for 2022.

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 underreporting of duration for longer claims.

Figure 3.14: 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 4.4 through 4.7 and 4.11: Vocational rehabilitation costs used in this report are the costs reported by qualified rehabilitation consultants (QRCs) on the *R-8 Notice of Rehabilitation Plan Closure* form. It does not include any costs that vendors and retraining institutions billed directly to insurers and are not reported to QRC firms. Also absent are costs for consultations that do not result in filing a rehabilitation plan. Figures 4.4, 4.7 and 4.11 report the cost of vocational rehabilitation for all plans associated with a claim. Figures 4.5 and 4.6 report about individual plans closed in the covered years.

Figure 5.10: To make the statistics comparable over time, a constant observation window of one year from the receipt date of the medical request or rehabilitation request was used. Only events that happened within that window were counted.

Endnotes

¹National Council on Compensation Insurance, *2025 State of the Line Guide*, [2025 State of the Line Guide](#).

²The estimated number of workers' compensation covered full-time-equivalent employees decreased from 2,293,000 in 2019 before the pandemic started to 2,137,000 in 2020. This number gradually rose to about 2,302,000 employees in 2024.

³The National Council on Compensation Insurance (NCCI) Medical Data Report for Minnesota provides medical benefit statistics at ncci.com/Articles/Pages/II_MedicalDataReportState_MN.aspx.

⁴MWCIA Minnesota Ratemaking Report: mwcia.org/Ratemaking-Report.

⁵The decline in the medical-only rate is also consistent with the Survey of Occupational Injuries and Illnesses (SOII), which shows a 13% decrease in "other recordable" cases (without lost workdays) between 2019 and 2024. This may be indicative of a change in the reporting of medical-only claims during and following the pandemic. SOII is conducted jointly by state agencies and the U.S. Bureau of Labor Statistics. See dli.mn.gov/our-areas-service/research/survey-occupational-injuries-and-illnesses for Minnesota injury and illness rates from the SOII.

⁶The indemnity claim numbers come from DLI data, while the numbers for medical-only claims come from MWCIA estimates.

⁷The number of COVID-19 indemnity claims in 2024 was about 67% lower than the number of COVID-19 indemnity claims reported in 2023 and 97% lower than the number of COVID-19 indemnity claims reported in 2022.

⁸See mwcia.org/Media/Default/PDF/Navigation/COVID-19_Insights_Phase_II.pdf for more information about differences in indemnity and medical payments for COVID-19 and non-COVID-19 claims nationwide. The report shows COVID-19 claims are generally low-cost claims. In Minnesota, average paid and paid-plus-case severities for COVID-19 lost-time claims were 84% to 87% less costly when compared with non-COVID-19 claims.

⁹The percentages shown in Figure 2.5 only reflect the indemnity and medical shares as a percentage of total benefit payments in the voluntary market. They are different than the indemnity and medical shares of system cost shown in Figure 2.8 because Figure 2.8 presents data for both insured and self-insured employers and reflects the shares of system cost that are allocated to state agency administrative expenses and insurer expenses, in addition to benefit payments.

¹⁰A [2026 report](#) from the Department of Commerce examines the overall trend in pure premiums, loss cost multipliers and the impact of the pure premium changes in more detail.

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

¹²Changes in pure premium rates directly following law changes also include anticipated effects of those law changes as estimated by MWCIA.

¹³One 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). (*Workers' compensation: benefits, costs, and coverage (2022 data)*, NASI, November 2024 (and prior reports), (nasi.org/wp-content/uploads/2024/11/2024-WC-Report-2022-Data-Final.pdf, Table 15. Relevant data also appears in National Council on Compensation Insurance, *2025 State of the Line Guide*, at ncci.com/SecureDocuments/SOLGuide_2025.html and *Understanding What Drives the Underwriting Cycle*, May 2014, at workcompwire.com/2014/06/new-ncci-report-understanding-what-drives-the-underwriting-cycle. The latter also explores several theories about the causes of the underwriting cycle.

¹⁴ $(1 - .27)^2 - 1 = -.46$.

¹⁵Values reported in last year's System Report showed that insurer expenses and medical benefits each accounted for roughly 33% of total system cost in 2023. The decline in the medical share in 2024 likely reflects statutory reductions in the hospital outpatient fee schedule (HOFs) beginning in October 2023, the stabilization of nonhospital professional service prices following earlier increases, and continued declines in claim frequency, as discussed in Workers Compensation Research Institute (WCRI) [Compscope Benchmarks](#) studies for Minnesota. Because this report calculates the share of insurer expenses as a residual after medical and indemnity benefits and state administrative costs, a reduction in the medical share can make insurer expenses appear larger as a percentage of total system cost by comparison. However, the percentages for recent years are subject to change as additional data updates become available.

¹⁶For 2024, the percentage of medical benefits is larger than the percentage of indemnity benefits in Figure 2.8, while the indemnity share is slightly larger than the medical share in Figure 2.5. This is because Figure 2.8 presents data for both insured and self-insured employers and excludes vocational rehabilitation from indemnity benefits. Figure 2.5 presents data only for the voluntary market and includes vocational rehabilitation in the indemnity benefits. If vocational rehabilitation were included in the indemnity benefits for Figure 2.8, the percentages of indemnity and medical benefits would be closer to the shares presented in Figure 2.5.

¹⁷ Recent [WCRI Compscope Benchmarks](#) reports for Minnesota have also shown increases in average TTD benefits from 2021 to 2024, driven by sustained wage growth and longer disability durations for non-COVID-19 claims. WCRI will examine the effects of the statutory increase in the TTD benefit maximum in future reports.

¹⁸The APIW has been declining relative to the SAWW since at least 1984, when the two were equal, but this trend was reversed in 2021 and 2022 due to accelerating wage growth in the low-wage sector driven by tight labor market conditions in the state, as well as the high number of COVID-19 claims in this period.

¹⁹Because of year-to-year fluctuations in the data, three-year averages were used to calculate the percentage of the change in adjusted average weekly benefits due to the decrease in the APIW relative to the SAWW.

²⁰The benefit amount per rating point increases with the size of the rating (Minnesota Statutes § 176.101, subdivision 2a). As a result, a given percent decrease in the average rating will tend to produce a somewhat larger percent decrease in the average benefit because more claims are in lower brackets in the schedule with lower benefit amounts per rating point.

²¹See further analysis on the impact of Minnesota's wage growth at wcrinet.org/reports/compscope-benchmarks-for-minnesota-2025-edition.

²²Data for the most recent years might also reflect changes in data reporting and settlement activity and be subject to change.

²³Settlement benefits depend in part on the value of benefits the worker might receive without a settlement. Settlement benefits can include payments for medical and vocational rehabilitation benefits in addition to total disability, TPD and PPD benefits. Under current DLI protocols, insurers do not separate the indemnity, medical and vocational rehabilitation components of settlement awards in their reporting to DLI. Settlements may close out some or all medical benefits. The settlement values also include contingent attorney fees. The method of identifying settlements was revised for the current report by using receipt of a settlement document by the department rather than settlement data alone due to poor data quality and missing forms. This may have caused a deviation from trends in past reports, particularly with regard to settlement and PPD data. The new approach allows DLI to capture settlement payments more accurately.

²⁴DLI analysis showed that there was a significant increase in both the number of claims with settlements and in average settlement payments per claim for police and public-sector employees for injury-year 2020. From 2019 to 2020, the number of claims with settlements in the police protection industry tripled. These claims also involved higher average settlement benefits per claim compared to other years. [The WCRI CompScope Benchmarks for Minnesota, 24th Edition](#) also shows a large one-time increase in lump-sum settlements per claim in 2020, which reflected settlements with larger payment amounts.

²⁵As shown in Figure 4.4, the cost of vocational rehabilitation has averaged around \$2,500 per paid indemnity claim (adjusted for wage growth) from 2004 to 2024. The MWCIA number in Figure 3.10 exceeded the DLI number by an average of \$3000 from 2004 to 2023 for all claims (and around \$2000 for non-Covid claims). Another possible factor for the difference between the MWCIA and DLI amounts is the MWCIA figure excludes self-insured employers while the DLI figure includes them, although the effect of this difference is uncertain.

²⁶Claim-specific reserves are funds an insurer sets aside to cover anticipated future costs of particular claims.

²⁷For injury year 2024, the DLI number for indemnity benefits per \$100 of payroll slightly exceeds the MWCIA number. As these are developed statistics, reported values for more recent years are less stable and are expected to change as the claims mature.

²⁸Modernization expenditures, funded by the workers' compensation assessment, amounted to about \$16.4 million from 2019 to 2021.

²⁹Through payment-year 2016, DLI required insurers to report paid medical benefits as a separate item in the annual *Workers' Compensation Report of Benefits Paid*. Beginning with payment-year 2017, DLI dropped medical benefits from the report; however, some insurers erroneously added these benefits to their reported paid indemnity benefits. Between the two payment-years, reported indemnity increased by 17.8%. This contributed the majority of the 23.8% decrease in the nominal assessment rate for assessments due in fiscal-year 2019. The remainder of the decrease resulted from a drop of 10.3% in assessment liabilities between the two years.

³⁰Minnesota Statutes § 176.102, subdivision 1(b), and Minnesota Rules, part 5220.0100, subpart 34. The statistics regarding vocational rehabilitation services in this part of the report do not include consultations provided to injured workers who are not found eligible for services or who do not have a vocational rehabilitation service plan filed.

³¹A settlement might have included consideration for PPD benefits. Some of the workers with a PPD benefit may also have received a settlement that included consideration for additional PPD.

³²The vocational rehabilitation service costs indicated here are those reported by QRCs to DLI on the plan-closure form. These costs do not always represent the amounts actually paid.

³³Injured workers with settlements are excluded from this group because PPD benefits are often in dispute when settlements occur.

³⁴According to the [Bureau of Labor Statistics](#), Minnesota's job opening rate declined from 6.9% in December 2022 to 4.7% in December 2025. A lower job-opening rate means reduced labor demand, which may translate into lower wages for workers who return to work with a different employer than their pre-injury one.

³⁵Minnesota Statutes § 176.081, subdivision 1(c).

³⁶Minn. Stat. § 176.106. In 2005, the Legislature increased the monetary limit on DLI jurisdiction in medical disputes from \$1,500 to \$7,500. In 2013, the Legislature removed this limit for disputes about medical fees, effective May 17, 2013. Also, DLI usually refers medical disputes to CAH if surgery is involved and it may refer medical or vocational rehabilitation disputes if same or similar litigation on the claim is pending at CAH. 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 CAH.

³⁷Minn. Stat. § 176.239.

³⁸Minn. Stat. § 176.1812.

³⁹The indemnity benefits provided must be those in Minnesota law.

⁴⁰The numbers in Figure 5.2 are not developed; they show the number of disputes filed by Dec. 31, 2025, for workers injured from 2020 through 2024. Therefore, the number of disputes shown for 2023 claims have an extra year of maturity compared with 2024 claims.

⁴¹These are developed denial rates. For 2020 through 2024, only the non-COVID-19 claim denials were developed and the reported number of COVID-19 claim denials were then added to the developed numbers to produce the 2020 through 2024 estimates.