Minnesota Workers' Compensation System Report, 2001

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Executive Summary

After a period of stability in the late 1990s, trends in the Minnesota workers' compensation system have begun to change:

- The claim rate, which had been falling gradually, is sharply down for 2001.
- Indemnity and medical benefits are up (adjusting for wage growth), both per claim and relative to payroll. This is at least partly due to longer claim duration and general medical inflation.
- Participation in vocational rehabilitation, already increasing, rose more rapidly in 2000 and 2001.
- The dispute rate increased sharply in 2000 and 2001.
- Total workers' compensation system cost rose 10 percent relative to payroll from 2000 to 2001, after seven years of decline.

The current recession may partly explain some of these developments—particularly the recent sharp drop in the claim rate and the increases in claim duration, vocational rehabilitation participation, and the dispute rate. However, this cannot be firmly established with the current data.

Another factor is the benefit increases enacted by the 2000 legislature. These contribute a relatively small amount to the increases in benefit payments over the last three years.

This report, part of an annual series, presents data from 1984 through 2001 on several aspects of Minnesota's workers' compensation system—claims, benefits, and costs; vocational rehabilitation; and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

Major Findings

Claims, Benefits, and Costs: Overview

- Claim rates showed a pronounced drop in 2001, after declining gradually from 1984 to 2000. In 2001 there were 7.2 paid claims per 100 full-time-equivalent (FTE) workers, consisting of 1.5 indemnity claims and 5.7 medical-only claims. The corresponding claim rates for 1984 were 10.3, 2.9, and 7.4, respectively.
- The total cost of Minnesota's workers' compensation system turned upward relative to payroll in 2001, after falling nearly in half from 1994 to 2000. In 2001, the cost was $1.44 per $100 of payroll, up 10 percent from 2000, but still down 44 percent from 1994. The main reasons for this increase are higher benefit payments relative to payroll, low insurance company investment returns during the last two years, and inadequate premiums from highly competitive pricing in the late 1990s.[1]
- The total cost of workers' compensation in 2001 was an estimated $1.16 billion.
- Indemnity and medical benefits—measured per claim and relative to payroll—have risen since 1998 but are still far below their peaks from 1990. Indemnity benefits were up 11 percent relative to payroll from 1998 to 2001, medical benefits were up 19 percent, and total benefits were up 15 percent. For the first time, medical benefits are greater than indemnity benefits.

Claims, Benefits, and Costs: Detail

- Among paid indemnity claims in 2001:

[1] See "Explaining Recent Workers' Compensation Premium Increases," *DLI Research Reporter,* September 2002, www.doli.state.mn.us/reportersept02.htm.

- 85 percent received total disability benefits (temporary or permanent);
- 29 percent received temporary partial disability (TPD) benefits;
- 24 percent received permanent partial disability (PPD) benefits;
- 18 percent received stipulated benefits.

These numbers have been stable since the mid-1990s, with a slight downward trend for TPD and stipulated benefits.

- The average duration of total disability benefits rose 24 percent between 1998 and 2001. For TPD benefits, average duration rose 8 percent between the periods 1998-1999 and 2000-2001.[2] These increases came after a period of stability at relatively low levels beginning in 1995. In 2001, average total disability and TPD durations were 11 and 16 weeks, respectively.

- Average indemnity benefits per indemnity claim (adjusted for wage growth) rose 23 percent between 1998 and 2001, driven primarily by the increase in total disability duration and by an increase in average stipulated benefits. The 2001 figure, $12,260, is somewhat higher than in 1993 but 30 percent below the peak in 1990.

- The cost of supplementary benefits and second-injury claims is projected at $66 million, or 5 percent of total workers' compensation system cost, for 2003. This cost (unadjusted for inflation) is expected to fall in half by 2020 and to disappear by 2045. Settlement activity will hasten the decline in this cost.

- State agency administrative cost in 2001 amounted to 3.5 cents per $100 of covered payroll, about the same as in 1990. This is about 2 percent of total workers' compensation system cost.

Vocational Rehabilitation

- About 21 percent of paid indemnity claimants injured in 2001—a projected total of 6,700—will receive vocational rehabilitation (VR) services.

- The VR participation rate increased by 4.2 percentage points from 1999 to 2001, more than double the increase from 1997 to 1999.

- Because of the rising participation rate, the total cost of VR services rose 32 percent from 1998 to 2001, adjusting for wage growth.

- The total cost of VR services for 2001, $37 million, was about 3 percent of total workers' compensation system cost.

- The average cost of VR services declined 4 percent between 1998 and 2001, adjusting for average wage growth.

- About three quarters of VR participants have a job at the time of plan closure; a majority of these are with their pre-injury employer.

Disputes and Dispute Resolution

- The overall dispute rate increased from 14.8 percent of filed indemnity claims in 1999 to 16.6 percent in 2001. This followed a period of relatively low dispute rates from 1995 to 1999.

- The rate of denial of filed indemnity claims has remained between 14 and 16 percent since 1991.

- For wage-loss claims filed in 2001, the proportion with "prompt first action" (payment initiation or denial within the legal time limit) was 84 percent, down from 85 percent in 1999.

- The percentage of paid indemnity claims with claimant attorney fees rose from 13.0 percent in 1999 to 14.5 percent in 2001. This parallels the increase in the dispute rate. The rate of claimant attorney involvement had decreased from 17 percent in 1991 to 13 percent in 1999.

- For 2001, total claimant and defense legal costs were about $83 million, roughly 10 percent of total benefits and 7 percent of total workers' compensation system cost.

[2] The increase of TPD duration is figured using two-year averages because of annual fluctuations.

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(Continued)

Figures

1

Introduction

During the early and middle 1990s, workers' compensation benefits and costs fell nationwide, through cost-control measures by employers and insurers and law changes in most states. In Minnesota, a combination of employer and insurer efforts and law changes in 1992 and 1995 produced major cost reductions in the first half of the 1990s, followed by a period of stability in the second half of the decade.

The most recent data, however, show total system cost increasing relative to payroll. This is partly related to insurance premium increases in response to low investment returns during the last two years and to under-pricing in a highly competitive environment in the late 1990s.[3] It is also related to increasing benefit payments, with medical benefits rising faster than indemnity benefits. The current recession is probably contributing through longer claim duration. The benefit increases enacted by the 2000 legislature account for a minor portion of the recent increases in benefit payments.

This report, part of an annual series, presents data from 1984 through 2001 on several aspects of Minnesota's workers' compensation system—claims, benefits, and costs; vocational rehabilitation; and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota.

Chapter 2 presents overall claim, benefit, and cost data. Chapter 3 presents more detailed data to explain some of the trends in Chapter 2. Chapters 4 and 5 provide statistics on vocational rehabilitation and on disputes and dispute resolution.

Appendix A contains a glossary. Appendix B summarizes portions of the 1992, 1995, and 2000 law changes relevant to trends in this report. Appendix C describes data sources and estimation procedures.

Some important points to keep in mind throughout the report:

Developed statistics. Most statistics in this report are presented by injury year or insurance policy year.[4] An issue with such data is that the originally reported numbers for more recent years are not mature because of long claims and reporting lags. In this report, all injury-year and policy-year data are "developed" as needed to a uniform maturity so that the statistics are comparable over time. The technique uses "development factors" (projection factors) based on observed data for older claims. Appendix C gives more detail.

Economic slowdown. The current economic slowdown has probably affected workers' compensation. However, although some theories are plausible, it is not known exactly how and to what degree this has occurred. The current slowdown should be recognized as a possible contributing factor to the recent statistics in this report. Possible effects of the economy are occasionally pointed out.

[3] See "Explaining Recent Workers' Compensation Premium Increases," *DLI Research Reporter,* September 2002, www.doli.state.mn.us/reportersept02.htm.

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

2

Claims, Benefits, and Costs: Overview

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

Major Findings

- Claim rates showed a pronounced drop in 2001, after declining gradually from 1984 to 2000. In 2001, there were 7.2 paid claims per 100 full-time-equivalent (FTE) workers, consisting of 1.5 indemnity claims and 5.7 medical-only claims. The corresponding claim rates for 1984 were 10.3, 2.9, and 7.4, respectively. (Figure 2.1)

- The sharp drop in the claim rate for 2001 may be related to the current recession, to the degree that injury rates fall when production is slower and fewer inexperienced workers are hired.

- The total cost of Minnesota's workers' compensation system turned upward relative to payroll in 2001, after falling nearly in half from 1994 to 2000. In 2001, the cost was $1.44 per $100 of payroll, up 10 percent from 2000, but still down 44 percent from 1994. (Figure 2.2) The main reasons for this increase are higher benefit payments relative to payroll, low insurance company investment returns during the last two years, and inadequate premiums from highly competitive pricing in the late 1990s.[5]

- Pure premium rates rose in 2002 and 2003 after falling nearly in half from 1994 to 2001. The 2003 rates are up 5.9 percent from 2002. (Figure 2.4)

- Indemnity and medical benefits—measured per claim and relative to payroll—have risen since 1998 but are still far below their peaks from 1990. (Figures 2.5, 2.7-2.8) Indemnity benefits were up 11 percent relative to payroll from 1998 to 2001, medical benefits were up 19 percent, and total benefits were up 15 percent. (Figure 2.5) For the first time, medical benefits are greater than indemnity benefits. (Figures 2.5, 2.6)

Background

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

Workers' Compensation Benefits and Claim Types

Workers' compensation provides three basic types of benefits:

Indemnity benefits compensate the injured or ill worker (or dependents) for wage loss, permanent functional impairment, or death.

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

Vocational rehabilitation benefits consist of a variety of services to help eligible injured workers return to work. These benefits are considered separately in Chapter 4.

Claims with indemnity benefits 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.

[5] See "Explaining Recent Workers' Compensation Premium Increases," *DLI Research Reporter,* September 2002, www.doli.state.mn.us/reportersept02.htm.

Insurance Arrangements

Employers cover themselves for workers' compensation in one of three ways. The most common is to purchase insurance in the "voluntary market," so named because an insurer may choose whether to insure any particular employer. Employers unable to insure in the voluntary market may insure through the Assigned Risk Plan, the insurance program of last resort administered by the Department of Commerce. Employers meeting certain financial requirements may self-insure.

Rate-Setting

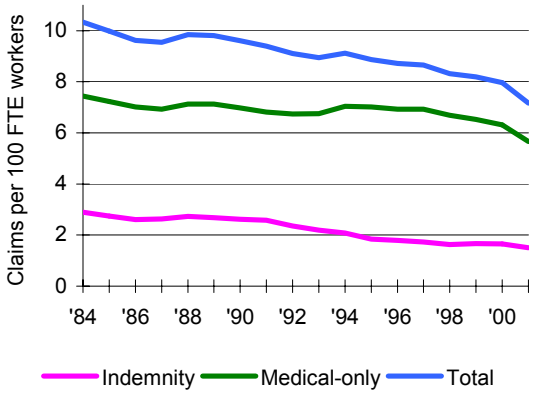
Minnesota is an open-rating state for workers' compensation, meaning rates are set by insurance companies rather than by a central authority. In determining their rates, insurance companies start with "pure premium rates" calculated every year by Minnesota's workers' compensation data service organization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

Claim Rates

Claim rates took a pronounced downward turn in 2001, after falling gradually from 1984 through 2000.

- In 2001, there were:
  - 7.2 paid claims per 100 FTE workers, down 10 percent from 2000.
  - 1.5 paid indemnity claims per 100 FTE workers, down 8 percent from 2000.
  - 5.7 paid medical-only claims per 100 FTE workers, down 10 percent from 2000.
- The sharp drop in the claim rate in 2001 may be related to the current recession.[6] Injury rates are likely to decrease during economic slow-downs because of slower production and relatively few inexperienced workers.[7]
- The overall paid claim rate for 2001 is down 25 percent from 1990 and 31 percent from 1984.
- Of the total decrease in the indemnity claim rate from 1984 to 2001, more than half occurred from 1990 to 1995, during which time indemnity claims fell from a 27-percent share of total paid claims to 21 percent. This percentage has shown little change since 1995.

Figure 2.1 Paid Claims Per 100 Full-Time-Equivalent Workers, Injury Years 1984-2001 [1]



Injury Year	Indemnity Claims	Medical-Only Claims	Total Claims
1984	2.9	7.4	10.3
1990	2.6	7.0	9.6
1995	1.8	7.0	8.9
1999	1.7	6.5	8.2
2000	1.7	6.3	8.0
2001	1.5	5.7	7.2

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

[6] In Minnesota, the total nonagricultural employment trend flattened in late 2000 and turned downward in 2001. U.S. Bureau of Labor Statistics, http://data.bls.gov.

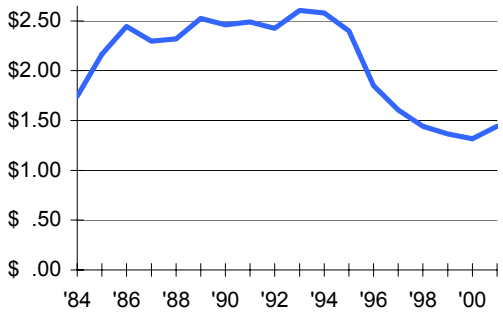
[7] Also, injured workers may be less likely to file a claim during a recession if they have a heightened fear that claiming will lead to lay-off. However, a recession could cause an increase in claiming as a response by injured workers to being laid off or to a belief that lay-off is imminent. According to some studies, the net effect is for claim rates to decrease during recessions. See, for example, Brooker, A., and T. Sullivan, "Workers' Comp and the Business Cycle," in *On Workers' Compensation,* 3(9), November 1994.

System Cost

The total cost of Minnesota's workers' compensation system turned upward relative to payroll in 2001, after falling nearly in half from 1994 to 2000.

- Between 2000 and 2001, cost rose from $1.32 per $100 of payroll (revised) to $1.44, a 10 percent increase. The main reasons for this increase are the following: [8]
  - Benefit payments have increased relative to payroll (documented later in this report).
  - Low investment returns of the last two years have reduced insurers' earnings on invested premiums.
  - In a highly competitive environment in the late 1990s, insurers set premiums to levels too low to cover benefits and other costs, and now need to raise premiums to adequate levels.
- The total cost of workers' compensation in 2001 was an estimated $1.16 billion, up from $1.02 billion in 2000 (not adjusted for inflation).
- These figures reflect benefits (indemnity, medical, and vocational rehabilitation) plus other costs such as claim adjustment, litigation, and taxes and assessments. The figures are computed primarily from actual premium for insured employers (allowing for costs under deductible limits) and pure premium for self-insured employers (see Appendix C).

Figure 2.2 System Cost per $100 of Payroll, 1984-2001 [1]



	Cost per $100 of Payroll
1984	$1.74
1990	2.46
1994	2.58
1998	1.44
2000 [2]	1.32
2001 [2]	1.44

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

[8] See "Explaining Recent Workers' Compensation Premium Increases," *DLI Research Reporter,* September 2002, www.doli.state.mn.us/reportersept02.htm.

Insurance Arrangements

The voluntary market lost market share in 2000 and 2001 after a period of increase during the late 1990s.

- The voluntary market share of paid indemnity claims was 74 percent in 2001, down from 76 percent in 1999 but still higher than the low point of 62 percent in 1993.
- The Assigned Risk Plan share increased in 2001 and the self-insured share increased in both 2000 and 2001, but both were still well below their high-points in 1993.
- These shifts are at least partly due to changes in insurance rates reflected in Figures 2.2 and 2.4. Increases in insurance rates tend to cause shifts from the voluntary market to the Assigned Risk Plan and self-insurance, and vice versa.
- When market share is measured by pure premium (not shown here), the trends are nearly identical.

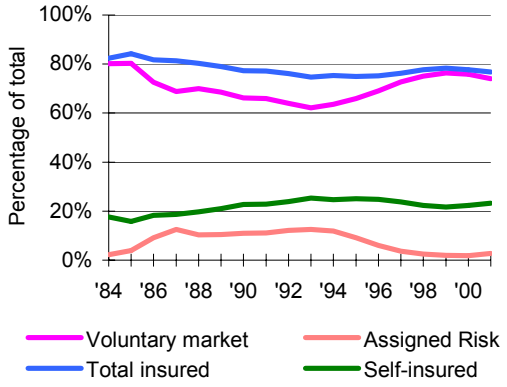
Pure Premium Rates

Pure premium rates rose in 2002 and 2003 after falling nearly in half from 1994 to 2001.

- Pure premium rates rose 5.9 percent in 2003. They are up 7.4 percent from 2001, but are still 45 percent below their peak in 1994.
- The increase in 2003 reflects increases in benefits relative to payroll (documented later in this report).
- The decreases during the 1990s reflect a combination of the 1992 and 1995 law changes and other factors, including safety programs, more active medical treatment, better management of claims and costs, and more effective return-to-work programs.[9]
- Insurers in the voluntary market use the pure premium rates in determining their own rates, which in turn affect total system cost (Figure 2.2).

[9] These are well-documented in the workers' compensation literature.

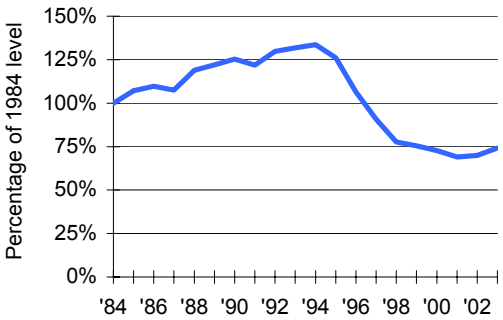
Figure 2.3 Market Shares of Different Insurance Arrangements as Measured by Paid Indemnity Claims, Injury Years 1984-2001 [1]



Injury Year	Voluntary Market	Assigned Risk Plan	Total Insured	Self-Insured
1984	80.1%	2.3%	82.4%	17.6%
1993	62.2	12.5	74.7	25.3
1999	76.3	2.0	78.4	21.6
2000	75.8	1.9	77.7	22.3
2001	74.0	2.7	76.7	23.3

1. Data from DLI.

Figure 2.4 Pure Premium Rates as Percentage of 1984 Level, 1984-2003 [1]



Effective Year	Percentage of 1984
1984	100.0%
1994	133.6
2001	69.0
2002	70.0
2003	74.1

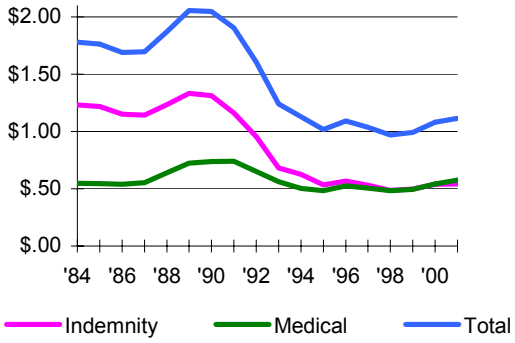
1. Data from the MWCIA. Pure premium rates represent expected indemnity and medical losses per $100 of covered payroll in the voluntary market.

Benefits Relative to Payroll

Indemnity and medical benefits rose relative to payroll from 1998 to 2001, but are still far below their peaks in 1990.

- Between 1998 and 2001, relative to payroll:
  - Indemnity benefits rose 11 percent.[10]
  - Medical benefits rose 19 percent.
  - Total benefits rose 15 percent.
- In 2001, total benefits relative to payroll were down 46 percent from their peak in 1990. Indemnity benefits were down 59 percent, medical benefits 22 percent.
- Most of the decreases occurred during the early 1990s; benefits were stable relative to payroll from 1995 to 1998.
- These figures ultimately drive the pure premium rate trend in Figure 2.4.[11]

Figure 2.5 Benefits per $100 of Payroll in the Voluntary Market, Accident Years 1984-2001 [1]



Accident Year	Indemnity Benefits	Medical Benefits	Total Benefits
1984	$1.23	$.55	$1.78
1990	1.31	.74	2.05
1995	.53	.48	1.02
1998	.49	.48	.97
1999	.50	.49	.99
2000	.54	.54	1.08
2001	.54	.57	1.12

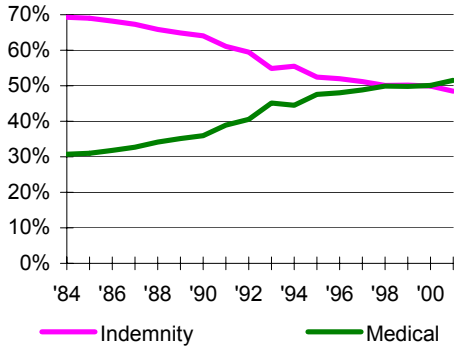
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan, and supplementary and second-injury benefits.

Indemnity and Medical Shares

The indemnity share of total benefits has fallen steadily since 1984, so total indemnity benefits are now somewhat less than total medical benefits.

- Reflecting the data in Figure 2.5, indemnity benefits were 48 percent of total benefits in 2001, down from 50 percent in 2000 and 69 percent in 1984.
- Medical benefits now account for 52 percent of total benefits.
- Most of the decrease in the indemnity share (and the increase in the medical share) occurred before 1995.

Figure 2.6 Indemnity and Medical Benefit Percentages in the Voluntary Market, Accident Years 1984-2001 [1]



Accident Year	Indemnity Benefits	Medical Benefits
1984	69.2%	30.8%
1995	52.4	47.6
1999	50.2	49.8
2000	49.9	50.1
2001	48.5	51.5

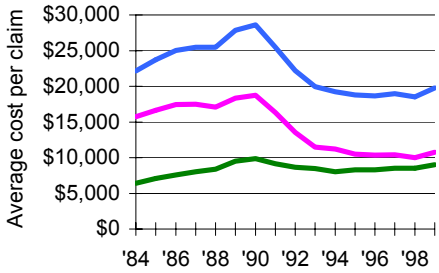
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan, and supplementary and second-injury benefits.

[10] The indemnity benefit trend in Figure 2.5, from insurance data, is closely corroborated by DLI data.

[11] Changes in pure premium rates directly following law changes also include estimated effects of those law changes.

Figure 2.7 Average Indemnity and Medical Benefits per Insured Claim, Adjusted for Wage Growth, Policy Years 1984-1999 [1]

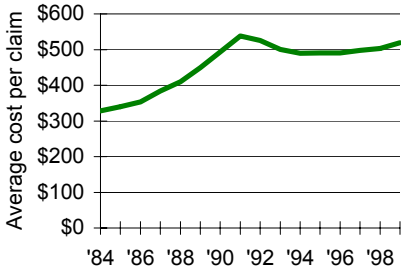
A: Indemnity Claims



Policy Year	Indemnity Benefits	Medical Benefits	Total Benefits
1984	$15,700	$6,400	$22,100
1990	18,700	9,900	28,600
1997	10,400	8,500	18,900
1998	10,000	8,500	18,500
1999	10,800	9,000	19,800

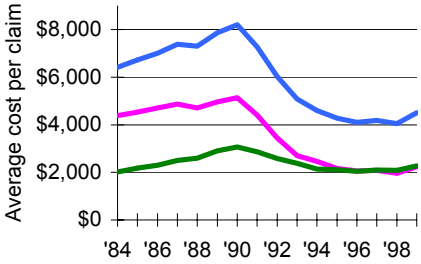
Indemnity Medical Total

B: Medical-Only Claims



Policy Year		Medical Benefits	Total Benefits
1984		$328	$328
1991		538	538
1997		498	498
1998		503	503
1999		519	519

C: All Claims



Policy Year	Indemnity Benefits	Medical Benefits	Total Benefits
1984	$4,390	$2,020	$6,410
1990	5,140	3,070	8,210
1997	2,080	2,100	4,180
1998	1,970	2,080	4,060
1999	2,230	2,270	4,510

Indemnity Medical Total

1. Developed statistics from MWCIA data (see Appendix C). Includes the Assigned Risk Plan; excludes self-insured employers. Benefits are adjusted for average wage growth between the respective year and 2001

Benefits per Claim

Adjusting for wage growth, average benefits per insured claim turned sharply upward in 1999, following a period of stability at relatively low levels during the middle and late 1990s.

- For all claims combined, in 1999 relative to 1998:
  - average total benefits were up 11 percent;
  - average indemnity benefits were up 13 percent;
  - average medical benefits were up 9 percent.
- However, relative to their peak in 1991:
  - average total benefits were down 45 percent;
  - average indemnity benefits were down 57 percent;
  - average medical benefits were down 26 percent.[12]
- The trend in benefits relative to payroll (Figure 2.5) is driven by the trends in average benefits per claim (Figure 2.7) and in claim rates (Figure 2.1)

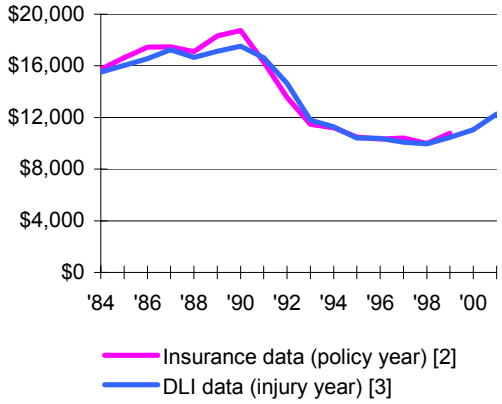
[12] The declines during the early 1990s were steeper for all claims combined than for indemnity or medical-only claims because the more expensive indemnity claims (for both indemnity and medical benefits) became a smaller proportion of total claims (see discussion of Figure 2.1).

Indemnity Benefits per Indemnity Claim: Insurance and DLI Data

As shown by DLI data, average indemnity benefits per indemnity claim increased for the last three years, adjusting for wage growth. The DLI data closely corroborate the insurance data.

- The 2001 DLI figure is up 11 percent from 2000 and 23 percent from 1998. Given the drop in the indemnity claim rate between 1998 and 2001 (Figure 2.1), this increase explains the increase in indemnity benefits relative to payroll over the same period (Figure 2.5).
- From 1990 to 1999, the insurance and DLI numbers differ by an average of 3 percent.

Figure 2.8 Average Indemnity Benefits per Indemnity Claim, Adjusted for Wage Growth, 1984-2001: Insurance and DLI Data [1]



Policy or Injury Year	Insurance Data [2]	DLI Data [3]
1984	$15,700	$15,500
1990	18,700	17,500
1998	10,000	10,000
1999	10,800	10,500
2000	[4]	11,000
2001	[4]	12,300

1. Benefits are adjusted for average wage growth between the respective year and 2001.
2. From Figure 2.7. Excludes self-insured employers, supplementary benefits, and second-injury claims. Includes the Assigned Risk Plan and vocational rehabilitation benefits.
3. Developed statistics (see Appendix C). Includes self-insured employers, the Assigned Risk Plan, supplementary benefits, and second-injury claims. Excludes vocational rehabilitation benefits.
4. Not yet available.

3

Claims, Benefits, and Costs: Detail

This chapter presents additional data on claims, benefits, and costs. Most of the data provide further detail on the indemnity claim and benefit information in Chapter 2. Some of the data relate to costs of special benefit programs and state agency administrative functions.

Major Findings

- Among paid indemnity claims in 2001:
  - 85 percent received total disability benefits (temporary or permanent);
  - 29 percent received temporary partial disability (TPD) benefits;
  - 24 percent received permanent partial disability (PPD) benefits;
  - 18 percent received stipulated benefits.

  These numbers have been stable since the mid-1990s, with a slight downward trend for TPD and stipulated benefits. (Figure 3.2)

- The average duration of total disability benefits rose 24 percent between 1998 and 2001. For temporary partial disability (TPD) benefits, average duration rose 8 percent between the periods 1998-1999 and 2000-2001.[13] These increases came after a period of stability at relatively low levels beginning in 1995. In 2001, average total disability and TPD durations were 11 and 16 weeks, respectively. (Figure 3.3)

- The current recession probably explains at least some of the recent duration increases, because injured workers are likely to need benefits for longer periods when job opportunities are less plentiful.

- Average indemnity benefits per indemnity claim (adjusted for wage growth) rose 23 percent between 1998 and 2001. The 2001 figure, $12,260, is somewhat higher than in 1993 but 30 percent below the peak in 1990. (Figures 3.5, 3.6)

- The 1998-2001 increase in average indemnity benefits per indemnity claim was driven primarily by the increase in total disability duration and by an increase in average stipulated benefits. The 2000 law change contributed a smaller amount to this increase.

- The cost of supplementary benefits and second-injury claims is projected at $66 million, or 5 percent of total workers' compensation system cost, for 2003. This cost (unadjusted for inflation) is expected to fall in half by 2020 and to disappear by 2045. Settlement activity will hasten the decline in this cost. (Figure 3.7)

- State agency administrative costs in 2001 amounted to about 3.5 cents per $100 of covered payroll, about the same as in 1990. This is about 2 percent of total workers' compensation system cost. (Figure 3.8)

Background

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

Benefit Types

Temporary total disability (TTD). A 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 minimum and maximum. TTD ends when the employee returns to work (among other reasons).

[13] The increase of TPD duration is figured using two-year averages because of annual fluctuations.

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

Permanent partial disability (PPD). PPD compensates for permanent functional impairment resulting from a work-related injury or illness. The benefit is based on the employee's impairment rating and is unrelated to wages.

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

Stipulated benefits. Indemnity and/or medical benefits specified in a claim settlement—"stipulation for agreement"—among the affected parties. A stipulation usually occurs in a dispute, and stipulated benefits are usually paid in a lump-sum.

Total disability. In most figures in this chapter—those presenting DLI data—the term "total disability" refers to the combination of TTD and PTD benefits, because the DLI data do not distinguish between these two benefit types.

Counting Claims and Benefits: Insurance Data and Department Data

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

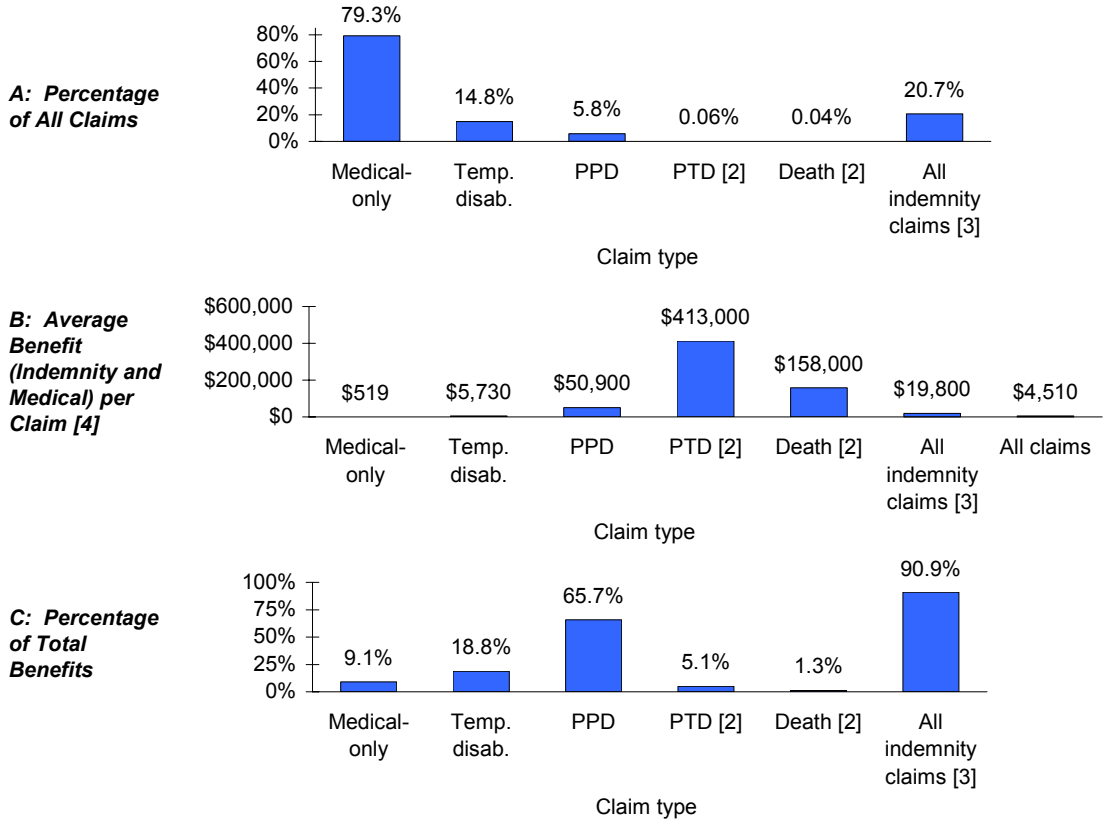
In the insurance data, claims and benefits are categorized by "claim type," defined according to the most severe type of benefit on the claim. In increasing severity, the benefit types are medical, temporary disability (TTD or TPD) , PPD, PTD, and death. For example, a claim with medical, TTD, and PPD payments is a PPD claim. PPD claims also include (1) claims with temporary disability benefits lasting more than one year and (2) claims with stipulated settlements. All benefits on a claim are counted in the one claim-type category that the claim falls into.

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

Costs Supported by Special Compensation Fund Assessment

DLI, through its Special Compensation Fund (SCF), levies an annual assessment on insurers (including self-insurers) to finance state agency administrative costs related to workers' compensation and certain benefits for which DLI is responsible. Primary among these benefits are supplementary benefits and second-injury benefits. Although these programs have been eliminated, benefits must still be paid on old claims (see Appendices B and C). Insurers add the assessment amount to premium charged to employers, and this is included in total workers' compensation system cost (Figure 2.2).

Figure 3.1 Benefits by Claim Type for Insured Claims, Policy Year 1999 [1]



1. Developed statistics from MWCIA data (see Appendix C).
2. Because of annual fluctuations, data for PTD and death claims are averaged over several years (see Appendix C).
3. Indemnity claims consist of all claim types other than medical-only.
4. Benefit amounts in Panel B are adjusted for average wage growth between 1999 and 2001.

Benefits by Claim Type

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

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

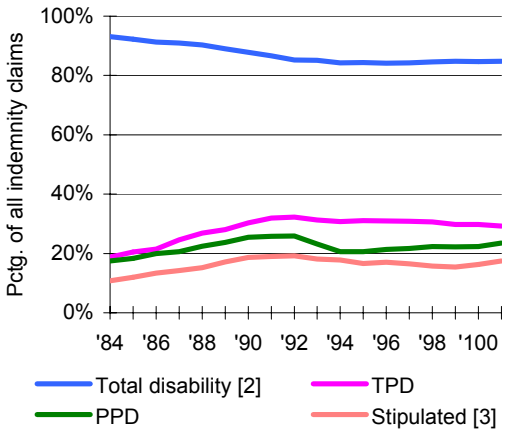
- PPD claims accounted for 66 percent of total benefits in 1999 (Panel C of Figure 3.1) because of a combination of moderate frequency (Panel A) and higher-than-average benefits per claim (Panel B).
- Other claim types contributed smaller amounts to total benefits because of low frequency (PTD and death claims) or low average benefits (medical-only claims).
- Indemnity claims were 21 percent of all paid claims, but accounted for 91 percent of total benefits because they have far higher benefits on average than medical-only claims ($19,800 vs. $519).

Claims by Benefit Type

Since the mid-1990s, the percentages of paid indemnity claims with different types of benefits have been stable or have changed slightly, depending on the benefit type.

- The percentage of claims with total disability benefits has remained steady since 1992, while the percentage with TPD benefits has gradually declined.
- The percentage of claims with PPD benefits increased between 1994 and 2001.
- The decrease in the percentage of claims with PPD benefits between 1992 and 1994 resulted from the introduction of a new PPD rating schedule in July 1993.[14]
- The percentage of claims with stipulated benefits—decreasing from 1992 through 1999 and increasing between 1999 and 2001—is probably related to a similar trend in the dispute rate (Figure 5.1).
- The 1984-1992 period experienced substantial increases in the percentages of claims with TPD, PPD, and stipulated benefits, along with a decrease in the percentage with total disability benefits.

Figure 3.2 Percentages of Paid Indemnity Claims With Selected Types of Benefits, Injury Years 1984-2001 [1]



Injury Year	Total Disab.[2]	TPD	PPD	Stipu-lated [3]
1984	93.1%	18.8%	17.5%	10.8%
1992	85.3	32.2	25.9	19.1
1995	84.3	31.1	20.6	16.6
1999	84.8	29.8	22.2	15.4
2000	84.7	29.7	22.4	16.3
2001	84.8	29.3	23.5	17.5

1. Developed statistcs from DLI data (see Appendix C). An indemnity claim may have more than one type of benefit paid. Therefore, the sum of the figures for the different benefit types is greater than 100 percent.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.
3. Includes indemnity and medical components.

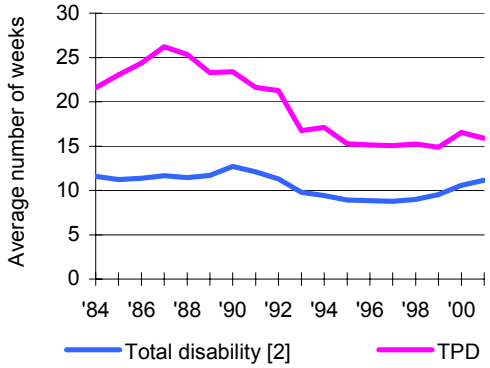
[14] "Analysis of the Effects of the 1993 Permanent Partial Disability Rating Schedule," DLI Research and Statistics, August 1999.

Benefit Duration

The average durations of total disability and TPD benefits increased in the last two to three years.

- After a period of stability at relatively low levels starting in 1995, total disability duration turned upward in 1999 and TPD duration did the same in 2000.
  - ➢ Total disability duration for 2001 was up 24 percent from 1998.
  - ➢ Using two-year averages, TPD duration for 2000-2001 was up 8 percent from 1998-1999. (Averages are used for TPD duration because of annual fluctuations.)
- These increases in duration affect indemnity costs (Figures 2.5, 2.7-2.8, 3.5, 3.6). As a result, they also affect pure premium rates and system cost (Figures 2.2, 2.4), although this is a delayed effect.
- The current recession probably explains at least some of the recent duration increases, because injured workers are likely to need benefits for longer periods when job opportunities are less plentiful. However, the importance of this factor cannot be established with the current data.

Figure 3.3 Average Duration of Wage-Replacement Benefits in Weeks, Injury Years 1984-2001 [1]



Injury Year	Total Disab.[2]	TPD
1984	11.6	21.6
1987	11.7	26.2
1990	12.7	23.4
1995	8.9	15.3
1999	9.5	14.9
2000	10.6	16.5
2001	11.2	15.9

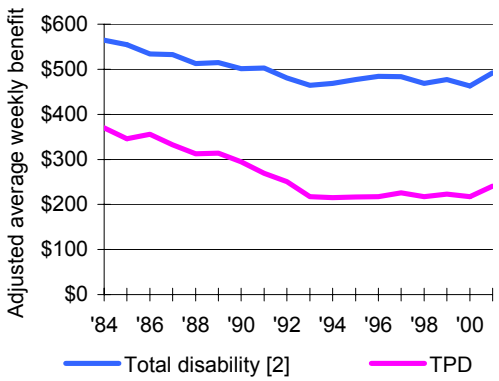
1. Developed statistics from DLI data (see Appendix C).
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.

Weekly Benefits

Average weekly total disability and TPD benefits turned upward in 2001 after a period of stability during the middle and late 1990s, adjusting for average wage growth.

- Average weekly total disability and TPD benefits were at about the same levels in 2000 as in 1993 after adjusting for wage growth. This means these weekly benefits increased by the same proportion as overall wage levels.
- Average weekly total disability benefits increased 6 percent between 2000 and 2001. This increase is partly attributable to the increase in minimum and maximum weekly benefits in the 2000 law change (see Appendix B).[15]
- Average weekly TPD benefits increased 11 percent between 2000 and 2001. This may be related to the recession if injured employees are returning to work at lower wages than before the economic downturn.
- Average weekly total disability and TPD benefits fell from 1984 through 1993, primarily because pre-injury wages (the basis for weekly benefits) grew more slowly than overall wage levels.[16]

Figure 3.4 Average Weekly Wage-Replacement Benefits, Adjusted for Wage Growth, Injury Years 1984-2001 [1]



Injury Year	Total Disab. [2]	TPD
1984	$565	$370
1993	465	218
1996	484	217
1999	477	223
2000	463	217
2001	492	241

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2001.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.

[15] As part of its overall cost estimate for the law change, DLI Research and Statistics estimated that the increase in the minimum and maximum would raise average weekly total disability benefits by 3.6 percent.

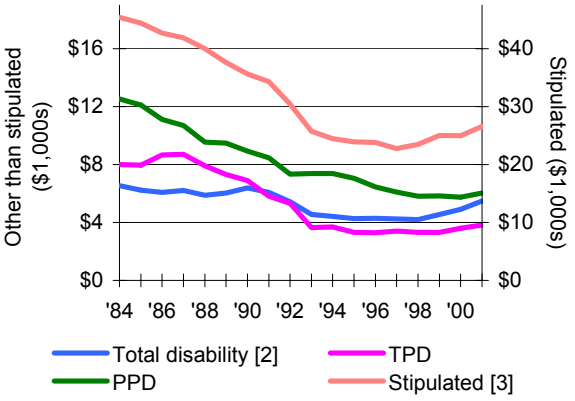
[16] Data on pre-injury wages from DLI; data on overall wages from the Minnesota Department of Economic Security.

Average Indemnity Benefits by Type

Adjusting for average wage growth, average total disability, TPD, and stipulated benefit amounts increased in the last two to three years after a stable period that had begun in the mid-1990s. Average PPD benefits reversed a steady decline by turning upward in 2001.

- In 2001 relative to 1998, adjusted average benefit amounts were higher as follows:
  - average total disability benefits were up 30 percent;
  - average TPD benefits were up 16 percent;
  - average stipulated benefits were up 13 percent.
- Relative to their low-point in 2000, adjusted average PPD benefits were up 5 percent in 2001.
- The increases for total disability and TPD benefits are attributable to increases in benefit duration (Figure 3.3) and in average weekly benefits (Figure 3.4).
- The increase in average PPD benefits in 2001 is primarily attributable to the increase in PPD benefits under the 2000 law change (see Appendix B).[17]
- Adjusted average PPD benefits fell steadily from 1984 through 2000 primarily because most PPD benefits were paid under a benefit schedule that remained fixed. Under this fixed schedule, PPD benefits fell by comparison with rising wages, which is reflected in the adjusted average benefit amounts.
- The recent increase in average stipulated benefit amounts is probably attributable primarily to increasing values of claims involved in settlements, as reflected by the recent increases for the other benefit types.

Figure 3.5 Average Indemnity Benefit by Type *Per Claim with that Benefit Type,* Adjusted for Wage Growth, Injury Years 1984-2001[1]



Injury Year	Total Disab.[2]	TPD	PPD	Stipulated [3]
1984	$6,540	$7,990	$12,530	$45,420
1995	4,260	3,310	7,050	23,930
1998	4,210	3,300	5,810	23,450
2000	4,900	3,600	5,750	24,980
2001	5,490	3,830	6,020	26,550

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2001.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.
3. Includes indemnity and medical components.

[17] As part of its overall cost estimate for the law change, DLI Research and Statistics estimated that the increase in the PPD benefit schedule would raise average overall PPD benefits by 14 percent compared to what they otherwise would have been. Two factors contribute to the difference between this figure and the 5-percent increase in adjusted average PPD benefits for 2001: First, the law change took effect for injuries on or after October 1, 2000, so only three quarters of the law change is felt between 2000 and 2001. Second, adjusting the numbers in Figure 3.6 for average wage growth reduces any increase in average benefits from one year to the next.

Indemnity Benefits per Indemnity Claim

Average indemnity benefits per indemnity claim rose during the last three years after reaching a historical low in 1998, adjusting for wage growth. The primary cause is an increase in total disability and stipulated benefits per claim. The increase in total disability benefits per claim is mostly attributable to duration increases. The 2000 law change contributed a relatively small amount to the 1998-2001 increase.

Note: Figure 3.6 differs from Figure 3.5 in that it shows the average benefit of each type *per indemnity claim,* rather than *per claim with that type of benefit.* Figure 3.6 reflects the percentage of indemnity claims with each benefit type (Figure 3.2) and benefit amounts per claim with the respective benefit type (Figure 3.5).

- Indemnity benefits per indemnity claim in 2001 were up 11 percent from 2000 and 23 percent from 1998. These numbers (last column of Figure 3.6) are the DLI numbers in Figure 2.8.

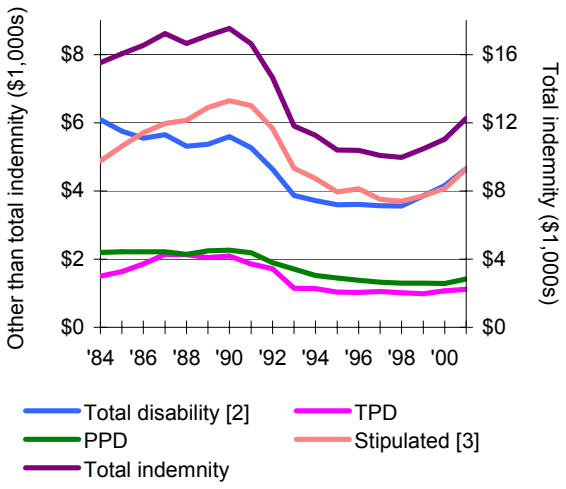
- Almost all of the total increase in indemnity benefits per claim between 1998 and 2001 ($2,300) came from increases in total disability benefits ($1,090) and stipulated benefits ($950).

  - The increase in total disability benefits per indemnity claim resulted primarily from an increase in duration (Figure 3.3) and to a lesser degree from an increase in average weekly benefits (Figure 3.4).
  - The increase in stipulated benefits per indemnity claim resulted partly from an increase in the proportion of claims with these benefits (Figure 3.2) and partly from an increase in average stipulated benefit amounts (Figure 3.5).

- The increase in PPD benefits per indemnity claim from 2000 to 2001 resulted partly from an increase in average PPD benefit levels (Figure 3.5) but also from an increase in the proportion of indemnity claims with PPD benefits (Figure 3.2).

- DLI estimated that the indemnity benefit increases enacted by the 2000 legislature would

Figure 3.6 Average Indemnity Benefit by Type *Per Paid Indemnity Claim,* Adjusted for Wage Growth, Injury Years 1984-2001 [1]



Injury Year	Total Disab. [2]	TPD	PPD	Stipu-lated [3]	Total Indem. [4]
1984	$6,090	$1,500	$2,190	$4,880	$15,520
1990	5,600	2,090	2,270	6,650	17,520
1995	3,590	1,030	1,450	3,970	10,400
1998	3,560	1,010	1,300	3,700	9,960
1999	3,860	990	1,290	3,850	10,470
2000	4,150	1,070	1,290	4,070	11,040
2001	4,650	1,120	1,410	4,650	12,260

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2001.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.
3. Includes indemnity and medical components.
4. Because some benefit types are not shown, total indemnity benefits are greater than the sum of the benefit types shown.

raise total indemnity benefits by 4.6 percent.[18] This accounts for somewhat less than half of the 11-percent increase in indemnity benefits per claim from 2000 to 2001. Most of the legislated benefit increase was in the form of an increase in PPD benefits (see Figure 3.5) and an increase in minimum and maximum weekly benefits (see Figure 3.4).

- In 2001, total disability and stipulated benefits per indemnity claim were about four times as great as TPD benefits per indemnity claim and more than three times as great as PPD benefits per indemnity claim.

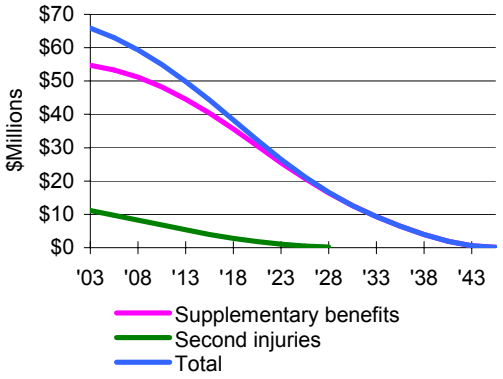
[18] The published estimate was that the benefit increase would raise total *system cost* by 1.7 percent. The two figures are related by the fact that indemnity benefits make up an estimated 37 percent of system cost, the remainder being medical benefits and other costs such as administrative expenses (1.7% = .37 x 4.6%). The MWCIA estimated that the 2000 law change would raise *total* benefit costs (indemnity and medical) by 4.2 percent.

Supplementary Benefit and Second-Injury Costs

DLI produces an annual projection of supplementary benefit and second-injury reimbursement costs as they would exist without future settlement activity. The total annual cost is projected to fall in half by 2020.

- The total projected cost for 2003, $66 million, is about 5 percent of total workers' compensation system cost.
- The 2003 cost consists of $55 million for supplementary benefits and $11 million for second injuries.
- Without settlements, supplementary benefit claims are projected to continue until 2045, and second-injury claims until 2030.
- Actual claim settlements, currently about $15 million per year, will reduce future projections of these liabilities.

Figure 3.7 Projected Cost of Supplementary Benefit and Second-Injury Reimbursement Claims, Fiscal Claim-Receipt Years 2003-2045 [1]



Fiscal Year of Claim Receipt	Projected Amount Claimed ($Millions) Supplementary Benefits	Second Injuries	Total
2003	$54.7	$11.1	$65.9
2010	48.8	7.1	55.9
2020	31.5	2.0	33.5
2030	13.3	.0	13.3
2045	.1	.0	.1

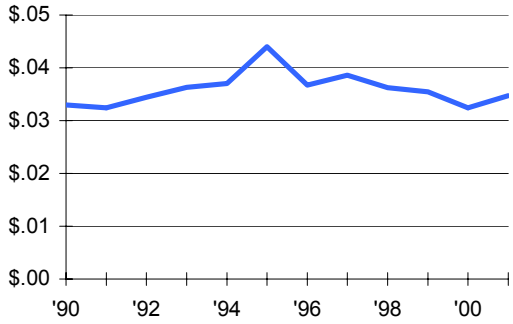
1. Projected from DLI data, assuming no future settlement activity. See Appendix C.

State Agency Administrative Cost

With the exception of a spike in 1995, state agency administrative cost has changed little relative to workers' compensation covered payroll over the last decade.

- In fiscal year 2001, state agency administrative cost (see note in figure) came to 3.5 cents per $100 of payroll, about the same as in 1990.
- Administrative cost for 2001 was about $27 million,[19] or about 2 percent of total workers' compensation system cost.

Figure 3.8 Net State Agency Administrative Costs per $100 of Payroll, Fiscal Years 1990-2001 [1]



Fiscal Year	Admin. Cost per $100 of Payroll
1990	$.033
1995	.044
1996	.037
1999	.035
2000	.032
2001	.035

1. Includes costs of workers' compensation functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals, and the Department of Commerce, as well as the cost of Minnesota's OSHA program. Costs are net of dedicated revenues. Data from DLI and MWCIA.

[19] Net of costs funded by dedicated revenues.

4

Vocational Rehabilitation

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

Major Findings

- A projected 21 percent of paid indemnity claimants injured in 2001—about 6,700 individuals—will receive VR services. (Figure 4.1)
- The VR participation rate increased by 4.2 percentage points from 1999 to 2001, more than double the increase from 1997 to 1999. This may be partly related to the current recession, to the degree that scarce jobs make return to work more difficult. (Figure 4.1)
- Because of the rising participation rate, the total cost of VR services rose 32 percent from 1998 to 2001, adjusting for wage growth. (Figure 4.2)
- The total cost of VR services for 2001, $37 million, was about 3 percent of total workers' compensation system cost. (Figure 4.2)
- The average cost of VR services declined 4 percent between 1998 and 2001, adjusting for average wage growth. (Figure 4.2)
- About three-quarters of VR participants have a job at the time of plan closure, a majority of these with their pre-injury employer. (Figure 4.6)
- The average VR participant returning to work receives a wage about the same as their pre-injury wage, but this varies widely among individuals. (Figure 4.7)

Background

VR is the third type of workers' compensation benefit, supplementing medical and indemnity benefits. VR services are provided to injured workers who need help in returning to work because of their injuries and whose employers are unable to offer them suitable employment.

VR services include:

- vocational evaluation,
- counseling,
- job analysis,
- job modification,
- job development,
- job placement,
- vocational testing,
- transferable-skills analysis,
- job-seeking-skills training,
- on-the-job training, and
- retraining.

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

Time Period Covered

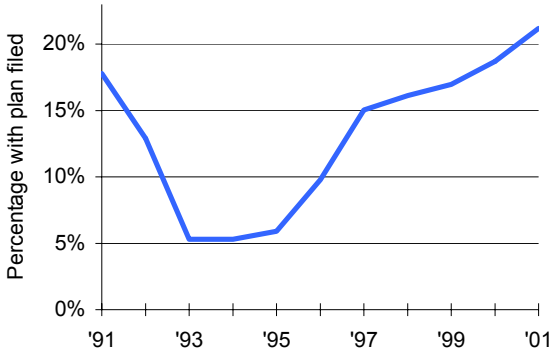
Most of the data in this chapter come from VR plan-closure forms filed with DLI. Since the VR system experienced major changes in the early and middle 1990s, only the closure data from 1998 through 2001 are used.

Participation Rate

The VR participation rate, already increasing since 1997, rose more rapidly in 2000 and 2001. Before 1997, the percentage of indemnity claimants receiving VR services varied widely, reflecting a law change, court decisions, and DLI initiatives.

- About 21 percent of paid indemnity claimants injured in 2001—about 6,700 individuals—are expected to receive VR services (some of these have not yet begun services).
- The VR participation rate increased by 4.2 percentage points from 1999 to 2001, more than double the increase from 1997 to 1999. This may be partly related to the current recession, to the degree that scarce jobs make return to work more difficult.

Figure 4.1 Percentage of Paid Indemnity Claims With a VR Plan Filed, Injury Years 1991-2001 [1]



Injury Year	Percentage with Plan
1991	17.8%
1993	5.3
1997	15.1
1999	17.0
2000	18.7
2001	21.2

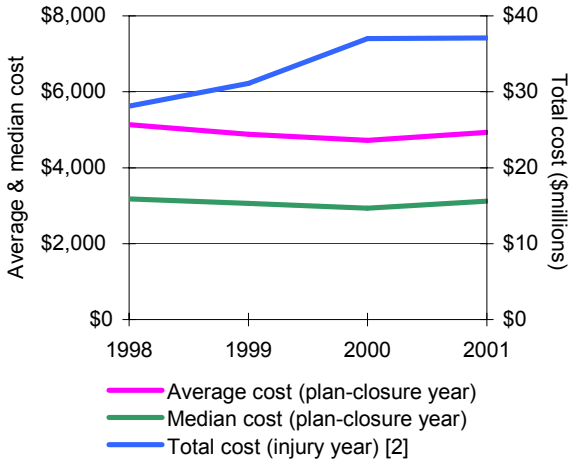
1. Data from DLI. Statistics for 1997-2001 are developed (see Appendix C).

Cost

Because of the increase in VR participation, the total cost of VR services for 2001 was up almost a third from 1998, adjusting for wage growth.

- The total cost of VR services for 2001 was about $37 million, about the same as 2000 but 32 percent higher than 1998, adjusting for wage growth.
- The average and median costs of VR services fell 4 percent and 2 percent, respectively, from 1998 to 2001.
- Total cost rose because of an increase in participation. The rising participation rate from 1998 to 2001 (Figure 4.1) caused an increase in the number of VR plans over that period, even though the total number of paid indemnity claims declined.
- The 2001 total cost for VR is about 3 percent of total workers' compensation system cost.

Figure 4.2 VR Plan Costs, Adjusted for Wage Growth, 1998-2001 [1]



	Average Cost	Median Cost	Total Cost ($Millions) [2]
1998	$5,130	$3,180	$28.1
1999	$4,880	$3,060	$31.1
2000	$4,720	$2,930	$37.0
2001	$4,930	$3,120	$37.1

1. Data from DLI. Costs are adjusted for average wage growth between the respective year and 2001.
2. Developed statistics. See Appendix C.

Timing of Services

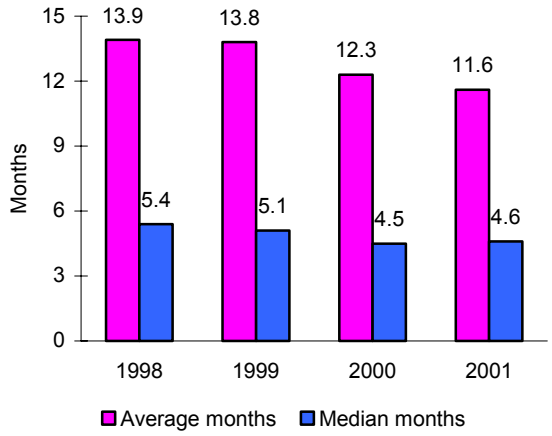
The average time between injury and the start of VR services has declined since 1998. The success of VR is closely linked to prompt service provision.

- From 1998 to 2001, the average time from injury to start of VR services declined 17 percent. The median time declined through 2000 but remained steady from 2000 to 2001 at about 4.5 months.

- Compared to workers who started VR more than one year after injury, workers who started within six months of injury (among plan closures in 2001) had:

  - lower VR costs by 15 percent ($4,390 vs. $5,180);
  - shorter VR service durations by 26 percent (10.5 months vs. 14.2 months); and
  - greater chances of returning to work with their pre-injury employer (53 percent vs. 36 percent).

Figure 4.3 Time from Injury to Start of VR Services, Plan-Closure Years 1998-2001 [1]



1. Data from DLI.

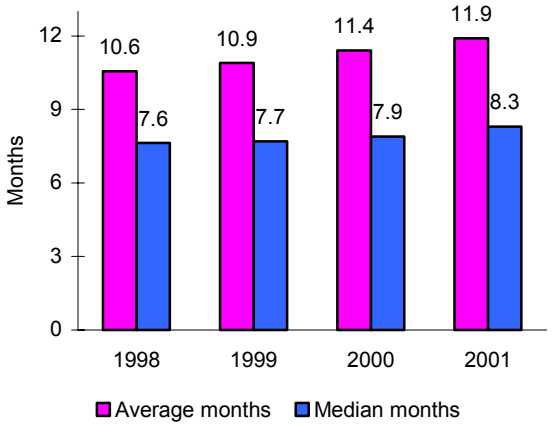
Service Duration

VR service duration has increased gradually since 1998.

- Average service duration increased by 13 percent from 1998 to 2001. Median duration increased by 9 percent.

- Among plan closures in 2001, average service duration was shortest for participants returning to work with their pre-injury employer (nine months) and longest for those going to a different employer or not returning to work (15 months).

Figure 4.4 VR Service Duration, Plan-Closure Years 1998-2001 [1]



1. Data from DLI.

Services Provided

The percentages of VR plans involving one of the services reported to DLI—on-the-job training, retraining, and job placement—have declined since 1998. This parallels a decreased proportion of plan outcomes involving placement with a new employer (Figure 4.6).

- Of the three services reported separately to DLI, only placement services are used to a significant degree: 27 percent of plans reported this service in 2001, down from 35 percent in 1998.
- On-the-job training and retraining are used in small numbers of cases, which have not changed significantly since 1999.

Figure 4.5 Provision of Specific Services, Plan-Closure Years 1998-2001 [1]

Plan-Closure Year	Number and Percentage of Plans Indicating Service		
	On-the-Job Training	Retraining	Placement Services
1998	29	76	1,561
	0.6%	*1.7%*	*34.9%*
1999	13	59	1,510
	0.3%	*1.2%*	*31.5%*
2000	18	60	1,334
	0.4%	*1.3%*	*29.1%*
2001	13	60	1,568
	0.2%	*1.0%*	*26.5%*

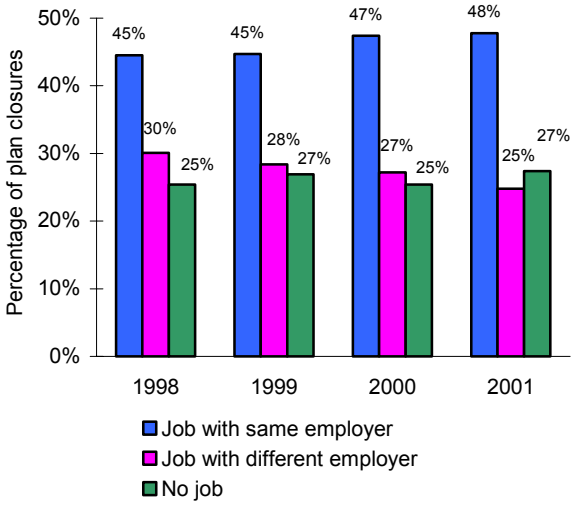
1. Data from DLI.

Return-to-Work Outcomes

The percentage of VR participants returning to work with their pre-injury employer has increased during the last three years; the percentage going to a different employer has decreased. The percentage with no job at closure—about 25 percent—has showed little change.

- Among 2001 plan closures, the average cost of services for participants returning to work with their pre-injury employer ($2,980) was less than half the cost for participants going to a different employer ($7,470) and for those not returning to work at plan closure ($6,280).[20]

Figure 4.6 Return-to-Work Outcomes, Plan-Closure Years 1998-2001 [1]



1. Data from DLI.

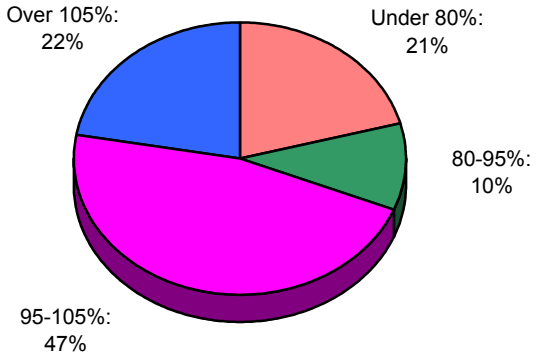
[20] These figures are limited to private service-providers.

Return-to-Work Wages

The average return-to-work wage of VR participants is about the same as their pre-injury wage. However, the return-to-work wage ratio varies widely.

- In 2001, more than two-thirds of participants returning to work received a wage of at least 95 percent of their pre-injury wage. About one-third made less than 95 percent of their pre-injury wage, with most of those earning less than 80 percent of their pre-injury wage.
- For plan closures in 2001, the average return-to-work wage ratio was:
  - higher for participants who returned to their pre-injury employer (105 percent) than for those who went to a different employer (92 percent), and
  - higher for service durations less than six months (106 percent) than for longer service durations (e.g. 87 percent for durations longer than 18 months).

Figure 4.7 Ratio of Return-to-Work Wage to Pre-Injury Wage for Participants Returning to Work, Plan-Closure Year 2001 [1]



Average: 101%
Median: 100%

1. Data from DLI.

Reasons for Plan Closure

A majority of plans close because they are completed, but more than a third close for other reasons.

- The 1998-2001 period saw a steady increase in the proportion of plans closed by agreement of the parties, and a decrease in the proportion closed by a decision and order.
- By definition, plan completion always involves a return to work. For plans closed for reasons other than completion in 2001, participants had returned to work only 27 percent of the time.

Figure 4.8 Reason for Plan Closure, Plan-Closure Years 1998-2001 [1]

Plan-Closure Year	Plan Completed	Claim Settlement	Decision and Order	Agreement of Parties
1998	63.5%	21.4%	5.2%	9.9%
1999	63.1	24.2	2.2	10.5
2000	64.8	21.4	1.1	12.6
2001	63.2	21.0	1.3	14.4

1. Data from DLI.

5

Disputes and Dispute Resolution

This chapter presents data on workers' compensation disputes and dispute resolution.

Major Findings

- The overall dispute rate increased from 14.8 percent of filed indemnity claims in 1999 to 16.6 percent in 2001. This followed a period of stability at relatively low levels from 1995 to 1999. (Figure 5.1)
- The recent increase in the dispute rate may be related to the current recession, to the degree that a denial or loss of benefits becomes more important to an injured worker in economic hard times.
- Claim petition disputes—usually over primary liability and benefit issues—are the most common type of dispute. (Figure 5.2)
- The rate of denial of filed indemnity claims, after increasing in the 1980s, has remained between 14 and 16 percent since 1991. (Figure 5.3)
- For wage-loss claims filed in 2001, the proportion with "prompt first action" (payment initiation or denial within the legal time limit) was 84 percent, down from 85 percent in 1999. (Figure 5.4)
- The percentage of paid indemnity claims with claimant attorney fees rose from 13.0 percent in 1999 to 14.5 percent in 2001. This parallels the increase in the dispute rate. The rate of claimant attorney involvement had decreased from 17 percent in 1991 to 13 percent in 1999. (Figure 5.6)
- For 2001, total claimant and defense legal costs were about $83 million, roughly 10 percent of total benefits and 7 percent of total workers' compensation system cost. (Figure 5.7)

Background

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

Types of Disputes

Disputes in Minnesota's workers' compensation system generally occur over five types of issues:[21]

- denial of primary liability,
- eligibility for and amount of monetary benefits,
- discontinuance of wage-loss benefits,
- medical issues, and
- rehabilitation issues.

Dispute Resolution Process

Depending on the nature of the dispute and the wishes of the parties, dispute resolution may be facilitated by the Customer Assistance (CA) unit of the Department of Labor and Industry (DLI) or by the Office of Administrative Hearings (OAH). Decisions from OAH can be appealed to the Workers' Compensation Court of Appeals and then to the Minnesota Supreme Court.

CA and OAH carry out a variety of dispute resolution activities:

Customer Assistance Activities

Informal assistance. This process, which can be initiated by any party to a dispute, may involve phone calls or correspondence with the parties, to avoid a longer, more formal and costly process.

[21] Disputes also occur over miscellaneous other types of issues, such as attorney fees, which are not considered in this report.

Dispute certification. In a medical or rehabilitation dispute, CA must certify that a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services.

Mediation. A mediation occurs when all parties agree to participate and may be used to deal with any type of dispute. The mediator, a CA specialist, works to facilitate agreement among the parties and formally records its terms.

Administrative conference and "nonconference decision-and-orders." An administrative conference is an expedited, informal proceeding where parties present and discuss viewpoints in a dispute. CA conducts administrative conferences on rehabilitation issues. CA also conducts administrative conferences on medical issues involving $1,500 or less if the claimant has filed the dispute and does not have an attorney. If agreement is not achieved, the CA specialist issues a "decision and order." For other medical issues involving $1,500 or less, CA issues a "nonconference decision and order."

Office of Administrative Hearings Activities

Mediation. OAH will conduct a mediation for any dispute. The judge actively participates in negotiations and provides advice as requested.

Settlement conference. OAH conducts settlement conferences in litigated cases to achieve a negotiated settlement where possible without a formal hearing.

Administrative conference. OAH conducts administrative conferences on most discontinuance disputes and on medical disputes involving more than $1,500. The OAH judge conducting the conference issues a "decision and order."

Formal hearing. OAH conducts formal hearings on disputes presented on claim petitions (see "claim petition disputes" below) and other petitions where resolution through a settlement conference is not possible. OAH also conducts hearings on some discontinuance disputes, disputes referred by CA because they do not seem amenable to less formal resolution, and disputes over miscellaneous issues such as attorney fees and pre-hearing disputes. OAH also conducts hearings *de novo* when a party disagrees with an administrative-conference or nonconference decision and order.

Data Issues

DLI is currently implementing a new data system in a multi-year process. Since dispute resolution is one of the first areas of implementation, this chapter's data come from both the old and new systems. While the new data provide greater detail than the old, this chapter uses categories compatible with data from the old system to achieve comparability over time. When data in the new system are sufficiently mature, they will be used alone, and the categories in the report will then be revised to capture the richer detail available.

Counting Disputes

Given the data currently available, four "dispute" categories are used in this report:

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

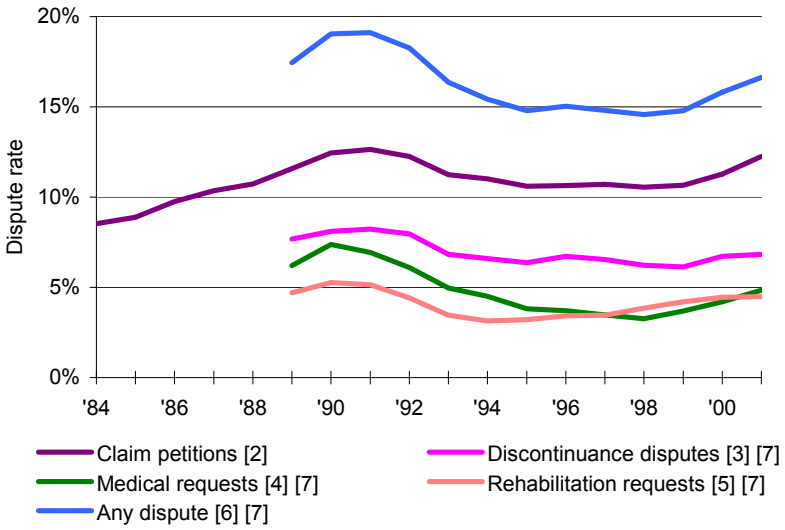
Discontinuance disputes. These disputes are most often initiated by a claimant's *Request for Administrative Conference* in response to the insurer's declared intention to discontinue temporary total or temporary partial benefits. They may also be presented on the claimant's *Objection to Discontinuance* or the insurer's petition to discontinue benefits, which leads to a hearing at OAH.

Medical requests. Medical disputes are often filed on a *Medical Request* form, which triggers an administrative conference at CA or OAH or a onconference decision and order from CA.

Rehabilitation requests. Vocational rehabilitation disputes are often filed on a *Rehabilitation Request* form, which leads to an administrative conference at CA.

Many disputes, especially those handled informally by CA through mediation or other means, are not counted in these categories.

Figure 5.1 Incidence of Disputes, Injury Years 1984-2001 [1]



Injury Year	Dispute Rate				
	Claim Petitions [2]	Discontinuance Disputes [3]	Medical Requests [4]	Rehabilitation Requests [5]	Any Dispute [6]
1984	8.5%	[7]	[7]	[7]	[7]
1990	12.5	8.1%	7.4%	5.3%	19.0%
1995	10.6	6.4	3.8	3.2	14.8
1998	10.5	6.2	3.3	3.9	14.6
1999	10.7	6.1	3.7	4.2	14.8
2000	11.3	6.7	4.2	4.4	15.8
2001	12.2	6.8	4.8	4.5	16.6

1. Developed statistics from DLI data (see Appendix C).
2. Percentage of filed indemnity claims with claim petitions. (Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.)
3. Percentage of paid wage-loss claims with discontinuance disputes.
4. Percentage of paid indemnity claims with *Medical Requests.*
5. Percentage of paid indemnity claims with *Rehabilitation Requests.*
6. Percentage of filed indemnity claims with any disputes.
7. Not available before 1989.

Dispute Rates

The dispute rate took a pronounced upward turn in 2000 and 2001.

- The overall dispute rate increased from 14.8 percent in 1999 to 16.6 percent in 2001. This followed five years of stability at relatively low levels compared to the heightened rates of the early 1990s.
- Among the four major dispute types, the largest contributors to the increase were the claim petition rate, up 1.5 percentage points from 1999 to 2001, and the rate of *Medical Requests,* up 1.1 percentage points over the same period (1.5 percentage points since 1998).
- The rate of *Rehabilitation Requests* showed a slower but more sustained increase—1.3 percentage points since 1995. Part of this increase is likely related to rising participation in vocational rehabilitation (Figure 4.1).
- The discontinuance dispute rate for 2000-2001 was slightly above 1998-1999, but not much different from 1993-1997.
- The increase in dispute rates may be related to the current recession:
  - Where claim petitions are concerned, if the insurer denies primary liability, the injured worker may be more likely to contest the denial in hard economic times. One reason is there is less income from other family members (particularly a spouse) to fall back on. Another reason is that if the worker is

partially disabled, his or her own earnings prospects are relatively poor in a recession. In either case, the workers' compensation benefit becomes more important. These considerations also come into play if the insurer has accepted primary liability but denies benefits for a claimed period of disability.

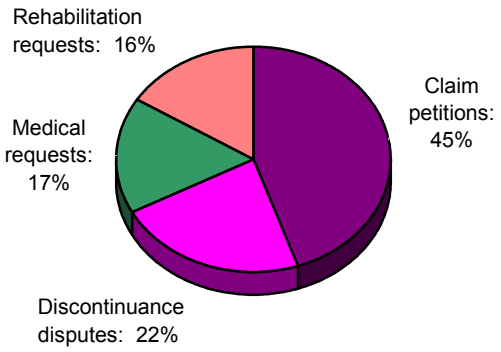
- Economic hard times may also affect the other dispute rates. If the family has suffered a loss of earnings or health insurance, or the injured worker's job prospects are relatively poor, the worker is more likely to contest a discontinuance or an adverse decision on medical or rehabilitation benefits.
- Another factor is that the last few years have produced relatively poor financial results for insurers.[22] Insurers may be more likely to make decisions unfavorable to the worker in times of financial difficulty, which would tend to increase dispute rates. However, as shown in Figure 5.3, this does not seem to have been a strong factor for denials of primary liability.

Dispute Types

Claim petitions constitute almost half (45 percent) of all disputes.

- Discontinuance disputes are the next most common, making up almost a quarter of disputes.
- *Medical Requests* and *Rehabilitation Requests* are somewhat less frequent.

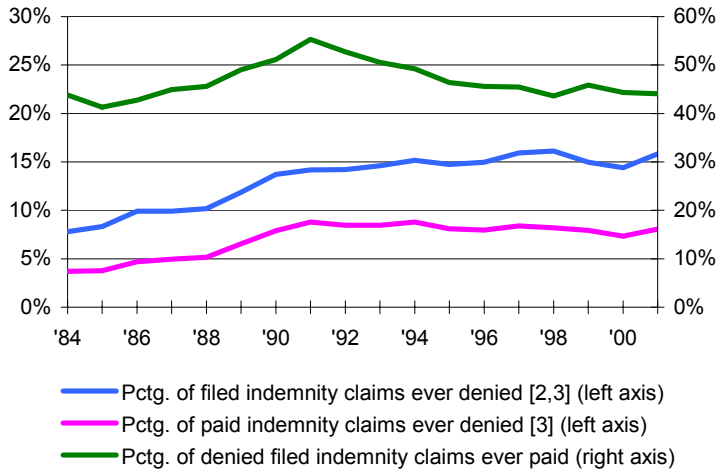
Figure 5.2 Dispute Types as Share of Total, Disputes Filed in 2001 [1]



1. Data from DLI.

[22] See "Explaining Recent Workers' Compensation Premium Increases," *DLI Research Reporter,* September 2002, www.doli.state.mn.us/reportersept02.html, especially Figure 3 and surrounding discussion.

Figure 5.3 Indemnity Claim Denial Rates, Injury Years 1984-2001 [1]



Injury Year	Filed Indemnity Claims [2] Total	Filed Indemnity Claims [2] Pctg. Ever Denied [3]	Paid Indemnity Claims Total	Paid Indemnity Claims Pctg. Ever Denied [3]	Pctg. of Denied Filed Indemnity Claims Ever Paid
1984	43,400	7.8%	40,100	3.7%	43.8%
1991	47,200	14.2	42,000	8.8	55.3
1998	38,100	16.1	32,700	8.2	43.6
1999	39,300	15.0	34,000	7.9	45.8
2000	39,700	14.4	34,600	7.3	44.4
2001	36,400	15.8	31,500	8.1	44.1

1. Developed statistics from DLI data (see Appendix C).
2. Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.
3. Denied claims include claims initially denied (some of which are eventually paid) and claims initially paid but later denied.

Denials

Denials of primary liability are of interest because they frequently generate disputes. Denials are also important because if they are improperly made, workers' compensation fails in its purpose of providing benefits to injured workers. Denial rates have fluctuated somewhat over the last five years but with no clear trend.

- The denial rate among filed indemnity claims (see notes 2 and 3 in figure) has remained between 14 and 16 percent since 1991.
- The denial rate among paid indemnity claims (see note 3 in figure) has been near 8 percent since 1991.
- Denials rates rose steeply in the late 1980s.
- Among filed indemnity claims that were denied, the proportion ever paid has ranged from 41 to 55 percent, with the highest rates occurring in the early 1990s.

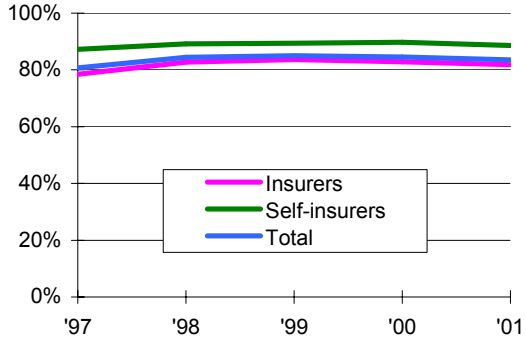
Prompt First Action

Insurers must either begin payment on a wage-loss claim or deny the claim within 14 days of when the employer has knowledge of the injury.[23] This "prompt first action" is important not only for the sake of the injured worker, but also because disputes are less likely if the insurer responds promptly to the claim. The prompt-first-action rate has change little since 1998.[24]

- The fiscal-year 2001 prompt-first-action rate was about 84 percent. This is down somewhat from 1999 but higher than 1997, the first year of data.

- The prompt-first-action rate is higher for self-insurers than for insurers. This is to be expected, because self-insurers are able to avoid the step of communicating between employer and insurer.

Figure 5.4 Percentage of Lost-Time Claims with Prompt First Action, Fiscal Claim-Receipt Years 1997-2001 [1]



Fiscal Year of Claim Receipt	Insurers	Self-Insurers	Total
1997	78.5%	87.3%	80.7%
1998	82.8	89.2	84.4
1999	83.6	89.4	85.0
2000	82.9	89.7	84.5
2001	81.9	88.6	83.5

1. Computed from DLI data by DLI Compliance Services. See DLI Compliance Services, *2001 Prompt First Action Report.* Fiscal claim-receipt year means the fiscal year in which DLI received the claim. Fiscal years run from July 1 through June 30; for example, July 1, 2000 - June 30, 2001 is fiscal-year 2001.

[23] Minnesota Statutes §176.221.

[24] To improve system performance, DLI Compliance Services publishes the annual *Prompt First Action Report* on the prompt-first-action performance of individual insurers and of the overall system.

Dispute Resolution Proceedings

Most informal dispute resolution activity takes place in the DLI Customer Assistance unit. Most formal dispute resolution activity occurs at the Office of Administrative Hearings.

- The most common means of dispute resolution is CA intervention in "potential disputes" (see note 2 in figure).
- Next most common are settlement conferences and administrative conferences at OAH.

Figure 5.5 Dispute Resolution Activities, Fiscal Year 2002 [1]

DLI Customer Assistance	
Resolutions of potential disputes [2]	10,103
Resolutions of *Medical and Rehabilitation Requests [3]*	983
Noncertifications [4]	1,070
Mediation awards	311
Administrative conference orders and agreements	865
Nonconference decision-and-orders	3
Office of Administrative Hearings	
Settlement conferences	3,537
Administrative conferences—discontinuance	1,726
Administrative conferences—medical and rehabilitation	544
Hearings [5]	888
Workers' Compensation Court of Appeals	
Cases received [6]	282

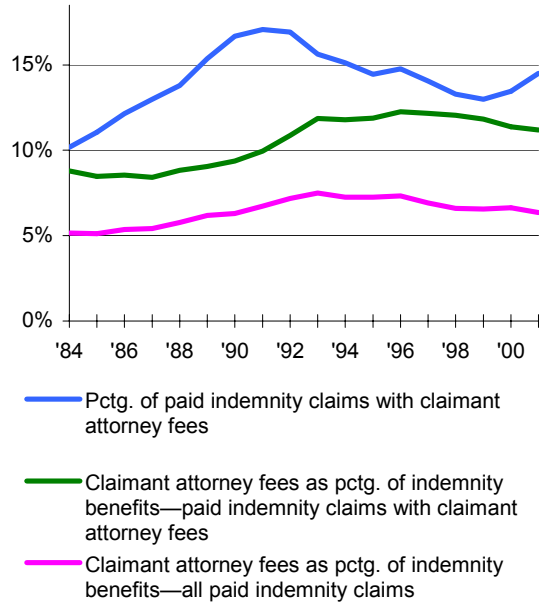
1. Data from DLI, OAH, and the Workers' Compensation Court of Appeals.
2. Potential disputes are cases in which a party to a claim contacts CA and, in the judgment of the CA specialist, a dispute would likely have arisen without CA involvement. In most of these cases, there has been little or no attorney involvement before CA was contacted.
3. These are resolutions achieved in ways other than a mediation award or an administrative conference (or nonconference) order and agreement.
4. These are cases in which CA determined a medical or rehabilitation dispute to be "not certified" after it intervened and resolved the dispute or determined that there was no dispute.
5. Includes 93 attorney fee hearings and 795 hearings on all other issues.
6. Includes cases with and without hearings. Cases with hearings are usually disposed of by decisions but sometimes by settlement. Cases without hearings are usually disposed of by settlement but sometimes by decisions. Statistics are unavailable on the number of hearings held.

Claimant Attorney Involvement

Claimant attorney involvement turned upward in 2000 and 2001, after eight years of general decrease.

- The percentage of paid indemnity claims with claimant attorney fees[25] rose from 13.0 percent in 1999 to 14.5 percent in 2001. This parallels a similar increase in the dispute rate (Figure 5.1).
- Among paid indemnity claims with claimant attorney fees, these fees fell from 12.3 percent of indemnity benefits in 1996 to 11.2 percent in 2001.
- Among all paid indemnity claims, the ratio of fees to benefits fell from 7.3 percent in 1996 to 6.4 percent for 2001.
- Total claimant attorney fees are estimated at $25 million for injury year 2001. This is roughly 2 percent of total workers' compensation system cost.

Figure 5.6 Claimant Attorney Fees Paid with Respect to Indemnity Benefits, Injury Years 1984-2001 [1]



Injury Year	Pctg. of Paid Indemnity Claims with Claimant Attorney Fees	Claimant Attorney Fees as Pctg. of Indemnity Benefits: Among Paid Indemnity Claims with Claimant Attorney Fees	Claimant Attorney Fees as Pctg. of Indemnity Benefits: Among All Paid Indemnity Claims
1984	10.2%	8.8%	5.2%
1991	17.1	9.9	6.7
1993	15.6	11.9	7.5
1996	14.8	12.3	7.3
1999	13.0	11.8	6.6
2000	13.5	11.4	6.6
2001	14.5	11.2	6.4

1. Developed statistics from DLI data. Includes claimant attorney fees determined as a percentage of indemnity benefits plus additional amounts awarded to the claimant attorney upon application to a judge. See Appendix C.

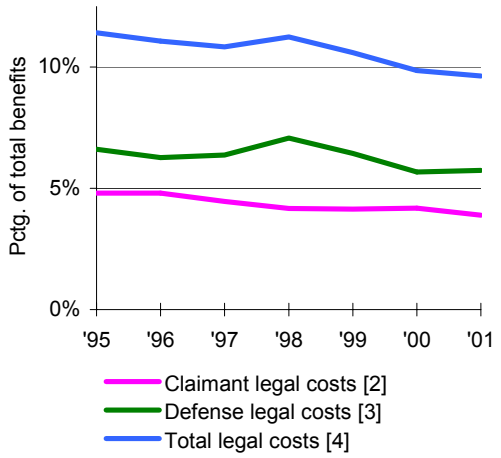
[25] See note 1 in figure.

Claimant and Defense Legal Costs

Total legal costs have grown more slowly than total benefits. Relative to total benefits, both claimant and defense legal costs in 2001 were at their lowest levels since 1995.

- Total legal costs fell from 11.4 percent of total benefits in 1995 to 9.6 percent in 2001.
- In 2001, claimant legal costs were equal to 3.9 percent of total benefits, as compared with 5.7 percent for defense legal costs.
- For 2001, total legal costs were about $83 million, or 7 percent of total workers' compensation system cost.

Figure 5.7 Total Legal Costs as Percentage of Total Benefits, 1995-2001 [1]



Year	Claimant Legal Costs [2]	Defense Legal Costs [3]	Total Legal Costs [4]
1995	4.8%	6.6%	11.4%
1999	4.1	6.4	10.6
2000	4.2	5.7	9.9
2001	3.9	5.7	9.6

1. Data from DLI and MWCIA. Includes claimant and defense attorney fees and other legal costs paid with respect to indemnity, medical, and rehabilitation benefits. Benefits (in the denominator) include indemnity, medical, and rehabilitation benefits. See Appendix C.
2. Numerator and denominator are developed statistics on an injury-year basis. See Appendix C.
3. Numerator and denominator are on a payment-year basis. See Appendix C.
4. Sum of first two columns.

Appendix A

Glossary

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. If agreement is not achieved, a "decision and order" is issued which is binding unless appealed. Currently, the Customer Assistance unit of the Department of Labor and Industry conducts administrative conferences on medical issues involving$1,500 or less (if filed by a claimant without attorney representation) and on vocational rehabilitation issues, and the Office of Administrative Hearings conducts conferences on medical issues involving more than $1,500 and on discontinuance disputes presented on a *Request for Administrative Conference* form.

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

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

Cost-of-living adjustment. An annual adjustment of temporary total disability, temporary partial disability, permanent total disability, and dependents' benefits computed from the annual change in the statewide average weekly wage (SAWW). 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. The timing of the first adjustment and the annual percent limit have changed over time, as described in Appendix B.

Customer Assistance (CA). A unit in the Department of Labor and Industry that provides information and clarification on workers' compensation statutes, rules, and procedures; carries out a variety of dispute prevention activities; conducts informal dispute resolution activities including mediations; and holds administrative conferences on some issues (see administrative conference).

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 proportion of the worker's gross pre-injury wage and are paid for a specified period of time, depending on the dependents concerned.

Developed numbers. Estimates of what the number of claims or their cost will be at a given maturity. Developed numbers are relevant for accident year, policy year, and injury year data. They are obtained by applying development factors, based on historical rates of development of claim and cost figures, to tabulated numbers.

Development. The change over time in the reported number or cost of claims for a particular accident year, policy year, or injury year. Claim costs develop whether the costs are paid or incurred. The reported figures develop

both because of the time necessary for claims to mature and, in the case of Department of Labor and Industry data, because of reporting lags.

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

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

Hearing. A formal proceeding on a disputed issue or issues in a workers' compensation claim, held at the Office of Administrative Hearings or Workers' Compensation Court of Appeals, after which the judge issues a decision that is binding unless appealed.

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

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 the temporary total disability or temporary partial disability benefits 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.

Mediation. A voluntary, informal proceeding conducted by the Customer Assistance Unit of the Department of Labor and Industry to facilitate agreement among the parties in a dispute. If agreement is reached, its terms are formally recorded. A mediation occurs when one party requests it and the others agree to participate. This often takes place after attempts at resolution by phone and correspondence have failed.

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. All reasonable and necessary medical costs related to the injury or illness are covered, subject to a maximum-fee schedule.

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 Customer Assistance (CA), or to an administrative conference or a nonconference decision and order. The conference is held by CA if the disputed amount is $1,500 or less; otherwise it is held by the Office of Administrative Hearings.

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

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

Nonconference decision and order. A decision issued by the Customer Assistance unit of the Department of Labor and Industry, without an

administrative conference, on a dispute for which it has administrative conference authority (see "administrative conference"), when it has sufficient information without conducting a conference. The decision is binding unless appealed or overturned by review at the Office of Administrative Hearings.

Notice of Intention to Discontinue (NOID). A form by which the insurer informs the worker of its intention to discontinue wage-loss benefits (temporary total, temporary partial, or permanent total). In contrast with the Petition to Discontinue Benefits, the NOID brings about benefit termination if the worker does not contest it.

Objection to Discontinuance. A form by which the injured worker requests a formal hearing to contest a proposed discontinuance of wage-loss benefits (temporary total, temporary partial, or permanent total disability). The hearing is held at the Office of Administrative Hearings.

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

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

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

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

Policy year. The year of initiation of the insurance policy covering the accident or condition that caused the 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 include claims and costs for injuries occurring in two different calendar years.

Primary liability. The overall liability of the insurer for any costs associated with a claim once the injury is determined to be compensable. An insurer may deny primary liability (deny that the injury is compensable) if it has reason to believe the injury was not work-related, was intentionally self-inflicted, resulted from intoxication, or happened during participation in a nonrequired recreational program.

Pure premium rates. Rates of expected indemnity and medical losses per year per $100 of covered payroll, also referred to as "loss costs." Pure premium rates are determined annually by the Minnesota Workers' Compensation Insurers Association for approximately 560 insurance classes in the

voluntary market. They are based on insurer "experience" and statutory benefit changes. "Experience" refers to actual losses relative to pure premium for the most recent report periods. The pure premium rates are published with documentation in the annual *Minnesota Ratemaking Report* subject to approval by the Department of Commerce.

Pure premium. A measure of expected losses, equal to the sum, over all insurance classes, of payroll times the applicable pure premium rate(s) (the rate(s) for the insurance class(es) concerned), 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.

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 Customer Assistance, or to an administrative conference.

Request for Administrative Conference. A form by which the injured worker requests an administrative conference to contest a proposed discontinuance of wage-loss benefits (temporary total, temporary partial, or permanent total disability).

Special Compensation Fund (SCF). A fund within the Department of Labor and Industry (DLI) that, among other things, pays uninsured claims and reimburses insurers (including self-insured employers) for supplementary and second-injury benefit payments. (The supplementary benefit and second-injury provisions only apply to older claims because they were eliminated by the law changes of 1995 and 1992, respectively.) Revenues come primarily from an assessment on paid indemnity benefits. The SCF also funds the operations of DLI, the workers' compensation portion of the Office of Administrative Hearings, the Workers' Compensation Court of Appeals, and workers' compensation functions in the Department of Commerce.

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

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

Settlement conference. A proceeding at the Office of Administrative Hearings to resolve issues presented on a claim petition when it appears possible to settle the issues without a formal hearing. If a settlement is reached, it typically includes an agreement by the claimant to release the employer and insurer from future liability for the claim other than for medical treatment.

Statewide average weekly wage (SAWW). The average wage used by insurers and the Department of Labor and Industry (DLI) to adjust certain workers' compensation benefits and by DLI to adjust provider fee limits. This report uses the SAWW to adjust average benefit amounts for different years so they are all expressed in constant (2000) wage dollars. The SAWW, from the Department of Economic Security, is the average weekly wage of nonfederal workers covered under Unemployment Insurance.

Stipulated benefits. Indemnity and/or medical benefits specified in a "stipulation for settlement," which states the terms of settlement of a claim among the affected parties. A stipulation usually occurs in the context of a dispute, but not always. The stipulation may be incorporated into a mediation agreement, or may be reached in a settlement conference or associated preparatory activities, in which case it must be approved by a workers' compensation judge. Stipulated benefits are usually paid in a lump-sum.

Supplementary benefits. Additional benefits paid to certain workers receiving temporary total disability (TTD) or permanent total disability

(PTD) benefits for injuries prior to October 1995. These benefits are equal to the difference between 65 percent of the statewide average weekly wage and the TTD or PTD benefit. The Special Compensation Fund reimburses insurers (and self-insured employers) for supplementary benefit payments. For injuries on or after Oct. 1, 1995, supplementary benefits were repealed (see Appendix B).

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

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 (1) the employee returns to work, (2) the employee withdraws from the labor market, (3) the employee fails to diligently search for work within his or her physical restrictions, (4) the employee is released to work without physical restrictions from the injury, (5) the employee refuses an appropriate offer of employment, (6) 90 days have passed after the employee has reached maximum medical improvement or completed an approved retraining plan, (7) the employee fails to cooperate with an approved vocational rehabilitation plan or with certain procedures in the development of such a plan, or (8) 104 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 and Appendix B.

Vocational rehabilitation (VR) dispute. A dispute over a vocational rehabilitation issue, such as whether the employee should be evaluated for VR eligibility, whether he or she is in fact eligible, whether certain VR 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 rehabilitation services, and is filed with the Department of Labor and Industry and provided to the affected parties. The plan indicates the vocational goal, the services necessary to achieve the goal, and their expected duration and cost.

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

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

Workers' Compensation Court of Appeals (WCCA). An executive branch body that hears appeals of workers' compensation decisions from the Office of Administrative Hearings. The next and final level of appeal is the Minnesota Supreme Court.

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

This appendix summarizes those components of the 1992, 1995, and 2000 workers' compensation law changes relevant to this report. Other components of the law changes, as well as law changes from other years, are not described.

1992 Law Change

Indemnity Benefits

The indemnity benefit changes in the 1992 law took effect for injuries on or after Oct. 1, 1992. The new permanent partial disability (PPD) rating schedule, promulgated by the Department of Labor and Industry (DLI) after clarifications of statutory authority in the 1992 law, took effect for injuries on or after July 1, 1993.

Temporary total disability (TTD) and permanent total disability (PTD) minimum benefit. The minimum weekly TTD and PTD benefit became the lesser of 20 percent of the statewide average weekly wage (SAWW) or the employee's pre-injury wage. Previously, the minimum was the lesser of 50 percent of the SAWW or the pre-injury wage, but no less than 20 percent of the SAWW.

TTD, temporary partial disability (TPD), and PTD maximum benefit. The maximum weekly TTD, TPD, and PTD benefit was increased from 100 percent of the SAWW to 105 percent of the SAWW.

Additional TPD weekly benefit limit. An additional limit was placed on the weekly TPD benefit, restricting it to no more than 500 percent of the SAWW minus the employee's weekly wage earned while receiving TPD benefits.

TPD duration limit. TPD benefits were limited to 225 weeks of total duration and to the first 450 weeks after the injury (with an exception for approved retraining).

Supplementary benefit eligibility. Supplementary benefit eligibility was limited to PTD beneficiaries. Previously, TTD beneficiaries were also eligible. The law retained the provision that (for injuries on or after Oct. 1, 1983) eligibility begins four years after the beginning of temporary total or permanent total disability.

Cost-of-living adjustments. Cost-of-living adjustments were limited to 4 percent per year and delayed until the second anniversary of the injury. Previously, adjustments were limited to 6 percent per year and began on the first anniversary of the injury. Cost-of-living adjustments are further described in Appendix A.

PPD rating schedule. The 1992 law clarified that PPD ratings must be based on objective medical evidence, and further provided that (1) the rating schedule must be reviewed periodically to determine whether any omitted impairments should be included, and must be amended accordingly; (2) the schedule may contain zero ratings for minor impairments; and (3) an impairment must be rated exclusively according to the categories in the schedule or, if it is not in the schedule, according to the most similar condition in the schedule. DLI promulgated a new permanent impairment rating schedule reflecting these provisions, effective for injuries on or after July 1, 1993. The department devised the schedule with the intent of following a pre-existing statutory provision that total PPD benefits should remain the same, to the extent possible, as under the old schedule.

The old schedule had assigned ratings primarily on the basis of diagnoses and surgeries performed. The new schedule relies less on these factors and more on objective findings of functional impairment and clinical test results. Thus, some cases that would have received a positive rating under the old schedule because of

a diagnosis or surgery do not receive such a rating under the new schedule if the condition has completely resolved with no remaining functional impairment. The new schedule contains more zero-rated categories than the old schedule, but also some positively rated categories for impairments not in the old one.

Medical Services and Fees

Maximum medical fees. The 1992 law froze maximum medical fees from October 1992 through September 1993 at the previous year's level and provided for a relative-value fee schedule for non-inpatient hospital services with a 15 percent overall payment reduction. The new fee schedule took effect in December 1993. Annual adjustments in the new schedule are based on growth in the SAWW (without the cap that applies to benefit adjustments), rather than on growth in medical charges as they had been previously.

Medical treatment parameters. The law required DLI to institute medical treatment parameters. An emergency one-year rule took effect on May 18, 1993; a permanent rule took effect on Jan. 4, 1995.

Certified managed care organizations (CMCOs). The law allowed employers and insurers to require workers (with certain exceptions) to obtain medical care for work injuries from providers in a CMCO network. CMCOs are certified by DLI on the basis of statutory criteria. They began to be used early in 1993.

Other Provisions

Second-injury reimbursement. The 1992 law ended Special Compensation Fund (SCF) reimbursement of insurers (including self-insured employers) for subsequent ("second") injuries to the same worker, effective for subsequent injuries on or after July 1, 1992.

Insurance policy deductibles. The law required all insurers, including the Assigned Risk Plan, to offer deductibles in workers' compensation policies. Under deductible provisions, employers directly bear costs up to the deductible amount (through reimbursements to insurers) in exchange for a reduced premium.

Fraud. The law required DLI to establish a unit to investigate fraudulent and other illegal practices of health care providers, employers, insurers, attorneys, employees, and others with respect to workers' compensation. It also stipulated that knowingly misrepresenting or concealing information in order to receive workers' compensation benefits to which a person is not entitled is theft punishable as a criminal offense.

Safety committees. The law required all private and public employers with more than 25 employees, and smaller employers in high-hazard industries, to establish and use joint labor-management safety committees.

Insurer safety consultation services. The law required insurers to offer safety consultation services to their insured employers.

Vocational rehabilitation. The vocational rehabilitation system was modified so that eligibility for services is determined in a consultation (by a qualified rehabilitation consultant) only at the request of the employee, the employer (or insurer), or DLI. For this purpose, the insurer must notify DLI when temporary total disability is likely to exceed 13 weeks, but no later than 90 days from the injury. Previously, the injured worker had to be referred into the vocational rehabilitation system after 30 days of lost work time for back injuries and after 60 days of lost work time for all other injuries.

Attorney fees. Effective for fee determinations on or after July 1, 1992, all claimant attorney fees related to the same claim became cumulative (with some exceptions) and were limited to 25 percent of the first $4,000 and 20 percent of the next $60,000 of disputed benefits awarded, not to exceed $13,000 except by petition. Previously, claimant attorney fees were limited to 25 percent of the first $4,000 and 20 percent of the next $27,500 of disputed benefits awarded, not to exceed $6,500 except by petition. The 1992 law change also introduced a limit on defense attorney costs of $13,000 per claim, with exceptions by petition.

Mandated 16-percent rate reduction. The law prohibited insurers from increasing their filed rates from April 1 through Oct. 1, 1992, mandated a 16-percent filed rate reduction effective Oct. 1, 1992, and prohibited filed rate

increases from that date until April 1, 1993, at which time insurers were again free to file rate increases.

1995 Law Change

Indemnity benefits

The following provisions took effect for injuries occurring on or after Oct. 1, 1995.

TTD minimum benefit. The minimum weekly TTD benefit was fixed at $104, not to exceed the employee's pre-injury wage. Previously, the minimum was 20 percent of the SAWW, not to exceed the pre-injury wage; 20 percent of the SAWW would have been $101 as of Oct. 1, 1995.

TTD, TPD, and PTD maximum benefit. The maximum weekly TTD, TPD, and PTD benefit was fixed at $615. Previously, the maximum was 105 percent of the SAWW; this amount would have been $530.25 as of Oct. 1, 1995.

TTD duration limit. TTD benefits were limited to a total of 104 weeks (regardless of when paid), with an exception for approved retraining.

PPD benefits. The higher tier of the two-tier PPD benefit schedule was eliminated. Previously, a PPD beneficiary received either "impairment compensation" (IC) or "economic recovery compensation" (ERC). The IC benefit was equal to the impairment rating (in percentage points) times a scheduled amount per rating point, with increasing amounts per point for higher ratings. The ERC benefit depended on both the impairment rating and the pre-injury wage, and was substantially higher than the IC benefit. If the employee received a "suitable job" offer, they received the IC benefit, paid in a lump-sum if they accepted the offer or in the same weekly amounts and intervals as TTD if they did not. If the employee did not receive a "suitable job" offer, they received the ERC benefit, paid in the same weekly amounts and intervals as TTD. The 1995 law eliminated ERC and provided for all PPD benefits to be determined under the previous impairment compensation schedule, which has been fixed since 1984, and to be paid in the same weekly amounts and intervals as TTD.

Supplementary benefits and PTD minimum benefit. Supplementary benefits, available only to PTD beneficiaries after the 1992 law change, were repealed, and the PTD minimum weekly benefit was raised to 65 percent of the SAWW. In contrast with supplementary benefits, the new minimum (1) is available to all PTD beneficiaries regardless of the amount of time since the first day of total disability, and (2) is subject to the offset provision along with the remainder of the PTD benefit.[26] Under the offset provision, after $25,000 of PTD benefits have been paid, the weekly PTD benefit is reduced by the amount of any other government disability benefits for the same disability and by the amount of any social security retirement or survivor benefits.

PTD eligibility threshold. The law required that for PTD eligibility, the injured worker must have (1) a 17 percent permanent impairment rating, (2) a 15 percent impairment rating if he or she is at least 50 when injured, or (3) a 13 percent impairment rating if he or she is at least 55 when injured and has not completed high school or obtained an equivalency certificate.

PTD benefit termination. The law provided that PTD benefits end at age 67 under a rebuttable presumption of retirement.

Cost-of-living adjustment. Cost-of-living adjustments were limited to 2 percent per year and delayed until the fourth anniversary of the injury. Previously, adjustments were limited to 4 percent per year and delayed until the second anniversary of the injury. Cost-of-living adjustments are further described in Appendix A.

Other Provisions

Attorney fees. The legislature removed the provisions allowing claimant and defense attorney fees to be paid above the statutory limits by petition. However, in 1999 the Minnesota Supreme Court ruled in the case of claimant attorney fees that absolute limits on attorney fees, without the right to petition for additional fees, were unconstitutional because they infringed on the authority of the judicial

[26] Vezina v. Best Western Inn and Shelton v. National Painting and Sandblasting, 627 N.W.2d 324 (Minn. 2001), May 31, 2001.

branch to oversee attorneys.[27] In 2000, the Workers' Compensation Court of Appeals applied this ruling to defense attorney fees.[28]

2000 Law Change

Indemnity benefits

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

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

TTD, TPD, and PTD maximum benefit. The maximum weekly TTD, TPD, and PTD benefit was raised from $615 to $750.

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

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

Other Provisions

Assigned Risk Plan surplus. $325 million of Assigned Risk Plan surplus was transferred to the Special Compensation Fund (SCF) to reduce liabilities in the second injury and supplementary benefit programs through claim settlement. DLI was required to reduce the SCF assessment rate (applied to indemnity payments) by at least 30 percent from the Jan. 1, 2000 rate. DLI reduced the rate from 30 percent to 20 effective July 1, 2000.

2002 Law Change

Assigned Risk Plan surplus. $250 million of Assigned Risk Plan surplus was transferred back from the Special Compensation Fund (SCF) to the state general fund to help balance the budget. In response, DLI raised the SCF assessment rate back to 30 percent effective January 1, 2002.

[27] Irwin v. Surdyk's Liquor, 599 N.W.2d 132 (Minn. 1999), Sept. 2, 1999.

[28] Tucker v. Plymouth Plumbing, 60 W.C.D. 160 (May 25, 2000).

Appendix C

Data Sources and Estimation Procedures

This appendix describes data sources and estimation procedures for those figures where additional detail is needed. Two general procedures are used throughout the report (1) "development" of statistics to incorporate the effects of claim maturation beyond the most current data and (2) adjustment of benefit and cost data for wage growth to achieve comparability over time. After a description of these procedures, additional detail for individual figures is provided. 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 (Department of Labor and Industry [DLI] data) (see Appendix A for definitions). For any given accident, policy, or injury year, these statistics grow, or "develop," over time because of claim maturation and reporting lags. This affects a range of statistics including claims, costs, dispute rates, attorney fees, and others. Statistics from the DLI database develop constantly as the data are updated from insurer reports received daily. With the insurance data, insurers submit annual reports to the Minnesota Workers' Compensation Insurers Association (MWCIA) giving updates on prior accident and policy years along with initial data on the most recent year. If the DLI and insurance statistics were reported without adjustment, time series data would give invalid comparisons because the statistics would be progressively less mature from one year to the next.

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

Research and Statistics has adapted this technique to DLI data. It tabulates statistics at regular intervals from the DLI database, computes development factors representing historical development for given injury years, and then derives developed statistics by applying the development factors to the most recent tabulated statistics. In this manner, the annual numbers in any given time series are developed to a constant maturity, e.g. an 18-year maturity for the claim and cost statistics in Chapters 2 and 3 since the DLI database extends back to injury year 1983 for claim and cost data. An example: In Figure 2.1, the developed number of indemnity claims for injury year 2000 is 31,500 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2002—28,633—times the appropriate development factor 1.0999.

All developed statistics are estimates, and are therefore revised each year in light of the most current data.

Adjustment of cost data for wage growth. Several figures present costs over time. As wages grow, a given cost represents a progressively smaller burden from one year to the next by comparison to the cost of labor. Except for costs expressed relative to payroll, all costs are adjusted for wage growth to standardize the costs over time. The number for each year is multiplied by the ratio of the 2000 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 2000 wage dollars.

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

The number of full-time-equivalent (FTE) workers covered by workers' compensation is estimated as total nonfederal Unemployment Insurance (UI) covered employment from the Department of Economic Security (DES) times 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). Nonfederal UI-covered employment is used because there are no data on workers' compensation-covered employment.

Figure 2.2. For insured employers, total cost is computed as written premium adjusted for deductible credits, minus paid policy dividends. Written premium and paid dividends for the voluntary market are obtained from the Department of Commerce. Written premium for the Assigned Risk Plan (ARP) is obtained from the Park Glen National Insurance Company, 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, in order to reflect that portion of cost for insured employers that falls below deductible limits. Premium credit data through policy year (PY) 2000 are from the MWCIA. The 2001 figure is estimated using the ratio of premium credits to written premium for 2000 (applying this to the 2001 premium figure). When the actual amount becomes available for 2001, that year's total cost figure will be revised.

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

Total workers' compensation covered payroll is computed as the sum of insured payroll, from the MWCIA (annual *Ratemaking Reports* through PY 1999, unpublished data for PY 2000), and self-insured payroll, from the WCRA. Insured payroll was not yet available for 2001, and self-insured payroll is not available for 1980-1989. These figures were estimated by extrapolating from actual figures using the trend in nonfederal UI-covered payroll (from DES) and the trend in the relative insured and self-insured shares of total pure premium (from the WCRA).

Figure 2.3. Paid indemnity claims are from the DLI database. The percentages are taken from undeveloped claim counts. 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.

Figures 2.5 and 2.6. Following the procedure in the MWCIA's *Ratemaking Report,* Figures 2.5 and 2.6 are based on paid losses because these are more stable than incurred losses, which include paid losses plus reserves. The data are from financial reports to the MWCIA by voluntary market insurers only.

Paid losses are developed to a uniform maturity of eight years (an "eighth-report basis") using the selected development factors in the 2003 *Ratemaking Report,* and are then converted to an incurred basis using the selected ratios of paid to incurred losses at eighth report, from the *Ratemaking Reports* of different years. The resulting figures thus represent incurred losses at eighth report.

Payroll data for Figure 2.5 are from insurer reports on policy experience.

Figures 2.7 and 3.1. Figures 2.7 and 3.1 use claim and loss data from the MWCIA's *2003 Minnesota Ratemaking Report.* These data come from insurance company reports on policy experience (claims and losses) for the voluntary market and the ARP. Data are developed to a

fifth-report basis using the development factors in the *Ratemaking Report,* and then adjusted for wage growth.

Figure 3.1 presents data by claim type. For permanent total disability (PTD) and death cases, the number of claims and their average cost (at any given maturity) fluctuate widely from one policy year to the next because of small numbers of cases. Therefore, in order to produce more meaningful comparisons among claim types, the data on PTD and death claims were averaged over policy years 1991-1997. 1998 and 1999 were excluded in order to avoid the relatively large variability in development for these claim types between first and third report.

Figure 4.1. The data for injury years 1997-2001 are developed statistics. For earlier years, the data are not amenable to producing developed statistics. However, for the earlier years, there is probably a small difference between the undeveloped and developed numbers.

Figure 4.2. Total cost is a developed statistic because it is by injury year. It was computed by deriving developed statistics for the number of plans and the average cost of new plans, both by injury year, and multiplying these together. In this calculation, the average plan cost (developed statistic by injury year) was different from the average plan cost shown in the figure, which is the actual figure for plans closed in the given year.

Figure 5.7. Insurers submit an annual report to DLI indicating total defense legal costs paid during the year (divided into attorney fees and other legal costs). For the percentage in the figure, these costs are compared to total indemnity and medical benefits paid during the year, compiled by DLI primarily from insurer reports to the SCF.