OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Oversight of Workers' Compensation

FEBRUARY 2009

PROGRAM EVALUATION DIVISION
Centennial Building – Suite 140
658 Cedar Street – St. Paul, MN 55155
Telephone: 651-296-4708 • Fax: 651-296-4712
E-mail: auditor@state.mn.us • Web Site: http://www.auditor.leg.state.mn.us
Through Minnesota Relay: 1-800-627-3529 or 7-1-1

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Evaluation Staff

James Nobles, *Legislative Auditor*

Joel Alter
Valerie Bombach
David Chein
Jody Hauer
Deborah Junod
David Kirchner
Carrie Meyerhoff
Judith Randall
Sarah Roberts
Jo Vos
John Yunker

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2009

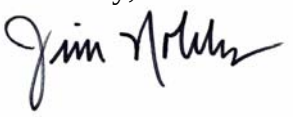
Members of the Legislative Audit Commission:

Workers' compensation is a form of insurance—required and regulated by the state—that provides benefits to people who suffer a work-related injury or illness. At your request, OLA evaluated how well state agencies are fulfilling their responsibilities, particularly to help injured workers, employers, and insurers resolve disputes over liability and benefits.

We found that the workers' compensation system works well for many injured workers; but for some, it fails to meet its goal of timely medical recovery and return to work. We offer several recommendations to improve the program.

Our evaluation was conducted by Deborah Parker Junod (manager), Dan Jacobson, and Sarah Roberts. We received the full cooperation of the Department of Labor and Industry, and we also received helpful insight from the Office of Administrative Hearings, the Department of Commerce, and the Union Construction Workers' Compensation Program.

Sincerely,



James Nobles
Legislative Auditor

Room 140 Centennial Building, 658 Cedar Street, St. Paul, Minnesota 55155-1603 • Tel: 651-296-4708 • Fax: 651-296-4712
E-mail: auditor@state.mn.us • Web Site: www.auditor.leg.state.mn.us • Through Minnesota Relay: 1-800-627-3529 or 7-1-1

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- DLI should do more to monitor whether insurers' denials of liability are appropriate (p. 27).
- DLI should improve its process for obtaining reimbursements from employers for which the state has paid benefits (p. 47).
- DLI should continue efforts to streamline the dispute resolution process (p. 67).
- DLI should track outcomes for workers who have settled claims and adjust, as needed, how such agreements are approved (p. 76).
- DLI and the Legislature should improve the workers' compensation information system (pp. 27, 47, and 68).

Report Summary

Workers' compensation is an insurance program that provides benefits to workers who suffer a work-related injury or illness. A compensable injury can be any condition that is caused, aggravated, or accelerated by employment activities. Injured workers are automatically eligible to receive reimbursement for medical and rehabilitation expenses, as well as indemnity payments for lost wages.

Insurers have been making more errors when processing claims.

Private sector employers, insurers, and claim administration companies bear much of the responsibility for administering workers' compensation. The Minnesota Department of Labor and Industry (DLI) oversees the workers' compensation system.

The number of workers' compensation claims filed in Minnesota has declined.

From 1998 to 2000, Minnesota workers filed about 168,000 workers' compensation claims per year. The number of claims filed decreased each year through 2007, when workers filed about 120,000 claims. In 2007, insurers spent about $950 million on all benefits.

Insurers have denied claims less frequently since 2005.

In late 2005, DLI staff began reviewing all instances in which insurers denied liability when a claim was first filed. They assessed whether each insurer reported a legal basis for denial and provided specific facts to support its judgment. The increased enforcement appears to have had a positive impact. After reaching a high of about 17 percent in 2004, the rate at which insurers denied primary liability declined to 12 percent in 2007.

Benefits were eventually paid in a large portion of denied claims, raising concerns that insurers improperly avoided liability.

Eventual payment of benefits on claims that were initially denied could be due to a variety of reasons, including that the insurer chose to improperly deny the claim or failed to conduct a good-faith investigation when the claim was first made. For injuries in 2006, about 25 percent of claims denied within 14 days of the injury (the time period allowed to determine liability) had been paid as of July 2008. This percentage is large enough to merit further investigation.

If questions over a denied claim are not promptly resolved, the affected worker can register a dispute with the insurer and request assistance through the state's dispute resolution process.

DLI auditors have identified an increasing number of insurer errors, including about $3 million a year in underpaid benefits.

The number of errors DLI found during audits has increased in recent years. Errors were most often related to the accuracy of permanent partial disability payments or the number of weeks of benefits that were to be paid. DLI audits identified more than $3 million in underpaid benefits in each of the past five fiscal years. This is less than 1 percent of roughly $470 million in annual indemnity benefits.

About three-fourths of all penalties DLI assessed in 2007 were against insurers that did not provide requested information within 30 days or failed to file a required form. From 2003 to 2007, the number of penalties assessed ranged from a low of 340 in 2004 to a high of 655 in 2006.

Employers that fail to obtain workers' compensation insurance need to be held more accountable.

Shortcomings in investigative and staff resources have undercut DLI's ability to enforce laws mandating workers' compensation coverage.

DLI identifies employers that fail to carry workers' compensation insurance from three primary sources: claims by one of their employees, tips, and lists of cancelled policies. None of the sources systematically alert DLI to employers that never had workers' compensation insurance in the first place. DLI has made limited use of automated data analysis techniques to identify noncompliant employers. For example, DLI does not use the state's database of employers registered in the unemployment system to find those that should also hold a workers' compensation policy but do not. Lack of a commonly used employer identifier is a key barrier.

The number of DLI investigators enforcing mandatory coverage laws declined from 6.5 investigators in 2000 to 3.5 in 2008. This created a large backlog of cases. DLI often did not investigate employers with lapsed policies until two years after policy cancellation.

DLI does an inadequate job tracking reimbursements from uninsured employers for benefits paid on their behalf.

If an injured worker's employer is uninsured, DLI pays benefits from the Special Compensation Fund. (Its revenues come from an assessment on insurers and self-insured employers.) State law then requires DLI to recover the benefits paid plus a penalty from the uninsured employer.

DLI's reimbursement database contains billing records for fewer than half the cases in which it paid benefits between 1998 and 2007. DLI staff assert that the department did not always create a billing record when an employer paid its reimbursement in a lump sum. They could not estimate how often this happened. Among claims with existing billing records, the settlement amount rarely equaled the 165 percent provided for in law. So far, DLI has recovered roughly $2 million from these employers. This constitutes 19 percent of the total settlement amounts the employers agreed to or were ordered to pay.

The proportion of claims in which workers and insurers have disputes over benefits has been rising.

The percentage of filed indemnity claims with disputes climbed from 15 to 19 percent between 1997 and 2007. Disputes can involve not only denials of liability, but conflicts over any aspect of benefits due once the claim has been accepted. The number of reported disputes between workers and insurers over allowable medical treatment doubled from 1997 to 2007.

Most injured workers had positive opinions about workers' compensation, but a sizeable number had negative experiences.

Most claimants we surveyed had positive opinions about their workers' compensation experience. About two-thirds of claimants thought they were treated fairly by their employers' insurance company, and 74 percent agreed that they had no trouble getting the medical treatment they needed.

Nevertheless, a sizeable number of respondents had negative experiences, particularly those who had disputes over their claims. Among those with disputes who expressed an opinion, 89 percent agreed that the dispute resolution system was too complex, and 88 percent agreed that the process took too long. Only 31 percent agreed that their dispute was resolved fairly, and 38 percent stated that they felt well informed about their rights.

The proportion of claims with disputes between injured workers and insurers has increased, and the state's dispute resolution program needs to be more effective.

Minnesota's alternative dispute resolution process is overly complex.

There are many possible steps and paths through the dispute resolution process, which is managed by the Office of Administrative Hearings (OAH) and DLI. The path varies depending on the nature of the disputed issue, the form used to file the dispute, the willingness of parties to negotiate, and the procedures used by DLI and OAH. A single claim can have multiple disputes that may be at different points in the process.

The Union Construction Workers' Compensation Program was designed to be simpler and less adversarial than the state system.

State law allows employers and unions to establish alternative processes for workers' compensation. Construction industry employers and unions have established the Union Construction Workers' Compensation Program (UCWCP). The UCWCP uses a dispute resolution process that is far simpler than the state's, with a single path and fewer steps. The UCWCP also has slightly lower denial rates and lower costs, and there is no evidence of greater worker dissatisfaction.

DLI and OAH have not made substantial progress getting disputes resolved before a formal hearing.

DLI's policy is to get disputes settled as early as possible, avoiding the need for administrative conferences or hearings. However, the number of administrative conferences held by DLI increased by more than 85 percent between 2000 and 2008. The state has made little progress reducing the number of costly hearings at OAH. In 2007, the department began to more actively encourage parties in disputes to look for mutual agreement, offering mediation services to assist. DLI staff mediated 204 disputes in 2006, 278 in 2007, and 463 in 2008, but this did not offset the increase in administrative conferences and hearings.

Concerns about the impact of settlement agreements on injured workers merit further study.

Settlement agreements are voluntary written agreements to close a claim or end a dispute. They often include a lump-sum payment for benefits. Some stakeholders are concerned that injured workers can be shortchanged by agreeing to these settlements.

One major concern is that injured employees are not back to work at the time of settlement. In our survey of workers who had agreed to settlements, about 30 percent reported that they were unemployed as of fall 2008 due to their work-related injury or illness. Also, some workers close their vocational rehabilitation plans as part of a settlement, even though the plans have not been followed through to completion. Among workers who closed their plans uncompleted as part of a settlement in 2006, only 29 percent were employed. In contrast, 98 percent of those who worked their plans through to completion in 2006 were employed when the plans closed.

Introduction

Workers' compensation is an insurance program that provides benefits to workers who suffer a work-related injury or illness. Under the workers' compensation system, employees are precluded from suing employers for damages resulting from workplace injuries, but they do not have to prove negligence on the part of their employers to get benefits. Injured workers are automatically eligible to receive reimbursement for medical and rehabilitation expenses, as well as payments for lost wages and permanent disability. The Minnesota Department of Labor and Industry (DLI) has primary oversight authority over the workers' compensation system.

Although establishing a workers' compensation system removed the contentious issue of employer negligence from workplace injury cases, disputes among injured workers, employers, and insurers still occur. Disputes typically involve whether injuries are work-related, the level of medical care and rehabilitative services that are needed, or when injured workers have recovered sufficiently to return to work. DLI and the Office of Administrative Hearings (OAH) provide alternative dispute-resolution services, such as mediation, to help resolve disputes and avoid hearings. Formal hearings on disputes, when they occur, are conducted by workers' compensation judges at OAH.

The Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate Minnesota's workers' compensation system in April 2007, although the project's start was delayed until March 2008. Legislators' concerns centered around the following questions, which we used to structure the evaluation:

- **How well does the Department of Labor and Industry ensure that employers and insurers file workers' compensation claims and pay benefits promptly and accurately?**

- **Does the department take appropriate action to penalize employers and insurers that do not meet program requirements?**

- **How effective are the Department of Labor and Industry's alternative dispute resolution efforts?**

To understand how Minnesota's workers' compensation system functions, we interviewed staff and managers from OAH and DLI's Workers' Compensation Division. We also interviewed staff from the Minnesota Department of Commerce, Insurance Fraud Division, and obtained data pertaining to workers' compensation fraud allegations and investigations. We met with representatives of various constituencies interested in workers' compensation, including the Minnesota Chamber of Commerce, vocational rehabilitation specialists, and labor union representatives. We reviewed DLI polices and publications and Minnesota statutes and rules related to workers' compensation. In addition, we reviewed the

findings and conclusions of a Minnesota Management and Budget assessment of the workers' compensation dispute resolution process.[1]

To gain perspective on an alternate approach to the administration of workers' compensation, we interviewed the director of the Union Construction Workers' Compensation Program (UCWCP) and reviewed publications describing its operations. The UCWCP Board of Trustees authorized our access to additional data about the program's dispute resolution proceedings for 2006 to 2008.[2] We used the data to compare the UCWCP to the state system overseen by DLI.

We obtained and analyzed individual-level data on claims reported to DLI, disputes handled by DLI or OAH, and claims denied by insurers. We also used data from DLI's *Minnesota Workers Compensation System Report*, an annual compilation of workers' compensation statistics.[3] Additionally, we analyzed data relating to DLI's compliance activities, including workers' compensation audits, penalty evaluations, and investigations of uninsured employers.

There are limitations associated with DLI's claims data. For example, DLI generally does not receive reports of "medical-only" claims, which are claims involving payments for medical services without any associated wage-loss or disability benefits. Although most workers' compensation claims are medical-only claims, they account for only a small percentage of benefits paid. As a result, this is not a serious shortcoming. Also, DLI is able to obtain information on medical-only claims and benefits paid by private insurers from the Minnesota Workers' Compensation Insurers Association. This leaves a remaining gap in DLI data for medical-only claims filed by self-insured employers.

Beyond the inherent incompleteness of DLI's data on workers' compensation claims and benefits paid, the department faces a number of challenges related to the quality and accessibility of the data in its workers' compensation information system. Claims and other information reported to DLI are submitted on forms or similar documents. DLI scans and retains images of the forms, and hand-enters much of the data from the forms into data tables. These tables and many others containing information related to DLI activities, disputes, and other aspects of workers' compensation administration make up a large, complex information system. Our ability to perform statistical and other analyses was limited to some extent, depending on the availability of data transcribed from forms and the way that other types of information was stored in the database.

We conducted four separate surveys to learn how well the workers' compensation system works from an injured worker's point of view. Survey One was directed at claimants who had disputes opened in DLI's information system

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[1] Minnesota Management and Budget, *Dispute Resolution Process Improvement: Report on Findings and Conclusions* (St. Paul, December 2008).

[2] We did not obtain any information identifying individual union members who participated in the program.

[3] Minnesota Department of Labor and Industry, *Minnesota Workers' Compensation System Report, 2006* (St. Paul, September 2008).

in 2006 or 2007. The sample was divided into two strata: (1) claimants likely to be union construction workers not working for employers participating in the UCWCP and (2) all others, except UCWCP participants. Survey Two went to the population of 145 union workers who participated in a UCWCP dispute resolution event (facilitation, mediation, or arbitration) from January 2006 through August 2008.

Survey Three was a general satisfaction survey that went to a stratified, random sample of claimants with dates of injury in 2006 or 2007 and who were not included in either of the two dispute surveys. The random sample was divided into four strata: (1) claimants associated with employers enrolled in the UCWCP in 2006 or 2007, (2) likely union construction workers not participating in the UCWCP, (3) claimants not in strata 1 or 2 who had disputes associated with their claims, and (4) claimants not in strata 1 or 2 who did not have disputes associated with their claims. Survey Four went to a random sample of claimants who agreed to a negotiated settlement of their workers' compensation claims. We selected the sample from claim records showing either a "stipulated agreement" or "mediation with award" in 2007, excluding any claimants chosen for the other three surveys.

We mailed surveys to all respondents in September 2008 and also gave them the option of responding online. We sent a follow-up postcard in October 2008 to those who had not yet responded. Response rates for the four surveys were as follows: 21 percent on dispute survey one, 19 percent on the UCWCP dispute survey,[4] 24 percent on the general satisfaction survey, and 25 percent on the settlement survey. While each of the four surveys had a distinct purpose, we included a common set of general satisfaction questions on each of the surveys. This allowed us to combine the (properly weighted) responses for a more robust sample.

[4] We surveyed all 145 claimants who used the UCWCP for dispute resolution and received completed questionnaires from 22 of them. This small group size limited our ability to make comparisons between the UCWCP and the state workers' compensation system.

1 Background

Workers' compensation is an insurance program that provides benefits to workers injured in the course of employment. Minnesota state government, employers, insurance companies, health care providers, and employees all play a role in ensuring that injured workers receive the workers' compensation benefits to which they are entitled.

Our evaluation focused on state oversight of workers' compensation claims. As background, this chapter provides:

1. An overview of Minnesota's workers' compensation system, including who is covered, benefits provided, and procedures for resolving disputes;

2. Information on administrative roles and responsibilities; and

3. Data on workers' compensation claims filed and benefits paid.

OVERVIEW

The purpose of workers' compensation is to provide quick and efficient delivery of benefits to injured workers at a reasonable cost to employers.

In establishing Minnesota's workers' compensation system, the Legislature stated its intent that the system assure the quick and efficient delivery of benefits to injured workers at a reasonable cost to employers.[1] Workers' compensation is a "no-fault" system designed to provide benefits to employees injured as a result of their employment activities and to limit the liability of employers. Because it is a no-fault system, an employee with a work-related injury or illness does not need to prove negligence on the part of the employer to establish liability. It also means that the employer can not use negligence on the part of the employee as a defense to a claim.

A compensable injury can be any condition that is caused, aggravated, or accelerated by employment activities. This includes traumatic injuries, gradual injuries, and occupational diseases. The employee needs to show only that the employment activities were a substantial contributing factor to the disability or need for medical care.

Coverage

Minnesota's workers' compensation system applies to all employers in Minnesota, unless specifically excluded by law.[2] An employer includes any person who employs another to perform a service for hire, including individuals, corporations, partnerships, associations, and governmental entities (state, county,

[1] *Minnesota Statutes* 2008, 176.001.

[2] *Minnesota Statutes* 2008, 176.021.

town, city, school district, or governmental subdivision). Employees are generally defined as people performing services for another for hire, including minors, workers who are not citizens, and workers who reside in other states. There is no minimum number of employees an employer must have before insurance is required. For example, even an employer with only one part-time employee generally must provide coverage.

Certain types of organizations and workers are excluded from the workers' compensation system. For example, some businesses, such as sole proprietorships and partnerships operated by individuals and their immediate family members, do not have employees and thus have no obligation to obtain workers' compensation coverage. Other categories of employers and workers are specifically excluded by law, including certain family farm operations, officers and family members of closely held corporations or limited liability corporations, casual laborers, certain domestic workers, and independent contractors.[3] These excluded classes of employers may elect to purchase workers' compensation coverage. When such coverage is provided, the insured worker becomes an "employee" as defined in state law for the purposes of workers' compensation.[4]

Minnesota employers must either purchase workers' compensation insurance or self-insure.

Employers must ensure workers' compensation coverage either by purchasing workers' compensation insurance from an authorized carrier or by obtaining approval from the Minnesota Department of Commerce (Commerce) to self-insure.[5] In 2007, for example, Minnesota insurers wrote more than 127,000 workers' compensation insurance policies. In addition, more than 1,200 employers were registered as self-insurers as of January 2009. Employers unable to purchase insurance in the private market may do so through the Assigned Risk Plan, the insurance program of last resort administered by Commerce.

State law includes procedures and remedies if an employer fails to carry mandatory insurance.[6] The Minnesota Department of Labor and Industry (DLI) can assess fines against employers for failing to insure employees, regardless of whether an injury has occurred. The employer may be ordered to provide the necessary insurance coverage, to refrain from employing any person at any time without insuring the employee, and to pay a penalty of up to $1,000 per employee per week during the time the employer was not insured.

If an employee suffers a compensable injury and the employer has not purchased insurance coverage or followed the proper procedures for self-insurance, benefits may be paid from the State of Minnesota's Special Compensation Fund.[7] The fund is administered by DLI, and its revenues come primarily from an

[3] *Minnesota Statutes* 2008, 176.041, subd. 1.

[4] *Minnesota Statutes* 2008, 176.041, subd. 1a.

[5] *Minnesota Statutes* 2008, 176.181, subd. 2.

[6] *Minnesota Statutes* 2008, 176.181, subd. 3 and subd. 4.

[7] *Minnesota Statutes* 2008, 176.183, subd. 1.

assessment on insurers and self-insured employers.[8] If DLI pays benefits from the Special Compensation Fund on behalf of an uninsured employer, state law requires DLI to recover the benefits paid. The employer is also subject to a penalty in the amount of 65 percent of those benefits plus expenses incurred by the department.[9]

Benefits

Workers' compensation provides several types of benefits, as shown in Table 1.1.

Table 1.1: Types of Workers' Compensation Benefits

Medical	Reasonable and necessary medical services and supplies related to a work-related injury or illness.
Indemnity	Cash benefits to the injured or ill worker to compensate for wage loss and permanent functional impairment. Benefits are paid to dependents if an employee dies from a work-related injury or illness.
Vocational Rehabilitation	A variety of services, including job modification, retraining, and job placement, to help injured workers return to work when their employers are unable to offer suitable work.

NOTE: Vocational rehabilitation and medical benefits are often paid in conjunction with indemnity benefits.

SOURCES: Office of the Legislative Auditor; and Minnesota Department of Labor and Industry, *Minnesota Workers' Compensation System Report, 2006* (St. Paul, September 2008).

Medical benefits cover medical services and supplies, including medical, psychological, and surgical treatment.

Medical

Medical benefits consist of reasonable and necessary medical services and supplies to cure or relieve the effects of a work-related illness or injury.[10] Treatment may include, but is not limited to, medical, psychological, chiropractic, podiatric, surgical, and hospital treatment. In the case of permanent disabilities, nursing services are also covered. The employee selects an initial treating physician unless the employer and insurer have agreed to provide

[8] *Minnesota Statutes* 2008, 176.129, subd. 2a and subd. 8. The Special Compensation Fund also funds workers' compensation program administration by 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.

[9] *Minnesota Statutes* 2008, 176.183, subd. 2 and subd. 3.

[10] *Minnesota Statutes* 2008, 176.135, subd. 1.

treatment through a certified managed care organization.[11] An employer may require the injured employee to be examined by the employer's physician.[12]

DLI sets medical and hospital maximum charges for allowable medical services, with the fee schedule based on that for the Medicare system. A conversion factor is applied each October 1 to adjust the fees. Treatment parameters are also incorporated into the workers' compensation rules. Through rulemaking, the department establishes treatment standards for common work-related injuries, including, but not limited to, lower back injuries and upper extremity repetitive trauma injuries. The parameters define excessive treatment and present guidelines for imaging, hospitalization, surgery, and management of chronic conditions.

Indemnity

Indemnity benefits are monetary benefits paid to compensate an injured worker for lost wages and permanent disability.

Indemnity benefits compensate the injured or ill worker for wage loss or permanent disability, and compensate dependents in the event of death. As shown in Table 1.2, indemnity benefits are categorized by the nature of the disability—temporary or permanent, partial or total. State law establishes the benefit terms for each of these categories.[13] The workers' wages and state law in effect at the date of injury or death are controlling factors in the determination of indemnity benefits. That is, the law in effect on the date of injury or death governs the type and amount of benefits that are payable to the employee or dependents of the employee. The compensation rate is based on the gross weekly wage at the time of the injury and does not include any wage increases the employee might receive in the future.

By law, disability is deemed to begin on the first calendar day or fraction of a calendar day that the worker is unable to work.[14] No wage-loss benefits are paid for the first three calendar days after the disability begins. However, if the disability continues, even intermittently, for ten calendar days or longer, the compensation is owed from the first day the worker was unable to work.

Vocational Rehabilitation

Vocational rehabilitation benefits encompass services to help eligible injured workers return to work.[15] Vocational rehabilitation is intended to result in the employee returning to a job related to his or her former employment or to a job in another work area which produces an economic status as close as possible to

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[11] With a certified managed care organization, there are exclusions that allow employees to seek treatment outside of the managed care organization.

[12] *Minnesota Statutes* 2008, 176.155, subd. 1. In addition, if there is a dispute as to the injury, the state authority hearing the dispute (the Commissioner of Labor and Industry, compensation judge, or Workers' Compensation Court of Appeals) may designate a neutral physician to make an examination of the injured worker. *Minnesota Statutes* 2008, 176.155, subd. 2.

[13] *Minnesota Statutes* 2008, 176.101.

[14] *Minnesota Statutes* 2008, 176.121.

[15] *Minnesota Statutes* 2008, 176.102, subd. 1(b).

Table 1.2: Types of Indemnity Benefits, 2008

	Description	Amount	Duration
Temporary partial disability	Paid to an employee who is working at less than his or her pre-injury earnings	Two-thirds of the difference between the average gross weekly wage at the time of injury and the gross weekly wage earned while partially disabled up to a maximum of $850 per week[a]	Up to 225 weeks, but not after 450 weeks from date of injury
Temporary total disability	Paid to an employee who is temporarily unable to work	Two-thirds of gross weekly wage at time of injury, with a minimum of $130 per week and a maximum of $850 per week	Until the employee returns to work or 90 days after reaching maximum medical improvement, up to 130 weeks from date of injury[b]
Permanent partial disability	Paid to compensate for partial or total permanent loss of use of a body part	A fixed amount determined using an impairment rating (expressed as a percentage of the whole body) multiplied by a corresponding benefit amount set in state law	Paid either in a lump sum or in installments at the same intervals and in the same amount as the employees' temporary total disability rate
Permanent total disability	Paid to an employee who cannot earn a living from work due to a work injury or illness[c]	Two-thirds of gross weekly wage at the time of injury, with a maximum of $850 per week and a minimum of 65 percent of the statewide average weekly wage, payable upon cessation of temporary total disability benefits[d]	Generally until age 67, the presumed age of retirement
Death/dependency	Paid to the dependents of an employee who has died as the result of a work-related injury or illness	Benefits vary depending on the number of surviving dependents, with the maximum (for a spouse and two dependent children) being two-thirds of the employee's daily wage at the time of injury	Ten years for a spouse with no dependent children Dependent children receive the total allowable benefit until the last child ceases to be a dependent, with reduced benefits paid to the spouse for ten years thereafter

[a] The temporary partial benefit plus wages earned while partially disabled cannot exceed 500 percent of the statewide average weekly wage.

[b] Temporary total disability benefits also must cease if the employee withdraws from the labor market, the total disability ends and the employee does not return to work or diligently search for work, the employee has been released to work without any physical restrictions caused by the injury, the employee refuses an offer of work that is consistent with the employee's rehabilitation plan or that the employee is otherwise capable of performing, or the employee retires.

[c] Eligiblity depends on the type of permanent disability, age, and education.

[d] After a total of $25,000 of weekly compensation has been paid, the amount of weekly permanent total disability benefits is reduced by the amount of any disability benefits being paid by any government disability benefit program if the disability benefits are for the same injury that gave rise to the workers' compensation benefits.

SOURCES: Office of the Legislative Auditor and *Minnesota Statutes* 2008, 176.101 and 176.111.

what the employee would have enjoyed without the disability. Economic status is to be measured not only by opportunity for immediate income but also by opportunity for future income. Services include vocational evaluation, counseling, job modification, placement, and retraining. Except for retraining, these services are delivered by qualified rehabilitation consultants and job placement vendors who are registered with DLI.[16] Consultants determine whether injured workers are eligible for services, develop rehabilitation plans for those who are eligible, and coordinate service delivery under those plans.

Dispute Resolution

Disputes in Minnesota's workers' compensation system can occur for a variety of reasons, including denial of a workers' compensation claim, eligibility for indemnity benefits, discontinuance of benefits, disagreements over medical treatment, or access to vocational rehabilitation services. Depending on the nature of the dispute and the wishes of the parties, dispute resolution may be facilitated by a specialist in DLI or a judge in the Office of Administrative Hearings (OAH).[17] Parties may choose to be represented by an attorney or can participate without representation.

The state offers both informal and formal dispute resolution processes.

DLI offers informal and formal dispute resolution services as an alternative to litigation. State law directs the department to make informal efforts to settle problems on behalf of employers and employees.[18] This includes contacting third parties (such as attorneys, insurers, and health care providers) and using the department's persuasion to settle issues quickly and cooperatively. In addition to informal assistance, the department provides formal dispute resolution procedures, including mediation and administrative conferences.

Most disputes that require a formal process for resolution are directed to OAH. This includes disputes involving a denial of primary liability, discontinuances of wage-loss benefits, medical disputes involving bills that exceed $7,500, medical and rehabilitation disputes that are consolidated with other OAH matters, and appeals of DLI administrative orders resulting from administrative conferences. OAH proceedings include administrative conferences, mediation, and hearings. Injured workers are not required to have an attorney at OAH proceedings, but OAH strongly recommends that workers retain one. Decisions from OAH can be appealed to the Workers' Compensation Court of Appeals and then to the Minnesota Supreme Court.

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[16] Workers may also choose to receive vocational rehabilitation services from qualified rehabilitation consultants on staff at DLI.

[17] OAH is an independent, executive-branch agency established in 1976 to provide an impartial hearing process for citizens who disagree with state government. It hears cases related to workers' compensation and cases related to state agency actions, such as nursing home penalties, permits for air and water discharge, and facility or professional licensing decisions. Workers' Compensation Judges hear workers' compensation cases, and Administrative Law Judges hear other types of cases. OAH proceedings are conducted in a manner similar to what occurs in a court of law.

[18] *Minnesota Statutes* 2008, 176.261.

ADMINISTRATIVE ROLES AND RESPONSIBILITIES

Much of the administrative responsibility for workers' compensation rests with private sector employers, insurers, and claim administration companies. But several state agencies play roles, relating primarily to oversight and dispute resolution. In addition, certain workers are covered by an alternative system—the Union Construction Workers' Compensation Program.

State Agencies

The Minnesota Department of Labor and Industry (DLI) oversees compliance with workers' compensation laws.

Department of Labor and Industry. DLI is the state agency responsible for overseeing Minnesota's workers' compensation system. It audits files; monitors payment of benefits; and penalizes insurers and employers that do not comply with state laws and rules governing filing of claims, payment of benefits, and reporting to DLI. The department also enforces compliance with mandatory workers' compensation coverage laws; provides assistance, education, and information to all parties; and provides dispute resolution services. It also has other duties related to workers' compensation policy, administrative reporting, and oversight of workers' compensation service providers.

In addition to overseeing various aspects of the workers' compensation system, DLI itself acts as an insurer under certain circumstances. DLI administers the Special Compensation Fund, from which benefits are paid to injured workers whose employers do not carry required workers' compensation coverage. This includes: (1) processing claims for injured employees of uninsured and bankrupt self-insured employers and (2) obtaining reimbursements from uninsured employers for benefits paid on their behalf.

Office of Administrative Hearings. OAH's primary mission is adjudication of workers' compensation cases. This is different than DLI, which has multiple roles and responsibilities with regard to workers' compensation. OAH provides pretrial dispute resolution (administrative conferences and mediation) and, if settlement is not achieved, hearings before workers' compensation judges.

Department of Commerce. Commerce is responsible for insurance fraud prevention and investigation, including fraud related to workers' compensation insurance. Commerce also regulates workers' compensation insurance carriers and self-insurers. For example, it issues licenses for insurers to write Minnesota workers' compensation policies, approves employers' applications for workers' compensation self-insurance, and disciplines carriers and self-insurers.

Union Construction Workers' Compensation Program

State law authorizes employers and labor unions to jointly establish alternate workers' compensation systems.

State law authorizes employers and unions to establish through collective bargaining certain alternative processes for administering workers' compensation.[19] Any agreement bargained under this provision must be limited to, but need not include, the following: (1) an alternative dispute resolution system to supplement, modify, or replace the state's system; (2) an agreed list of medical treatment providers; (3) the use of a limited list of impartial physicians to conduct independent medical examinations; (4) the creation of a light-duty, modified-job, or return-to-work program; (5) the use of a limited list of vocational rehabilitation or retraining programs; (6) the establishment of safety committees and safety procedures; and (7) the adoption of a 24-hour health care coverage plan.[20] Nothing in the collectively-bargained alternative system can diminish an employee's entitlement to benefits as otherwise set forth in state law.[21]

Under this authority, a group of Minnesota construction unions and employers jointly established the Union Construction Workers' Compensation Program (UCWCP). It began operations in July 1997. Key elements of the UCWCP include (1) an alternative dispute resolution system that includes facilitation, mediation, and arbitration steps; (2) exclusive networks of health care providers and rehabilitation specialists with expertise in construction injuries; and (3) a panel of neutral doctors to provide opinions to help resolve disputes over medical benefits. About 20 construction trade unions and 280 contractors employing roughly 15,000 union construction workers participated in the UCWCP at the end of 2008.

NUMBER OF CLAIMS AND BENEFIT EXPENDITURES

When describing the size of Minnesota's workers' compensation system, it is useful to distinguish between claims and benefits. Workers' compensation claims are broadly divided into two major categories: indemnity claims and medical-only claims. Claims can be divided into more specific subtypes based on the type of benefits paid (discussed further in Benefits section below). Paid indemnity claims typically result in indemnity benefits (replacing wages or compensating for a permanent disability) as well as medical benefits (coverage for doctor appointments, procedures, and medications, for example). Depending

[19] *Minnesota Statutes* 2008, 176.1812, subd. 1. Originally, this authority was restricted to employers and unions in the construction industry, but the Legislature repealed the restriction in 2005. *Laws of Minnesota* 2005, chapter 90, sec. 13.

[20] *Minnesota Statutes* 2008, 176.1812, subd. 1.

[21] *Minnesota Statutes* 2008, 176.1812, subd. 4.

on the situation, indemnity claims may also include vocational rehabilitation benefits, such as job counseling. Medical-only claims, on the other hand, only have medical benefits associated with them.

Claims

Determining the number of workers' compensation claims filed in Minnesota is not straightforward. Data on the number of claims are collected by two agencies: Minnesota Workers' Compensation Insurers Association (MWCIA) and DLI. DLI calculates estimated claim numbers by combining data from the two sources.

MWCIA is a nonprofit corporation licensed as a workers' compensation data service organization by the state of Minnesota. State law requires that every insurance company in Minnesota report specific data on its workers' compensation insurance policies to the MWCIA.[22] The organization uses the claim and benefit information it receives to establish the base premiums that insurance companies use in determining the premiums charged to insured employers. Self-insured employers, however, do not use MWCIA's rate-setting services and are not required to report their claims or expenditures to the organization. Therefore, MWCIA's data cannot by itself provide a complete picture of the number of workers' compensation claims.

A workers' compensation claim must be reported to DLI any time an employee misses more than three days of work due to a work-related injury or illness.

DLI's workers' compensation data are incomplete for a different reason. A workers' compensation claim must be reported to DLI any time an employee misses more than three days of work due to a work-related injury or illness. Injuries do not have to be reported to DLI if the workers' compensation claim is for medical treatment only or if the employee lost three or fewer days of work.[23] Since the reporting of medical-only claims is not required, DLI's data on medical-only claims is not complete.

In order to estimate the total number of claims filed, DLI uses the number of indemnity claims it receives (which includes those from both commercially-insured and self-insured employers) and adds an estimated number of medical-only claims. DLI arrives at this estimate using a ratio of medical-only to indemnity claims that it creates using MWCIA data.[24] DLI also adjusts claim and benefit data using a "development factor." Not all injuries are reported in the year that they occur, and some start out as medical-only claims that later result in lost work time. For this reason, the number of claims attributable to a given year may increase as time passes. DLI applies a development factor to each year of data to estimate what the claim numbers will be when they reach maturity.

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[22] *Minnesota Statutes* 2008, 79.60, subd. 1(a).

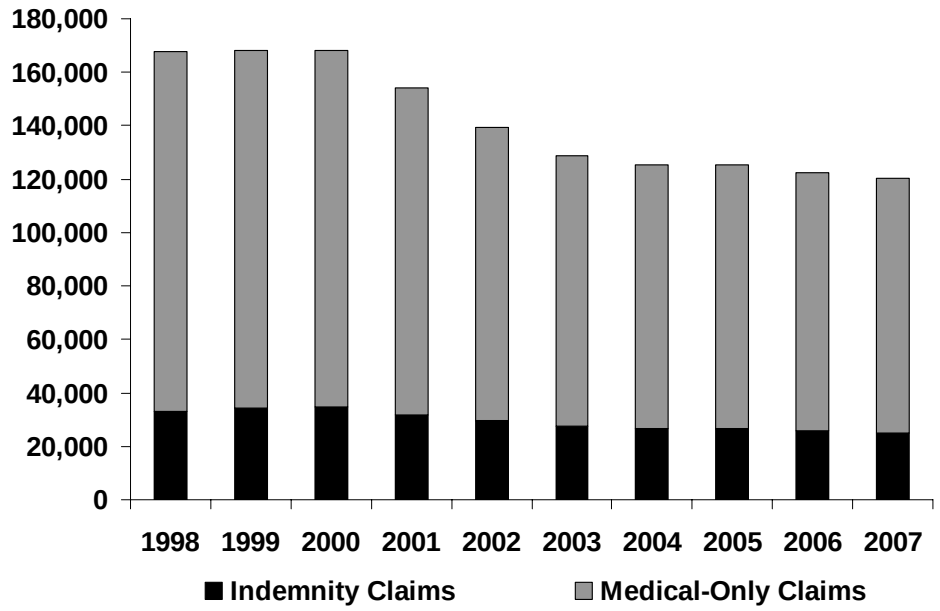
[23] Some medical-only claims are reported to DLI. Employers are required to report medical-only claims to DLI if a dispute occurs. Also, some employers choose to preemptively report injuries in case they result in lost time later on.

[24] As mentioned previously, MWCIA does not regularly collect data from self-insured employers and no ratio for these employers is available. Since DLI applies the insurance company-based ratio to all reported indemnity claims in its estimation process, it implicitly assumes that the indemnity to medical-only claim ratio is similar between self-insured and commercially-insured employers.

The number of workers' compensation claims filed in Minnesota has been declining.

The estimated number of workers' compensation claims filed in Minnesota declined between 1998 and 2007. Figure 1.1 shows that from 1998 to 2000, the combined totals of indemnity and medical-only claims hovered around 168,000 claims filed per year.[25] The total number of claims decreased by more than 10,000 per year between 2001 and 2003 before slowing to a more gradual decline beginning in 2004. In 2006 and 2007, Minnesota workers filed roughly 120,000 workers' compensation claims each year.[26]

Figure 1.1: Workers' Compensation Claims, 1998 to 2007



NOTES: Claims are counted in the year the injury or illness occurred. Indemnity claim numbers are "developed statistics," or estimates of what the claim numbers will be once they reach maturity. DLI applies a development factor to recent data in order to account for the fact that the number of claims for injuries in a given year tends to increase over time (because not all injuries are reported or result in benefits being paid immediately). Medical-only claims are estimated based on the ratio of medical-only to indemnity claims found in MWCIA data.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry claims data.

[25] While there are several types of workers' compensation benefits, claim numbers are reported simply in terms of medical-only and indemnity claims. Indemnity claims include those with lost-time benefits such as temporary disability, permanent total, and dependency benefits, as well as permanent partial disability benefits and vocational rehabilitation benefits.

[26] Since vocational rehabilitation benefits are associated with indemnity claims, claims requiring rehabilitation are included in the totals presented in this paragraph. DLI estimates that roughly 5,360 claimants injured in 2006 will eventually receive vocational rehabilitation benefits.

Medical-only claims make up the bulk of the workers' compensation claims filed in the state. Between 1998 and 2007, medical-only claims consistently accounted for about 79 percent of the claims filed, while indemnity claims made up the remaining 21 percent.

Benefits

Workers' compensation benefits costs in 2007 totaled approximately $952 million.

DLI collects data on the amounts of medical and indemnity benefits paid by insurers and self-insured employers each calendar year. Between 1998 and 2007, DLI reports that insurers spent roughly $4.5 billion on indemnity benefits and $4.1 billion on medical benefits.[27] On average, insurers spent about $865 million per year on both indemnity and medical benefits for injured workers. Over the ten-year period examined, medical payments gradually increased as a proportion of the total, from 42 percent in 1998 to 52 percent in 2007. Benefits totaled $952 million in 2007.

In order to look at benefit payments in more detail, we analyzed MWCIA data reporting the benefit amounts associated with many subtypes of claims. In insurance data, claims are defined by the most severe type of benefit associated with the claim. In order of decreasing severity, these claim subtypes are death, permanent total disability, permanent partial disability, temporary disability, and medical-only. (See Table 1.2 for descriptions of the different types of indemnity benefits.) If multiple types of benefits are paid on a claim, the most severe benefit prevails; for instance, if a claim results in medical, temporary disability, and permanent partial disability benefits being paid, the permanent partial benefits define the claim. The remainder of the chapter presents analysis of MWCIA data on benefits paid for given claim subtypes.[28]

Insurers pay medical benefits on medical-only claims as well as indemnity claims of all types. If the injured worker did not miss more than three days of work or sustain a partial disability, his or her claim is considered strictly medical. To illustrate, MWCIA reports that private insurers paid about $378 million in medical benefits during policy year 2005. Only $58 million of those medical benefits were associated with these medical-only claims. The claim is considered an indemnity claim if the work-related injury or illness results in a permanent partial disability or in the employee missing more than three days of work. Insurers pay wage-replacement benefits, permanent partial disability, and the medical bills as part of the claim. The remaining $320 billion in medical payments (85 percent) made in 2005 were associated with indemnity claims.

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[27] Because of the way insurers report their data, payments made on vocational rehabilitation benefits are included in the totals for indemnity benefits. DLI, however, analyzes rehabilitation benefits in a separate analysis and estimates that the cost of vocational rehabilitation services in 2006 was $41 million, or about 2.5 percent of DLI's estimated workers' compensation system costs.

[28] The benefit amounts discussed below cannot be compared to the overall benefit amounts presented earlier in the section for three reasons: (1) MWCIA does not regularly collect data from self-insured employers, (2) MWCIA data on benefits paid are organized by policy year, meaning that payments are counted in the year of the inception of the policy that was in effect when the injury occurred, and (3) the most recent year of data available is 2005.

Claims involving only medical treatment and supplies account for 9 percent of benefits paid but 80 percent of claims filed.

The different claim subtypes occur with varying frequency and levels of expense to the insurer. Table 1.3 shows claim and benefit payment data by claim subtype, as reported to MWCIA by private insurers (the data do not include expenditures by self-insured employers, which do not report to MWCIA). Between 1998 and 2005, insurers spent the most on permanent partial disability claims, which accounted for two-thirds of all medical and indemnity benefits paid but only 6 percent of claims filed. In contrast, medical-only claims accounted for 9 percent of benefits paid but almost 80 percent of all claims filed. Thus, medical-only claims are relatively inexpensive on a per-claim basis; during the period examined, benefit payments averaged $598 per claim. The most expensive individual claims are those in which the most severe benefits paid are permanent total disability benefits, averaging more than $380,000 per claim.

Table 1.3: Claims and Benefits Paid by Private Insurers by Claim Subtype, 1998 to 2005

	Claims	Claims as Percentage of Total	Benefit Payments (Millions)	Benefit Payments as Percentage of Total	Average Benefit Payments Per Claim
Death/ dependency	405	<1%	$ 78	2%	$191,955
Permanent total disability	1,031	<1	393	8	380,991
Permanent partial disability	55,166	6	3,189	66	57,803
Temporary disability	127,824	15	789	16	6,170
Medical-Only	696,327	79	417	9	598

NOTES: Claims and payments are counted by policy year, meaning they are counted in the year of inception of the insurance policy in effect when the injury occurred. Depending on the particular policy and the timing of the injury, the policy year may or may not be the same as the injury year. Due to the time lag associated with reporting policy year data, 2005 is the last complete year of data available. Claim subtype is determined by the most severe type of benefit paid on a given claim. Temporary disability claims include those in which either temporary total or temporary partial benefits were the most severe benefit type paid. "Payments" includes both medical and indemnity payments associated with the claim type in question. The claim numbers and benefit payments presented are the sums of all claims reported over the eight-year period. The percentages, however, should be considered typical; the claim proportions remained almost constant over the period examined.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry and Minnesota Workers' Compensation Insurers Association claims data.

2 Compliance

The Minnesota Department of Labor and Industry (DLI) is the state agency primarily responsible for overseeing the workers' compensation system, although other agencies are also involved. State laws and rules establish numerous requirements for employers, insurers, and injured workers regarding the provision of workers' compensation insurance and the timely and accurate filing of workers' compensation claims.

Our evaluation focused on how well the state oversees compliance with these requirements. Specifically, we assessed the following:

1. DLI's efforts to audit files, monitor benefits, and penalize insurers and employers for lack of compliance in claims reporting and benefit payments;

2. DLI's procedures to identify and penalize employers that lack mandatory workers' compensation coverage;

3. The extent to which DLI holds uninsured employers accountable for repaying benefits paid on their behalf; and

4. The results of workers' compensation insurance fraud investigations conducted by the Department of Commerce.

CLAIMS REPORTING AND BENEFIT PAYMENTS

DLI's oversight of the claims process focuses on the timely filing of forms and accurate calculation of benefits by insurers.

We assessed DLI's procedures for the routine monitoring of workers' compensation claims and its application of penalty authority in cases of noncompliance. In addition, we analyzed claims data to look for indications that insurers were systematically denying claims that should have been accepted.

Overall, we found that:

- **DLI oversight of workers' compensation claims focuses primarily on procedural compliance with filing and payment requirements, leaving injured workers, employers, and insurers to resolve conflicts about compensability through the dispute process.**

DLI's compliance procedures are linked to state laws that focus on timely filing of forms and accurate calculation of benefits. DLI's oversight is less focused on whether the worker's injury or illness is job-related and should be covered by workers' compensation. Generally speaking, questions regarding whether an insurer correctly accepted or denied liability are raised and resolved through the dispute resolution process, not DLI's compliance procedures. DLI procedures

focus on whether insurers do a timely and accurate job of explaining the reasoning for the denial, not whether the insurer's denial is justifiable.

We discuss DLI's compliance procedures in more detail, below. Ultimately, we do not recommend major changes in DLI's approach. However, we think the department needs to extend its compliance activities to test the appropriateness of insurers' judgments regarding liability. If the department finds a pattern or practice of inappropriate denial by specific insurers, industries, or across the board, then further action (insurer education, application of penalties, etc.) is warranted. Assuring appropriate access to benefits at the time they are needed is certainly within the purview of DLI's statutory oversight authority. We think the department is obligated to look for and address systemic problems that impede timely access to benefits.

Automated Monitoring, Auditing, and Use of Penalty Authority

State law provides that DLI "shall actually supervise and require prompt and full compliance with all provisions of" Minnesota's workers' compensation statutes "relating to the payment of compensation."[1] To meet this mandate, DLI has two primary compliance functions aimed at ensuring the accurate, timely processing of workers' compensation claims: (1) in-depth auditing of select claims; and (2) evaluation of claims in which noncompliance with state law or rule may merit a financial penalty. Hereafter, the two functions will be referred to as "audit" and "penalty" or, when referencing the staff, "the audit team" and "the penalty team." Both functions use automated screening to identify potential noncompliance among the claims reported to the department.

Claim information submitted to DLI is screened by computer for possible errors.

Organizationally, the two compliance functions are located in the DLI Workers' Compensation Division, Benefit Management and Resolution Unit, Compliance section.[2] Excluding administrative staff, the audit team consists of six auditors, and the penalty team consists of three compliance officers.

Identifying Potential Noncompliance

Based on our analysis of these teams' operations and results, we found that:

- **DLI uses extensive automated procedures to screen nearly all indemnity claims for specific types of potential errors but could further expand its procedures to address oversight gaps.**

The purpose of the audit function is to systematically review claims for accurate calculation and timely payment of benefits to injured workers and the submission of appropriate forms to DLI. To do this, the department uses computerized

[1] *Minnesota Statutes* 2008, 176.251.

[2] Prior to June 25, 2008, the two functions resided in separate units. The penalty team was in the Benefits Management and Resolution Unit, Compliance section; the audit team was in the Data Management and Training Unit, Data Monitoring section.

Claims flagged during the automated screening process go to DLI auditors for further review.

selection to identify groups of claims that meet certain criteria of interest, such as insurer notices that benefits are being discontinued for a reason other than return to work. Other general selection criteria are listed in Table 2.1. Audit selection focuses on those claims that must be reported to DLI—indemnity claims involving more than three days of lost time—but all claim documents filed with the department are subject to computerized review and selection. Auditors review the claims and correspond with insurers to resolve any problems identified.

Table 2.1: Criteria for Auditor Reviews of Workers' Compensation Claims, 2008

- Certain claims are automatically sent to auditors for review, including first reports of serious or fatal injury, notices of benefit payments, and notices of discontinued dependent benefits, among others.
- Monthly, auditors review open files with permanent partial disability ratings in the database where no payment for permanent partial disability has been made.
- Administrative staff review claims that had previously been closed but for which the department has received a new Notice of Primary Liability Determination, Interim Status Report,[a] or Notice of Intent to Discontinue Benefits. The staff select certain claims for further scrutiny by auditors under a variety of circumstances, including (1) if the insurer reports an employee back to work at full wage but lost time exceeded two weeks; (2) if the insurer intends to discontinue benefits for reasons other than return to work; and (3) if questionable payment dates appear on an Interim Status Report.
- Claims are reviewed when a form was not received when due. For example, when a notice of primary liability has been received but no document is later filed showing subsequent action on the claim (such as a notice of benefits paid).
- All medical reports, health care provider reports, and physician reports of work ability are screened and selected for further scrutiny if permanent partial disability is indicated or if a surgery is noted and a permanent partial disability is likely.
- Auditors may also review claims referred by other DLI staff or when requested by a party to the claim, such as an employee who believes his or her benefits may not be correct.

NOTE: The table is not an all-inclusive list of audit selection criteria.

[a] The Interim Status Report form is used to notify the department of compensation paid on claims with payments lasting for a year or more.

SOURCES: Office of the Legislative Auditor and Minnesota Department of Labor and Industry.

The penalty team identifies claims that may be candidates for a penalty assessment through computer screening and referrals. Referrals for the penalty team to evaluate compliance come from external sources, such as injured workers, their attorneys, or health care providers. They may also come from other Workers' Compensation Division staff, including auditors and dispute resolution specialists. Additionally, the department's computer system is programmed to generate lists of case files that (1) may have late reporting or late payments based on the information submitted by workers' compensation payers

and (2) involve denials of primary liability when the records show the employee has lost time from work as a result of the alleged work injury.

The penalty team is exploring opportunities to add new computer screening procedures. For example, the department is developing a protocol to generate penalty candidate lists related to late subsequent payments (their current screening protocol tests the timeliness of the first benefit payment made for a claim). Specifically, this initiative would test the timeliness of two payment types: (1) lump-sum awards and (2) commencement of permanent partial disability.

Improvements to the workers' compensation information system would allow more automated review of claims.

Limitations in the workers' compensation information system are a barrier to implementing this additional automated review of claims. DLI staff enter into the system's data tables many pieces of information from the forms and other documents submitted to the department. The forms themselves are scanned and stored as images. However, the searchable information in the claims database does not include all relevant data for compliance purposes.

The department is upgrading the information system in stages to have more data submitted electronically rather than on paper forms. In the first stage, started in October 2008, vocational rehabilitation providers began submitting data from five selected rehabilitation forms.

Audit Team Results

In addition to finding that the department uses a fairly comprehensive process for reviewing indemnity claims, we reviewed data on audit results. We found that:

- **The number of insurer errors identified has been increasing in recent years, with about 60 percent of problems related either to the accuracy of permanent partial disability payments or the number of weeks of benefits paid.**

DLI auditors look for claim errors that favor the insurer as well as errors that favor the injured worker.

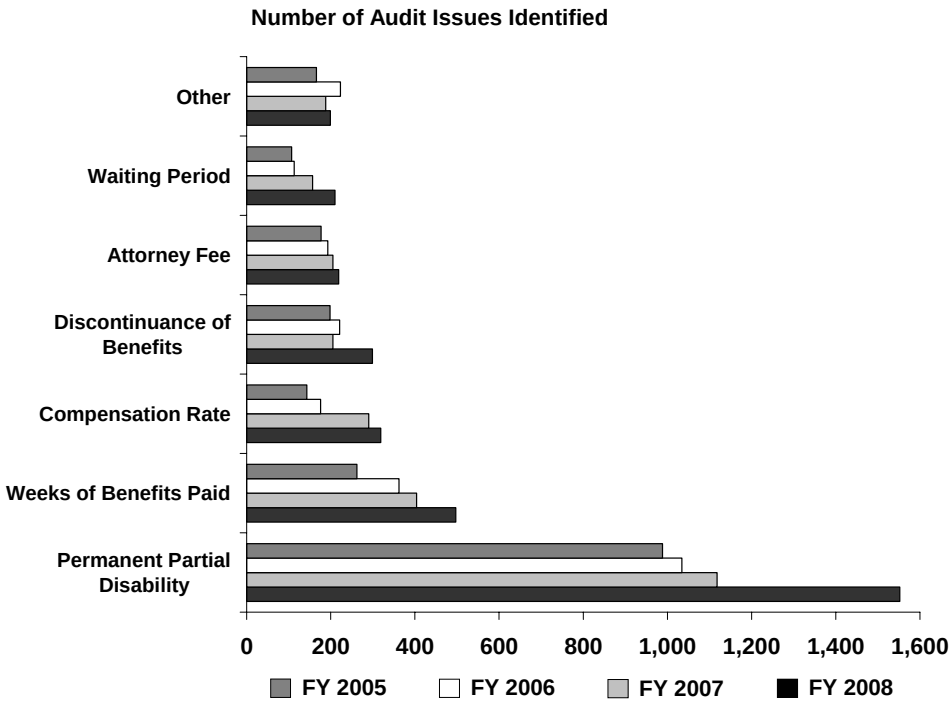
Once selected for audit, auditors review all documents in the file (not just the document that may have triggered the audit) to determine if all benefits owed have been calculated correctly and paid on time. For example, the auditor will consider whether the employee's wage was determined correctly, the waiting period on wage-loss benefits was applied appropriately, or the duration of benefits is within allowed maximums. Some data elements are repeated on multiple forms and any discrepancies must be reconciled.

Auditors look for errors going in both directions. If auditors identify benefit errors or omissions, they correspond with the claim administrators asking for clarification and/or advising them of noncompliance with statute or rule. According to DLI, this may include a discussion of mistakes that, when corrected, may benefit either the insurer or employee. Most audit issues identified, however, are those that when corrected, benefit workers.

Figure 2.1 shows the frequency of audit issues identified when correction of the errors would benefit workers. The accuracy and timeliness of permanent partial disability payments was the most common audit issue raised with insurers,

Figure 2.1: Issues Identified In Workers' Compensation Claim Audits, Fiscal Years 2005 to 2008

The number of issues found during DLI audits has been increasing.



NOTES: Data are for audit issues favoring workers. The department did not begin tracking audit issues that, when corrected, favored insurers until March 2008. Counts are of unique issues identified during an audit; a claim may involve more than one issue.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry audit data.

followed by claim discrepancies related to the number of weeks of benefits that were to be paid. Together, these two issues accounted for about 60 percent of audit issues raised with insurers for fiscal years 2005 through 2008.

DLI attributes the increase in audit findings to a lack of expertise among insurance claim adjustors based outside of Minnesota.

DLI did not start tracking audit issues that (when corrected) favored insurers until March 2008. As with audit findings that ultimately benefit workers, the most common audit issues favoring insurers also had to do with payment of permanent partial disability benefits. From March 2008 to January 2009, auditors identified 113 issues favoring insurers; 66 of them (58 percent) were related to permanent partial disability.

The number of audit issues identified increased from fiscal year 2005 to fiscal year 2008. According to DLI audit staff, the increase in audit issues is related to the expertise of claim adjusters. DLI staff said they are encountering more insurance adjusters who are based outside of Minnesota and who handle claims from a variety of states. These adjusters, according to DLI, do not understand the complexities of Minnesota's workers' compensation system, which increases

mistakes and DLI audit issues. Staff said that they use the audit process to help educate adjusters and, over time, hope to increase compliance.

DLI audits have resulted in corrected payments being sent to injured workers. We found that:

- **The department's audits found insurer underpayments of about $3 million a year, or less than 1 percent of indemnity benefits.**

As shown in Table 2.2, DLI audits identified over $3 million in underpaid benefits in each of the past five fiscal years. For context, total indemnity benefit payments in recent years (2004 to 2007) averaged about $470 million. Thus, the $3 million in underpayments constitute less than 1 percent of all indemnity benefits paid. The department does not track the amount of any overpayments to workers.

According to DLI, most insurers correct benefit underpayments when notified of the errors.

Table 2.2: Number and Amount of Benefit Underpayments Recovered, Fiscal Years 1999 to 2008

	Number of Underpayments	Amount Recovered
1999	909	$1,692,000
2000	1,124	2,258,000
2001	1,089	2,308,000
2002	1,200	2,887,000
2003	1,272	2,748,000
2004	1,179	3,154,000
2005	1,199	3,073,000
2006	1,300	3,667,000
2007	1,223	3,659,000
2008[a]	1,359	3,407,000

NOTES: An underpayment of benefits is recorded as recovered when DLI receives documentation from the claim administrator confirming that payment has been made for the requested underpaid benefits. DLI does not track the amount of any overpayments discovered during audits.

[a] Through May 2008.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry data.

According to DLI, most insurers rectify underpayments when notified of errors. The department generally allows two notices, with 60-day response periods each, for insurers to correct benefit payments to injured workers. In a few cases a year (five in 2007, for example), insurers failed to respond, and the cases were referred for penalties.

Penalty Team Results

Independent of the auditors, DLI's penalty team also systematically reviews claims for compliance with state laws and rules. State law authorizes DLI to issue penalties for various types of noncompliance, as shown in Table 2.3. The penalty team's workload comes from three sources: (1) computer-generated lists of claims identified for review because they may involve late first report of injury or late first payment of benefits, (2) computer-generated lists of all claims with a denial of primary liability, and (3) referrals. Most cases come from the first category. In 2007, for example, computer screening identified about 7,900 late report and late payment cases and 3,000 denials of primary liability. The team received just over 100 requests for penalty evaluation from other DLI staff (such as auditors) and external parties.

About three-fourths of the penalties assessed in 2007 were against insurers who responded late to a request for information or failed to file a form with DLI.

Table 2.3: Types of Workers' Compensation Penalties, 2008

Determinations of Liability	Late denial of liability Nonspecific denial of liability Frivolous denial of liability
Payment of Benefits	Late first payment of benefits Late payment of ongoing benefits Failure to pay or late payment of waiting period benefits Failure to pay benefits up to date of discontinuance[a] Late payment (or denial) of medical charges Late payment of a settlement award Improper discontinuance of benefits
Filing of Required Forms	Late filing of First Report of Injury form by employer Late filing of First Report of Injury report by insurer Failure to file required form (general) Failure to file medical data or medical reports
Other Prohibited Practices	Failure to respond to a DLI request for information within 30 days

NOTES: Penalty amounts vary. For some penalty types, state law provides for issuance of warnings prior to assessing a monetary penalty.

[a] If an insurer discontinues benefits for a reason other than return to work, benefits must be paid up to the date that the Notice of Benefit Discontinuance form is filed.

SOURCE: Office of the Legislative Auditor, compilation from *Minnesota Statutes* 2008, 176.135, 176.194, 176.221, 176.225, 176.231, 176.238, and DLI documents.

In analyzing the results of these penalty cases, we found that:

- **Most penalties against insurers were assessed for procedural errors, such as late filing of forms.**

As shown in Table 2.4, DLI assessed most penalties for two reasons: (1) failure to respond to DLI's request for information within 30 days and (2) failure to file a required form with the department. In 2007, these two penalty types accounted for 73 percent of penalties assessed. Penalties for frivolous denial of primary

liability accounted for 14 percent of penalties, and late payment of benefits accounted for another 8 percent.[3] In recent years, the number of penalties assessed against insurers and employers ranged from a low of 340 in 2004 to a high of 655 in 2006. The number of penalties associated with improper denials of liability increased markedly in 2006. We discuss DLI's efforts to monitor denials of primary liability in the next section.

Table 2.4: Number of Penalties Assessed, 2003 to 2007

	2003	2004	2005	2006	2007
No response to a request within 30 days	248	176	213	252	173
Failure to file required form	112	125	129	163	179
Late payment of benefits	36	32	40	30	40
Frivolous denial of liability	0	2	8	141	66
Nonspecific denial of liability	1	1	1	52	13
Improper discontinuance of benefits	4	3	0	3	7
Other	3	1	1	14	6
Total	404	340	392	655	484

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry compliance data.

Evidence of Improper Denials

Before 2005, DLI did not systematically enforce legal requirements governing how insurers are to report a denial of liability.

Insurers may deny primary liability for injuries that did not arise out of employment or were not covered by Minnesota's workers' compensation law. When an insurer denies liability, the injured worker does not receive workers' compensation medical, indemnity, or vocational rehabilitation benefits. It is important, then, to check that insurers' decisions to deny liability are warranted.

According to DLI, before 2005, the department did not systematically enforce legal requirements governing how insurers report a denial of liability.[4] From 2000 to 2004, the percentage of filed indemnity claims denied by insurers increased from 15.0 percent to 17.3 percent. DLI staff said they were aware of the increasing denial rate and, prior to 2005, had issued additional guidance to educate insurers about proper reporting of denials. We found that:

- **DLI strengthened its enforcement of denial standards late in 2005; since then, insurers have denied claims less frequently.**

[3] According to DLI, most insurers rectify underpayment of benefits when identified by an auditor. Auditors do not refer underpaying insurers for a penalty if they make timely repayment.

[4] To deny primary liability for a workers' compensation claim, state law requires insurers to notify the employee within 14 days of the injury and specify a valid reason for the denial. *Minnesota Statutes* 2008, 176.221, subd. 1, and 176.84.

The proportion of claims denied declined after DLI started systematically reviewing denials in late 2005.

DLI's Compliance section implemented the "denial project" in November 2005. The project involved DLI penalty team staff systematically reviewing all denials of primary liability. Their review focused on whether the insurer (1) reported a legal basis for the denial (for example, the injury did not occur at work) and (2) provided specific facts to support its judgment (for example, another worker was with the claimant over the weekend when the injury occurred).

The increased enforcement appears to have had a positive impact. After reaching a high of about 17.3 percent in 2004, the rate at which insurers denied primary liability declined to 12.2 percent in 2007.

DLI's compliance review does not include an attempt to evaluate the compensability of claims. Instead, it focuses on whether insurers followed the correct procedures for documenting a denial of primary liability, specifically whether their reports include allowable criteria for the denial and provide specific evidence to support the denial. Thus, an insurer can file a compliant denial of primary liability form when the denial of liability itself is wrong.

One way to measure the prevalence of this problem is to look at the extent to which insurers later pay benefits on claims that were initially denied. Eventual payment of benefits on claims that were initially denied could occur for a variety of reasons, including an insurer's willingness to deny improperly or an insurer's failure to conduct a good-faith investigation. We performed such an analysis and found that:

- **Benefits were eventually paid in a large portion of denied claims, raising additional concerns about the accuracy of insurers' initial decisions to deny primary liability.**

We began our analysis by looking at the proportion of denied claims that at some point also had paid benefits. Denied claims that were ever paid include claims that were initially denied but later paid and claims that were initially paid but later denied. From 1998 to 2007, insurers paid benefits on more than 40 percent of claims in which they at some point denied primary liability. The percentage was as high as 48 percent in 2003.

It does appear that DLI's increased monitoring of claim denials has had a positive impact on the accuracy of initial decisions on compensability. The percentage of denied claims that were at some point paid declined following the start of the department's denial project, going from 47 percent in 2004 to 43 percent in 2007. Nonetheless, we think a rate of over 40 percent merits further scrutiny.

Not all of the claims that were ever paid are necessarily errors by the insurer. Claims that were initially paid and subsequently denied may reflect the insurer changing its decision in light of new information. We are more concerned about the denial decisions when the claim was initially denied and later paid. Our data do not indicate definitively which came first, but paid claims that were denied shortly after the injury are more likely to have been denied first and paid later. Even when we restrict our analysis to claims for which the denial likely came first, we found that a large portion may have been denied improperly. For

injuries in 2006, about 25 percent of claims denied within 14 days of the injury (the time period allowed to approve or disapprove a claim) had been paid as of July 2008. This percentage will likely increase since not all disputes over 2006 claims were settled as of July 2008.

Benefits were eventually paid in about 25 percent of 2006 claims that were initially denied.

According to DLI, this trend is not particularly concerning. Some denied-then-paid scenarios likely result from claim investigations that take more than the 14 days allowed (for example, the insurer submitted a claim denial in time to meet the 14-day decision deadline, finished the investigation, and then paid benefits). DLI also said that many denied-then-paid claims have complicated issues that are litigated, which is not cause for concern.

We identified a second shortcoming in the department's review of claim denials. We found that:

- **DLI does not monitor insurers' denial of benefits in circumstances other than a denial of primary liability.**

The denial project focuses on denials of primary liability and does not look at denials of liability made under other circumstances. For example, an insurer can accept overall liability for a claim (acknowledging a work-related injury) but deny payment of wage-loss benefits. The insurer's reasoning could include that the worker had missed fewer than three days of work or that the employer had not supplied necessary documentation of the amount of wages lost, among other things. Denials under these circumstances are referred to as "type 2" denials.

We used DLI claims data to examine trends in the prevalence of type 2 denials to determine whether insurers were bypassing increased enforcement of primary liability denials by using other types of denials. We estimated that type 2 denials increased by roughly 1 percentage point between 2004 and 2007 (from 12.3 to 13.5 percent of all claims reported to DLI). According to department staff, a small increase in type 2 denials is not necessarily a problem. Staff asserted that prior to increased enforcement efforts, some insurers improperly classified type 2 denials as denials of primary liability. The 1 percent increase may simply reflect that insurers are now correctly coding the denials. When type 2 denials are combined with denials of primary liability, total denials declined from 29.7 to 25.7 percent of claims reported to DLI between 2004 and 2007.[5] Nonetheless, because the enforcement only looks at denials of primary liability, we think DLI should monitor type 2 denials in the future.

[5] Claim denials for injuries in a certain year may not occur or be reported for months (and sometimes years) after the injury. The department tracks reporting of denials of primary liability to estimate how much denial counts for recent years will likely increase when reporting is complete. However, as we said, the department has not tracked reporting of type 2 denials. To estimate the number of type 2 denials, we assumed that these denials follow the same development pattern as denials of primary liability.

Recommendations

RECOMMENDATIONS

The Department of Labor and Industry should:

1. ***Expand its computerized monitoring of claims to screen for more types of potential errors and***

2. ***Expedite its plans to enter more data into the workers' compensation information system in order to create more searchable data fields.***

While we found that the department makes considerable efforts to monitor compliance with filing requirements, it can add additional screening measures to identify other types of potential errors. In particular, the department should follow through on plans to screen for late subsequent payment of benefits (current procedures test the timeliness of the first payment of benefits).

To facilitate additional computerized monitoring of workers' compensation claims, DLI staff told us that they need some additional data elements added to the searchable data tables in the claims database. The department is aware of the information system limitations that affect its compliance monitoring activities. We urge the department to continue its efforts to make related improvements.

RECOMMENDATION

The Department of Labor and Industry should monitor claim and benefit data to identify and address trends indicating that injured workers may not be getting appropriate access to benefits at the time they need them.

DLI needs to more closely monitor the appropriateness of insurers' decisions to deny liability for a workers' compensation claim.

We think that assuring appropriate access to benefits at the time they are needed is within the purview of DLI's oversight authority. Thus, it is important that DLI engage in additional oversight of insurers' decisions regarding acceptance of primary liability (rather than focusing solely on proper documentation of the decision). The denial project that DLI initiated in 2005 was a step in the right direction. Still, we think the prevalence of type 2 denials and denials that ultimately had benefits paid are concerning. The department should expand its reviews of denied claims by monitoring the appropriateness of type 2 denials and denied claims that are later paid. If such monitoring reveals a pattern or practice of inappropriate denials on the part of specific insurers, in an industry, or across the board, DLI should implement an appropriate response. This could include targeted education and training, application of penalties, or changes to DLI's automated compliance procedures.

DLI needs to broaden the scope of its compliance activities to look for systemic problems affecting timely access to benefits.

DLI should use this compliance-research approach to investigate other areas of concern that arise regarding access to benefits. For example, very few workers receive retraining benefits as part of their vocational rehabilitation plans.[6] Retraining is an available option, but not a guaranteed benefit. Hence, low utilization of retraining benefits is not necessarily a problem if the level of use reflects the level of need. However, stakeholders raised some concerns that the low utilization may indicate that injured workers are not receiving the benefit as often as they should. DLI should investigate sufficiently to determine whether the benefit is rarely needed or if insurers are inappropriately limiting access to it.

This is an incremental change in DLI's compliance approach. We do not expect the agency to conduct field investigations to determine whether insurers made correct decisions regarding compensability. Nor do we think that the department's monitoring of denials or access to retraining or other benefits will eliminate all disputes over these benefits. Rather, we are suggesting that DLI do more research to determine whether there are systemic problems that should be addressed through education or compliance initiatives. As we discuss in Chapter 3, the department places heavy emphasis on either preventing disputes or resolving them as early as possible. The compliance actions we suggest support these goals.

MANDATORY COVERAGE

While DLI's Benefit Management and Resolution unit performs audits to ensure that employers and insurers file and administer their claims properly, the department's Claims Services and Investigations unit conducts two types of investigations into whether employers are complying with the state's statute on "mandatory coverage." To ensure that all workers have access to benefits in the event of a work-related injury or illness, Minnesota state law requires that all employers either purchase workers' compensation insurance or self-insure with the permission of the Commissioner of Commerce.[7] Minnesota Rules also delineate the penalties that can be assessed against employers that fail to carry workers' compensation insurance.[8]

In our examination of mandatory coverage, we assessed (1) the extent to which Minnesota employers fail to carry mandatory workers' compensation coverage and (2) how well DLI's Claims Services and Investigations unit identifies and penalizes employers failing to meet mandatory coverage requirements.

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[6] In 2006, 27 of 5,940 closed vocational rehabilitation plans included a retraining component.

[7] *Minnesota Statutes* 2008, 176.181, subd. 2 (a). The state of Minnesota and its municipal subdivisions are excluded from this section. They are, however, liable for compensation under *Minnesota Statutes* 2008, 176.021, subd. 1. The state self-insures, but does not need the approval of the Commissioner of Commerce to do so.

[8] *Minnesota Rules* 2008, 5220.2865, subp. 2.

Failure to Insure

Extent of the Mandatory Coverage Problem

We examined two primary indicators of the extent to which Minnesota employers fail to carry workers' compensation coverage. The first is the number of individual claims filed with DLI by injured workers whose employers do not have workers' compensation coverage. DLI's investigations associated with uninsured *claims* are known as "initial claims" investigations. Secondly, the results of DLI's broader investigations of *employers* that may lack workers' compensation coverage help demonstrate the extent of the mandatory coverage problem. These investigations are referred to as "mandatory coverage" investigations and do not necessarily have to start with an uninsured claim. We analyzed DLI's initial claims and mandatory coverage investigation data and found that:

- **Although measures are imperfect, the incidence of employers being uninsured for workers' compensation appears to be small relative to the total number of claims filed and the number of employers with insurance.**

It appears that most Minnesota employers have workers' compensation coverage as required.

DLI's investigation results are imperfect indicators and likely to underestimate the extent of the problem. DLI's ability to identify potentially noncompliant employers and conduct mandatory coverage investigations is limited by the staff resources available and the effectiveness of techniques used to identify potentially noncompliant employers. Also, DLI's uninsured claims data may underestimate noncompliance to the extent that employees of businesses without coverage may not know how to file claims when they are injured on the job.

While the indicators are inherently flawed, the data they do yield indicate that the failure to carry workers' compensation coverage is a relatively small problem given the size of the workers' compensation system. For instance, the number of claims associated with possibly uninsured employers is less than a tenth of a percent of all claims filed with Minnesota insurers. DLI conducted a total of 1,219 initial claims investigations between 1998 and 2007. Employers were found to lack the required insurance coverage in 990 (81 percent) of the investigations. By comparison, DLI estimates that more than 1,419,500 medical-only and indemnity claims were filed during the same ten-year period.

Similarly, the number of employers flagged for DLI's mandatory coverage investigations indicates that noncompliance is the exception rather than the rule. The department's most consistent and systematic source of mandatory coverage cases is the Minnesota Workers' Compensation Insurers Association (MWCIA). The MWCIA furnishes DLI with a monthly list of employers with workers' compensation insurance policies that have lapsed or been cancelled. Each monthly list includes roughly 200 employers whose insurers have cancelled their

policies for nonpayment of premiums. DLI uses this subset of the list as a starting point for mandatory coverage investigations.[9]

For context, MWCIA reported that in 2007 there were 127,170 workers' compensation policies on file with private insurers in the state of Minnesota. Even if DLI found each of the estimated 2,400 employers with policies cancelled in 2007 to be out of compliance, they would constitute only 2 percent of the employers that purchase workers' compensation insurance policies.[10] While it is currently the department's best tool for gauging the extent of the mandatory coverage problem, the MWCIA list has its limitations. The list helps DLI identify employers that have discontinued a workers' compensation policy, but it does not alert DLI to the existence of new employers or other employers that never had policies to begin with.

Reasons Employers Lack Workers' Compensation Coverage

Some violations of mandatory coverage laws are unintentional; in other cases, employers choose not to insure because the coverage is expensive.

Employers fail to properly insure for a variety of reasons. According to DLI staff, businesses that willfully choose not to purchase workers' compensation coverage typically do so because the business owners believe coverage is too expensive. The cost of workers' compensation coverage depends on the risk associated with insured employees' jobs; it ranges from less than 1 percent of total payroll for office workers to more than 50 percent of payroll costs for roofers and other high-risk workers.[11] Other employers find themselves unintentionally uncovered because they do not understand the insurance requirements. According to DLI, some employers incorrectly assume that when they purchase an overall business insurance policy, workers' compensation insurance is included in the package (it is not). Finally, some employers set up workers' compensation insurance policies based on their initial staff levels, only to have their policies cancelled when their staff levels increase and they fail to submit the difference in premiums. According to DLI staff, employers they investigate are typically small businesses with fewer than ten employees.

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[9] DLI investigators perform preliminary checks for reinstated insurance on each of the MWCIA list cases. According to department staff, most employers are found to be out of business or in compliance with workers' compensation mandatory coverage law. Of the 200 per month, typically 15 or 20 employers are found to be both viable and out of compliance; these become the subjects of mandatory coverage investigations. It should be noted that the DLI's case backlog is such that the department performs preliminary checks as much as one to two years after policy cancellation. We discuss constraints on case volume in a subsequent section.

[10] One policy does not necessarily correspond with one employer. Some employers have multiple policies during the course of the year. Alternately, some policies cover multiple employers that have the same parent company. Also, self-insured employers (roughly 1,200) do not carry private policies and are excluded from the discussion. Two percent, therefore, is a rough estimate. Regardless, the cancelled policies that result in mandatory coverage cases represent a very small percentage of all policies.

[11] In a previous report, we found that rising cost of workers' compensation premiums was one of the factors that led employers in injury-prone industries to misclassify their employees as independent contractors. Minnesota Office of the Legislative Auditor, *Misclassification of Employees as Independent Contractors* (November 2007), 8.

DLI's Enforcement of Mandatory Coverage Laws

Mandatory coverage investigations are designed not only to determine whether an employer carried workers' compensation insurance during a specific period, but also to build a case for mandatory coverage penalties. Specifically, investigators must secure payroll information and determine the length of the employer's coverage gap. During the course of an investigation, DLI staff check the Secretary of State's office for employer registration and the Department of Employment and Economic Development (DEED) to see whether the business paid wages during the period in question. DLI sends every employer under investigation a letter confirming contact information and asking it to explain any inadequacies in its insurance coverage. Once the investigator has obtained sufficient information about the employer, he or she either closes the case with no action required (if the employer was able to disprove or satisfactorily explain the alleged lack of coverage) or refers the case to the penalty administrator.

DLI has used four primary methods to identify cases for mandatory coverage investigations. First, DLI often investigates the employers named in uninsured claims.[12] The department also investigates tips that concerned citizens submit via the department's telephone tip line or internet form. As discussed previously, DLI gets a large portion of its cases from MWCIA's lapsed-policy list. In the past, DLI also had one investigator who manually searched DEED's database for employers that reported labor. This type of search provides a reasonable starting place for mandatory coverage investigations because employers that need unemployment insurance typically need workers' compensation insurance as well.

Mandatory Coverage Investigation Results

From 2004 to 2007, DLI investigated roughly 300 employers a year for failure to carry workers' compensation coverage.

We analyzed DLI's mandatory coverage investigation data and found that:

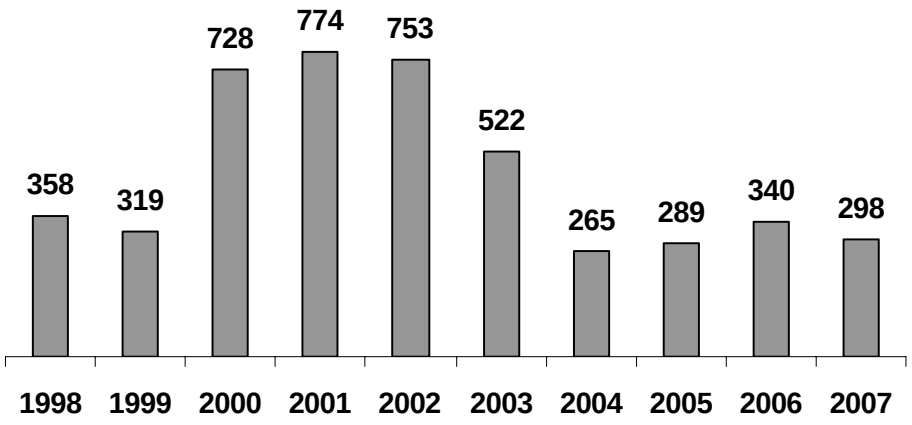
- **The number of mandatory coverage investigations conducted declined significantly after 2003, but the proportion resulting in penalty referrals increased.**

In the ten-year period between 1998 and 2007, DLI conducted 4,646 mandatory coverage investigations of employers it suspected were uninsured for workers' compensation. DLI investigated an average of about 587 employers per year, but the actual number of cases investigated rose and fell dramatically during the period (see Figure 2.2). Between 1999 and 2000, the department added

[12] Uninsured claims are subject to both possible types of investigations. The initial claims investigator secures the information required to pay the claimant's benefits out of the Special Compensation Fund (discussed later in this section), while the investigator of the mandatory coverage case focuses on obtaining the information required for penalty formulation. Not all initial claims investigations have mandatory coverage companion cases. As an example, DLI staff said that if a claim is in litigation, the department might not open an additional investigation as it could actually hinder legal proceedings.

investigation staff and nearly doubled the number of mandatory coverage cases investigated. In 2003, the number of investigations dropped dramatically (from 753 to 522), and from 2004 to 2007 the department investigated closer to 300 cases a year.

Figure 2.2: Number of Mandatory Coverage Investigations, 1998 to 2007



NOTE: Cases count toward the year that they were assigned to a DLI investigator. Depending on the timing of the injury and progress of the claim, the date of injury may or may not be during the same year the investigation was assigned.

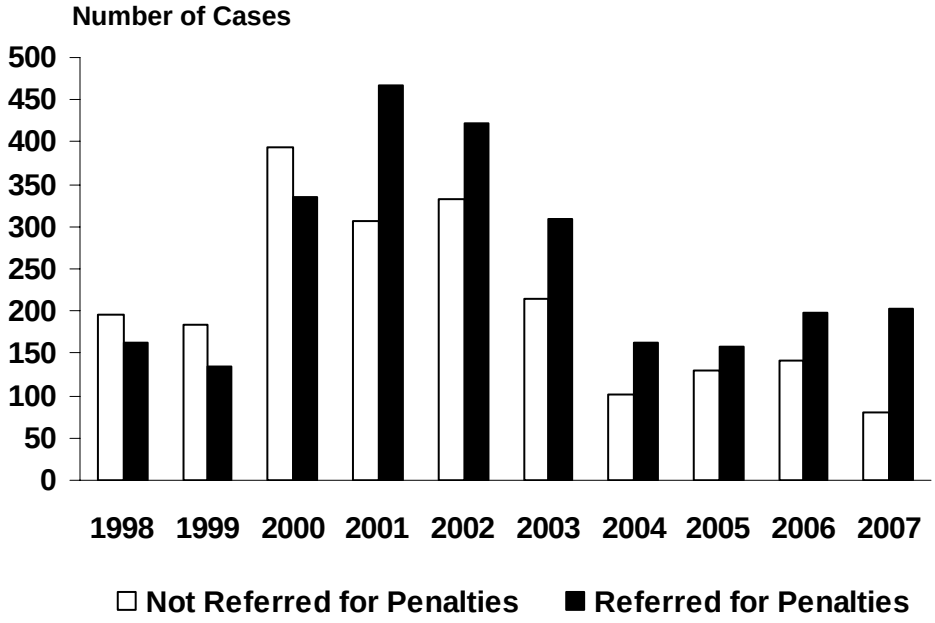
SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry investigation data.

In about 55 percent of mandatory coverage cases, investigators found that the employer should have been insured but was not.

Between 1998 and 2007, DLI referred about 55 percent of all mandatory coverage investigations to the penalty administrator because it found that the employer should have been insured but was not. This breaks down to penalty referral for almost 58 percent of the cases originating from uninsured claims, 62 percent resulting from the MWCIA list, and 65 percent of those cases found by mining the unemployment insurance database. Only 33 percent of the cases resulting from tips were ultimately referred for penalties. It is interesting to note, as shown in Figure 2.3, that early in the period (1998-2000) investigators referred fewer than 50 percent of cases for penalties. Since 2001, however, investigators have referred at least 55 percent and as high as 68 percent of cases to the penalty administrator.

During the ten-year period analyzed, DLI investigators referred 2,552 mandatory coverage cases (55 percent of those investigated) for penalties. The penalty administrator did not assess penalties in roughly 18 percent of those cases. According to DLI staff, the penalty administrator opts not to assess penalties

Figure 2.3: Penalty Referrals Resulting from Mandatory Coverage Investigations, 1998 to 2007



NOTE: Cases are counted in the year that they were assigned to a DLI investigator. Depending on the timing of the injury and progress of the claim, the date of injury may or may not be during the same year the investigation was assigned.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry investigation data.

Employers that fail to insure can receive penalties of up to $1,000 per employee per week of being uninsured.

when the penalty was suggested in error or when the penalty amount would end up being too small to reasonably assess. DLI ultimately assessed "failure penalties" in 2,083 mandatory coverage cases. The following sections discuss DLI's formulation and collection of failure penalties.

Determination of Mandatory Coverage Penalty Amounts

Penalty determination is a multi-step process, and penalty amounts are restricted by Minnesota rule. Minnesota rules prohibit DLI from assessing an initial penalty of an amount smaller than $200 and impose an upper limit of $1,000 per employee, per week.[13] Table 2.5 breaks down the different stages of penalty formulation, including estimation of the employer's evaded premiums, application of situational multipliers, negotiations with the employer, and the addition of interest as appropriate.

[13] *Minnesota Rules* 2008, 5220.2865, subp. 2(A).

Table 2.5: Mandatory Coverage Penalty Formulation

Stage	Definition	How Penalty is Formulated
Estimated Evaded Premium	Amount employer would have paid in workers' compensation premiums if it had been insured	Evaded premium is determined using payroll hours, the employer's dominant premium rate (which reflects the risk associated with the employer's primary work activity), and an experience rating based on the employer's claim history
Initial Penalty	The estimated evaded premium, adjusted by a series of situational multipliers	Multipliers are applied depending on whether the lack of coverage was willful or unintentional, whether the employer cooperated with DLI's investigation, and whether there is a current uninsured claim against the employer, among other things
Negotiated Penalty	The principal amount agreed upon by DLI and the employer	When an employer receives notice of its initial penalty, it has ten working days to respond to DLI with any objections
		Penalties may be reduced for a number of reasons, including that the employer provided updated payroll information, the employer provided proof of insurance coverage, or the employer demonstrated that its failure to insure was the result of a good faith error
Final Penalty	Negotiated penalty with up to two types of interest added	Interest is added when the penalized employer fails to pay or set up a payment plan within 30 days of billing
		A penalized employer agreeing to a payment plan is charged 4 percent interest over the life of the plan

SOURCES: Office of the Legislative Auditor and Minnesota Department of Labor and Industry.

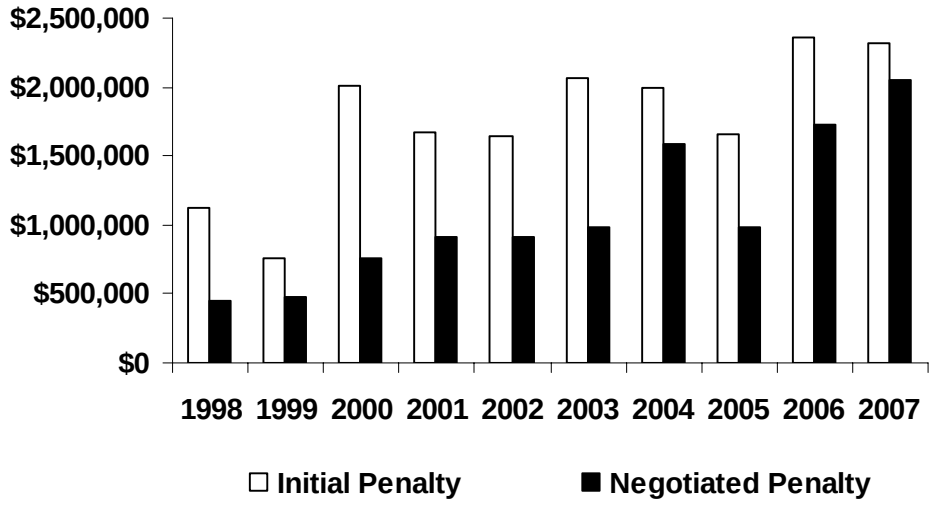
We analyzed data showing the evolution of DLI's penalty amounts and found that:

- **DLI does not record sufficient data to determine whether it appropriately penalized employers that failed to insure for workers' compensation.**

Figure 2.4 shows the dollar amounts of initial penalty assessments compared with the negotiated penalty amounts for each year from 1998 to 2007. Over the entire ten-year period, initial penalties totaling more than $17.6 million were reduced to about to $10.8 million in negotiated penalties. The department eventually reduced the amounts in 36 percent of the 2,083 cases in which penalties were initially assessed.

Penalty reductions on account of employer objections are common because the manner in which DLI calculates the employer's estimated evaded premium (the basis for the initial penalty) is imprecise. When calculating the evaded premium, DLI uses the governing code, a classification assigned by MWCIA that describes the employer's dominant activity, to determine the premium the employer would

Figure 2.4: Initial and Negotiated Mandatory Coverage Penalties, 1998 to 2007



NOTE: Cases are counted in the year that they were assigned to a DLI investigator. Depending on the timing of the injury and the progress of the claim, the date of injury may or may not be during the same year as the investigation.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor Industry mandatory coverage penalty data.

Penalties for failure to insure are often reduced after employers provide DLI with more information about covered employees.

have paid during the coverage gap. DLI applies the employer's prevailing governing code to all employees, despite the fact that not all workers at a single company perform jobs with the same amount of risk.[14]

Given the overestimation built into DLI's initial penalty determination process, one would expect quite a few reductions to occur once the employers and DLI together reach the true evaded premium. DLI's data, however, are incomplete and do not allow us to determine for certain how many penalties were reduced because the true evaded premium was provided and how many were reduced for other reasons. It is our concern that failing to record the reason for a reduction, and the true evaded premium when applicable, makes it difficult for DLI to systematically evaluate whether its negotiations result in reasonable reductions, or whether the department failed to collect penalties that it should have assessed.

[14] For example, if a company's primary activity is roofing, DLI would calculate its evaded premium using the assumption that every employee on the company's payroll is a roofer and must be insured at upwards of 50 percent of total payroll. The company's clerical employees, however, are exposed to none of the risk that the roofers encounter in their daily activities. The clerical workers would actually be insured at a rate of less than 1 percent of payroll. Once DLI notifies an employer of its initial penalty, the employer often provides a "deck sheet" listing its employee classifications, after which the department reduces the penalty amount to reflect the employer's true evaded premium.

DLI has taken steps to address these data problems. Since spring of 2006, the department has increased emphasis on the proper recording of true evaded premiums. In November 2007, the department moved its penalty administration data from a standalone program into the workers' compensation claims database. With this transition, DLI also added a data field to track reasons for penalty reductions, along with other system changes to improve reporting and tracking.

Penalties for Failure to Insure

Once DLI has determined the final amount of a failure penalty, the department then attempts to collect money from the employer. Employers have the option to pay their penalty in a lump sum or to set up a payment plan. In analyzing DLI's penalty data, we found that:

- **To date, the penalty amounts DLI has collected equal roughly one-third of the penalty amounts it assessed against uninsured employers, although the department expects continued regular payments from some employers on multi-year payment plans.**

Of $11 million in failure-to-insure penalties assessed between 1998 and 2007, DLI has collected about $4 million and written off $1 million as not collectable.

After the addition of interest to the negotiated penalty amounts, DLI's final penalty assessments against uninsured employers exceeded $11 million on cases investigated between 1998 and 2007. DLI has collected nearly $4 million (35 percent) of the penalties it is owed. DLI wrote off more than $1.3 million as uncollectible, leaving nearly $6 million still to be collected. Table 2.6 shows the penalty dollars collected and written off for cases investigated from 1998 to 2007. The data show an overall decline in collections as a percentage of total assessments starting in 2004. This is to be expected because many employers elect to pay their penalties using a multi-year payment plan. DLI anticipates collecting roughly $1.1 million of the penalties associated with open payment plans. Therefore, the collection results on recently assessed penalties may not be complete for years to come.

DLI experienced some success collecting payments on relatively small penalties. The final penalty amounts assessed by the department between 1998 and 2007 ranged from $88 to more than $500,000 per case.[15] DLI has already received full payments from more than three-quarters of the employers against which it assessed penalties. The penalty amounts in these cases averaged roughly $2,000. It seems that in general, cases involving larger penalties are paid more slowly, if at all. Sixteen percent of cases in which DLI assessed penalties are still open, and these average about $19,000 in penalties per case. DLI anticipates collecting full penalty amounts in about a third of the cases, while it has had trouble

[15] We mentioned previously that the minimum penalty according to Minnesota Rules is $200. There were a total of 18 cases with final penalty amounts less than $200. DLI's initial assessment on each of these cases was at or above the minimum. The penalties were reduced, presumably after employee negotiations, which seems to be allowable under law.

Table 2.6: Penalties Assessed, Collected, Written-Off, and Uncollected, 1998 to 2007

		Penalties Collected		Write-Offs		Penalties Uncollected as of June 2008	
	Dollars Assessed	Dollars Collected	Percentage of Total Assessment	Dollars Written-Off[a]	Percentage of Total Assessment	Dollars Uncollected[b]	Percentage of Total Assessment
1998	$ 459,532	$ 284,196	62%	$ 164,658	36%	$ 10,678	2%
1999	476,333	151,140	32	278,357	58	46,836	10
2000	756,856	524,093	69	160,752	21	72,011	10
2001	909,474	528,595	58	185,480	20	195,399	21
2002	907,556	540,170	60	149,959	17	217,426	24
2003	980,678	582,497	59	102,653	10	295,529	30
2004	1,699,735	242,984	14	239,696	14	1,217,054	72
2005	1,054,468	442,781	42	41,589	4	570,099	54
2006	1,808,291	286,657	16	6,289	<1	1,515,345	84
2007	2,077,218	314,825	15	1,201	<1	1,761,191	85
Total	$11,130,140	$3,897,938	35%	$1,330,634	12%	$5,901,568	53%

NOTES: Assessments, collections, and write-offs are counted in the year that the case was assigned to a CSI investigator. Depending on the timing of the injury and progress of the claim, the date of injury may or may not be during the same year the investigation was assigned. Dollar amounts are current as of June 2008.

[a] The sums of dollars written-off include both penalties written off in their entireties, and the written-off portions of penalties otherwise considered paid. If a written-off penalty was partially paid before the write-off occurred, the payment amount is not included in the write-off amount.

[b] Roughly $1.1 million of the uncollected penalties are associated with payment plans on which DLI expects to collect in the future.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry penalty data.

recovering the penalties it is owed in the other two-thirds. The final 7 percent of the cases are those that DLI wrote off as uncollectible, which averaged almost $9,000 in penalties per case.

Barriers to Effective Mandatory Coverage Investigations

As discussed previously, it is difficult to gauge the extent of the mandatory coverage problem using the number of investigations that DLI conducts. While the MWCIA list arrives routinely and provides a presumably complete list of lapsed policies, DLI currently does not have a systematic method of identifying employers that never purchased a workers' compensation policy in the first place. Consequently, we do not know the scope of that issue, or what percentage of said businesses DLI ends up investigating.

Through interviews with DLI staff and our analysis of mandatory coverage data, we found that:

- **Weaknesses in available investigative techniques and declining staff resources have undercut DLI's ability to identify and investigate employers that lack mandatory coverage.**

The following section discusses DLI's failure to take advantage of all available methods of identifying potentially noncompliant employers for investigation. We go on to discuss the related problem of declining staff numbers in DLI's investigations unit.

Identifying Uninsured Employers

As detailed in a previous section, DLI currently depends on three primary sources for identifying mandatory coverage cases: uninsured claims, tips, and MWCIA's list of cancelled policies. Cases from each of the sources are generated externally and DLI has no control over how many potential cases are presented for investigation. In addition, none of the sources provide a systematic means of identifying employers that never had workers' compensation insurance in the first place—either those that are new or older employers that have been habitually out of compliance.

DLI does not make proactive efforts to search for new employers that fail to carry workers' compensation insurance.

DLI does not make proactive efforts to search for new employers that might be out of compliance. Due to difficult logistical issues, DLI has made limited use of automated data mining or data sharing with other state agencies to identify employers that may lack workers' compensation coverage. For example, most employers with employees should carry both unemployment and workers' compensation insurance. For this reason, the unemployment insurance system would be a good source of data on employers that should also have workers' compensation coverage.

Despite this ready-made data source, DLI does not systematically match employers with workers' compensation coverage to the list of employers registered with DEED for unemployment. There are a couple of key barriers to doing so through computer matching. First, DLI does not actually maintain a list of Minnesota employers insured for workers' compensation; such a list would have to come from MWCIA. Second, even should DLI possess such data, matching is complicated by the absence of a commonly used employer identification number.[16]

One DLI investigator used to manually review DEED data searching for employers that reported labor but lacked workers' compensation insurance. This method allowed the department to identify some new employers (as well as established employers) to use as starting points in mandatory coverage

[16] Performing a data match using employer name would not work because any difference in spelling, abbreviations, or punctuation between two names would result in a mismatch. DLI and DEED currently use different naming conventions, which makes it likely that a great many employers would be unmatchable despite existing in some form in both databases.

investigations. The method appears to have been useful. Between 1998 and 2007, 65 percent of the cases found through manual searches of the unemployment database were referred for penalties. However, that investigator has since taken a new position within the department, and the number of cases initiated through the DEED database has dwindled to practically none.

DLI does little to identify or monitor employers that repeatedly let their workers' compensation coverage lapse. This is partially due to limitations in DLI's data system. DLI's investigation data are not employer-based. The department's investigation database includes a field for Federal Employer Identification Number (FEIN), but investigators typically do not record it unless they refer a case for penalty. Of the 2,552 mandatory coverage cases referred for penalties during the period we analyzed, about 14 percent of them lacked FEIN.[17] When opening a new investigation, DLI staff try to cross-reference related cases. At the moment, they must manually search their database for each employer's name and its likely variations, as well as the owner's name. This process is time consuming and can easily result in missed cases. While repeat offenders may be a small segment of the employer population, identifying "problem employers" could be a good source of mandatory coverage investigations.

Declining Staff Numbers

Even if DLI made greater efforts to proactively identify employers that lack workers' compensation insurance, recent trends indicate that the department might be unable to conduct additional mandatory coverage investigations. As demonstrated previously (see Figure 2.2), the number of mandatory coverage investigations declined after 2002.

Staff reductions after 2001 led to a large backlog of mandatory coverage investigations.

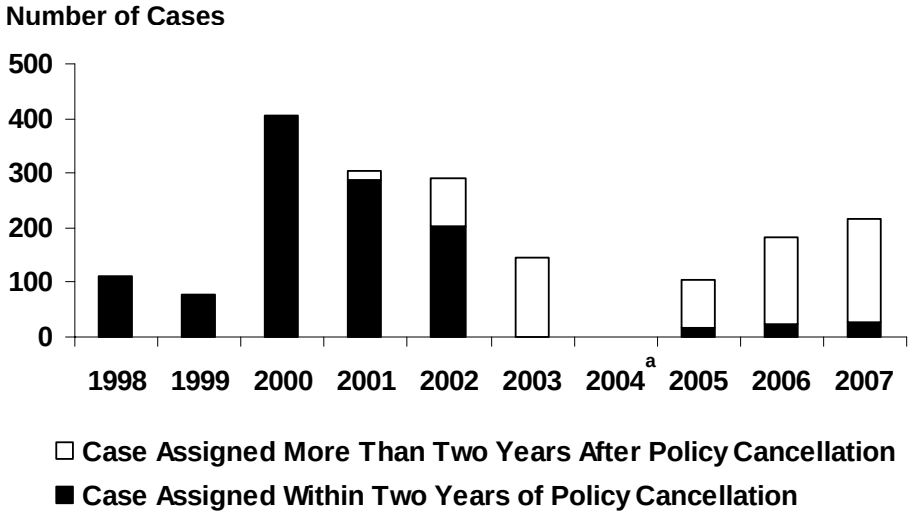
DLI staff attribute this decline to a reduction in the number of investigators working for the Claims Services and Investigation unit. The unit had a total of 6.5 investigators in 2000 and 6 in 2001; that number dropped steadily until the unit had only 3.5 investigators in 2004. Staff levels remained between 3.5 and 4.5 investigators through 2008. Investigators work on both initial claims and mandatory coverage cases. Initial claims cases must be investigated first to meet statutory requirements for timely processing of workers' compensation claims. DLI conducts mandatory coverage investigations to the extent that resources remain available.

DLI's backlog of mandatory coverage cases is so large that investigators often address MWCIA list cases more than two years after policy cancellation. DLI has been investigating cases later and later over the past several years. As shown in Figure 2.5, until 2000, DLI investigated virtually all MWCIA list cases within two years of policy cancellation, meaning that the investigators were likely to close their investigations and penalize employers before the employers' violations were two years old. The two year cut-off is significant because

[17] According to DLI staff, investigators may be unable to determine an employer's FEIN for several reasons, including the employer (1) does not have a FEIN, (2) chooses to use the owner's social security number for tax reporting instead of FEIN, or (3) was unable to remember its FEIN in an interview with the investigator.

Minnesota rules specify that DLI must assess all penalties within two years of the violation occurring.[18] After 2000, however, investigators started investigating an increasing number of cases more than two years after policy cancellation. Since 2003, the department investigated cases from the MWCIA list an average of 26 to 28 months after the policy was cancelled.

Figure 2.5: Time Lag on Investigations of Employers with Cancelled Insurance Policies, 1998 to 2007



NOTES: Figure is based on 1,840 investigations originating from the MWCIA's list of cancelled policies. Cases are counted in the year that they were assigned to a DLI investigator.

[a] Due to staff reductions, DLI did not investigate any lapsed insurance policy cases in 2004.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry investigation data.

Investigation delays could cause DLI to miss its opportunity to assess penalties against uninsured employers.

Depending on the length of the employer's coverage gap, late investigations could cause DLI to miss its opportunity to assess penalties against uninsured employers. The investigation lag also reduces the likelihood that investigators will be able to find the employer—which could have gone out of business, or changed names, addresses, or owners, making it more difficult to locate and penalize.

DLI's decreased staffing prevents the department from pursuing other leads that it could find using its own data. We discussed DLI's failure to reinvestigate habitually noncompliant employers in a previous section. DLI's data are not designed to identify employers that have been the subject of multiple investigations, but department staff indicated that the reduced number of investigators constrains their ability to follow up on even those employers they know to have a history of problems. Similarly, DLI staff have identified specific

[18] *Minnesota Rules* 2008, 5220.2710.

industries, such as trucking, construction, and personal care assistance, which have high incidences of uninsured employers. Department staff said they do not, however, have the time to perform extra investigations or educational outreach activities targeted to those industries.

After we completed our analysis, DLI informed us that as of January 2009, it had significantly decreased its backlog of MWCIA list cases. According to department staff, investigators currently address employers with cancelled policies within one year of policy cancellation.

Recommendations

RECOMMENDATION

The Department of Labor and Industry should reduce the time lag between the receipt of the cancelled-policy list and the instigation of mandatory coverage investigations.

DLI could improve the timeliness of its investigations by better targeting those employers likely to be out of compliance.

The long delays and backlog of investigations from MWCIA cases are a problem. DLI staff said they need at least six months to obtain data from various sources (such as wage data from DEED) to conduct the dropped-policy investigations. Accordingly, we think DLI should investigate all employers identified through the MWCIA cancelled policy list between six months and one year after the policy cancellation date.

To implement this recommendation, DLI may wish to further target its investigations. DLI used to investigate all employers flagged on the MWCIA's cancelled policy list, but it was able to target investigations based on internal data analysis. By limiting its mandatory coverage investigations to employers whose policies were cancelled for nonpayment of premiums, DLI reduced its MWCIA list caseload from roughly 1,000 to about 200 cases a month. DLI staff stated that employers that respond to the department's initial request for information tend not to cause problems meriting investigation. Hence, DLI should further limit the cases it investigates to employers that did not respond to DLI's information requests. A systematic decrease in the number of cancelled-policy cases would allow the department to more promptly address employers that are more likely to lack workers' compensation insurance.

RECOMMENDATION

The Department of Labor and Industry should pursue the use of unemployment insurance data to identify employers that lack workers' compensation insurance.

DLI should continue to pursue using unemployment insurance data to identify employers that have never had workers' compensation insurance policies. New employers that are uninsured, as well as employers that have habitually lacked insurance, currently do not come to the department's attention unless an injured

worker names them in an uninsured claim. DLI might be able to identify these employers more systematically by matching DEED data on employers registered for unemployment insurance with a list of employers carrying workers' compensation insurance (or self-insured).

To improve its ability to detect never-insured employers, DLI needs to make better use of automated data matching techniques.

DLI would need to address several barriers to do this matching. First, DLI does not currently keep lists of employers carrying workers' compensation coverage; such a list would have to come from MWCIA. MWCIA, however, does not collect data from self-insured employers, so any list it provided would be incomplete. Second, both datasets would need to include a valid and useable unique identifier to facilitate matching. Employers should be matched using a unique numerical identifier such as a Federal Employer Identification Number (FEIN). DLI should work with MWCIA to ensure that the data service organization is collecting FEINs consistently and accurately.

DLI staff told us they have had many discussions about increasing the department's ability to match with DEED's employer data base, including the use of employer FEINs. Staff added that, since the FEIN is a federal number, it does not always match how some employers are organized in Minnesota. Nevertheless, the department is continuing to look for a solution.

Until data matching of the type explained above is possible, DLI could resume its manual searches of the DEED database. When DLI conducted this type of search several years ago, the resulting investigations resulted in penalty referral more often than any other type of investigation, indicating that it is a fruitful area of investigation.

RECOMMENDATION

The Department of Labor and Industry should consider increasing staffing in its Claims Services and Investigations unit.

DLI should consider increasing the number of staff dedicated to performing investigations of uninsured employers. During the early 2000s, the length of time between policy cancellation and case assignment increased as the number of investigation staff decreased. Data indicate that, with current staffing levels, the department investigated roughly 300 mandatory cases a year. Hypothetically, if DLI targets its investigations as suggested above and reduces its MWCIA caseload by half, the department will still get more than 1,000 new cancelled-policy cases each year. Adding data matching or manual searches of the unemployment data would further increase the number of cases to pursue. Unless additional resources are dedicated to addressing this backlog, the department will only fall further and further behind in its investigations.

RECOVERY OF WORKERS' COMPENSATION BENEFITS PAID BY THE SPECIAL COMPENSATION FUND

DLI pays workers' compensation benefits on behalf of uninsured employers from the insurer-funded Special Compensation Fund.

DLI is authorized to pay workers' compensation benefits from the state's Special Compensation Fund (SCF) under a variety of circumstances.[19] Most of the claims paid by SCF fall into one of three categories: claims against bankrupt, self-insured employers; claims related to occupational diseases such as asbestosis; and claims against uninsured employers (the focus of this section).[20] Between 1998 and 2007, the SCF has paid benefits, on average, for 74 uninsured claims each year. Since medical treatment and indemnity benefits for many claims are ongoing, the value of the claims accepted during that time cannot be stated definitively. So far, however, SCF has paid almost $28 million in benefits and expenses toward 1,245 claims accepted between 1998 and 2007.

When DLI pays workers' compensation benefits from SCF on behalf of an uninsured employer, Minnesota law mandates that the employer reimburse the fund for the benefits paid, expenses incurred, and a penalty amounting to 65 percent of the benefits paid.[21] In practice, DLI often negotiates with employers to reach agreements of reimbursement and penalty owed. The terms of repayment are formalized in "reimbursement agreements." In other cases, the employers are uncooperative, and must be ordered to pay by a judge. Regardless of source, the final settlement amounts reached are recorded in the reimbursement billing table of DLI's claims administration database.

Settlement Amounts

For our evaluation, we wanted to know whether uninsured employers were held accountable for reimbursing the SCF for benefits paid to injured workers. We analyzed DLI's SCF database in conjunction with its reimbursement billing records. We found that:

- **Based on available data, employers rarely reimbursed the Special Compensation Fund to the full extent provided for in law, but DLI has been more aggressive in seeking repayment since 2003.**

[19] *Minnesota Statutes* 2008, 176.129, subd. 6, states that the Workers' Compensation Division, a compensation judge, the Workers' Compensation Court of Appeals, or a district court shall direct the distribution of workers' compensation benefits. According to *Minnesota Statutes* 2008, 176.129, subds. 1 and 2a, the Commissioner of Finance is the SCF custodian and annually estimates the funds liabilities based on indemnity benefits paid by insurers and self-insured employers during the previous year. The commissioner assesses the entire required amount against insurers and self-insured employers.

[20] The uninsured claims constitute the same set of claims for which DLI might conduct initial claims investigations.

[21] *Minnesota Statutes* 2008, 176.183, subd.2.

DLI's records of reimbursements and penalties owed by uninsured employers are incomplete.

DLI has reimbursement billing records containing settlement amounts (both negotiated and ordered) for fewer than half the cases in which it paid benefits. We restricted our analysis of the department's SCF database to the uninsured cases in which the department paid benefits and should have sought reimbursement.[22] Our analysis was further limited to cases in which benefit payment data could be matched with initial claims investigation data (and thus reimbursement billing records). Based on these criteria, we evaluated 741 uninsured claims in which the state paid benefits to injured workers. While DLI should have attempted to recover money from each of these employers, the department's data include reimbursement billing records with final settlement amounts in only 285 of the cases (38 percent). From 1998 to 2007, the percentage of cases with reimbursement billing records fluctuated between 29 and 49 percent.

DLI staff gave two reasons a case might lack a reimbursement billing record. According to DLI, the reimbursement billing database does not accurately reflect settlement amounts reached prior to 2007. In the past, the department did not establish reimbursement billing records for all employers that made lump-sum payments. These payments were handled directly by DLI's accounting department and the payment amounts were never linked to their associated claim records. DLI staff are unable to estimate how many cases might have been resolved this way. In other cases, financial recovery is not possible because the employer is no longer viable. Since the SCF payment database does not track reimbursement efforts, there is no way to determine the number of cases resolved with lump-sum payments or involving nonviable employers. Therefore, we cannot estimate how many cases lacking reimbursement billing records are justifiable and how many reflect a lack of persistence in pursuing negotiations with the employer.

Among the 285 cases with reimbursement billing records, settlement amounts rarely equaled the 165 percent provided for in law. When DLI negotiates with an employer, it takes into account the employer's ability to pay. According to DLI staff, when an employer is hurting financially, pressing for a large settlement will often result in the department recovering no money at all. Claim managers review employers' financial records and are open to reducing settlement amounts for employers that cannot afford to pay the full amount owed. Employers either agreed to or were ordered to pay settlement amounts of 165 percent of benefits

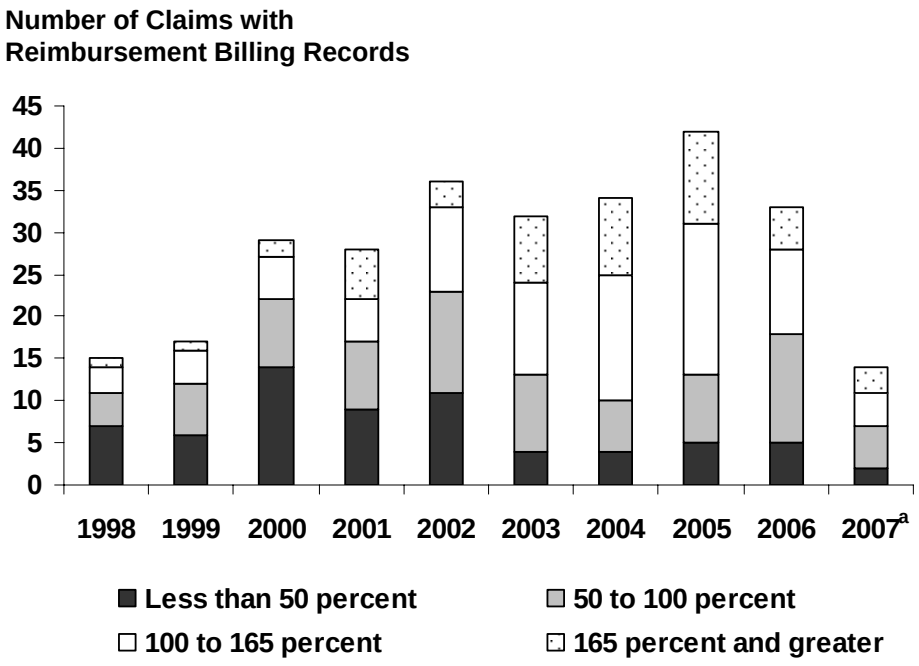
[22] There are two types of cases in which an SCF data record should not have a matching reimbursement billing record: (1) the employer's insurer was found and the case was closed before the state paid any benefits, and (2) the case is in litigation and the appropriateness/amount of benefits to be paid has not yet been determined.

paid or greater in only 17 percent of the cases for which DLI has reimbursement billing records.[23]

DLI has routinely negotiated repayment agreements worth less than the amount of the benefits that had already been paid on the claim.

However, DLI is now being more aggressive in negotiating settlement amounts. According to DLI staff, the department used to routinely settle for "pennies on the dollar." In recent years, DLI's settlement amounts came much closer than previously to matching the amounts originally paid out of the SCF. Figure 2.6 shows the number of cases with reimbursement billing records for which the settlement amounts as a percentage of benefits paid fell within predefined ranges.

Figure 2.6: Settlement Amounts as a Percentage of Benefits Paid, 1998 to 2007



NOTE: Cases count toward the year that they were assigned to a DLI investigator. Depending on the timing of the injury and progress of the claim, the date of injury may or may not be during the same year the investigation was assigned.

[a] The number of 2007 cases with reimbursement billing records and penalty amounts is smaller because the cases are so recent. According to DLI staff, the department may still be in negotiations with the employers or the claims may be in litigation.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry Special Compensation Fund and investigation data.

[23] Settlement amounts include those that the employer agreed to voluntarily, as well as payment amounts ordered by a judge. Settlement amounts include the reimbursement of benefits and expenses paid by the state, the employer's penalty, and any appropriate interest. Penalties and reimbursements are often rolled together into a lump-sum settlement, and DLI's data does not typically present them as distinct amounts. The lack of "clean" penalty data makes it impossible to analyze the reimbursement and penalty elements separately.

As shown, until 2002, the majority of cases were settled for less than the amount of the benefits the state had already paid on the claim. Starting in 2003, a greater percentage of the claims were settled for 100 percent or more of the benefits paid, with increasing numbers of claims settled for the recommended 165 percent or more. The trend reversed itself in the last two years of the period, with more claims settled below full value, as well as a considerable drop in the number of 2007 claims settled. DLI staff said that these cases are more likely to still be in litigation or negotiations, so the current data may not be complete.

Collection of Reimbursements Owed

DLI cannot determine the proportion of reimbursements and penalties owed that are actually collected from uninsured employers.

So far, DLI has collected roughly $2 million worth of reimbursements and penalties on the 285 claims for which the department has reimbursement billing records. This constitutes 19 percent of the total settlement amounts those employers agreed to or were ordered to pay, and 17 percent of the SCF-paid benefits on the claims. Due to the unrecorded lump-sum payments discussed previously, DLI believes that that it has collected more than $2 million worth of reimbursements. The department's accounting system, which has recorded dollars collected by year since 2001, shows that DLI collected more than $3.75 million in reimbursement payments between 2001 and 2007. Given that the unaccounted for lump-sum payments cannot be tied to a particular claim, we cannot determine what percentage of SCF-paid benefits the $3.75 million represents.

Analysis of SCF benefits paid, settlement agreements, and reimbursements collected cannot be easily performed using DLI's current data system. In attempting to analyze SCF-paid benefits and employer reimbursements, we found that:

- **DLI did not effectively use payment and reimbursement data to track of amounts due or paid, largely because of problems with the organization of its data systems.**

Beyond the complete lack of searchable data on certain lump-sum reimbursement payments, DLI's data is difficult to use because SCF payment records and their associated reimbursement records are housed in different databases. Records of benefit payments on uninsured claims are contained within the GenComp data system, while the reimbursement and penalty information is housed within the investigation portion of DLI's claims administration database. The two databases do not contain a common, unique identifier. The lack of a common identifier prevents DLI from easily matching records of state benefits paid to their corresponding employer reimbursement data, and it makes tracking actual collection of amounts due nearly impossible.

We were able to do our analysis by matching cases on a combination of identifiers: claimant social security number and date of injury. Beyond being complicated and time-consuming to perform, linking cases in this manner is not fully effective or accurate. Inconsistencies in the use of any one of the identifiers may result in cases dropping out of the match between the two systems. The incompatibility of these two data systems means that DLI cannot conduct valid comparisons of benefit payment and reimbursement amounts.

Recommendations

RECOMMENDATIONS

To improve collection of reimbursements owed, the Department of Labor and Industry should:

1. ***Reorganize its data system to better track investigations, benefits paid from the Special Compensation Fund, and reimbursement information, and***

2. ***Use these data to evaluate its process for obtaining reimbursements from employers.***

DLI needs to improve its information systems to better hold uninsured employers accountable for payment of reimbursements and penalties.

To better manage its investigations of uninsured employers and ability to obtain reimbursements from them, DLI needs to take steps to make its data more compatible and useable. One option would be to migrate all transactions related to uninsured claims into a single information system. At the very least, records in all tables, *regardless of data system*, should include a standard, unique identifier. For simplicity's sake, we suggest using the "Workers' Compensation Case File ID," which is the number assigned to a claim when it first arrives at DLI.[24] If every table containing information about a given claim includes this original identification number, DLI can more easily conduct analysis of all information related to a claim, regardless of the table or system from which the data originated. According to DLI staff, the department is in the process of gathering requirements for replacing GenComp, the information system used for claims paid from the SCF. Staff said the ability to link data will be a key element of the new system.

Also, DLI should ensure that its investigators, claim managers, and penalty administrators fill in each data record as completely and accurately as possible. DLI may wish to consider its evaluation needs and highlight specific fields, those that would be useful in analyzing trends in employer behavior or department performance, for immediate improvement. Examples of fields that could serve the department well, but are currently underutilized, are FEIN, reason for penalty reduction, and true evaded premium amount.

Once DLI has addressed these data shortfalls, it should conduct regular analysis of settlements reached and reimbursements collected relative to SCF benefits paid. Conducting analysis of this sort will allow DLI to evaluate its own performance in negotiations and collections, and to set goals for improvement.

[24] Not every DLI record is related to a specific claim. Mandatory coverage investigations, for example, focus on specific employers that might not have had uninsured injury claims against them. In cases such as these, a dummy identifier should be assigned.

FRAUD INVESTIGATION

The Minnesota Department of Commerce, Division of Insurance Fraud Prevention investigates allegations of fraud involving any type of insurance, including auto, disability, homeowners, health, life, and workers' compensation. We found that:

- **The Department of Commerce reviews about 145 workers compensation fraud referrals a year, but few proceed to prosecution.**

The division has received roughly 145 workers' compensation fraud referrals a year since 2004. These cases accounted for 16 percent to 28 percent of the division's overall insurance fraud caseload between 2004 and 2008. Other significant categories of referrals in 2008 were for auto insurance fraud and homeowner insurance fraud.

Most of the workers' compensation cases referred to the Department of Commerce for fraud investigation alleged fraud on the part of individual claimants.

Ultimately, few workers' compensation cases are referred for prosecution. The division closes many of the referrals after preliminary review and analysis because there are insufficient grounds for further action. Among those that are investigated further, the division may choose to close cases that lack prosecutorial merit or are settled in a civil proceeding initiated by an insurer. The division will refer to prosecutors those cases with sufficient evidence to prove an intent to commit fraud. The division referred eight cases for prosecution in 2006; it referred four in 2007.

The vast majority of referrals allege fraud on the part of individuals claiming workers' compensation. According to division staff, two of the most common scenarios are (1) individuals who are "lingering" in their recovery in order to continue receiving benefits and (2) individuals who have other jobs or start their own businesses while claiming workers' compensation benefits from another employer. The division receives few referrals per year related to workers' compensation insurers or employers—perhaps one allegation a year of fraud related to failure to pay workers' compensation benefits.

The value of individual fraud cases varies. According to division staff, cases can involve from $20,000 to $150,000 in benefits per individual. Fraud valuations consider the value of fraudulently paid indemnity benefits only; the value of medical benefits is excluded because it is based on a patient's subjective representation of his or her medical condition.

Commerce cannot estimate the extent to which prosecuted fraud cases reflect the actual scope of workers' compensation fraud in Minnesota. Officials said the frequency of prosecutions is tempered by the many cases settled in civil litigation. While the staff would not speculate as to whether workers' compensation fraud is a big or small problem in Minnesota, they said that the National Insurance Crime Bureau recently reported that workers' compensation fraud was the fastest growing category of insurance fraud in the nation. The division plans to increase its ability to detect workers' compensation fraud cases through increased cooperation with insurance company special investigation units and law enforcement agencies. The division also plans to hire an in-house attorney to enhance the prosecution of workers' compensation fraud.

3 Dispute Resolution

Minnesota's workers' compensation system was designed to quickly provide benefits specified by law to workers injured on the job, regardless of who was at fault. However, disputes between workers and workers' compensation insurers occur in roughly one out of every five indemnity claims. The process used to prevent and resolve disputes is important because it affects the timeliness and accuracy of benefits paid to injured workers as well as the cost to employers.

Depending on the nature of the dispute and the wishes of the parties, dispute resolution may be facilitated by a specialist in the Department of Labor and Industry (DLI) or a judge in the Office of Administrative Hearings (OAH). Our evaluation focused primarily on dispute resolution activities at DLI. This chapter presents our evaluation results with respect to the following:

1. Trends in the nature and frequency of workers' compensation disputes;
2. Injured workers' experiences with the workers' compensation system;
3. Overall design of the state's dispute resolution system, including a comparison to the alternative process provided by the Union Construction Workers' Compensation Program; and
4. Results of DLI's efforts to help resolve disputes as early as possible.

DISPUTED CLAIMS

The workers' compensation system is complex. Employees, employers, and insurers may disagree over any aspect of a claim. For example, disputes can occur over questions of primarily liability—whether an injury or illness is work-related and the employee is entitled to workers' compensation. Disputes can also occur over any aspect of benefits due once a claim has been accepted—for example, whether workers' compensation should cover a surgery or retraining.

DLI estimates that about 19 percent of indemnity claims filed in 2007 will eventually involve at least one of the four main types of disputes, listed in Table 3.1.[1] We analyzed DLI's claims data and found that:

- **The proportion of claims that have disputes has been rising over the past decade.**

[1] These figures do not include (1) disputes resolved informally by DLI before entering the formal dispute resolution process and (2) disputes that were not between the injured worker and the employer/insurer, such as a dispute over attorney fees.

Table 3.1: Major Dispute Types

Claim Petition	Dispute over denial of primary liability, eligibility for benefits, or amount of benefits
Discontinuance	Dispute over discontinuance of wage-loss benefits, usually the insurer's declared intention to discontinue temporary total or temporary partial benefits
Medical Request	Dispute over a medical issue, such as choice of provider or nature and timing of treatment
Vocational Rehabilitation Request	Dispute over a vocational rehabilitation issue such as eligibility for rehabilitation benefits, appropriateness of rehabilitation plan, or the employee's cooperation with the rehabilitation plan

NOTE: DLI categorizes a dispute based on the form used to file it.

SOURCE: Minnesota Department of Labor and Industry, *Workers' Compensation System Report, 2006* (St. Paul, September 2008), 72-77.

The percentage of filed indemnity claims with at least one of the four major types of disputes climbed from 15.4 percent in 1997 to 19.1 percent in 2007, as shown in Table 3.2. Medical dispute rates increased faster than any other major dispute category, doubling during this time period from 3.8 percent to 7.6 percent of paid indemnity claims.[2]

Several factors, including rising health care costs, contribute to higher dispute rates.

Stakeholders in the system have identified a number of factors contributing to higher dispute rates. These include: (1) rising health care costs that create incentives for insurers and employers to limit medical services; (2) increasing prevalence of claim adjusters who do not know Minnesota law and make mistakes that create disputes; and (3) increasing complexity of claims as the workforce ages, creating causation disputes over the relative work-related and age-related contributions to the injury or illness. Another factor that may explain the increase in the dispute rate is the decline in number of early, informal dispute resolutions. We examine this factor later in the chapter.

While the proportion of claims with disputes has been growing, the number of claims with disputes has declined because of the rapid drop in indemnity claims filed since 2000. Between 2000 and 2007, the number of indemnity claims filed declined by 30 percent (from 39,900 to 28,000 per year). Because the drop in filed claims more than offsets the increase in the dispute rate, the number of indemnity claims with a dispute declined by 20 percent after 2000.

[2] Medical dispute rates are measured as a percentage of *paid* indemnity claims (rather than *filed* indemnity claims) because medical disputes would only occur in claims that have been accepted. *Filed* indemnity claims are claims for indemnity benefits, whether ultimately paid or not.

Table 3.2: Percentage of Indemnity Claims Disputed, by Major Dispute Type, 1997 and 2007

Dispute Type	Percentage of Indemnity Claims 1997	2007
Claim Petition[a]	11.3%	14.0%
Discontinuance Dispute[b]	6.5	7.3
Medical Request[c]	3.8	7.6
Vocational Rehabilitation Request[d]	3.6	5.5
Claims with at least one of the four major dispute types[e]	15.4	19.1

[a] Measured as a percentage of *filed* indemnity claims. *Filed* indemnity claims are claims for indemnity benefits, whether ultimately paid or not.

[b] Measured as a percentage of paid wage-loss claims, excluding paid indemnity claims involving only permanent partial disability payments. By definition, a discontinuance dispute is a dispute over the insurer's decision to stop wage-loss benefits.

[c] Measured as a percentage of *paid* indemnity claims (rather than *filed* indemnity claims) because medical disputes would only occur in claims that have been accepted.

[d] Measured as a percentage of *paid* indemnity claims.

[e] Measured as a percentage of *filed* indemnity claims. Percentages do not equal the sum of the percentages above because some claims have more than one type of dispute.

SOURCE: Department of Labor and Industry dispute data.

CLAIMANT SATISFACTION

We surveyed a sample of workers who filed claims or had disputes in 2006 and 2007.

To place disputes in perspective, we used surveys to ask injured workers about their experiences with the state's workers' compensation system. To learn more about claimants' general satisfaction with the workers' compensation system, we surveyed a sample of workers who filed a workers' compensation indemnity claim for an injury in 2006 or 2007. To examine claimants' experiences with the dispute resolution process in greater depth, we also surveyed a sample of those who had a workers' compensation dispute in 2006 or 2007. We found that:

- **Most injured workers had some positive opinions about their workers' compensation claim experience, but a sizeable number were frustrated with the dispute resolution process.**

Opinions were mostly positive in our survey of a sample of all claimants. Most claimants were satisfied with the parties they dealt with for their claim, including insurance companies, employers, and state agency employees, as shown in Table 3.3. About two-thirds of claimants thought they were treated fairly by the insurance company, and 74 percent agreed that they had no trouble getting the medical treatment they needed, as shown in Table 3.4.

Table 3.3: Claimants' Satisfaction with Various Parties in the State Workers' Compensation System, 2008

	N	Percentage of Claimants Who Were Satisfied or Very Satisfied
Your employer's actions after you reported the injury	627	71%
The health care providers who treated you	652	87
The insurance company that handled your claim	634	69
Your attorney	292	78
Your vocational rehabilitation providers	316	84
State agency employees that you contacted for help	300	78

NOTE: The above figures (*N* and percentage who were satisfied) were calculated after excluding respondents who did not answer the question, had no opinion, or who said the statement did not apply.

SOURCE: Office of the Legislative Auditor, analysis of survey responses from workers' compensation claimants, September 2008.

Table 3.4: Opinions About the Claim Experience in the State Workers' Compensation System, 2008

About two-thirds of claimants surveyed thought they were treated fairly by the insurance company, and 74 percent agreed that they had no trouble getting medical treatment.

	N	Percentage of Claimants Who Agreed or Strongly Agreed
I knew how to get the workers' compensation process started when I got hurt on the job.	632	63%
My employer has helped me get the benefits I need.	623	74
Getting workers' compensation benefits has been a frustrating experience.	637	38
I felt sufficiently informed about my rights.	631	66
The insurance company handling my claim has treated me fairly.	621	69
I have had no trouble getting the medical treatment I need.	647	74
A person who gets hurt on the job should talk to a lawyer as soon as possible about workers' compensation.	553	40
It took too long for my benefits to start.	576	30

NOTE: The above figures (for *N* and percentage agreeing) exclude respondents who did not answer the question or had no opinion.

SOURCE: Office of the Legislative Auditor, analysis of survey responses from workers' compensation claimants, September 2008.

The following comments typify responses from claimants satisfied with their workers' compensation experiences:

> This was my first and only experience with the workers' compensation system in over fifty years of employment! The system worked well, and I was very satisfied with the outcome.

> Everything was handled professionally and smoothly. All expenses were taken care of and my benefits were right on time. My contact person with the insurance company was very easy to work with. I have no complaints whatsoever!

> Everything throughout my claim was handled professionally and in a timely manner. No problems occurred.

However, a sizeable number of respondents had negative opinions about their workers' compensation experiences.

Nevertheless, a sizeable number of respondents had negative experiences, particularly those who had disputes over their claim. For example, 38 percent of all claimants agreed that getting their workers' compensation benefits was a frustrating experience. Among those with disputes who expressed an opinion, 89 percent agreed with the statement that the dispute resolution system was too complex, and 88 percent agreed that the process took too long. Only 31 percent agreed that their dispute was resolved fairly, and 38 percent stated that they felt well informed about their rights.

This survey response was typical of many written comments from workers frustrated with their workers' compensation experience:

> My claim was accepted, but then I was cut off of my medical, my benefits, everything, four times. It was fought and ruled in my favor four times. After one year and two months I received surgery. (That day I stood waiting for authorization for meds for four hours because the insurance company canceled my prescription card. I spent another two hours making phone calls to borrow money so I could get them because the authorization did not go through until the next day.) During my first month of recovery I was put on job search, not yet being finished with [physical therapy]. Now during my third month of recovery, I am cut off again, even the job search specialist was let go! My MMI (maximum medical improvement) is scheduled for October and I have not even been released from my doctor's care. I have no job, no money, have not been reimbursed anything. I have another court date and I am very frustrated.

Another survey respondent wrote:

> In five years and four months, I have had at least eight hearings in court rooms and by telephone conference. The judges have ruled in my favor every time but the insurance company and my employer don't pay much attention to them. I have seen no evidence that the court has any way of really enforcing these rulings. My benefits have stopped for the most foolish of

> reasons, treatment denied and refusal to pay for prescriptions. I contact my attorney and have waited up to ten months for a hearing before a judge to resolve issues that should never have seen the inside of a court room. The small fines and penalties the court rules have no real effect on the employer or insurance company.

Some negative opinions should be expected simply because some workers may have unrealistic expectations of the benefits they should receive. Other negative opinions are likely a reaction to insurer behavior. We also think the complexity of the workers' compensation system, particularly the dispute resolution process, is also a factor. In the next section, we examine the design of the dispute resolution system in greater detail.

SYSTEM DESIGN

The workers' compensation dispute resolution system includes processes to help parties reach agreement without the need for a hearing before a workers' compensation judge. Early on, as shown in Figure 3.1, DLI provides informal assistance to prevent or resolve problems before they enter the formal dispute resolution process. Once a formal dispute has been registered, the dispute resolution steps that take place before a hearing are generally referred to as "alternative dispute resolution."[3] As described in Table 3.5, there are two types of formal proceedings that can take place during alternative dispute resolution: mediation and administrative conferences. One or both of these proceedings can take place at DLI or OAH depending on the nature of the dispute.

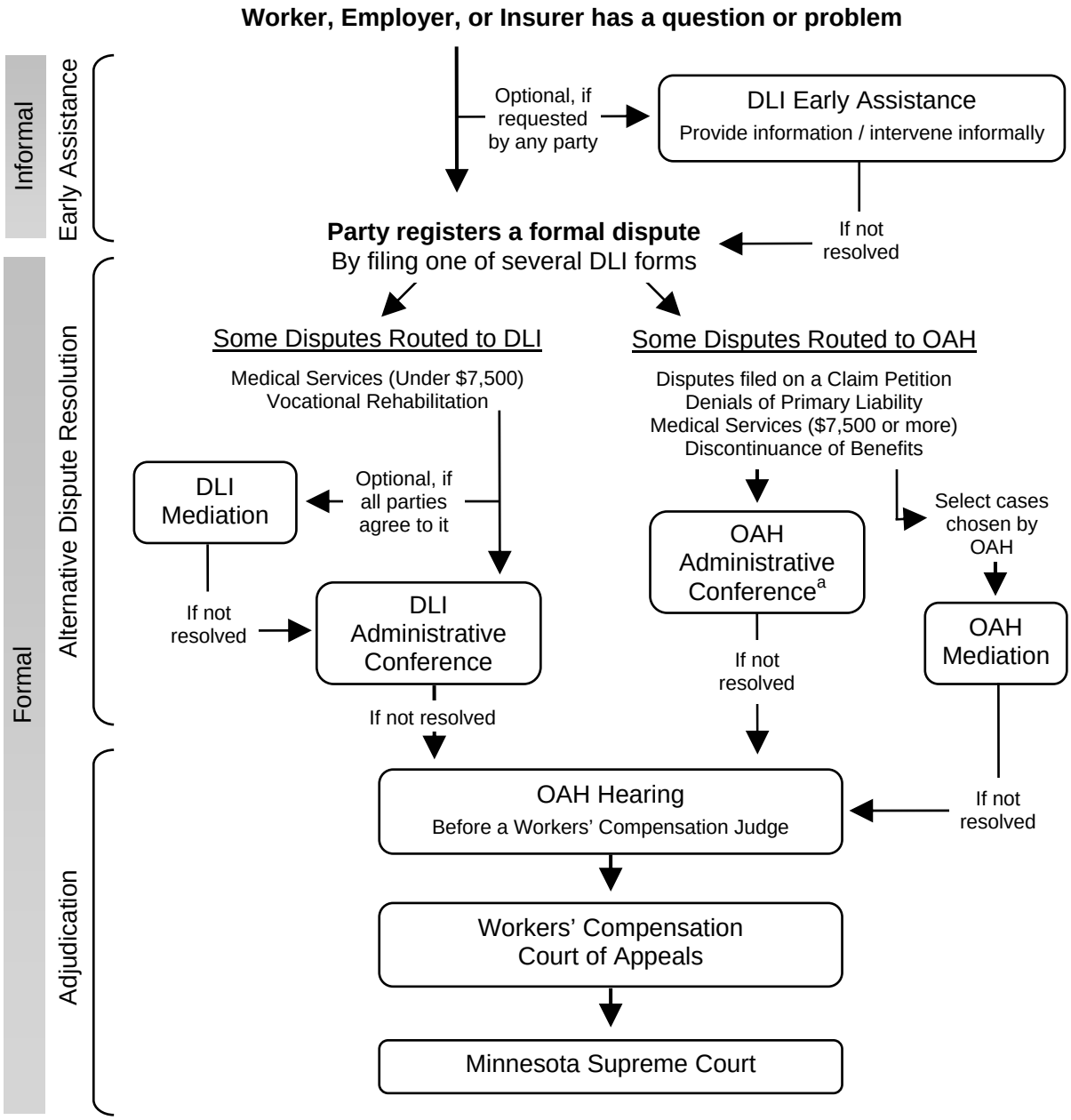
Impartiality on the part of state staff is an essential element of the dispute resolution system.

Impartiality on the part of state staff is an essential element of the dispute resolution system. DLI policies, for example, explicitly state that dispute resolution staff must recuse themselves from proceedings if they cannot provide services in an impartial manner. Staff are also prohibited from pressuring or coercing parties to settle claims or to accept particular options sought by an opposing party.

In this section, we discuss the steps involved in the dispute resolution process, how long it takes for disputes to be resolved, and information system issues affecting how the process is managed. We also compare the state dispute resolution system to that of the Union Construction Workers' Compensation Program.

[3] Dispute resolution assistance occurs on a continuum from informal help over the telephone to administrative hearings before a workers' compensation judge. For this report, we place the division of informal and formal dispute resolution as shown in Figure 3.1. We consider a dispute to be in the formal process once a form registering the dispute has been filed at DLI. As discussed later in the section, DLI has a process for "certifying disputes." We consider this certification process itself to be part of the formal stage of dispute resolution.

Figure 3.1: Dispute Resolution Process for Minnesota's Workers' Compensation System, 2008



NOTES: DLI is the Department of Labor and Industry. OAH is the Office of Administrative Hearings. Disputes may be settled by agreement of the parties (with or without mediation) at any time. If DLI or OAH administrative conferences do not result in mutual agreement, the presiding official will render a decision on the case; disputed decisions go to an OAH hearing. Multiple disputes associated with a single claim may be consolidated at one agency. Also, DLI may refer some complex cases in its jurisdiction to OAH.

[a] For simplicity, we refer to several types of OAH proceedings as "administrative conferences." These include settlement conferences for disputes filed on claim petitions, administrative conferences for discontinuance disputes, and medical and rehabilitation conferences.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota's dispute resolution system for workers' compensation.

Table 3.5: Alternative Dispute Resolution Proceedings

Type of Proceeding	Definition	Description
Mediation	A voluntary proceeding conducted either at DLI or OAH to facilitate agreement among the parties in a dispute	A mediation occurs when one party requests it and the others agree to participate. Trained staff serve as neutral facilitators of negotiations between the disputing parties. If agreement is reached, its terms are formally recorded. Mediation often takes place after attempts at resolution by phone and correspondence have failed.
Administrative Conference	An expedited proceeding conducted at either DLI or OAH where parties present and discuss viewpoints in a dispute	Staff conducting the conferences are to be impartial, ensuring that disputed issues are properly identified, all relevant information obtained, and voluntary agreements reached whenever possible. If agreement is not achieved, a "decision and order" is issued which is binding unless a dispute party requests a hearing before a workers' compensation judge.

SOURCES: Office of the Legislative Auditor, compilation from Minnesota Department of Labor and Industry, *Workers' Compensation System Report, 2006* (St. Paul, September 2008), 72 and 74; and the Department of Labor and Industry's Benefit Management and Resolution procedure manual, 2007.

Steps in the Dispute Resolution Process

After assessing Minnesota's system for resolving workers' compensation disputes, we found that:

- **Minnesota's alternative dispute resolution process is overly complex.**

One reason the system is complex is that disputes can formally enter the dispute resolution system in a variety of ways, most of which are associated with filing a form. Each of the four major dispute types—claim petitions, discontinuance disputes, medical disputes, and rehabilitation disputes—has its own form to trigger the dispute resolution process. In addition, a dispute may be initiated by filing a form requesting DLI to "certify" that a dispute exits.[4] Occasionally, DLI staff may also register a dispute based on a phone call, e-mail, or written correspondence.

A second reason that the system is complex is that there are many possible steps and paths through the dispute resolution process, as illustrated in Figure 3.1. OAH and DLI share responsibility for alternative dispute resolution. Some issues are directed to OAH, including: (1) issues filed on a claim petition, (2) disputes over discontinuance of wage-loss benefits, and (3) medical disputes

[4] *Minnesota Statutes* 2008, 176.081, subd. 1(c), provides that no attorney's fees can be charged in rehabilitation or medical matters until the department has determined that a genuine dispute exists and that it has tried to resolve it. The process of verifying the existence of a dispute, trying to resolve it, and notifying the attorney of the outcome is called dispute certification.

The steps in the dispute resolution process vary depending on the nature of the disputed issue, the form used to file the dispute, and the procedures used by DLI and OAH.

exceeding $7,500. DLI provides early intervention to prevent or resolve problems before they become formal disputes. It also handles disputes involving rehabilitation issues and medical issues under $7,500, although DLI may refer complicated cases in its jurisdiction to OAH. Thus, the path through the alternative dispute resolution process varies depending on the nature of the disputed issue, the form used to file the dispute, and the procedures used by DLI and OAH.

The path also depends on the willingness of parties to negotiate and whether the parties accept administrative decisions. DLI may mediate a dispute at any time if both parties are willing. OAH also may mediate disputes under its jurisdiction, such as claim petitions. Finally, disputes that go to administrative conferences at either DLI or OAH can be appealed for a hearing at OAH.[5]

Another factor that makes the system complex is that a single claim can have multiple disputes, which may be at different points in the process. This typically happens when there is a rehabilitation dispute in the DLI process and a discontinuance dispute at OAH, both dealing with the same injury.[6] Although DLI and OAH try to consolidate multiple disputes that are based on the same injury, staff said that does not always happen. In addition, if a party appeals a decision and order resulting from an administrative conference, it becomes a new dispute in the information system.

Duration of Disputes

Injured workers may suffer serious economic harm when workers' compensation disputes take a long time to resolve. We analyzed the amount of time that certain types of disputes spent in the various stages of dispute resolution—alternative dispute resolution at DLI, alternative dispute resolution at the OAH Settlement Division, and adjudication at the OAH Hearing Division. We found that:

- **Many of the most common disputes take a long time to resolve.**

Claim petitions accounted for about 40 percent of new disputes in 2007. Among claim petitions filed in 2007, more than half of the cases were resolved during alternative dispute resolution at the OAH Settlement division, as shown in Table 3.6. The median time for doing so was 217 days, or roughly 7 months. Among claim petition disputes that went to the OAH Hearing Division after unsuccessful alternative dispute resolution, the median time to resolve the dispute was roughly 11 months—a median of 224 days in alternative dispute resolution and 105 days in the hearing process.

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[5] For the sake of simplicity and with OAH's agreement, we collectively refer to several types of OAH proceedings as "administrative conferences." These include settlement conferences for disputes filed on claim petitions, administrative conferences for discontinuance disputes, and medical and rehabilitation conferences. These proceedings are handled in OAH's Settlement Division.

[6] Complete data on the number of claims with disputes in both jurisdictions were not readily available. However, of 2,051 rehabilitation disputes registered at DLI in 2007, roughly 7 percent were later combined with a dispute from the same claim that was at OAH.

Disputes filed on claim petitions took roughly 7 to 11 months to resolve at OAH.

Table 3.6: Duration of Claim Petitions and Discontinuance Disputes Filed in 2007

	Number of Disputes	Percentage	Median Days: Settlement Division	Median Days: Hearing Division
Claim Petitions				
Resolved in Settlement Division[a]	2,789	56%	217	
Referred to Hearing Division	1,079	22	224	105
Pending as of July 2008	1,112	22	288	
Total	4,980	100%	239	
Discontinuance Disputes				
Resolved in Settlement Division[a]	1,808	78%	28[b]	
Referred to Hearing Division	347	15	28[b]	73
Pending as of July 2008	158	7	399[c]	
Total	2,313	100%	28	

NOTE: OAH's Settlement Division handles dispute resolution activities, such as administrative conferences, that take place before a hearing. The Hearing Division handles disputes once they are slated for a hearing. The table excludes claim petition and discontinuance disputes that were combined with other issues.

[a] Cases resolved in the Settlement Division include those that were dismissed and those in which the parties reached agreement, withdrew the dispute, or did not appeal a decision and order.

[b] Median time in the Settlement Division was calculated using the two categories of cases (Resolved in Settlement Division and Referred to Hearing Division) combined.

[c] This median should be interpreted with caution. Some pending cases may actually have been stricken from the hearing calendar or settled without updating the dispute status in the information system. This may contribute to the high median.

SOURCE: Office of the Legislative Auditor, analysis of dispute data from the Department of Labor and Industry and Minnesota Management Analysis and Development.

Disputes over the discontinuance of wage-loss benefits took about 28 days to resolve at OAH if a hearing was not required.

State law provides for expedited resolution of disputes over the discontinuance of benefits.[7] In fact, discontinuance disputes were more often resolved while at the Settlement Division and were resolved more quickly. As shown in Table 3.6, disputes over discontinued benefits that were resolved in the Settlement Division took about 28 days to resolve. Those that went into the hearing process (appeals of earlier decisions and disputes going straight to a hearing) were resolved in a median of a little more than three months.

Smaller medical disputes were typically resolved in about a month. As shown in Table 3.7, about 87 percent of medical disputes handled by DLI were resolved during alternative dispute resolution in a median of 34 days. The pattern for resolution of vocational rehabilitation disputes at DLI was similar. The median time to resolve these disputes was about a month. Medical disputes directed to OAH took longer. The median time to resolve these disputes was roughly three months.

[7] *Minnesota Statutes* 2008, 176.239.

Table 3.7: Duration of Medical Disputes Handled by the Department of Labor and Industry and Filed in 2007

	Number of Disputes	Percentage	Median Days at: DLI	Median Days at: OAH Hearing Division
Resolved at DLI[a]	1,761	87%	34	
DLI decision appealed to and resolved at OAH	194	10	57	90
Other[b]	63	3		
Total	2,018		36	

[a] Cases resolved at DLI include those in which the parties reached agreement, withdrew the dispute, or did not appeal a decision and order, among others.

[b] The other disputes include 23 that had no outcome posted as of July 2008 and 40 that were combined with another dispute. We did not calculate duration medians for these cases.

SOURCE: Office of the Legislative Auditor, analysis of dispute data from the Department of Labor and Industry and Minnesota Management Analysis and Development.

Various factors can cause a legitimate postponement of hearings.

According to OAH, various factors can intervene to cause a legitimate postponement of hearings. When a case goes to the OAH Hearing Division, it is set for hearing within six months (and in many cases within three to four months). The judge has another 60 days to issue a decision (30 days if it is an expedited case) after the hearing is completed. OAH judges said, however, that hearings do not always take place as scheduled. For example, the employee may have lost his or her job or recently had surgery. According to the judges, such events can affect which issues are ready for trial or can change the nature of the dispute altogether. As a result, the parties may need more time to prepare, and the hearing is postponed.

Information Technology

The day-to-day management of the dispute resolution process is intertwined with the design of the workers' compensation information system. We found that:

- **Information technology shortfalls inhibit efficient management of the dispute resolution system.**

For example, records in the system's database tables for workers' compensation disputes are organized around discrete disputes. Individuals may have multiple disputes associated with one or more claims, and disputes may be assigned to DLI, OAH, or both. Staff at both agencies said that workers are best served if

their claims (or multiple claims) are treated holistically. As currently designed, the database is not well-suited to this approach.[8]

The information system also does not currently support certain electronic transactions that would improve efficient management of the process. For example, some types of communication to parties in the dispute—such as sending OAH hearing notices—could be done electronically rather than by mail. The system currently does not support that function. In addition, OAH would like to have an electronic calendaring system that would facilitate scheduling of OAH settlement conferences and hearings. Under current practice, scheduling can take a great deal of time.

Comparison to the Union Construction Workers' Compensation Program

The UCWCP was designed to resolve disputes quickly in a simpler, less adversarial process than the state system.

To explore ways to simplify the dispute resolution process, we examined an alternative used by construction unions and employers: the Union Construction Workers' Compensation Program (UCWCP). The UCWCP was designed to resolve disputes quickly in a simpler, less adversarial process than the state system. It tries to get injured workers back to work quickly to reduce workers' compensation costs for the employer and reduce wage and benefit losses for injured workers. We compared the two systems with regard to the process used to resolve disputes, the overall cost of benefits paid, and effects on injured workers.

We found that:

- **The dispute resolution process in the Union Construction Workers' Compensation Program is far simpler and results in lower workers' compensation benefit costs than the state system.**

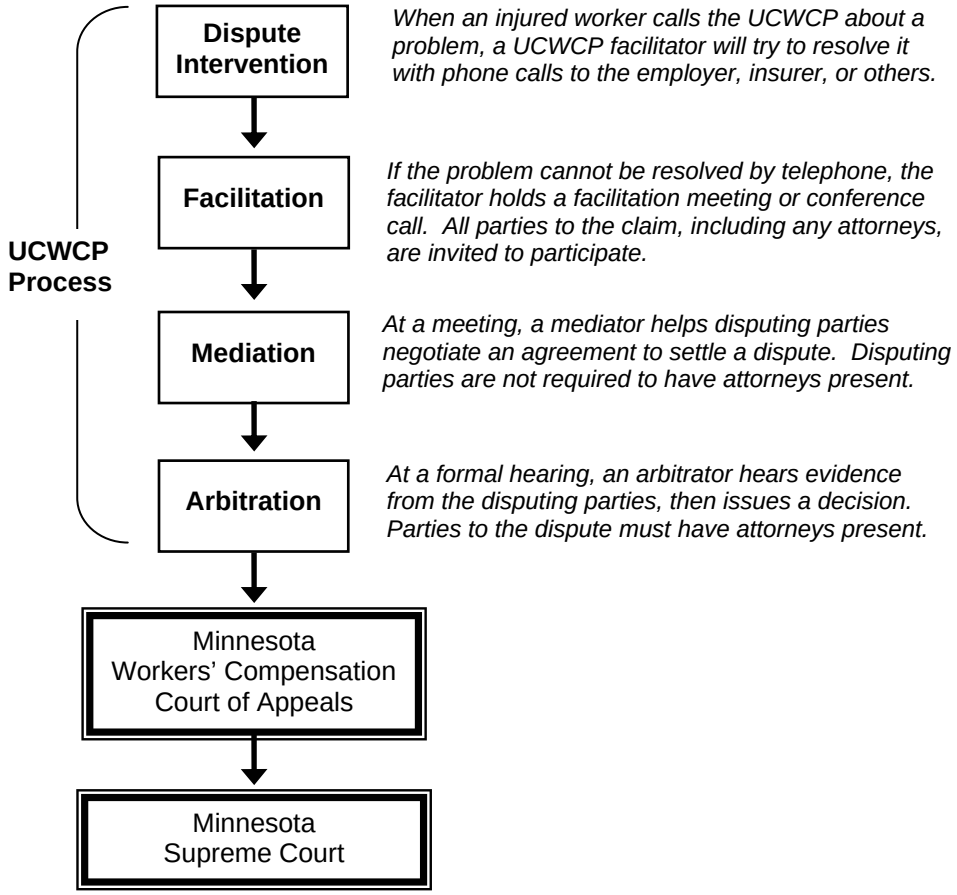
Process Comparison

The UCWCP's dispute resolution process is simpler than the state system in several ways. First, the UCWCP dispute resolution process uses a single entity to resolve disputes, unlike the state, which uses two (DLI and OAH). Second, as shown in Figure 3.2, the UCWCP process has a single path and fewer steps than the state's process (shown in Figure 3.1). Nearly all disputes in the UCWCP process use the same sequence of steps—dispute intervention, facilitation, mediation, and arbitration—although disputes typically do not reach the later stages.[9] This is a notable contrast to the state system's multiple steps and paths, the sequence of which varies from case to case. The UCWCP also simplifies the

[8] Dispute records contain information on the employees and claims associated with them. If needed, the system can be programmed to group dispute records by claim or individual.

[9] Some disputes may go directly to mediation. To further speed the process, parties in a dispute over primary liability can bypass mediation and go directly to arbitration.

Figure 3.2: Dispute Resolution Process in the Union Construction Workers' Compensation Program (UCWCP), 2008



NOTE: The UCWCP Board of Trustees selects private attorneys who know workers' compensation law for a panel of available mediators and arbitrators. In most cases, UCWCP staff select from the panel to assign a mediator or arbitrator to each case (working in alphabetical order as cases arise). Under some circumstances, parties can mutually request a particular panel member. For each case, the UCWCP asks the mediator/arbitrator to assess whether they have any conflicts of interest in the case. If so, they contact the parties to disclose the conflict and/or recuse themselves.

SOURCE: Office of the Legislative Auditor, compilation from documents describing the Union Construction Workers' Compensation Program.

dispute resolution process by treating each case as a whole. All disputes related to a claim are considered together.

Finally, the UCWCP uses neutral physician examiners and exclusive treatment providers that are jointly selected by participating employers and unions. In contrast, workers and insurers can generally choose their own doctors for

examinations and treatment under the state system.[10] The rationale for the UCWCP approach is that it makes the process less adversarial and shorter by reducing disagreements. The disadvantage is that injured workers are required to choose a doctor from the program's physician network.

Cost Comparison

Workers' compensation costs under the UCWCP are lower than those for comparable construction workers using the state system.

Workers' compensation costs under the UCWCP are lower than those for comparable construction workers using the state system. For policy years 2003 through 2005, we estimated that insurers will pay 43 percent less in workers' compensation costs per $100 of payroll for UCWCP participants than for comparable construction workers in the state program.[11] Both indemnity and medical payments were substantially lower under the UCWCP (50 percent lower for indemnity benefits and 37 percent for medical benefits). Almost all of the difference in medical payments occurred on indemnity claims. There was very little difference in medical benefit payments for medical-only claims.

Supporters of UCWCP argue that the program reduces costs because it resolves disputes more quickly and results in a faster return to work for injured employees. Comparable data on time to resolve disputes was not available, but lower dispute rates and lower costs for the UCWCP suggest that the UCWCP resolves disputes more quickly than the state system.

Impact on Injured Workers

To assess the quality of injured workers' experiences under the UCWCP and state system, we compared denial rates, dispute rates, and injured workers' satisfaction with their claim experience. We found that:

- **Though limited, evidence suggests that injured workers in the UCWCP fare as well as, if not better than, comparable workers using the state system.**

Insurers denied claims of construction workers in the UCWCP slightly less often than they did for comparable construction workers in the state system. We estimated that from January 2003 to July 2008, insurers denied primary liability for an average of 10.2 percent of UCWCP claims, compared with 11.1 percent for comparable workers in the state system. Insurers also made fewer "type 2"

[10] Some employers participate in a workers' compensation certified managed care plan that has been certified by the state to manage health care for injured workers. Injured workers of participating employers must use providers in the managed care plan under most circumstances.

[11] Our comparisons are based on data compiled by DLI from UCWCP's annual reports and Minnesota Workers' Compensation Insurance Association's annual ratemaking reports. To identify construction workers comparable to the UCWCP participants, DLI used the 10 (11 for 2005) construction classifications with the largest payroll covered by the UCWCP. These top classifications account for about 70 percent of the UCWCP's total covered payroll.

denials for UCWCP claims.[12] For the same five-and-a-half-year period, insurers made type 2 denials in 7.8 percent of UCWCP claims compared with 9.9 percent for construction worker claims in the state system.

Injured workers are less likely to have disputes that require formal dispute resolution activity under the UCWCP than the state system. Although the two systems use different processes to resolve disputes, we defined formal stages to be facilitations that involve a meeting, mediation, and arbitration for the UCWCP and mediation, administrative conferences, and OAH hearings for the state system. Over the last three years for which we have data, disputed claims in the UCWCP were less likely to reach the formal dispute stage (20 percent compared with 25 percent under the state system).[13]

Injured workers in the UCWCP are less likely to have disputes that require formal dispute resolution activity.

We compared survey responses of likely UCWCP participants who made a workers compensation claim in 2006 or 2007 with construction workers who had a claim under the state system.[14] Among 14 questions about their claim experience, results were mixed—some favored the UCWCP and others favored the state system, as shown in Tables 3.8 and 3.9. Only two differences were statistically significant: UCWCP claimants were less likely to agree that it took too long for their benefits to start, while state claimants were more likely to be satisfied with their vocational rehabilitation providers. Large majorities of both groups were satisfied with their health care providers, even though UCWCP participants were required to select providers from a network established by the program.

Lower workers' compensation benefits for injured workers do not necessarily mean that the workers are financially worse off. By state law, injured workers under both systems are entitled to the same benefit levels; they receive the same compensation for wage loss, permanent impairment, and medical expenses.[15] Cost differences may arise because workers return to work more quickly under one system than the other (the goal of the UCWCP).

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[12] As discussed in Chapter 2, an insurer can accept overall liability for a claim (acknowledging a work-related injury) but deny payment of indemnity benefits. Denials under these circumstances are referred to as "type 2" denials.

[13] The data is based on dispute resolution activity between January 1, 2006, and August 1, 2008, for UCWCP, between July 1, 2005, and June 30, 2008, for OAH, and January 1, 2006, and December 31, 2008, for DLI. Because UCWCP-reported dispute resolution activity for 2 years and 7 months, we compared this activity with 2 years and 7 months of UCWCP indemnity claims.

[14] DLI's claims data do not identify whether a claimant participates in the UCWCP. Using data available in the claims database and information provided by the UCWCP, we identified likely UCWCP participants as those claimants who had a construction job when injured and worked for an employer participating in the UCWCP. Our "likely UCWCP participant" group may include some nonparticipants because some employers who participate in the UCWCP have multiple unions representing construction workers. Workers are covered by the UCWCP only if both their employer and union agree to participate in the program. To restrict our state system comparison group to construction workers who are more likely to be union members, we excluded construction workers with weekly wages under $600.

[15] *Minnesota Statutes* 2008, 176.1812, subd. 4.

Table 3.8: Opinions About the Claim Experience, Union Construction Workers' Compensation Program Compared with the State System, 2008

	Percentage of Survey Respondents Who Agreed or Strongly Agreed	
(*N*=UCWCP, state)	Union Construction Workers' Compensation Program (UCWCP)	Likely Union Construction Workers Using State System
I knew how to get the workers' compensation process started when I got hurt on the job. (*N*=90, 142)	68%	68%
My employer has helped me get the benefits I need. (*N*=88, 138)	77	68
Getting workers' compensation benefits has been a frustrating experience. (*N*=85, 140)	42	48
I felt sufficiently informed about my rights. (*N*=88, 141)	60	65
The insurance company handling my claim has treated me fairly. (*N*=88, 139)	65	54
I have had no trouble getting the medical treatment I need. (*N*=89, 147)	72	78
A person who gets hurt on the job should talk to a lawyer as soon as possible about workers' compensation. (*N*=76, 118)	48	48
It took too long for my benefits to start. (*N*=83, 130)	24	41

NOTES: None of the differences between the two systems was statistically significant at the 95-percent confidence level except "It took too long for my benefits to start." The above figures (*N* and percentage who agreed) were calculated after excluding respondents who did not answer the question or had no opinion.

DLI's claims data do not identify whether a claimant participates in the UCWCP. We identified likely UCWCP participants as those claimants who had a construction job when injured and worked for an employer participating in the UCWCP. To restrict our state system comparison group to construction workers who are more likely to be union members, we excluded construction workers with weekly wages under $600.

SOURCE: Office of the Legislative Auditor, analysis of survey responses from workers' compensation claimants, September 2008.

Table 3.9: Claimants' Satisfaction with Various Parties, Union Construction Workers' Compensation Program Compared with the State System, 2008

(*N*=UCWCP, state)	Percentage of Survey Respondents Who Were Satisfied or Very Satisfied: Union Construction Workers' Compensation Program (UCWCP)	Likely Union Construction Workers Using State System
Your employer's actions after you reported the injury or illness (*N*= 89, 143)	77%	67%
The health care providers who treated you (*N*=90, 146)	79	85
The insurance company that handled your claim (*N*=89, 142)	66	55
Your attorney (*N*=18, 62)	94	82
Your vocational rehabilitation providers (*N*=33, 72)	76	90
State agency or UCWCP employees that you contacted for help (*N*=28, 65)	61	72

NOTES: None of the differences between the two systems was statistically significant at the 95-percent confidence level except for satisfaction with vocational rehabilitation providers. The above figures (*N* and percentage who were satisfied) were calculated after excluding respondents who did not answer the question, had no opinion, or who said the statement did not apply.

DLI's claims data do not identify whether a claimant participates in the UCWCP. We identified likely UCWCP participants as those claimants who had a construction job when injured and worked for an employer participating in the UCWCP. To restrict our state system comparison group to construction workers who are more likely to be union members, we excluded construction workers with weekly wages under $600.

SOURCE: Office of the Legislative Auditor, analysis of survey responses from workers' compensation claimants, September 2008.

High-wage workers have a strong financial incentive to get back to work quickly.

To the extent that UCWCP participants get back to work earlier, they would be better off financially because workers' compensation benefits only partially compensate injured workers for their lost wages and benefits. For example, as of October 2008, wage-loss benefits equal two-thirds of an injured worker's gross wages up to a maximum of $850 per week. The maximum weekly benefit payment is reached with a weekly wage of $1,275 or an annual wage of $66,300. Union construction workers earning more than this wage are compensated at less than two-thirds of their weekly wage. In addition, workers' compensation does not cover losses in nonwage benefits, such as pension and health insurance benefits, which typically do not accrue for union construction workers when they do not work. Union construction workers, therefore, have a strong financial incentive to get back to work quickly. Unfortunately, we could not evaluate the two systems with respect to return-to-work time because comparable data were not available.

While we cannot conclude that injured workers are better off under the UCWCP, we found no evidence that they are worse off. Since the UCWCP has lower denial rates, lower costs, and no evidence of greater worker dissatisfaction, and since it is a much simpler system, we conclude that it is worth considering broader use of the UCWCP approach in Minnesota.

Recommendations

RECOMMENDATION

The Legislature should amend state law to establish an ombudsperson for injured workers.

An ombudsperson would help those injured workers who are overwhelmed with the workers' compensation process.

The Legislature has established ombudspersons to assist Minnesotans involved with other state programs, including the Taxpayer Rights Advocate, Ombudsman for Managed Health Care Programs, and Ombudsman for Mental Health and Developmental Disabilities.[16] We recommend that the Legislature establish a similar position specific to workers' compensation. As in other programs, we would expect an ombudsperson for injured workers to provide a fresh look at claimants' individual situations, problem-solve, and suggest options to claimants' dilemmas. DLI's dispute resolution staff cannot play such a role because they are to act impartially; the ombudsperson would provide a separate avenue for injured workers who want assistance focused on their point of view. We learned through our surveys that some injured workers feel overwhelmed with the workers' compensation process and lost in the system. An ombudsperson for injured workers would be a single point of contact for workers in similar circumstances.

The legislature could consider already-existing models for organizing the function. Options include establishing the office within the Department of Labor and Industry, as an independent state agency, or as an arm of an affiliated council or board.[17] In a December 2008 report, the Commissioner of Labor and Industry presented a Workers' Compensation Advisory Council proposal to create a workers' compensation ombudsperson office as part of another administrative initiative.[18] This proposal could be a starting point for the Legislature as well. With any option, we think it is essential that the position be established outside of DLI's Workers' Compensation Division.

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[16] *Minnesota Statutes* 2008, 270C.37; 256B.69, subd. 20; and 245.92.

[17] The Office of Ombudsman for Long-Term Care is an office of the Minnesota Board on Aging. The Office of the Ombudsman for Mental Health and Developmental Disabilities is an independent state agency. The Taxpayer Rights Advocate is located in the Department of Revenue as a direct report to the Commissioner. Similarly, the Office of Ombudsman for State Managed Health Care Programs is in the Department of Human Services.

[18] Minnesota Department of Labor and Industry, *Commissioner Recommendations, Workers' Compensation Advisory Council* (St. Paul, December 2008).

RECOMMENDATION

The Department of Labor and Industry and Office of Administrative Hearings should continue work on streamlining the dispute resolution process, with an emphasis on reducing the forms used to enter the system and focusing on individual workers and claims instead of disputes.

The state's dispute resolution process needs to be streamlined, and aspects of the UCWCP serve as a model.

There are several ways in which DLI, OAH, and the Legislature could simplify the workers' compensation system. DLI and OAH have already been working to consolidate disputes that are part of the same case. Restructuring the system to focus on claims and individuals rather than disputes would further enhance this effort. DLI could increase its early intervention efforts by holding meetings between all involved parties if an issue cannot be resolved quickly by phone or e-mail. The facilitation step used by UCWCP could serve as a model. Among the options that the Legislature could consider is greater use of neutral doctors. We have not studied all the effects of this option, but the UCWCP appears to have effectively used this approach.

Officials from both DLI and OAH said that the dispute resolution system needs to be streamlined across the two departments. One option is to assign conference duties to one organization. One DLI manager suggested that making a clear division between conference and trial duties would go a long way toward cleaning up the system. DLI officials suggested putting all conferences at DLI, leaving trials at OAH. However, OAH officials argued that most conferences already take place at OAH, so it would make sense to consolidate there. We do not make a judgment on which option to pursue. Any decisions to consolidate will have to be made in light of the budget and staffing situation following the 2009 legislative session.

RECOMMENDATION

To expand use of alternate workers' compensation programs like the Union Construction Workers' Compensation Program, the Department of Labor and Industry should (1) provide assistance to employers and unions in other industries that are interested in establishing alternate systems, and (2) evaluate establishing an alternate system for unionized state of Minnesota employees.

We support broader use of alternate systems like the UCWCP. DLI staff told us that employers and unions from industries other than construction may be interested in establishing alternate systems. The impetus for any new program must come from the industry employers and unions, but we think DLI could support the process with outreach and technical assistance. Another opportunity exists within Minnesota state government and its unionized workforce. The state as an employer and public employee unions could establish an alternate workers' compensation system through collective bargaining. As a first step, we recommend that DLI study how such a system might be structured.

RECOMMENDATION

The Department of Labor and Industry and the Legislature should make information system upgrades to improve tracking of individuals and cases.

Day-to-day handling of disputes and dispute resolution practices is intertwined with the design of DLI's information system. DLI and OAH staff are aware of the limitations in the claims administration database that undermine efficient management of the dispute resolution process. Specifically, the system needs to better allow tracking of dispute data by person and case. Our recommendation here goes along with similar recommendations in Chapter 2. All require legislative support and are intended to underscore the urgency of implementing the department's plans to improve its workers' compensation information system.

RESOLUTION OF DISPUTES

According to state law, DLI must make efforts to settle disputes between employees and employers by contacting parties in the dispute and using the department's persuasion to settle issues quickly and cooperatively. This obligation to make efforts to settle problems exists whether or not a formal dispute has been filed with the department. As a result, DLI staff offer early, informal dispute resolution as well as providing dispute resolution assistance once a dispute has formally entered the system.

DLI's policy is to help get disputes settled as early as possible.

Because long disputes can be economically harmful to workers, DLI's policy is to help get disputes settled as early as possible. In 2005, DLI reorganized its dispute resolution program to increase focus on obtaining resolutions early in a dispute's life cycle. In 2007, the department began to more actively encourage disputing parties to look for mutual agreement, offering DLI mediation services to assist. Department managers reiterated to their staff the DLI policy to resolve issues as quickly as possible. To help resolve more disputes before an administrative conference or hearing is required, managers also realigned 3 of 14 dispute resolution specialists to focus on mediations. The department set performance expectations that the 3 staff conduct eight mediations a month and increase outreach regarding DLI's mediation services. The remaining 11 staff are expected to complete two mediations per month.[19]

Informal Assistance

Individuals may contact DLI by telephone or in writing, or they may walk in with questions or concerns about workers' compensation claims. DLI dispute resolution staff are to respond with informal assistance. For example, one type of informal assistance is providing information, the purpose of which is to help

[19] Some of the dispute resolution staff we interviewed said they disagreed with the decision to realign three specialists to mediation. They were concerned that the remaining staff would not be able to keep up with existing demand for administrative conferences, particularly with the added expectation to do two mediations a month.

DLI staff provide information and informal assistance to employees and others who call or write with questions.

parties have appropriate expectations about the workers' compensation process and avoid or resolve disputes on their own. DLI staff may also intervene more actively to resolve problems, by calling an insurance representative on behalf of an injured worker, for example.

We examined DLI's early, informal dispute resolution activities and found that:

- **DLI's success in resolving problems through informal assistance and intervention has declined since 2000, as did the number of parties requesting help.**

The number of requests for informal assistance declined after 2000, as shown in Table 3.10. In 2000, DLI recorded 5,482 requests for assistance. The number of requests recorded declined to a low of 1,765 in 2006 and grew to 4,025 in 2007—short of 2000 levels.[20] Informational assistance and problems resolved through DLI staff intervention also declined. For example, DLI intervened to help resolve problems in 967 cases in 2000. Such intervention resulted in

Table 3.10: Disposition of Requests for Informal Assistance from the Department of Labor and Industry, 2000 to 2007

		Type of Disposition				
	Number of Requests for Informal Assistance[a]	Information Provided	Intervention by Staff and Problem Resolved	Referred to Different DLI Unit	Issue Left Pending	Other Outcome[b]
2000	5,482	1,489	967	342	680	2,004
2001	5,494	1,604	744	546	614	1,986
2002	4,727	1,997	1,109	79	722	820
2003	2,979	1,177	873	43	628	258
2004	2,963	1,078	834	39	715	297
2005	2,356	879	719	24	521	213
2006	1,765	1,047	291	9	155	263
2007	4,025	2,472	637	166	408	342

[a] DLI staff log each contact with a party requesting assistance. For this table, multiple contacts with the same staff person were counted as a single request. On average, there were 1.6 contacts per request from 2000 to 2007. One-contact requests accounted for 69 percent of the total, and only 0.3 percent of requests had more than 10 contacts. According to DLI, changes in the way staff recorded requests for assistance may account for some of the variation in the number recorded.

[b] Other outcomes include cases that were not resolved and went on to be addressed in the formal dispute resolution process.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry informal requests for assistance data.

[20] According to DLI, some of this variation over time is due to changes in how staff recorded requests for informal assistance and related outcomes. Over the years, DLI has revised its definition of terms and record-keeping requirements to improve consistency.

problem resolution for only 291 cases in 2006 and 637 in 2007. Some of the requests were for information only. Looking at staff-assisted resolutions as a proportion of requests other than information-only, the percentage of cases in which DLI provided a resolution ranged from 24 percent in 2000, to a high of 48 percent in 2003, and back to 41 percent in 2006 and 2007.

If not resolved quickly, small issues often escalate into full disputes.

The decline in early dispute resolutions has important consequences. According to DLI staff, many disputes in the formal dispute resolution system start with small issues (such as an adjuster mistake worth $500 in benefits). If not resolved quickly, these small issues often escalate. For example, a late response by the insurer can lead an injured worker to hire a lawyer who then places the dispute into the formal dispute resolution process. DLI staff said when that happens, more issues often get added to the dispute as bargaining chips.

The decline in early, informal resolutions may be partly responsible for the rising dispute rate we described earlier in this chapter. Issues that become formal disputes may take a long time to resolve and are more likely to significantly deplete the resources of the parties to the dispute and of the workers' compensation system.

Formal Disputes Handled at DLI

Once an issue becomes a formal dispute, DLI still prefers to see it resolved voluntarily before it reaches an administrative conference. In fact, many disputes handled by DLI are resolved prior to an administrative conference and without mediation, as shown in Table 3.11. In 2008, 75 percent of disputes were resolved prior to mediation or an administrative conference, about 6 percent were resolved through mediation and the remaining 19 percent were resolved through an administrative conference. [21]

Nevertheless, after examining the trend in dispute resolution activities at DLI, we found:

- **Over the past eight years, the department has not made substantial progress resolving disputes prior to an administrative conference.**

Since 2000, the proportion of disputes resolved prior to an administrative conference fluctuated between 75 and 80 percent, except in 2006. The percentage of disputes resolved prior to mediation or administrative conference declined from 79 percent in 2000 to a low of 69 percent in 2006, then rose to 75 percent in 2007 and 2008.

[21] Disputes that are resolved by a decision and order after an administrative conference at DLI may be appealed to OAH. The case is resolved in the sense that it reached the end of the process at DLI.

Since 2000, the proportion of disputes resolved prior to an administrative conference fluctuated between 75 and 80 percent.

Table 3.11: Dispute Resolution Trends at the Department of Labor and Industry, 2000 to 2008

	Disputes Closed Out from DLI's Dispute Resolution Process	Agreements Reached Outside of Mediation or Administrative Conference	
		Number	Percentage
2000	5,004	3,960	79%
2001	4,748	3,805	80
2002	5,358	4,139	77
2003	5,221	4,093	78
2004	5,364	4,201	78
2005	5,025	3,780	75
2006	4,956	3,424	69
2007	6,166	4,615	75
2008	6,792	5,102	75

NOTE: Disputes closed out of DLI's dispute resolution process include disputes resolved prior to dispute certification, cases withdrawn and cases whose decision at an administrative conference was appealed to the Office of Administrative Hearings.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry dispute resolution data.

Mediations, which are also used to resolve a dispute voluntarily before an administrative conference, declined between 2001 and 2006 but rapidly increased during the next two years. As shown in Table 3.12, the number of mediations held by DLI declined from 356 in 2000 to a low of 204 in 2006. By 2008, the number of mediations increased to 463 because, according to DLI, the department increased emphasis on encouraging parties to use mediation.

Table 3.12: Mediations and Administrative Conferences Held by the Department of Labor and Industry, 2000 to 2008

	Mediations	Administrative Conferences	Total
2000	356	694	1,050
2001	283	677	960
2002	358	839	1,197
2003	343	756	1,099
2004	248	949	1,197
2005	252	1,037	1,289
2006	204	1,358	1,562
2007	278	1,316	1,594
2008	463	1,281	1,744

SOURCES: Department of Labor and Industry data on dispute resolutions.

As the number of early interventions and mediations declined, the number of administrative conferences has grown, as shown in Table 3.12. Between 2000 and 2008, the number of administrative conferences held by DLI increased by about 85 percent. Another factor that explains some of the increase in administrative conferences is that the 2005 Legislature changed the maximum threshold for medical disputes handled by DLI from $1,500 to $7,500. The subsequent decline in OAH administrative conferences for medical disputes indicates that this change explains roughly 40 percent of the growth in administrative conferences at DLI.

Formal Disputes Handled at OAH

OAH conducts the majority of administrative conferences and all hearings for workers' compensation disputes. Both DLI and OAH try to settle disputes prior to holding an administrative conference or hearing at OAH. Minimizing the number of hearings held at OAH is especially important because it is the last and most formal administrative stage in the state's dispute resolution process. After analyzing trends in conferences and hearings conducted by OAH, shown in Table 3.13, we found that:

The number of hearings held at OAH did not keep pace with the decline in disputes, which was a missed opportunity to reduce the time and expense needed to resolve disputes.

- **The state has made little progress reducing the number of costly and time-consuming workers' compensation hearings.**

As we discussed earlier, the number of workers' compensation claims and disputes has been declining in Minnesota. Between 2000 and 2007, the number of disputes declined by about 20 percent.[22] The number of hearings held at OAH, however, did not fall as much—a missed opportunity to reduce the time and expense needed to resolve disputes. Between 2000 and 2008, the number of hearings held by OAH declined by 16 percent. It fluctuated from 753 hearings in 2001 to over 900 in 2004 and 2006, then dropped to 718 in 2008. During the same time period, the number of administrative conferences held by OAH declined by 26 percent, going from 5,185 to 3,812.[23] Since this decline roughly parallels the decline in disputes, the percentage of disputes reaching this stage is slowly improving.

[22] 2008 dispute rate data were not available.

[23] The number of OAH administrative conferences for 2000 is not available. The 26 percent decline was calculated for 2001 to 2008. The number of OAH medical and rehabilitation conferences (a subtype of OAH administrative conferences) declined by 50 percent during this period, primarily because of the change in jurisdiction threshold made by the 2005 Legislature. Excluding medical and rehabilitation conferences, the number of OAH administrative conferences decreased by 24 percent.

Table 3.13: Dispute Resolution Activity at the Office of Administrative Hearings, 2000 to 2008

	Administrative Conferences	Hearings	Total
2000	Not available	851	Not available
2001	5,185	753	5,938
2002	5,807	795	6,602
2003	5,295	895	6,190
2004	4,800	914	5,714
2005	4,707	860	5,567
2006	4,254	910	5,164
2007	4,173	814	4,987
2008	3,812	718	4,530

NOTE: Administrative conferences include conferences often referred to as settlement conferences, discontinuance conferences, and medical and rehabilitation conferences.

SOURCE: Office of the Legislative Auditor, analysis of Department of Labor and Industry dispute resolution data.

Settlement Agreements

Because settling disputes as early as possible is an important goal of the workers' compensation dispute resolution system, we examined issues associated with certain types of settlement agreements more closely. We found that:

- **Concerns about the impact of some settlement agreements on injured workers merit further study.**

Settlement agreements are voluntary, written agreements to close a claim or end a dispute.

Settlement agreements are voluntary, written agreements to close a claim or end a dispute.[24] They can be "full, final, and complete" settlements, in which the claimant agrees to give up the right to all future benefits (or more often, all future benefits except medical) in exchange for a lump-sum payment. Or they can be "to date" settlements that provide for a lump-sum payment to settle a claim for a time period of benefits, such as January 1 to June 30 (claim activity after June 30 would then proceed normally). Agreements must be approved with a signature from a workers' compensation judge or DLI dispute resolution specialist.

Some stakeholders that we interviewed were concerned that injured workers can be shortchanged by agreeing to these lump-sum settlements. Chief among these concerns is terminating workers' compensation benefits when the injured worker has not gone back to work.

We found the employment issue to be a valid concern. In our survey of workers who had workers' compensation settlement agreements, about 30 percent of

[24] A more formal name for the type of settlements discussed in this section is "stipulation for settlement." A stipulation for settlement is documented in either a "mediation award" or "award on stipulation."

About 30 percent of injured workers surveyed reported being unemployed after settling their workers' compensation claims.

respondents reported that they were unemployed at the time of the survey because of their work-related injury. Four percent reported being unemployed for other reasons. Similarly, settlement agreements can end vocational rehabilitation plans before they are completed. As shown in Table 3.14, for 2004 to 2006, when vocational rehabilitation plans were completed as intended and closed, nearly all injured workers were back to work at the time of plan closure. When a plan was not completed but closed to settle a claim, far fewer of the employees were back to work at the time of settlement and plan closure—about 29 percent in 2006.[25]

Table 3.14: Percentage of Employees Back to Work When Their Vocational Rehabilitation Plans Closed, 2004 to 2006

	Percentage of Injured Workers Back to Work		
Reason Plan Was Closed	2004	2005	2006
Plan completed	99%	99%	98%
Claim settled, plan not completed	18	27	29

SOURCE: Department of Labor and Industry, unpublished data on vocational rehabilitation plan closures, 2008.

This survey response typifies comments from claimants who felt dissatisfied with their situations after settlement:

> My employer and their insurance company made me feel like a criminal. My employer begged me not to file a claim because they just wanted me to get better and come back to work. But in the meantime, they contacted their insurance company and told them that I failed to file in the proper amount of time, which left me no choice but to hire an attorney. Because of escalating bills I was forced to accept the first offer they gave me. Because of my injury, I can now only work a part-time job and it has changed my and my family's lives considerably.

Another respondent wrote:

> I had to go in debt with my credit cards. I was expecting a check every 2 weeks. Never got it. My settlement equaled a year's pay. I didn't get compensation for the injury itself, or for pain and suffering. My medical is open. I had to settle because of the added debt I was getting in. It took me a year to get another job. It was a terrible experience. I hope this helps others trying to get benefits right away. I wish I could have waited. My attorneys didn't work hard for me or to my best interest.

[25] In 2006, just over half (53 percent) of vocational rehabilitation plans were worked to completion. About 27 percent of plans were closed as part of a settlement agreement, but uncompleted.

Timing is another concern. Some early settlements may be finalized without sufficient information to make a good valuation of the claim. A senior OAH official pointed out that it can take quite some time—months or a year or more—to know the end result of the injury and any work restrictions. In his professional opinion, hasty settlements—before the employee's work status is clearly understood—can be very detrimental to the worker. He added that there is a place for early intervention, but speed must be balanced with deliberation.

Determining the settlement value of a claim can be very complicated. Injured workers' perceptions regarding the monetary value of their claims may not match actual valuations determined by OAH or DLI in similar cases. DLI dispute resolution staff are prohibited from assigning a monetary value to injured workers' claims. Staff may advise parties of methods to calculate the reasonable value of a claim, if appropriate.

DLI staff said that the department plans to help educate injured workers about the realistic values of their claims. Educational materials would include historical data on types of injury and their typical settlement amounts along with a discussion of the factors considered in the valuation process. DLI said that providing better information to injured workers might help prevent some workers from agreeing with settlements that are too small and others from continuing with disputes when they have unrealistic expectations about the size of the settlement.

Some survey respondents reported feeling pressured to settle, and only 35 percent agreed that parties negotiated fairly.

Many injured workers who responded to our survey reported that they were unhappy with the settlements they had agreed to. For example, only 21 percent of survey respondents who settled their claims either agreed or strongly agreed that the amount of their settlement was fair. Only 35 percent agreed or strongly agreed that the parties negotiated fairly. Some survey respondents commented that they felt pressured to settle. For example, one respondent wrote: "After waiting 2 1/2 years to get my workman's compensation hearing, I settled because I drastically needed money at the time. I gave up on future rights to medical help and benefits because I was desperate for money." Another respondent wrote: "I was told that if I don't settle the judge will throw the case out and I would have to pay all the bills myself." Nevertheless, 57 percent of respondents agreed or strongly agreed that settling was the right thing to do.

Most workers responding to our survey reported that they understood the terms of the settlement they were agreeing to, but other evidence suggests that they were less informed than desirable. About 75 percent of survey respondents agreed or strongly agreed that the terms of the settlement had been clearly explained to them. Only about half agreed that someone had clearly explained how the lump-sum payment should be reported on tax returns. We also asked if the worker had gone to a financial advisor for input about the settlement before agreeing to it. No respondents reported doing so.

Recommendations

RECOMMENDATION

The Department of Labor and Industry should encourage workers, employers, and insurers to take greater advantage of early assistance opportunities.

Because the consequences of long-delayed workers' compensation benefits can be harmful to workers, we agree with DLI's emphasis on resolving disputes as early as possible. We are concerned by the apparent decline in informal resolutions of problems. Preventing and resolving problems before they enter the formal dispute resolution process benefits all parties in the workers' compensation system. DLI should boost its education and communication efforts to encourage workers' compensation participants to take advantage of its informal dispute resolution assistance.

RECOMMENDATION

To ensure that voluntary settlements are in the workers' best interests, the Department of Labor and Industry should track settlement terms and outcomes for the workers and, as needed, adjust the criteria for approving such awards.

DLI should do more to track the terms of settlement agreements and their impact on injured workers.

Once a dispute has entered the formal dispute resolution process, however, it is more difficult to discern the optimal timing of a voluntary settlement. Too early, and a worker may settle before knowing the long-term impact of his or her injury. Too late, and the injured worker may be in desperate financial straits and feel forced to settle for far less than the full value of benefits due. Hence, we think it is important for DLI to do more to track the terms of settlement agreements and their impact on injured workers. Workers should not be settling workers' compensation claims under terms that defeat the purpose of workers' compensation—helping injured workers recover their health and get back to work at a wage comparable to what they earned before being injured.

List of Recommendations

- The Department of Labor and Industry should expand its computerized monitoring of claims to screen for more types of potential errors (p. 27).
- The Department of Labor and Industry should expedite its plans to enter more data into the workers' compensation information system in order to create more searchable data fields (p. 27).
- The Department of Labor and Industry should monitor claim and benefit data to identify and address trends indicating that injured workers may not be getting appropriate access to benefits at the time they need them (p. 27).
- The Department of Labor and Industry should reduce the time lag between the receipt of the cancelled-policy list and the instigation of mandatory coverage investigations (p. 41).
- The Department of Labor and Industry should pursue the use of unemployment insurance data to identify employers that lack workers' compensation insurance (p. 41).
- The Department of Labor and Industry should consider increasing staffing in its Claims Services and Investigations unit (p. 42).
- The Department of Labor and Industry should (1) reorganize its data system to better track investigations, benefits paid from the Special Compensation Fund, and reimbursement information; and (2) use these data to evaluate its process for obtaining reimbursements from employers (p. 47).
- The Legislature should amend state law to establish an ombudsperson for injured workers (p. 66).
- The Department of Labor and Industry and Office of Administrative Hearings should continue work on streamlining the dispute resolution process, with an emphasis on reducing the forms used to enter the system and focusing on individual workers and claims instead of disputes (p. 67).
- To expand use of alternate workers' compensation programs like the Union Construction Workers' Compensation Program, the Department of Labor and Industry should (1) provide assistance to employers and unions in other industries that are interested in establishing alternate systems, and (2) evaluate establishing an alternate system for unionized state of Minnesota employees (p. 67).
- The Department of Labor and Industry and the Legislature should make information system upgrades to improve tracking of individuals and cases (p. 68).
- The Department of Labor and Industry should encourage workers, employers, and insurers to take greater advantage of early assistance opportunities (p. 76).
- To ensure that voluntary settlements are in the workers' best interests, the Department of Labor and Industry should track settlement terms and outcomes for the workers and, as needed, adjust the criteria for approving such awards (p. 76).

443 Lafayette Road N.
St. Paul, Minnesota 55155
www.doli.state.mn.us

MINNESOTA DEPARTMENT OF
LABOR & INDUSTRY

(651) 284-5005
1-800-DIAL-DLI
TTY: (651) 297-4198

February 13, 2009

James Nobles
Office of the Legislative Auditor
Room 140 Centennial Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

The Department of Labor and Industry has received your report entitled "Oversight of Workers' Compensation." On behalf of the management and staff, I appreciate the work of your staff and feel the recommendations listed in the report are on point with the direction and needs of our workers' compensation system in Minnesota.

Our agency's mission is to best serve the citizens of Minnesota with a system that is impartial, just and fair to all; especially to the two most important stakeholders: the injured workers and the businesses that pay the premiums.

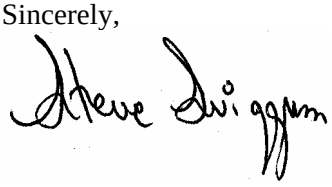
As you know, our agency has a unique structure for the advancement of reform within the workers' compensation system by using a Workers' Compensation Advisory Council to determine the course and scope of all legislative initiatives. We are working diligently with the council to develop reforms in line with your recommendations this legislative session. Specifically, we have brought forth the following recommendations to the council:

- To streamline the alternative dispute resolution process by expanding a Union Construction Workers' Compensation Program and realigning the duties between the Office of Administrative Hearings and our agency.
- To allocate funding for improvements to the information technology systems.

In addition, the department is interested in pursuing the use of an ombudsperson in a manner that will not compromise our neutrality.

I appreciate your acknowledgement of our continued improvement efforts as we strive to assure in an equitable and impartial manner, the quick and efficient delivery of benefits to injured workers at a reasonable cost to employers.

Sincerely,



Steve Sviggum
Commissioner

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