Minnesota Workers' Compensation System Report

DEPARTMENT OF LABOR AND INDUSTRY

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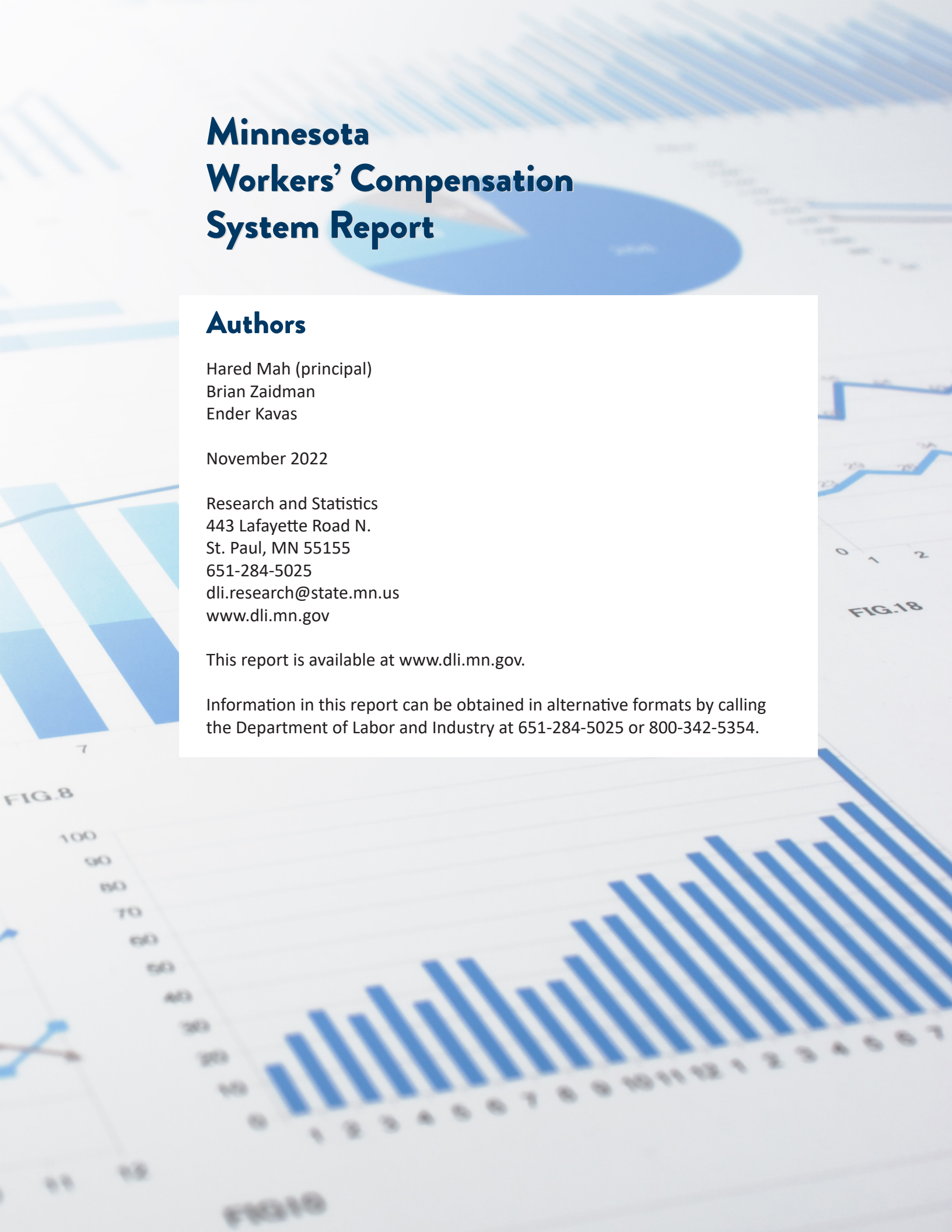

Executive summary

The 2022 Workers' Compensation System Report presents trend data from 2000 to the present regarding several aspects of Minnesota's workers' compensation system: claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

The report includes COVID-19 claims with injury dates during calendar-year 2020 and filed through September 2021. Some of the statistics involve activities that took place in 2020 for workers' compensation claims that occurred in 2019 and earlier years. The impact of COVID-19 on overall claims – benefits, costs and developed statistics (see pages 2 and 3) – is detailed in subsequent chapters. In January 2021, the Department of Labor and Industry (DLI) produced a report about the first six months of COVID-19 workers' compensation claims. DLI posts updated COVID-19 claims statistics on its COVID-19 resources webpage.[1]

Note about the report timelines and trends

The statistics are computed using the most recently available data from various sources, which leads to different data years being presented for different measures. DLI statistics about claims, cost and indemnity benefits are displayed using the most recent injury year of 2020, while some vocational rehabilitation statistics include data for the most recent plan-closure year of 2021. Statistics about dispute-resolution filings and timelines are displayed by the year the dispute was filed or by the year an action occurred and are presented through 2021. The report also includes statistics reported by policy year or fiscal year.

In the past couple of years, the workers' compensation system presents two faces: one for the whole system, including COVID-19 claims; and the other excluding the COVID-19 claims, showing a pattern more similar to prior years. DLI believes it is important for the public to be aware of how COVID-19 affected the entire workers' compensation system, as well as to show the extent to which the trends for non-COVID-19 claims were affected.

The following are the major findings of the report.[2]

Part 2 – Claims, benefits and costs – overview

- There were 4.0 total paid claims per 100 full-time-equivalent (FTE) workers in 2020, down 51% from 2000. (The decline from 2000 to 2019 was 49%.)

[1]The legislatively mandated COVID-19 report is available at dli.mn.gov/sites/default/files/pdf/MN_work_comp_response_to_COVID19.pdf. The updated statistics are available at dli.mn.gov/sites/default/files/pdf/COVID-19_work_comp_claims_statistics.pdf.

[2]See the glossary in Appendix A. The time periods involved in these findings vary because of data availability and because statistics by injury year are projected to full maturity and may not be sufficiently stable for the most recent years.

  - The estimated total claim rate for non-COVID-19 claims in 2020 was 3.4 paid claims per 100 FTE workers.
  - *The estimated total claim rate for COVID-19 claims was 0.6 paid claims per 100 FTE workers.*

- Adjusting for average wage growth, both medical and indemnity benefits per insured claim rose rapidly between 2000 and 2003, but showed little net change thereafter. Adjusted indemnity benefits per claim were 4% higher and medical benefits per claim were 9% lower in 2019 than in 2003. The average cost of a 2019 workers' compensation claim was $11,610 for medical and indemnity benefits combined (including vocational rehabilitation).

- Relative to total payroll, indemnity benefits were down 30% between 2000 and 2020, while medical benefits were down 47%. These trends are the net result of a falling claim rate and higher (wage-adjusted) benefits per claim. Medical and indemnity benefits (including vocational rehabilitation) amounted to $0.64 per $100 of payroll for 2020.

- By counteracting the increase in unadjusted benefits per claim, the falling claim rate has brought benefits per $100 of payroll to historically low levels, which has affected pure premium rates and system cost per $100 of payroll.

- Pure premium rates for 2022 were down 36% from 2000 in a consistent downward trend.

- The total cost of Minnesota's workers' compensation system was an estimated $1.56 billion for 2020, or $0.96 per $100 of payroll.

- Total system cost per $100 of payroll follows a multi-year cycle in line with a nationwide insurance pricing cycle; however, extrapolating from comparable periods in the cycle indicates a decrease of 43% over 20 years.

- In 2020, on a current-payment basis, the three largest components of total workers' compensation system cost were medical benefits (33%), indemnity benefits other than vocational rehabilitation (32%) and insurer expenses (30%).

Part 3 – Claims, benefits and costs – detail

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

- Total disability benefits (temporary total disability benefits and permanent total disability benefits combined) per paid indemnity claim were largely stable from 2000 to 2019, and in 2020 for non-COVID-19 claims.
  - *When COVID-19 claims were included, there was a 30% decrease from 2019 to 2020.*

- Compared to 2000, temporary partial disability benefits per paid indemnity claim fell by 36% in 2019 and by 41% in 2020 for non-COVID-19 claims.
  - *When COVID-19 claims were included, there was a 41% decrease from 2019 to 2020.*

- Permanent partial disability benefits per paid indemnity claim fell 63% from 2000 to 2020 for non-COVID-19 claims – the same as the decrease from 2000 to 2019.
  - *When COVID-19 claims were included, there was a 40% decrease from 2019 to 2020.*

- Settlement benefits per indemnity claim rose 8% from 2000 to 2019 and 17% from 2000 to 2020 for non-COVID-19 claims. This increase resulted from an increase in the proportion of claims with settlement benefits and in the wage-adjusted average amount of these benefits where they were paid.
  - *When COVID-19 claims were included, settlement benefits decreased 31% from 2019 to 2020. This decrease was the result of the drop in the proportion of claims with settlement benefits, as only a very small percentage of COVID-19 claims had settlement agreements.*

Part 4 – Vocational rehabilitation

- Participation in vocational rehabilitation rose from 19% of paid indemnity claims for injury-year 2000 to 24% for 2019, but decreased to 21% among non-COVID-19 indemnity claims (Figure 4.1). There was a 22% decrease in the estimated number of workers who will receive vocational rehabilitation services for their injuries and illnesses in 2020.
  - *The 2020 vocational rehabilitation participation rate was 14% when COVID-19 indemnity claims were included.*

- After adjusting for average wage growth, the $9,360 average cost of vocational rehabilitation services for injury-year 2020 was 21% below the 2007 peak of $11,800.

- Vocational rehabilitation services accounted for an estimated 2.8% of total workers' compensation system cost for 2020.

- Sixty percent of vocational rehabilitation participants reported a job at plan closure in 2021, just above the 10-year average of 59%. The percentage of workers with a reported job had dipped to 57% in closure-year 2020.

Part 5 – Disputes and dispute resolution

Because the Office of Administrative Hearings (OAH) has a court case-management system (C-Track) separate from the DLI workers' compensation data system (Work Comp Campus[3]), this report currently includes dispute-resolution statistics about DLI proceedings but no detailed OAH proceeding information. As DLI and OAH work together to enhance data-sharing between C-Track and the DLI system (Campus), future reports may also include OAH dispute-resolution statistics.

[3]"Campus" stands for Claims Access and Management Platform User System.

- *There were very few disputes associated with COVID-19 claims — the dispute filing rate was 0.5% for COVID-19 claims in 2020 and 11.8% for non-COVID-19 claims.*

- There were 7,600 dispute filings receive in 2021 among the four major dispute types – claim petitions, discontinuance disputes, medical requests and rehabilitation requests. This was the same number as in 2019 and 500 more than in 2020.

- The denial rate for 2020 non-COVID-19 claims was 17%. This was above the rate of 15% for 2019 and equal to the rate of 17% in 2015, the previous high rate in the past 20 years.
  - *The rate of denial of filed indemnity claims, including COVID-19 claims, was 23% for 2020. This was substantially above the rate of 15% for 2019. The 2020 increase was due to the influx of COVID-19 claims; the denial rate for COVID-19 claims was 28%.*

Among disputes filed at DLI the following was found.

- From 2000 to 2021, the certification rate for medical and vocational rehabilitation disputes combined dropped from 63% to 51%. A majority of noncertifications of medical and rehabilitation disputes occur because the issues were resolved by DLI.

- In 2021, 48% of the *scheduled* proceedings were mediations, but 72% of the *completed* proceedings were mediations; the remaining 28% of completed proceedings were administrative conferences.

- For medical and rehabilitation requests received in 2021, the median times from the request to the first scheduled conference date were 72 and 25 days, respectively. The time interval for medical requests has been increasing since 2013. The interval for rehabilitation requests was close to the intervals for recent years, reflecting DLI's response to the 2013 law change requiring that most rehabilitation conferences be scheduled within 21 days of the request.

- Nearly all DLI conferences and mediations in 2020 and 2021 were conducted through teleconference.

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Figures

Part 1: Introduction

Nationwide, workers' compensation claim rates have declined since 2000. During the same period, indemnity benefits per claim increased at about the same rate as wages, while medical benefits per claim increased more than wages through 2008 but have been largely stable relative to wages since then. However, inflationary pressure could affect future medical costs.[4]

In Minnesota, relative to wages, indemnity and medical benefits per claim rose steeply from 2000 to 2003 but have shown little net change thereafter. A falling claim rate in Minnesota has counteracted the increases in total benefits per claim relative to wages, causing both indemnity and medical benefits per $100 of payroll to be substantially lower in 2020 than in 2000. However, the economic fallout from COVID-19 impacted the workers' compensation system in Minnesota and the nation.[5]

This report, part of an annual series, presents trend data regarding several aspects of Minnesota's workers' compensation system: claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution.[6] Like other reports in the series, this report presents data from the most recently available 20-year window, beginning with 2000 for the present report. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

Minnesota's COVID-19 presumption

Minnesota enacted a COVID-19 presumption that established certain employees who contracted COVID-19 are presumed to have an occupational disease covered by Minnesota workers' compensation law. The presumption is effective for employees who contracted COVID-19 between April 8, 2020, and Dec. 31, 2021, and between Feb. 3, 2022, and Jan. 13, 2023. Employees are entitled to the presumption if they contracted COVID-19 while employed in one of these occupations:

- licensed peace officer, firefighter, paramedic or emergency medical technician;
- nurse or health care worker, correctional officer or security counselor employed by the state or a political subdivision (such as a city or county) at a corrections, detention or secure treatment facility;
- health care provider, nurse or assistive employee employed in a health care, home care or long-term care setting, with direct COVID-19 patient care or ancillary work in COVID-19 patient units; or

[4]National Council on Compensation Insurance, "2022 State of the Line Guide," ncci.com/SecureDocuments/SOLGuide2022.html.

[5]See, for example, the Workers' Compensation Research Institute's *CompScope Medical Benchmarks, 23rd Edition*: wcrinet.org/reports/compscope-medical-benchmarks-23rd-edition.

[6]"Benefits" in this report refers to monetary benefits, medical benefits and vocational rehabilitation benefits. "Costs" refers to the combined costs of these benefits and other costs, such as insurer expenses. Using 2000 as the base year gives a 20-year observation window through 2020.

- required to provide childcare to children of first responders and health care workers.

Impact of COVID-19

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

Report layout

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

Appendix A presents a glossary. Appendix B includes portions of the 2000, 2008, 2011, 2013, 2018 and 2020-2022 law changes relevant to trends in this report. Appendix C describes data sources and estimation procedures.

Developed statistics

Many statistics in this report, from both the Department of Labor and Industry (DLI) and the insurance industry, are presented by injury-year (also referred to as "accident year" in the insurance data), insurance policy-year or vocational rehabilitation plan-closure year.[7] As such, the timeframe presented varies across data elements; however, the report presents the most recent data available for each statistic.

An issue with injury-year and policy-year data is that the originally reported numbers for more recent years are not mature because of longer claims and reporting lags. In this report, all injury-year and policy-year data is "developed" to a uniform maturity to produce statistics that are comparable over time. The technique uses "development factors" (projection factors) based on observed data for older claims.[8]

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

In previous reports, DLI reviewed the developed statistics each year to determine their stability and suitability for publication and determined that some of the developed statistics from its own data for the most recent injury-years were not sufficiently stable estimates. However, to show the impact of COVID-19 in 2020, DLI

[7]Definitions in Appendix A.

[8]Development occurs in vocational rehabilitation (VR) plan-closure-year data because a claim may have more than one VR plan and the plan-closure-year statistics are computed for all plans combined, categorized by the closure year of the last plan. See Appendix C for more detail about the claim development techniques for the injury-year, policy-year and plan-closure-year data.

decided to publish statistics for the most recent years in this report, despite the fluctuations in the data caused by COVID-19.

Computing developed statistics for COVID-19 indemnity claims is nearly impossible because these claims are unlikely to follow the pattern of claims from previous years. DLI does not expect significant reporting of 2020 COVID-19 episodes in future years, nor does it expect significant changes to benefit payments and claims durations for the claims already reported. Therefore, the 2020 non-COVID-19 claims were developed based on past data and then combined with the undeveloped 2020 COVID-19 claims.

Adjustment of cost data for wage growth

Some figures in this report present average or median costs per claim or per vocational rehabilitation (VR) plan over time. As wages and prices grow, a given cost in dollar terms represents a progressively smaller economic burden from one year to the next. If the total cost of indemnity and medical benefits grows at the same rate as wages, there is no net change in cost as a percentage of total payroll. Therefore, all costs per claim or per VR plan are adjusted for average wage growth. The adjusted trends reflect the extent to which cost growth per claim or per VR plan exceeds or falls short of average wage growth.[9]

This report includes statistics through injury-year 2020, so the rate and composition of claims are affected by the pandemic. Costs for COVID-19 injuries, as reflected in the data, were affected as injured workers had difficulty returning to work in the economic downturn or had fears of doing so in a potentially dangerous work environment. Moreover, DLI received an influx of COVID-19 claims with 2020 injury dates that had a substantial impact on some benefit statistics. More details about COVID-19 and its impact on the system are presented in subsequent parts of the report.

Additionally, since developed statistics are computed with projection factors based on historical data, the actual numbers when claims are mature (being affected by COVID-19 factors) may differ from earlier projections based largely on pre-COVID-19 projection factors.

[9]See Appendix C for computational details.

Part 2: Claims, benefits and costs – overview

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

The COVID-19 pandemic led to an influx of COVID-19 claims, lower numbers of claims for other injuries and illnesses and a reduction in employment.[10] These factors led to changes in the estimates for workers' compensation claims rates for injury-year 2020. Furthermore, in November 2020, DLI transitioned from the paper-based workers' compensation system to the Work Comp Campus online portal. Changes in reporting due to this system transition may have affected some of the data reported to DLI for the most recent years.

Major findings

- Relative to the number of full-time-equivalent workers, the total number of paid claims dropped by 51%, indemnity claims by 16% and medical-only claims by 60% from 2000 to 2020 (Figure 2.1).
    - *Due to the influx of COVID-19 indemnity claims, there was a 46% increase in the indemnity claim rate from 2019 to 2020. This reversed the long-term downward trend in indemnity claim rate (the decline from 2000 to 2019 was 42%).*

- Adjusting for average wage growth, both medical and indemnity benefits per insured claim rose rapidly between 2000 and 2003 but showed little net change thereafter. Adjusted indemnity benefits per claim were 4% higher and medical benefits per claim were 9% lower in 2019 than in 2003 (Figure 2.3).

- Relative to total payroll, indemnity benefits were down 30% between 2000 and 2020, while medical benefits were down 47% (Figure 2.4). These trends are the net result of a falling claim rate and higher (wage-adjusted) benefits per claim.
    - By counteracting the increase in benefits per claim, the falling claim rate has brought benefits per $100 of payroll to historically low levels, which has, in turn, affected pure premium rates and system cost per $100 of payroll.

- Pure premium rates for 2022 are down 36% from 2000 (Figure 2.6).

- The total cost of Minnesota's workers' compensation system relative to payroll follows a multi-year cycle, but a comparison of similar points in the cycle indicates a long-term decrease that extrapolates to 43% over a 20-year period (Figure 2.7).

[10]The number of workers' compensation covered full-time equivalent employees was estimated around 2,136,840 in 2020 compared to 2,292,750 in 2019.

- In 2020, on a current-payment basis, the three largest components of total workers' compensation system cost were medical benefits (33%), indemnity benefits other than vocational rehabilitation (32%) and insurer expenses (30%) (Figure 2.8).

- Benefits per $100 of payroll, pure premium rates and system cost per $100 of payroll all decreased at roughly 2% to 3% a year during the past 20 years. This is to be expected given the claim rate decreased by roughly 4% annually and wage-adjusted cost per claim increased by about 1% annually during the same period. That is, the downward pressure exerted by the falling claim rate on cost relative to payroll was partly offset by the increase in wage-adjusted cost per claim (Figure 2.9).

Background

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

Workers' compensation benefits and claim types

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

Monetary benefits compensate the injured or ill worker (or surviving dependents) for wage loss, permanent functional impairment or death. These benefits are often called **indemnity benefits.** They are considered in detail in Part 3.

Medical benefits consist of reasonable and necessary medical services and supplies related to the injury or illness.[11]

Vocational rehabilitation (VR) benefits consist of a variety of services to help eligible injured workers return to work. With very few exceptions, only workers receiving monetary benefits receive VR benefits. VR benefits are counted as indemnity benefits in insurance data but are counted separately in DLI data. They are considered in detail in Part 4.

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

Insurance arrangements

Minnesota requires all employers to have workers' compensation insurance coverage. Employers are covered for workers' compensation in one of three ways. The most common is to purchase insurance in the "voluntary market," so named because an insurer may choose whether to insure any particular employer. Employers unable to insure in the voluntary market may insure through the Assigned Risk Plan, the insurance program of last resort administered by the Department of Commerce. Self-insurance is allowed for employers and employer groups that meet the financial requirements set by the Department of Commerce.

[11]The National Council on Compensation Insurance (NCCI) Medical Data Report for Minnesota is the best source for medical benefit statistics: ncci.com/Articles/Pages/II_MedicalDataReportState_MN.aspx.

Rate setting

Minnesota is an open-rating state for workers' compensation, meaning rates are set by insurance companies rather than by a central authority. In determining their rates, insurance companies start with "pure premium rates" (also known as "advisory loss costs"). These rates represent expected losses (indemnity and medical) per $100 of payroll for some 600 payroll classifications. The Minnesota Workers' Compensation Insurers Association (MWCIA) — Minnesota's workers' compensation data service organization and rating bureau — annually calculates the pure premium rates for the next year from insurers' most recent pure premium (computed from prior pure premium rates and payroll) and indemnity and medical losses.[12] Insurance companies add their own expenses to the pure premium rates and make other modifications in determining their own rates (which are filed with the Department of Commerce).[13]

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

Claim rates

A starting point for understanding trends in the Minnesota workers' compensation system is the claim rate — the number of paid claims per 100 full-time-equivalent (FTE) workers. Except for a rise in the indemnity claim rate in 2020 due to the influx of COVID-19 claims, claim rates declined nearly continually for the past 20 years.

- In 2020, there were:
  - 1.40 paid indemnity claims per 100 FTE workers, down 16% from 2000. (The decline from 2000 to 2019 was 42%.) The indemnity claim rate was 0.87 for non-COVID-19 claims and 0.53 for COVID-19 claims.
  - 2.6 paid medical-only claims per 100 FTE workers, down 60% from 2000. (The decline from 2000 to 2019 was 51%.) The medical-only claim rate was 2.5 for non-COVID-19 claims and 0.1 for COVID-19 claims.
  - 4.0 total paid claims per 100 FTE workers, down 51% from 2000. (The decline from 2000 to 2019 was 49%.) The total claim rate was 3.4 for non-COVID-19 claims and 0.6 for COVID-19 claims.

- The rates of indemnity, medical-only and total claims reached low-points in 2016 and 2017; these rates were relatively stable from 2016 through 2019 but were affected by COVID-19 in 2020.
  - For non-COVID-19 claims in 2020, the indemnity claim rate was 0.87 – 10% below the 2019 rate.
  - *When COVID-19 claims were included, there was a 46% increase in the indemnity claim rate and a 19% decrease in the medical-only claim rate from 2019 to 2020. Much of this change can be attributed to the influx of COVID-19 indemnity claims in 2020.*

- Since 2009, indemnity claims have made up 23% to 24% of all paid claims, with medical-only claims constituting the remaining 76% to 77%.

[12]MWCIA "Ratemaking Report." mwcia.org/Ratemaking-Report.

[13]In response to legislative and regulatory activity in 2021 and 2022, MWCIA made significant changes to its calculation of advisory pure premium base rates for 2023. For the first time, the advisory rates for 2023 include trend, development to ultimate and loss adjustment expenses in the pure premium base rates it provides to the industry.

- *In 2020, due to the influx of COVID-19 claims, indemnity claims constituted 35% of all paid claims. COVID-19 claims accounted for 38% of the 2020 claims; nearly 90% of COVID-19 claims were for indemnity benefits, while most claims for all other injuries and illnesses were medical-only claims.*[14]

- Since 2000, the total claim rate has followed a downward trend similar to Minnesota's total reportable case rate from the Survey of Occupational Injuries and Illnesses.[15]

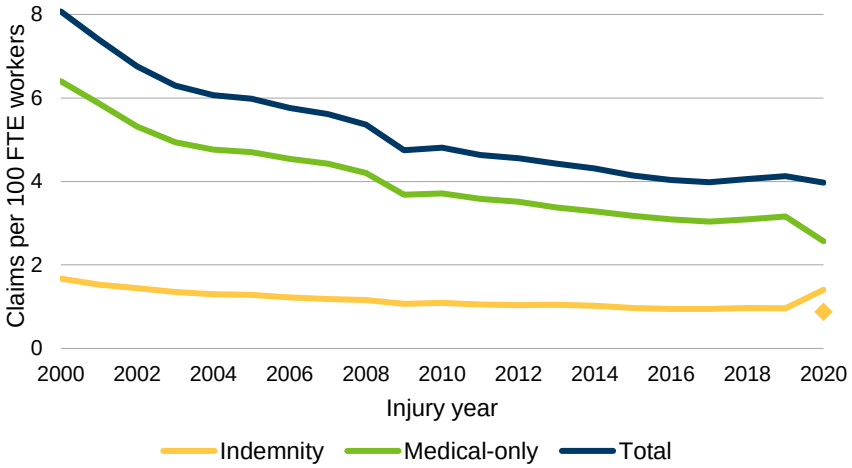
- Because of the falling claim rate, the number of claims since 2000 has fallen despite an increase in the number of covered workers. From 2019 to 2020, due to COVID-19, the number of covered workers decreased, while the number of paid indemnity claims increased. However, the number of total paid claims continued to go down.
  - There were an estimated 30,000 paid indemnity claims in 2020, down 14% from 2000, but up 30% from 2019. *Approximately 11,300 of these were COVID-19 claims.*
  - There were an estimated 84,900 total paid claims in 2020, down 50% from 2000. Despite the influx of COVID-19 indemnity claims in 2020, the number of total paid claims was 10% lower than the number of total paid claims in 2019.

- The falling claim rate has direct negative effects on benefits per $100 of payroll (Figure 2.4) and workers' compensation system cost per $100 of payroll (Figure 2.7).

[14]The indemnity claim count and percentage are from DLI data, while the numbers comparing the indemnity and medical-only claims come from MWCIA.

[15]This survey (the "SOII") is conducted jointly by state agencies and the U.S. Bureau of Labor Statistics. See dli.mn.gov/our-areas-service/research-and-statistics/survey-occupational-injuries-and-illnesses for Minnesota injury and illness rates from the SOII and for a description of the SOII itself.

Figure 2.1. Paid claims per 100 full-time-equivalent workers [1]



Injury year	Indemnity claims	Medical-only claims	Total claims
2000	1.67	6.4	8.1
2016	.95	3.1	4.0
2018	.97	3.1	4.1
2019	.96	3.2	4.1
2020	1.40	2.6	4.0

1. Developed statistics from DLI data and other sources (see Appendix C). Lines show claim rates for all paid claims, including COVID-19 claims in 2020. The diamond marker shows the indemnity claim rate for only non-COVID-19 paid indemnity claims in 2020.

Insurance arrangements

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

- The voluntary market share of paid indemnity claims was 61% in 2020, down from 73% in 2019. This also represents a decrease from the 76% mark reached in 2000 and the low point of 68% for 2005.

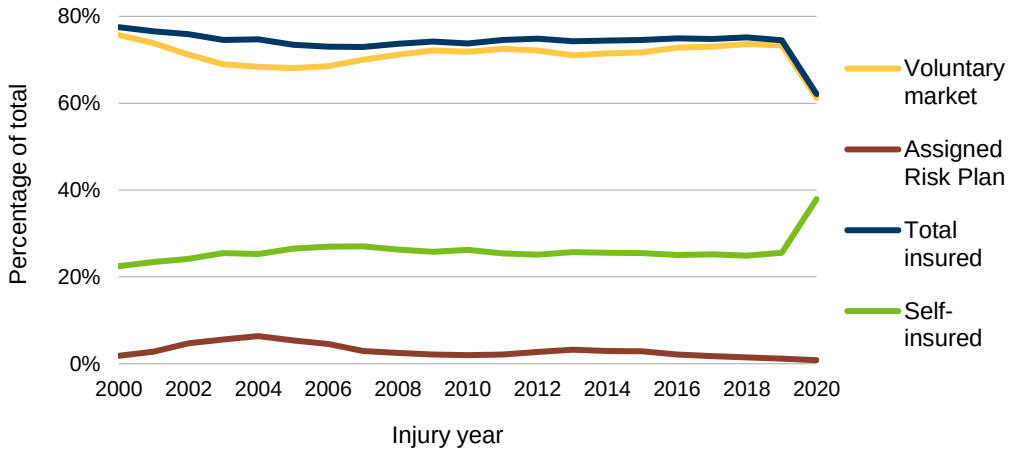
- The self-insured share, 38% for 2020, showed a significant increase from 26% in 2019. It has ranged from 25% to 27% since 2003; its low point was 23% for 2000.

- The Assigned Risk Plan share has generally ranged from 2% to 3% for the period shown, with a high point of 6.4% in 2004 and a low point of 0.8% in 2020.

- These shifts, in the long term, are at least partly due to changes in insurance costs shown in Figure 2.7. Cost increases in the voluntary market tend to cause shifts from the voluntary market to both the Assigned Risk Plan and self-insurance, while cost decreases in the voluntary market tend to cause shifts in the opposite direction.
    - ➢ *The COVID-19 pandemic also caused a significant shift from the voluntary market to self-insurance among workers injured in 2020. Many of the workers covered by the COVID-19 presumption – first responders, corrections workers and health care workers – had self-insured employers.*

- These figures have generally followed similar trends to market-share percentages based on pure premium.[16]

Figure 2.2. Distribution of paid indemnity claims by insurance type [1]



Injury year	Voluntary market	Assigned Risk Plan	Total insured	Self-insured
2000	75.7%	1.8%	77.5%	22.5%
2005	68.1	5.4	73.5	26.5
2018	73.6	1.5	75.1	24.9
2019	73.3	1.1	74.5	25.5
2020	61.3	.8	62.1	37.9

1. Data from DLI.

Benefits per claim

Adjusting for average wage growth, both medical and indemnity benefits per insured claim rose rapidly between 2000 and 2003, but showed little net change thereafter (Figure 2.3).

- For all claims combined, in 2019 relative to 2003:
  - average indemnity benefits were up 4%;
  - average medical benefits were down 9%; and
  - average total benefits were down 4%.[17]

- From 2000 to 2019: average indemnity benefits for all claims combined were up 25%; average medical benefits were up 22%; and average total benefits were up 23%.

- Statutory changes in the past few years concerning medical-service reimbursement and indemnity benefits have affected the benefit trends displayed in Figure 2.3.
  - Effective Jan. 1, 2016, Minnesota changed its method of paying for workers' compensation inpatient hospital services. The change was from a charge-based system to a "DRG" system

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

[17]The most recent data available from MWCIA is 2019.

based on Medicare's Inpatient Prospective Payment System.[18] DLI estimated that in its first year this change reduced inpatient hospital cost by 9% to 16% and total workers' compensation medical cost by 1.3% to 2.3%, relative to what these costs would otherwise have been.[19] In panels A and C of Figure 2.3 (the medical-only claims in panel B are unlikely to involve hospitalizations), average medical benefits per claim rose between policy-years 2015 and 2016 after adjusting for average wage growth. The DLI finding implies these per-claim benefits would have risen by a larger amount had it not been for the switch to the new inpatient reimbursement system.

- On Oct. 1, 2018, a new system took effect for reimbursing ambulatory surgical centers (ASCs) for their services. Before the new Ambulatory Surgical Center Payment System (ASCPS) began operating, DLI estimated it would reduce ASC payments by 20% and workers' compensation medical costs by 2.1% relative to what they would have been under the prior system.[20] Using data that became available after ASCPS took effect, DLI estimated the new system had reduced payments to ASCs by 25%, which would also lead to a reduction in overall medical costs.[21]
- For injuries on or after Oct. 1, 2018, indemnity benefit changes took effect that, by DLI's estimate, raised total indemnity benefits by 2.0% relative to what they otherwise would have been.[22]
- A new system for reimbursing hospitals for outpatient facility services also took effect Oct. 1, 2018, but this new system, by statute, was structured to leave total payments to these facilities unchanged.

- The benefits per claim shown in Figure 2.3 have a direct effect on benefits per $100 of payroll (Figure 2.4) and, thereby, on workers' compensation system cost per $100 of payroll (Figure 2.7).

[18]See Appendix A and Appendix B.

[19]"Minnesota workers' compensation DRG evaluation report," DLI Research and Statistics, January 2018, dli.mn.gov/business/workers-compensation/work-comp-reports-publications, pp. 24-26.

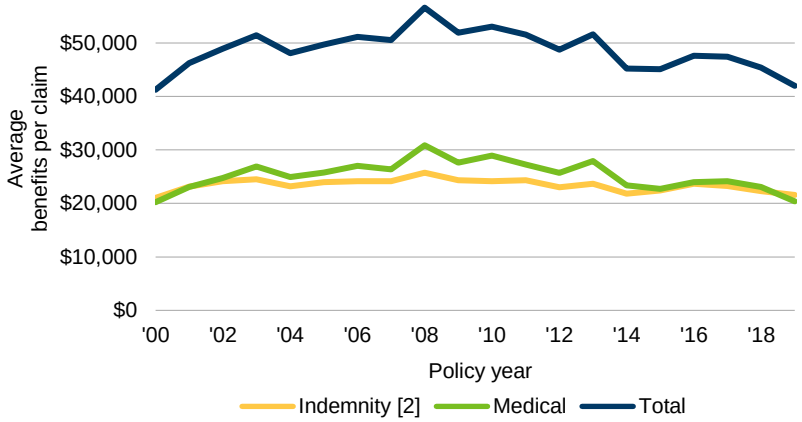
[20]Unpublished estimate.

[21]"Evaluation of the impact of the Minnesota workers' compensation Ambulatory Surgical Center Payment System (ASCPS)," DLI Research and Statistics, January 2021, dli.mn.gov/business/workers-compensation/work-comp-reports-publications, pp. 4-5.

[22]For details about all of these changes, see Appendix A and Appendix B.

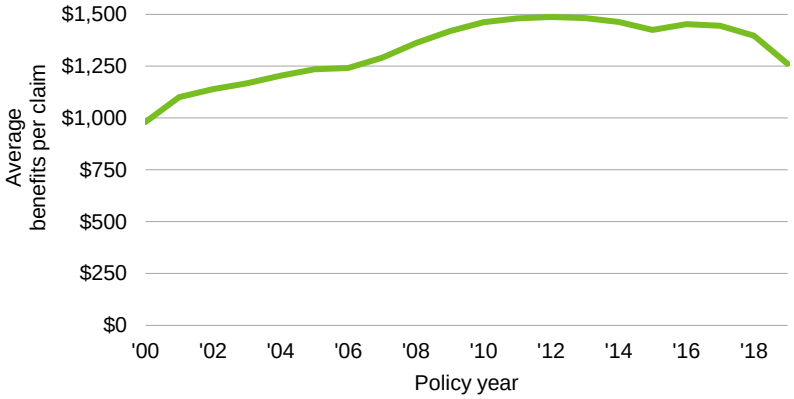
Figure 2.3. Average indemnity and medical benefits per insured claim, adjusted for average wage growth [1]

A: Indemnity claims



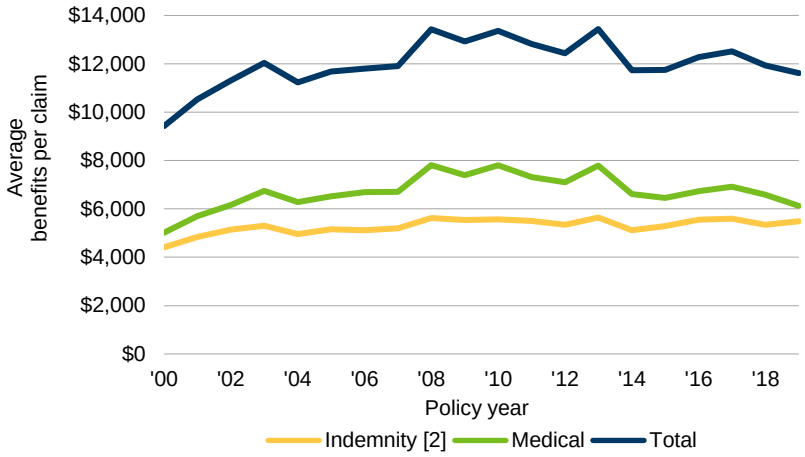
Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
2000	$21,030	$20,220	$41,260
2003	24,510	26,920	51,430
2015	22,400	22,710	45,120
2016	23,670	23,950	47,620
2017	23,240	24,170	47,410
2018	22,300	23,080	45,370
2019	21,600	20,390	41,990

B: Medical-only claims



Policy year	Medical benefits	Total benefits
2000	$980	$980
2003	1,170	1,170
2015	1,430	1,430
2016	1,450	1,450
2017	1,450	1,450
2018	1,400	1,400
2019	1,260	1,260

C: All claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
2000	$4,410	$5,010	$9,420
2003	5,300	6,740	12,040
2015	5,290	6,460	11,750
2016	5,550	6,730	12,270
2017	5,590	6,920	12,510
2018	5,340	6,590	11,930
2019	5,490	6,120	11,610

1. Developed statistics from MWCIA data (see Appendix C). Includes the voluntary market and Assigned Risk Plan; excludes self-insured employers. Benefits are adjusted for average wage growth between the respective year and 2020. The most recent year available is 2019.
2. Because these statistics are from insurance data, indemnity benefits include vocational rehabilitation benefits.

Benefits relative to payroll

Relative to total payroll, indemnity and medical benefits were substantially lower in 2020 than in 2000.

During the 21 years shown, relative to payroll, indemnity and medical benefits reached peaks in 2001 and 2003, respectively; both fell almost continually thereafter, except for the past few years.

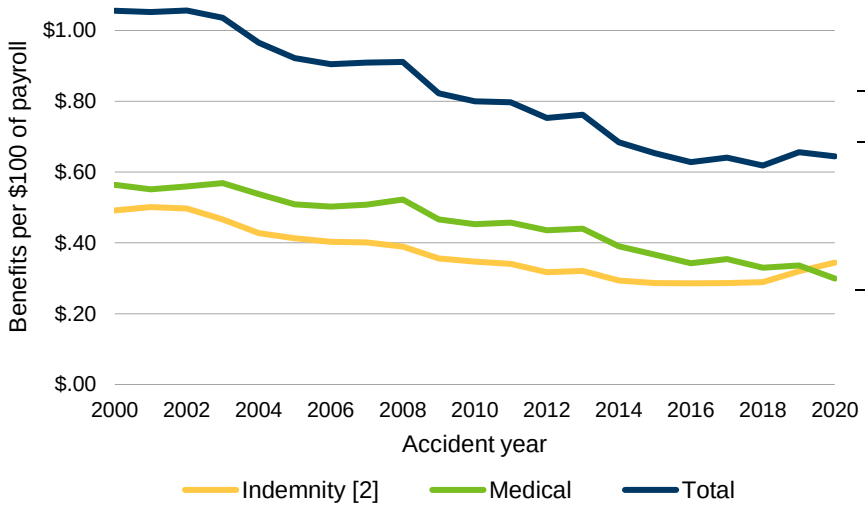
- In 2020 as compared to 2000, relative to payroll:
  - indemnity benefits were 30% lower;
  - medical benefits were 47% lower; and
  - total benefits were 39% lower.

- These changes are the net result of a decreasing claim rate (Figure 2.1) and higher indemnity and medical benefits per claim (as adjusted for average wage growth) (Figure 2.3).

- Recent changes concerning medical-service reimbursement and indemnity benefits, discussed in the context of Figure 2.3, are also relevant in viewing Figure 2.4.

- The falling benefits per $100 of payroll have a direct negative effect on pure premium rates (Figure 2.6) and, thereby, on workers' compensation system cost per $100 of payroll (Figure 2.7).

Figure 2.4. Benefits per $100 of payroll in the voluntary market [1]



Accident year	Indemnity benefits [2]	Medical benefits	Total benefits
2000	$.49	$.56	$1.06
2001	.50	.55	1.05
2003	.47	.57	1.04
2018	.29	.33	.62
2019	.32	.34	.66
2020	.34	.30	.64

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

Indemnity and medical shares

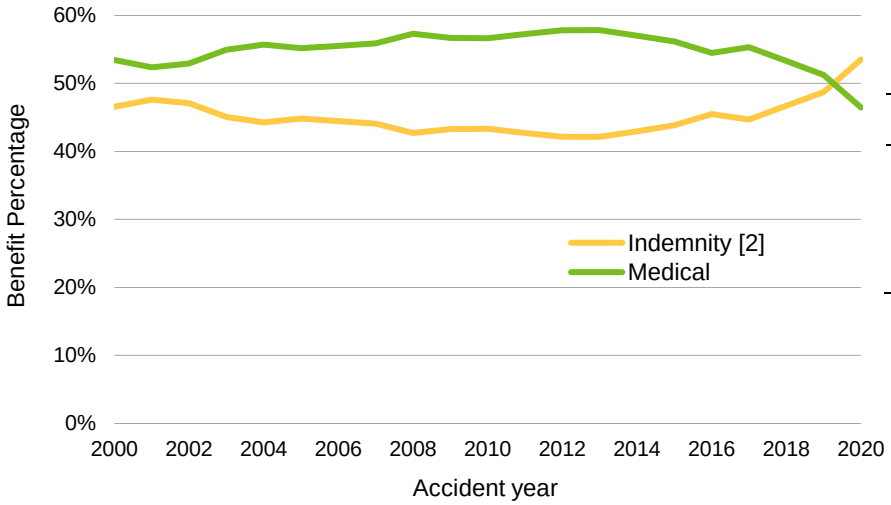
The medical share of total benefits rose from 2000 to 2013 but has fallen since 2013. The increase through 2013 occurred primarily from 2002 to 2008.

- Medical benefits rose from 53% of total benefits in 2000 to 58% in 2013, but fell back to 47% by 2020. From 2019 to 2020, the share of medical benefits fell from 51% to 47% because the majority of COVID-19 claims paid only indemnity benefits.

- Indemnity benefits fell from 47% of total benefits to 42% by 2013, but increased to 54% by 2020. The large increase from 2019 (49%) to 2020 (54%) was a result of the influx of COVID-19 indemnity claims in 2020.

- In 2020, the indemnity share of total benefits exceeded the medical share of total benefits for the first time since 2000.

Figure 2.5. Indemnity and medical benefit percentages in the voluntary market [1]



Accident year	Indemnity benefits [2]	Medical benefits
2000	46.6%	53.4%
2008	42.7	57.3
2013	42.2	57.8
2018	46.7	53.3
2019	48.7	51.3
2020	53.5	46.5

1. Note 1 in Figure 2.4 applies here.
2. Includes vocational rehabilitation benefits.

Pure premium rates

Pure premium rates have decreased substantially since 2000.

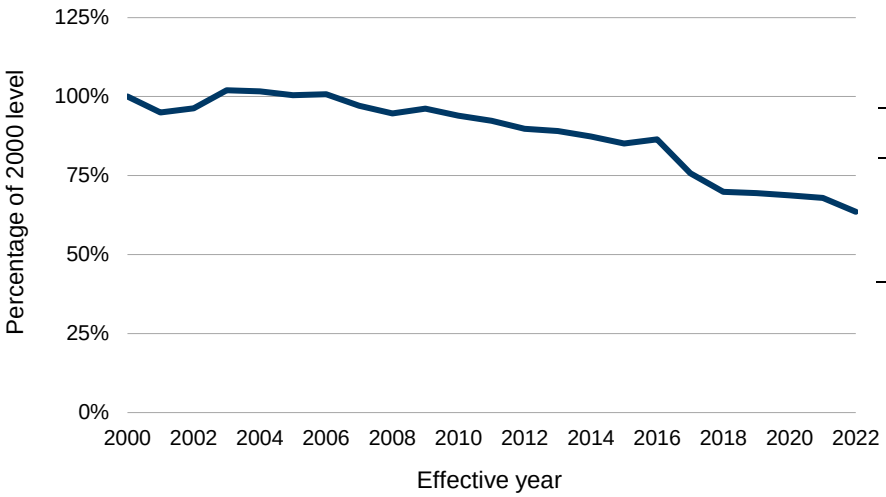
- The 2022 rates are down 36% from 2000. The rates fell 27% between 2016 and 2022 alone.[23]

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

- Pure premium rates, determined by MWCIA, are ultimately driven by the trend in benefits relative to payroll (Figure 2.4). However, this occurs with a lag of two to three years because the pure premium rates for any period are derived from prior premium and loss experience.[24]

- Insurers in the voluntary market consider the pure premium rates, along with other factors, in determining their own rates, which, in turn, affect total system cost (Figure 2.7).[25]

Figure 2.6. Average pure premium rate as percentage of 2000 [1]



Effective year	Percentage of 2000
2000	100.0%
2016	86.5
2020	68.8
2021	68.0
2022	63.6

1. Data from MWCIA. Pure premium rates represent expected indemnity and medical losses per $100 of covered payroll in the voluntary market (see p. 5). Since MWCIA has been increasing the loss maturity in its calculations for the past few years, the rates shown here are adjusted to reflect a constant loss maturity (see Appendix C).

System cost

The total cost of Minnesota's workers' compensation system per $100 of payroll has followed a cycle since 2000, with low points reached in 2000 and 2010 and high points in 2004 and 2012. Amid the annual fluctuations, the long-term trend is downward.

- The total cost of the system was an estimated $0.96 per $100 of payroll in 2020, well below the previous low point reached in 2010.

- The total cost of workers' compensation in 2020 was an estimated $1.56 billion.

- These figures reflect benefits (indemnity, medical and vocational rehabilitation) plus other costs, such as insurance brokerage, underwriting, claim adjustment, litigation, and taxes and assessments. They are computed primarily from actual premium for insured employers (adjusted for costs under deductible limits) and experience-modified pure premium for self-insured employers (see Appendix C).

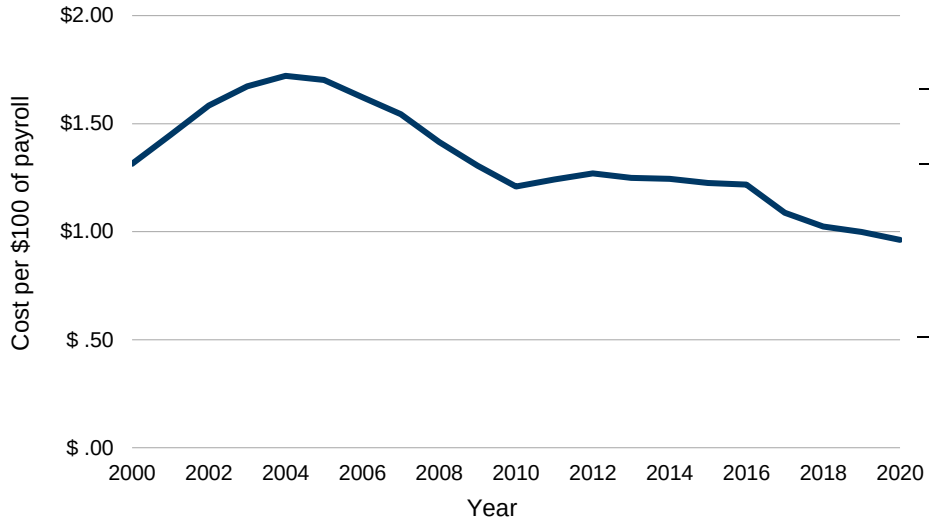
[24]Changes in pure premium rates directly following law changes also include anticipated effects of those law changes as estimated by MWCIA.

[25]See footnote 13 regarding the changes MWCIA made to its calculation of pure premium base rates for its 2023 Ratemaking Report.

- These figures partly reflect trends in pure premium rates (Figure 2.6) and in insurance expenses relative to payroll; however, they also reflect a nationwide insurance pricing cycle, in which the ratio of premium to insurance losses varies over time.[26]

- The average system cost per $100 of payroll was $1.52 for 2001 to 2010, and $1.15 for 2011 to 2020 — two comparable cycles 10 years apart; this indicates a long-term downward trend with a 24% decrease between the two cycles. Extrapolated to 20 years, this would be a 43% decrease.[27] This is close to the average pure premium rate decrease of 36% for 2000 to 2022, which is to be expected because insurers use the pure premium rates as the starting point for determining their filed premium rates.

Figure 2.7. System cost per $100 of payroll [1]



Year		Cost per $100 of payroll
2000		$1.31
2004		1.72
2010		1.21
2012		1.27
2018	[2]	1.02
2019	[2]	1.00
2020	[2]	.96

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

System cost components

Medical benefits had largest share of total workers' compensation system cost in 2020.

- In 2020, on a current-payment basis, medical benefits accounted for an estimated 33% of total system cost, followed closely by indemnity benefits other than vocational rehabilitation at 32% and insurer expenses at 30%.

[26]One indicator of this pricing cycle is the nationwide ratio of employers' cost of workers' compensation insurance (primarily reflecting premium) to workers' compensation benefits paid, computed by the National Academy of Social Insurance (NASI). (*Workers' compensation: benefits, costs, and coverage (2019 data),* NASI, October 2021 (and prior reports), (nasi.org/wp-content/uploads/2021/10/2021-Workers-Compensation-Report-2019-Data.pdf), Table 15. Relevant data also appears in National Council on Compensation, "2022 State of the Line Guide," at ncci.com/SecureDocuments/SOLGuide2022.html and "Understanding What Drives the Underwriting Cycle," May 2014, at workcompwire.com/2014/06/new-ncci-report-understanding-what-drives-the-underwriting-cycle/. The latter also explores several theories about the causes of the underwriting cycle.

[27]$(1 - .24)^2 - 1 = -.43$.

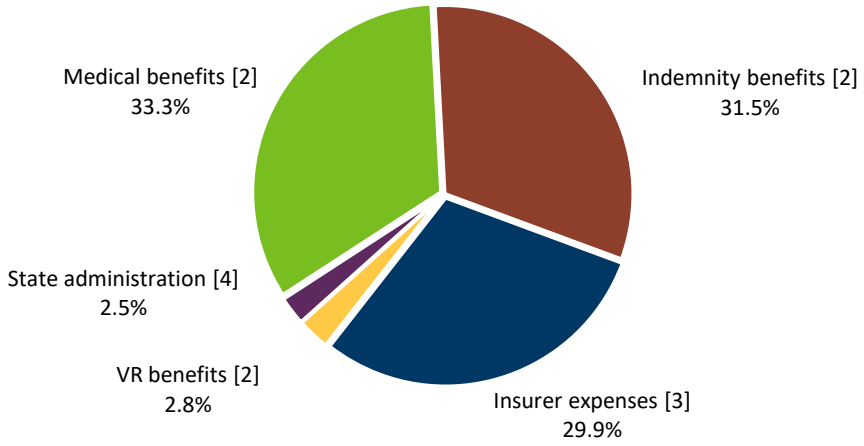
- The share of medical benefits was down from 35% and the share of indemnity benefits was up from 29% in 2019. The share of insurer expenses, vocational rehabilitation benefits and state administration remained roughly the same from 2019.

- Total benefit payments accounted for 68% of total system cost.

- As shown in Figure 2.5, the indemnity and medical shares of total benefits have varied over time.
  - In 2020, the indemnity share of total benefits exceeded the medical share of total benefits for the first time since 2000 due to the effects of COVID-19.

- As shown in Figure 3.14, state agency administrative cost has declined relative to payroll since 2000.

Figure 2.8. System cost components, 2020 [1]



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

Annual rates of change in key measures

At earlier points in this part of the report, it is pointed out that: benefits per $100 of payroll depend on the total paid claim rate and average benefits per claim (as adjusted for wage growth); and the average pure premium rate and system cost per $100 of payroll depend on benefits per $100 of payroll. Figure 2.9

summarizes these relationships by presenting average annual rates of change for these key measures of the workers' compensation system.

- Combining the rates of change in the claim rate and benefits per claim (adjusted for average wage growth) gives an average annual rate of change of -2.5%. As expected, this is close to the average annual rate of change in benefits per $100 of payroll of -2.7% (see note 4 in figure).

- The rate of change in the average pure premium rate (-1.9%) is somewhat less (in absolute terms) than the rate of change in benefits per $100 of payroll (-2.7%). An exact match is not expected because of different data sources and the fact that the pure premium rates reflect the computational methodology of MWCIA in addition to actual loss experience.

- The rate of change in system cost per $100 of payroll (-2.7%) is closer to the rate of change in benefits per $100 of payroll (-2.7%) than to the rate of change in the average pure premium rate (-1.9%). Exact correspondence is not expected because of differences in the measures (see note 7).

Figure 2.9. Annual rates of change in key measures

	Measure	Beginning period	Ending period	Average annual rate of change [1]
1.	Total claim rate [2]	2000-2002	2018-2020	-3.3%
2.	Total benefits per total claim [3]	2000-2002	2017-2019	+0.8%
3.	Combined change in total claim rate and total benefits per total claim [4]			-2.5%
4.	Total benefits per $100 of payroll [5]	2000-2002	2018-2020	-2.7%
5.	Average pure premium rate [6]	2000-2002	2020-2022	-1.9%
6.	System cost per $100 of payroll [7]	2001-2010	2011-2020	-2.7%

1. The average annual rate of change is computed from the average value for the beginning period to the average value for the ending period. The number of years used in computing the rate of change is from the mid-point of the beginning period to the mid-point of the ending period.
2. From Figure 2.1.
3. From Panel C of Figure 2.3. Adjusted for average wage growth.
4. (1 + -3.3%) x (1 + 0.8%) - 1 = -2.5%. Since the growth in benefits per claim used in this calculation is adjusted for average wage growth, the combined average annual change of -2.5% can be viewed as an expectation regarding the rate of change in total benefits per $100 of payroll (line 4). The exact relationship is this: claims per 100 FTE workers (claim rate, line 1) x (benefits per claim ÷ wages per worker) (wage-adjusted benefits per total claim, line 2) = benefits per $100 of payroll (line 4). This relationship is only approximate in the actual data because the three measures have different data sources.
5. From Figure 2.4. See note 4.
6. From Figure 2.6. MWCIA computes the pure premium rate change every year essentially by comparing historical pure premium (computed by applying historical pure premium rates to payroll) to total claim costs (or "benefits"). It is expected that, in the long run, the pure premium rates will change at about the same rate as benefits per $100 of payroll (line 4). This relationship is only approximate because the two measures have different data sources and because the pure premium rates reflect MWCIA's computational methodology in addition to actual loss experience.
7. From Figure 2.7. Because system cost per $100 of payroll follows an approximately 10-year cycle, the beginning and ending periods for this measure are 10 years apart. Also, because of the variability of the cyclical pattern from one cycle to the next, the averages are taken over all 10 years in each cycle. System cost is primarily a premium-based number and individual insurers use the pure premium rates as the starting point in establishing their own premium rates each year. It is expected that, in the long run, system cost per $100 of payroll will change at about the same rate as the average pure premium rate. This relationship is only approximate because the two measures have different data sources, system cost reflects insurer pricing behavior and system cost includes self-insured employers, while the average pure premium rate does not.

Part 3: Claims, benefits and costs – detail

This part presents additional information about workers' compensation claims, benefits and costs. Most of the statistics provide further detail about the indemnity claim and benefit information in Part 2. Some of the reported results relate to costs associated with special benefit programs and state agency administrative functions. Most of the trend statistics presented are by the year of the worker's injury or illness and are developed to a uniform maturity as described in more detail in Appendix C. Claims development means some of the values reported for 2019 and earlier years have been updated in this report. The 2020 data is presented separately for all claims, including COVID-19 claims, and for only non-COVID-19 claims to show how the pandemic has affected the statistics for that year. Other statistics in this part are reported by policy year or fiscal year.

Major findings

- Compared to 2000, the average amount of time an injured worker received total disability benefits was 14% longer in 2019 and 18% longer in 2020 for non-COVID-19 claims.
  - *When COVID-19 claims were included, total disability duration decreased 39% from 2019 to 2020 due to the significantly shorter duration of COVID-19 claims (Figure 3.3).*

- Compared to 2000, the average duration of temporary partial disability (TPD) fell 21% by 2019 and 24% by 2020 for non-COVID-19 claims.
  - *When COVID-19 claims were included, TPD duration decreased 9% from 2019 to 2020 (Figure 3.3).*

- After adjusting for average wage growth, the following was found.
  - Settlement benefits per paid indemnity claim rose 8% from 2000 to 2019 and 17% from 2000 to 2020 for non-COVID-19 claims (Figure 3.10). This increase resulted from a rise in the proportion of claims with settlement benefits (Figure 3.2) and in the wage-adjusted average amount of these benefits where they were paid (Figure 3.9).
    - *When COVID-19 claims were included, settlement benefits per paid indemnity claim decreased 31% from 2019 to 2020 (Figure 3.10). This decrease was largely due to the decrease in the proportion of claims with settlement benefits (Figure 3.2), because only a small percentage of COVID-19 claims had settlement agreements.*
  - Total disability benefits (temporary total disability benefits and permanent total disability benefits combined) per paid indemnity claim were largely stable from 2000 to 2019 and in 2020 for non-COVID-19 claims. This reflects a stable trend in the proportion of claims with these benefits (Figure 3.2) and a small net change in the average amount of these benefits where they were paid (Figure 3.9).
    - *When COVID-19 claims were included, total disability benefits per paid indemnity claim fell 30% from 2019 to 2020 (Figure 3.10). This large decrease reflects the COVID-driven*

increase in the proportion of claims with these benefits (Figure 3.2) and the decrease in the average amount of these benefits in 2020 (Figure 3.9).

- Temporary partial disability (TPD) benefits per paid indemnity claim fell 36% from 2000 to 2019 and 41% from 2000 to 2020 for non-COVID-19 claims (Figure 3.10). These decreases resulted from declines in: the proportion of claims with TPD benefits (Figure 3.2), the average duration of these benefits (Figure 3.3) and the wage-adjusted average weekly amounts of these benefits (Figure 3.4).
  - *When COVID-19 claims were included, there was a 41% decrease in TPD benefits per paid indemnity claim from 2019 to 2020.*
- Permanent partial disability (PPD) benefits per paid indemnity claim fell 63% from 2000 to 2020 for non-COVID-19 claims – the same as from 2000 to 2019 (Figure 3.10).
  - *When COVID-19 claims were included, there was a 40% decrease in PPD benefits per paid indemnity claim from 2019 to 2020.*
  - The long-term decrease in PPD benefits occurred primarily because, under the fixed PPD benefit schedule, PPD benefits became smaller relative to rising wages. Other factors were a decline in the percentage of claims with PPD benefits and a decline in the average PPD impairment rating. This was somewhat offset by relatively minor increases in statutory benefit levels in 2000 and 2018.

- Department of Labor and Industry (DLI) indemnity benefits per paid indemnity claim and per $100 of payroll closely follow their counterparts computed from Minnesota Workers' Compensation Insurers Association (MWCIA) data (Figures 3.11 and 3.12).

- The Special Compensation Fund assessment rate fell from 30.0% of paid indemnity benefits in 1999 to 13.2% in 2022 (Figure 3.15). This reflects decreasing liabilities under the supplementary and second-injury benefit programs and other factors (Figure 3.13).

Background

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

Benefit types

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

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

Permanent partial disability (PPD) — A benefit that compensates for permanent functional impairment resulting from a work-related injury or illness. The benefit is based on an impairment rating that ranges from 0% to 100%. The benefit amount is derived by multiplying the impairment rating by a statutory benefit amount per rating point that increases for higher ratings. The total benefit is unrelated to pre-injury earnings.

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

Settlement benefits — Indemnity, medical and vocational rehabilitation benefits included in a claim settlement — "stipulation for settlement" — agreed to by the parties to a claim and include the worker's attorney fees. A settlement usually occurs in a dispute and settlement benefits are usually paid in a lump sum.

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

Counting claims and benefits: Insurance data and department data

The first figure in this part uses insurance data from MWCIA; all other figures use DLI data; two figures present DLI and MWCIA data side by side. MWCIA does not include claims from self-insured employers.

MWCIA categorizes claims and benefits by "claim type," defined according to the most severe type of benefit on the claim. In increasing severity, the benefit types are medical, temporary disability (TTD or TPD), PPD, PTD and death. For example, a claim with medical, TTD and PPD payments is a PPD claim. PPD claims also include claims with temporary disability benefits lasting more than 130 weeks and claims with settlements. In MWCIA insurance data, all benefits on a claim are counted in the one claim-type category into which the claim falls.

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

How COVID-19 has affected developed estimates

As shown in the figures of this part of the report, COVID-19 indemnity claims are unlike non-COVID-19 claims. In brief, nearly all the COVID-19 claims, as of this reporting period, are of short duration and involve only total disability benefits. Claims development computations involve using the patterns of claims duration and cost change from previous years to estimate their ultimate values. Currently, computing developed statistics for COVID-19 indemnity claims is nearly impossible because these claims are unlikely to follow the pattern of claims from previous years. DLI does not expect significant reporting of 2020 COVID-19 episodes in future years, nor does it expect significant changes to benefit payments and claims durations for the reported claims. Therefore, the claims development computations were used only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims.

Costs supported by Special Compensation Fund assessment

DLI, through its Special Compensation Fund, levies an annual assessment on insurers and self-insured employers to finance: costs in DLI, the Office of Administrative Hearings (OAH) and other state agencies to administer the workers' compensation system; and certain benefits for which DLI is responsible. DLI is responsible for **supplementary benefits** and **second-injury benefits**. Although these benefits were eliminated in the 1990s, benefits must still be paid on prior claims (see Appendix A). The assessment (or benefits and administrative costs paid with the assessment) is included in total workers' compensation system cost (Figures 2.7 and 2.8).

Benefits by claim type

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

In the insurance data, the benefits for each claim type include all types of benefits paid on that type of claim. PPD claims, for example, may include medical, TTD, TPD and vocational rehabilitation benefits in addition to PPD benefits.

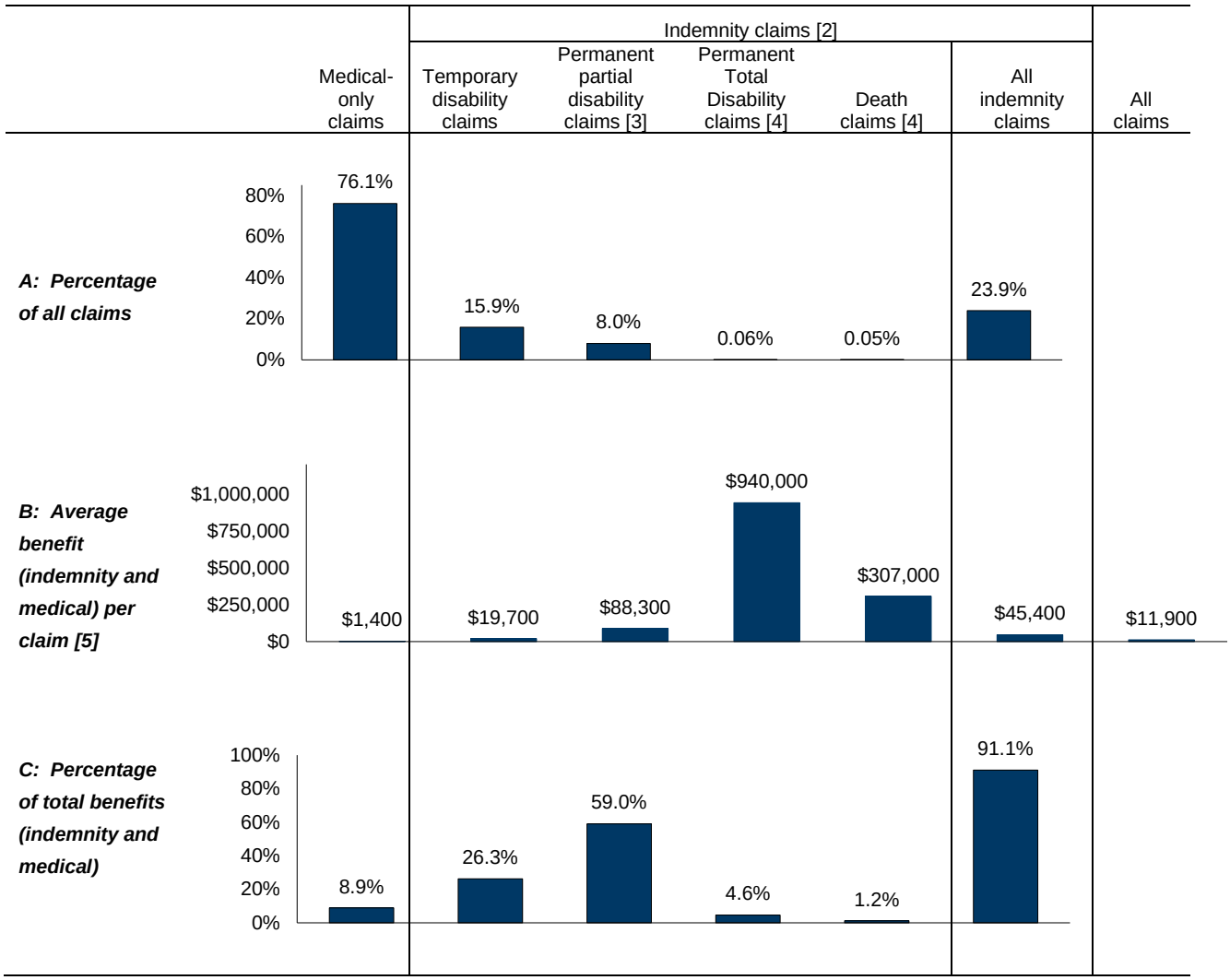
- PPD claims accounted for 59% of total benefits in 2018 (panel C in Figure 3.1) through a combination of moderately low frequency (panel A) and substantially higher-than-average benefits per claim (panel B).[28]

- Other claim types contributed smaller amounts to total benefits because of very low frequency (PTD and death claims) or relatively low average benefits (medical-only and temporary disability claims).

- Indemnity claims were 24% of all paid claims, but accounted for 91% of total benefits because they have far higher benefits, on average, than medical-only claims ($45,400 versus $1,400 for 2018). Medical-only claims accounted for 76% of claims, but only 9% of total benefits.

[28]The most recent year available from MWCIA data is 2018.

Figure 3.1. Benefits by claim type for insured claims [1]



1. Developed statistics from MWCIA data (see Appendix C). The most recent year available is 2018.
2. Indemnity claims consist of all claim types other than medical-only. These claims typically have both indemnity and medical benefits.
3. PPD claims in the insurance data, and as shown here, include any claims with settlements or with temporary disability lasting more than 130 weeks, in addition to claims with PPD.
4. Because of large annual fluctuations, data for PTD and death claims is averaged from 2014 to 2018 (see Appendix C).
5. Benefit amounts in panel B are adjusted for overall wage growth between 2018 and 2020.

Claims by benefit type

The majority of paid indemnity claims receive total disability benefits (temporary total disability benefits and permanent total disability benefits combined). Only a minority of paid indemnity claims receive PPD, TPD or settlement benefits (Figure 3.2). The proportion of claims with settlement benefits has shown a substantial increase since 2000 but started to decrease after 2018; the proportion with PPD benefits has fallen significantly since 2009 after rising gradually before that time; the proportion with total disability and TPD benefits have changed by smaller amounts. However, in 2020, the proportion of claims with total disability benefits increased as result of the influx of COVID-19 claims that mostly received only total disability benefits, while all other benefits fell.

- For non-COVID paid indemnity claims in 2020, 85% received total disability benefits, while the proportion receiving the other benefit types was estimated at 14% for PPD benefits; 20% for settlement benefits; and 25% for TPD benefits. These percentages were consistent with earlier trends.
  - *When COVID-19 claims were included, an estimated 90% of all paid indemnity claims received total disability benefits in 2020. The proportion receiving the other benefit types shown was 9% for PPD benefits; 13% for settlement benefits; and 17% for TPD benefits.*

- The percentage of claims with settlement benefits rose 24% from 2000 to 2017 but has been decreasing since.[29]
  - For non-COVID-19 claims in 2020, the percentage of claims with settlement benefits was 20% – the same as the 2019 value.
  - *When COVID-19 claims were included, there was a 36% decrease in claims with settlement benefits from 2019 to 2020, because only a handful of COVID-19 paid indemnity claims had settlement benefits.*

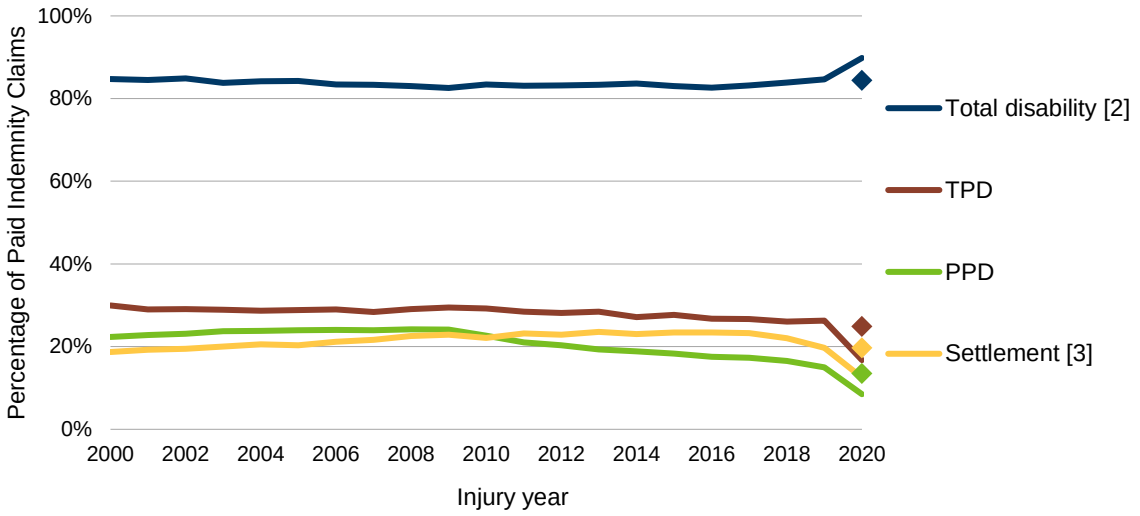
- The percentage of claims with PPD benefits rose gradually from 2000 to 2009 but fell substantially between 2009 and 2020.
  - For non-COVID-19 claims in 2020, the percentage of claims with PPD benefits was 14% – slightly below the 2019 value of 15%.
  - *When COVID-19 claims were included, the percentage of claims with PPD benefits decreased 43% from 2019 to 2020.*

- Except for a rise in 2020, the percentage of claims with total disability benefits has remained stable throughout the period, with minimal yearly fluctuations.
  - For non-COVID-19 claims in 2020, the percentage of claims with total disability benefits was 84% – slightly below the 2019 value of 85%.
  - *When COVID-19 claims were included, there was a 6% increase from 2019 to 2020 because of the influx of COVID-19 claims that mostly received only total disability benefits.*

- The percentage of claims with TPD benefits has fallen gradually since 2000, with a sharper decline in 2020.
  - For non-COVID-19 claims, the percentage of claims with TPD benefits was 25%, just below the 2019 value of 26%.
  - *When COVID-19 claims were included, there was a 36% decline from 2019 to 2020.*

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

Figure 3.2. Percentages of paid indemnity claims with selected types of benefits [1]



Injury year	Total disability [2]	TPD	PPD	Settlement [3]
2000	84.8%	30.0%	22.3%	18.7%
2009	82.6	29.5	24.1	22.9
2018	83.9	26.0	16.5	22.0
2019	84.7	26.3	15.0	19.7
2020	89.8	16.7	8.5	12.5
Non-COVID	84.4	24.9	13.5	19.7

1. Developed statistics from DLI data (see Appendix C). An indemnity claim may have more than one type of benefit paid; therefore, the sum of the percentages for the different benefit types is greater than 100%. The 2020 statistics include all paid indemnity claims, including COVID-19 claims. The non-COVID-19 percentages for 2020 are indicated by the diamond markers on the graph.
2. Total disability includes TTD and PTD.
3. Settlement includes indemnity, medical and vocational rehabilitation components.

Benefit duration

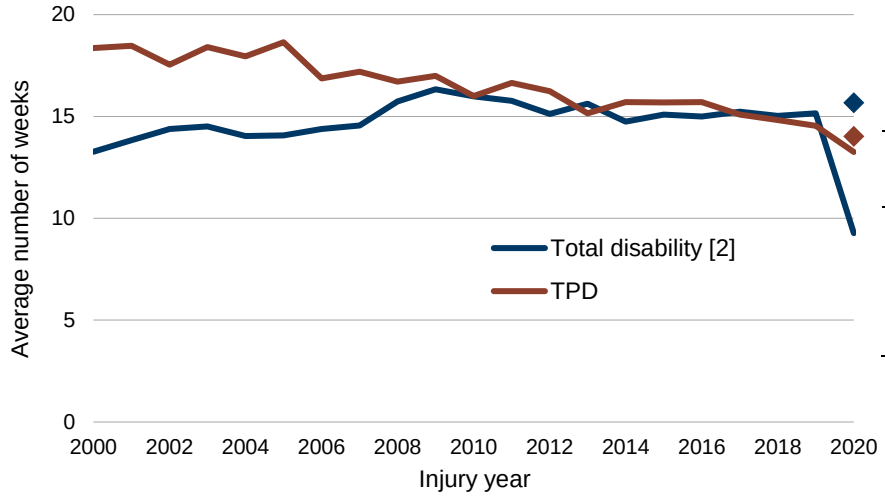
The average duration of total disability benefits rose significantly between 2000 and 2009. It was relatively stable since then but showed a significant drop in 2020 due to COVID-19, because the average benefit duration of COVID-19 claims was significantly shorter. The duration of TPD has been declining since 2000, with most of the decline occurring by 2010.

- For non-COVID-19 claims in 2020, the estimated average duration of total disability benefits was 15.7 weeks – up from 15.2 weeks in 2019 and consistent with earlier trends (14% increase from 2000 to 2019).
  - *When COVID-19 claims were included, estimated total disability duration averaged 9.3 weeks for 2020, 30% below 2000. This reversed the upward trend of earlier years. Essentially all of this decrease can be attributed to the significantly shorter duration of COVID-19 claims. From 2019 to 2020, there was a 39% decrease in total disability duration.*

- For non-COVID-19 claims in 2020, estimated TPD duration averaged 14.0 weeks in 2020 – just below the 2019 value of 14.5 weeks and 24% below 2000.
  - *When COVID-19 claims were included, TPD duration for 2020 claims averaged 13.0 weeks, 9% below the 2019 value and 28% below 2000.*

- The increase in total disability duration in 2008 and beyond, in comparison with earlier years, suggests an effect from the Great Recession.[30] However, TPD duration did not show any changes during the recession.

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



Injury year	Average weeks: Total disability [2]	Average weeks: TPD
2000	13.3	18.4
2008	15.7	16.7
2018	15.0	14.8
2019	15.2	14.5
2020	9.3	13.3
Non-COVID	15.7	14.0

1. Developed statistics from DLI data (see Appendix C). The non-COVID-19 statistics for 2020 are indicated by the diamond markers on the graph.
2. Total disability includes TTD and PTD.

Weekly benefits

- After adjusting for average wage growth, average weekly total disability decreased between 2000 and 2019, but increased from 2019 to 2020.
  - Compared with 2000, adjusted average weekly total disability benefits fell 11% by 2019 and 15% by 2020 for non-COVID-19 claims.
  - *When COVID-19 claims were included, average weekly total disability increased 7% from 2019 to 2020. Much of this increase can be attributed to increased weekly wages of workers with COVID-19 claims, discussed in the next section.*

- TPD benefits declined between 2000 and 2020.
  - Compared with 2000, TPD benefits fell 8% by 2020, consistent with the trend for earlier years.[31] *There was no substantial difference between COVID-19-included and non-COVID-19 values for 2020.*

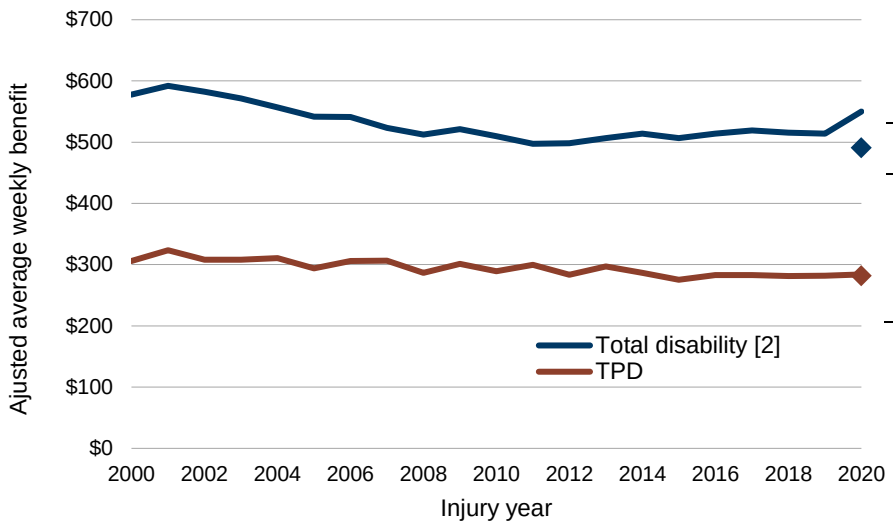
[30]For 2006 to 2011, Minnesota's annual average unemployment rate was (as a percentage, by year) 4.1, 4.7, 5.4, 8.0, 7.4 and 6.5; for the same years, total unemployment-insurance-covered employment was (in millions) 2.68, 2.69, 2.68, 2.57, 2.56 and 2.60. Data from the Minnesota Department of Employment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

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

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

- For both benefit types, much of the decrease had occurred by 2008.

Figure 3.4. Average weekly wage-replacement benefits, adjusted for wage growth [1]



Injury year	Total disability [2]	TPD
2000	$578	$306
2008	512	287
2018	516	282
2019	514	282
2020	550	284
Non-COVID	491	282

1. Developed statistics from DLI data. Benefit amounts are adjusted for average wage growth between the respective year and 2020. See Appendix C. The non-COVID-19 values for 2020 are indicated with the diamond markers on the graph.
2. Total disability includes TTD and PTD.

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

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

The average pre-injury wage of injured workers (APIW) rose more slowly than the SAWW from 2000 to 2020.

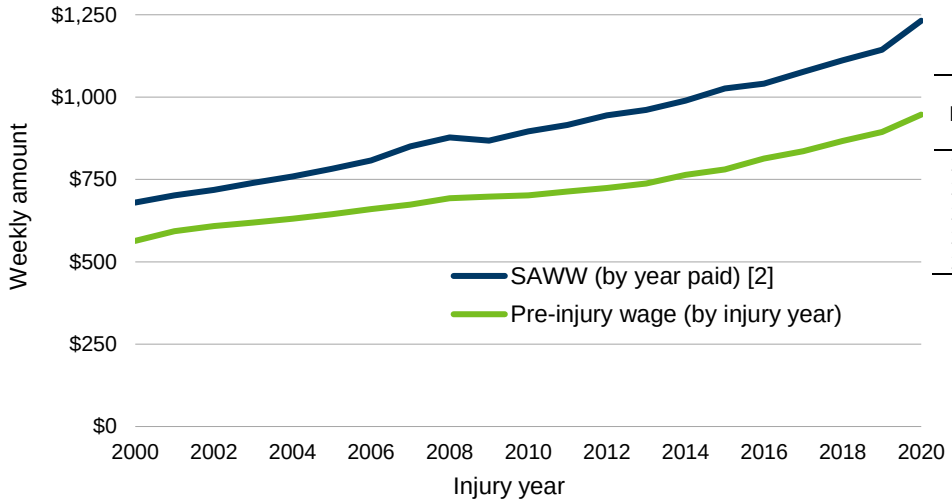
- While the SAWW rose 81% during this period, the APIW rose 77% (Figure 3.5).
- The APIW is less than the SAWW because paid claims are more common in lower-wage jobs.
- Because of its relatively slow rate of increase, the APIW fell from 83% of the SAWW in 2000 to 77% in 2020 (Figure 3.6).[32]
- Because average weekly benefits (Figure 3.4) are adjusted for growth in the SAWW, a change in the APIW relative to the SAWW will cause a change in these adjusted benefits, other things equal. The decrease in the APIW relative to the SAWW explains about 47% of the estimated decrease in adjusted average weekly benefits for total disability, and 90% for TPD, for 2000 through 2020.[33]

[32]The APIW has been declining relative to the SAWW at least since 1984, when the two were equal.

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

- In 2020, wage-adjusted weekly total disability benefits averaged about $490 for non-COVID-19 claims and $630 for COVID-19 claims. Adjusted weekly TPD benefits averaged about $282 for non-COVID-19 claims and $318 for COVID-19 claims. Most COVID-19 indemnity claims were by workers with the COVID-19 presumption, which includes first responders, corrections workers and health care workers, many of whom have relatively high weekly wages, compared with other workers.

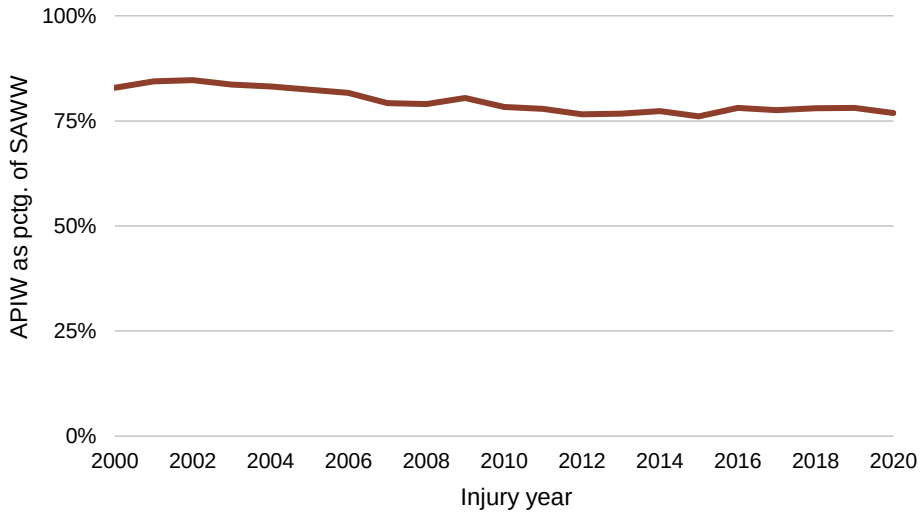
Figure 3.5. Statewide average weekly wage and average pre-injury wage [1]



Injury year	SAWW (by year paid) [2]	APIW (by injury year)
2000	$680	$564
2010	896	702
2018	1,112	867
2019	1,144	894
2020	1,232	947

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

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



Injury year	APIW as pctg. of SAWW
2000	82.9%
2010	78.3
2018	78.0
2019	78.1
2020	76.9

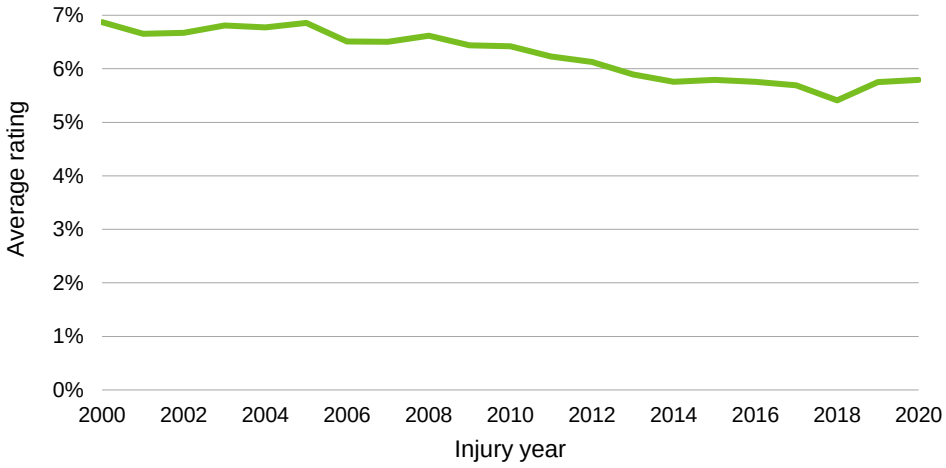
1. Data from Figure 3.5

Average permanent partial disability rating

The trend in the average PPD rating helps to explain the trend in average PPD benefits in Figure 3.9. PPD ratings are reported for injured workers who receive PPD benefits and for some workers whose PPD benefits are determined and paid through the settlement process; however, PPD ratings are not reported for many workers with settlements. The average PPD rating has fallen since 2000.

- The average rating was 5.8% for injury-year 2020. This represents a 16% decrease from 2000.[34]
- By itself, a decrease in the average rating would decrease average PPD benefits because the PPD benefit is calculated as the rating times a statutorily specified benefit amount per rating point.[35]

Figure 3.7. Average permanent partial disability rating [1]



Injury year	Average PPD rating
2000	6.9%
2010	6.4
2018	5.4
2019	5.7
2020	5.8

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

Average level of permanent partial disability benefit schedule

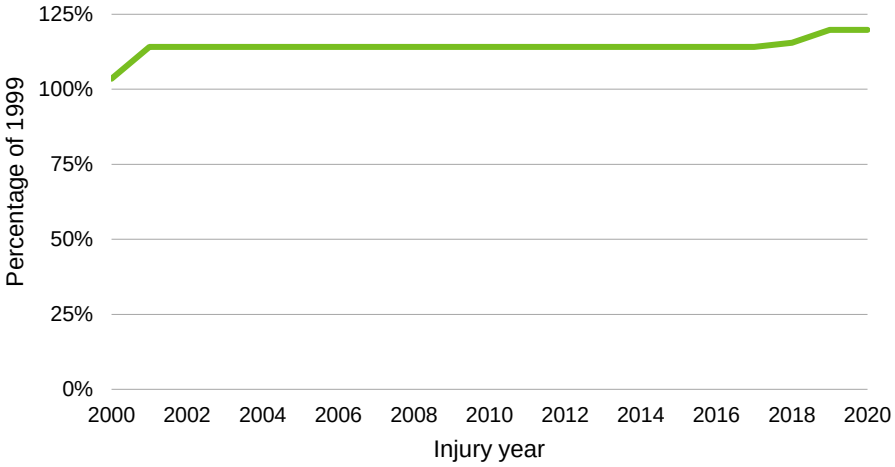
The trend in average PPD benefits in Figure 3.9 is also partly explained by the trend in the level of the PPD benefit schedule. This benefit schedule is fixed in statute, but has been raised twice since 1998.

- The PPD benefit schedule was raised in 2000 by an estimated 14.1% and in 2018 by 5% (see note 1 in Figure 3.8).
- As a result of these changes, the benefit schedule was higher by an estimated 16.3% for injury-year 2020 than for injury-year 2000 (see note 1 in Figure 3.8).

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

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

Figure 3.8. Average level of permanent partial disability benefit schedule as percentage of 1999 [1]



Injury year	Pctg. of 1999
2000	103.5%
2002	114.1
2018	115.5
2019	119.8
2020	119.8

1. This reflects the law changes of 2000 and 2018. The 2000 law change raised PPD benefits by different proportionate amounts throughout the benefit schedule, effective for injuries on or after Oct. 1, 2000. DLI estimated this change would increase PPD benefits by 14.1% overall. One quarter of the effect is assumed to occur for injury-year 2000 and the remaining additional three-quarters for injury-year 2001, with the full 14.1% felt in 2001 and later years. The 2018 law change raised PPD benefits by a uniform 5% throughout the benefit schedule, effective for injuries on or after Oct. 1, 2018. Thus, one quarter of the 5% increase was assumed to be felt for injury-year 2018.

Average benefits by type

Settlement benefits are far higher, on average, (where they are paid) than total disability, TPD and PPD benefits (Figure 3.9). With respect to trends, after adjusting for average wage growth, average benefits of different types have moved in widely divergent ways. These are all developed statistics; reported values for recent years, especially for 2020 claims, are subject to change as the data matures.

- For non-COVID-19 claims in injury-year 2020, settlement benefits averaged about $54,900 per claim where they were paid. In comparison, total disability benefits averaged about $7,700, TPD benefits $3,900 and PPD benefits $6,300.
  - *When COVID-19 claims were included, both settlement benefits and PPD benefits per claim averaged about the same as non-COVID-19 claims, whereas total disability and TPD benefits averaged lower – about $5,100 and $3,800, respectively.*

- After adjusting for average wage growth, the following was found.
  - Average total disability benefits were largely stable from 2000 to 2019 because of opposing trends in benefit duration and average weekly benefits (Figures 3.3 and 3.4). For non-COVID-19 claims in 2020, the trend was consistent with earlier years.
    - *When COVID-19 claims were included, there was a 35% decline from 2019 to 2020. This was driven largely by the decrease in average benefit duration of COVID-19 claims.*
  - Average TPD benefits fell 33% from 2000 to 2020 (compared to 27% for 2000 to 2019). The falling trend in average TPD benefits occurred because of slightly falling trends in both duration and average weekly benefits (Figures 3.3 and 3.4).

- Average PPD benefits fell nearly continually (39%) from 2000 to 2019, but rose slightly from 2019 to 2020. This decrease occurred primarily because the statutory PPD benefit schedule changed only twice during that period with an overall combined increase of 16.3% (Figure 3.8). In contrast, the SAWW increased by 68% from 2000 to 2019 (Figure 3.5). Under the mostly fixed schedule, PPD benefits become smaller relative to rising wages, which is reflected in falling adjusted average benefits.
  - As shown in Figure 3.7, the average PPD rating fell roughly 16% from 2000 to 2019.[36] This would produce a decrease in the average PPD benefit (unadjusted for wage growth) of roughly the same percentage.[37] The net effect of this decrease and the 16.3% increase in the benefit schedule (Figure 3.8) would be a predicted decrease in average *unadjusted* benefits of roughly 3%.[38]
  - Actual average PPD benefits, *unadjusted for average wage growth,* decreased during the period by 4%, about as expected from the preceding calculation.
  - This decrease is only a very small fraction of the 43% decrease in average PPD benefits *as adjusted for average wage growth* shown in Figure 3.9. Again, this decrease represents the fall in unadjusted average PPD benefits relative to rising wages. Most of the decrease in the adjusted average benefit occurred because the average wage used to adjust the average benefits grew by 68% from 2000 to 2019.
  - The increase in average PPD benefits in 2019 and 2020 corresponds to the rise in the average PPD rating and the PPD benefit schedule after 2018.[39]

- Average settlement benefits rose 11% from 2000 to 2020 (compared to 3% for 2000 to 2019). Settlement benefits depend in part on the value of benefits the worker might receive without a settlement. When considering the trend in average settlement benefits, it should be borne in mind that these benefits include medical and vocational rehabilitation benefits in addition to total disability, TPD and PPD benefits.[40]

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

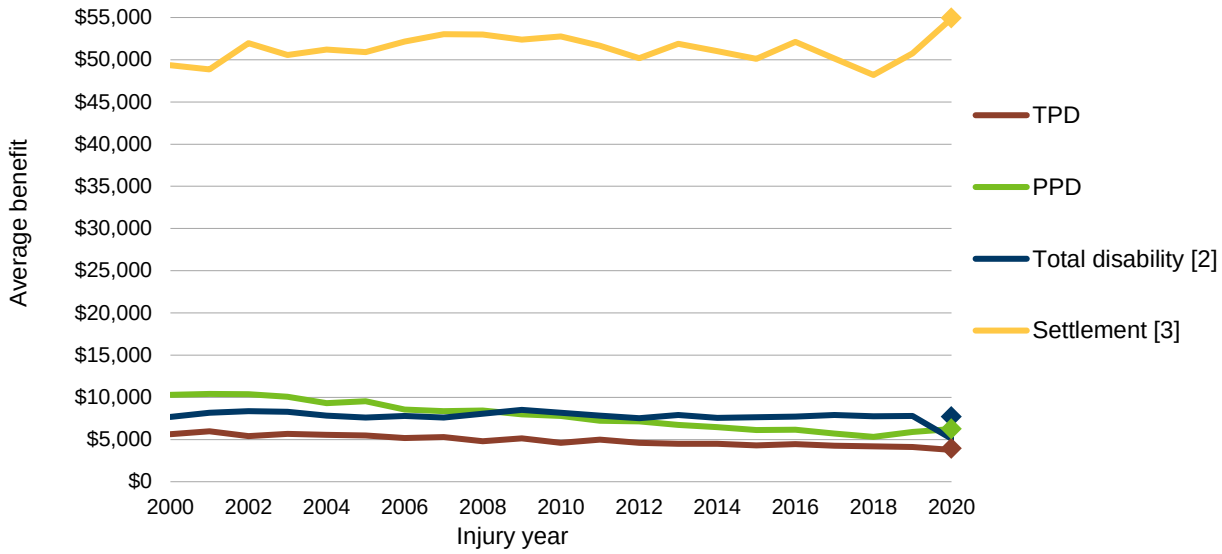
[37]See the second bullet on p. 28 and note 35 on that page.

[38](1 - .163 [the more exact decrease in the average rating]) x (1 + .163) = .97, or a 3% decrease. When the progressive nature of the PPD benefit schedule is considered, a given change in the average rating can be expected to produce a somewhat-more-than-proportionate change in the average PPD benefit.

[39]Data for the most recent years might also reflect changes in data reporting and be subject to change.

[40]Under current DLI protocols, insurers do not separate the indemnity, medical and vocational rehabilitation components of settlement awards in their reporting to DLI. Settlements rarely close out all medical benefits, but they often close out certain types of these benefits.

Figure 3.9. Average benefit by type *per claim with that benefit type*, adjusted for wage growth [1]



Injury year	Total disability [2]	TPD	PPD	Settlement [3]
2000	$7,660	$5,620	$10,280	$49,340
2010	8,150	4,630	7,800	52,740
2018	7,750	4,170	5,310	48,190
2019	7,790	4,100	5,890	50,750
2020	5,100	3,770	6,260	54,890
Non-COVID	7,690	3,950	6,260	54,950

1. Developed statistics from DLI data (see Appendix C). An indemnity claim may have more than one type of benefit paid. Benefit amounts are adjusted for average wage growth between the respective injury-year and 2020. The 2020 values reflect average benefit amounts for all claims, including COVID-19. The non-COVID-19 average benefit values for 2020 are indicated by the diamond markers on the graph.
2. Total disability includes TTD and PTD.
3. Settlement includes indemnity, medical and vocational rehabilitation components.

Benefits by type per indemnity claim

Per paid indemnity claim, settlement benefits are far higher than total disability, TPD or PPD benefits (Figure 3.10). With respect to trends, after adjusting for average wage growth, average benefits per paid indemnity claim followed widely divergent paths. These are all developed statistics; reported values for recent years, especially for 2020 claims, are subject to change as the data matures.

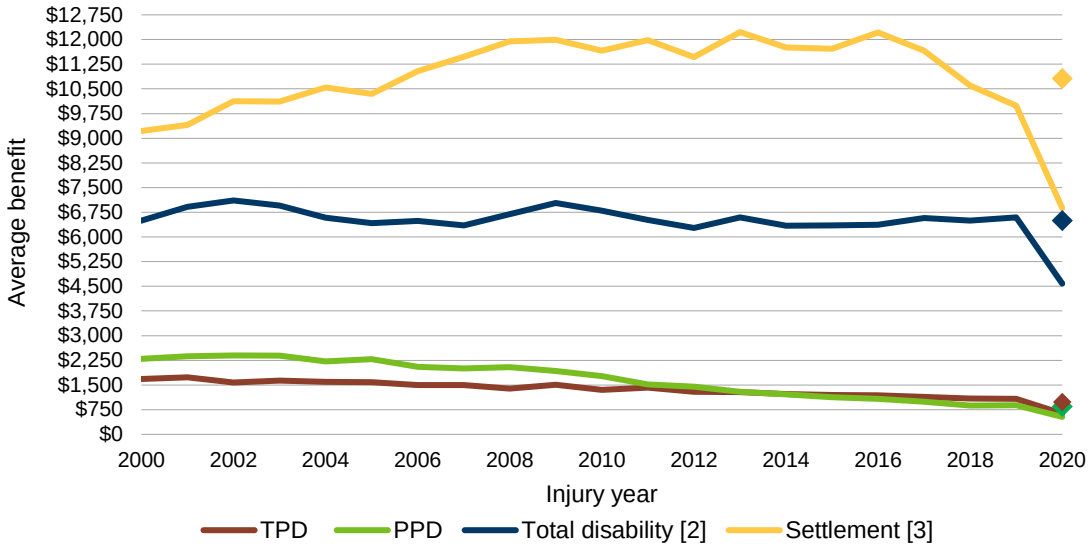
Note: Figure 3.10 differs from Figure 3.9 in that it shows the average benefit of each type *per paid indemnity claim* rather than *per claim with that type of benefit.* Figure 3.10 reflects the percentage of indemnity claims with each benefit type (Figure 3.2) and the average benefit amount per claim with that benefit type (Figure 3.9). For example, the $6,870 average settlement benefits per paid indemnity claim for 2020 (Figure 3.10) is equal to the percentage of indemnity claims with settlement benefits (12.5%, Figure 3.2) multiplied by the average settlement benefit where paid ($54,890, Figure 3.9).

- The table presented in Figure 3.10 provides the average indemnity benefits for all 2020 indemnity claims, including COVID-19 claims, and below it, the average values for only non-COVID-19 claims. The average values for all four benefit types were higher for the non-COVID-19 claims than for all claims. This effect was due to the low average benefits paid to COVID-19 claims. The low average benefits paid

to workers with COVID-19 claims was the result of the relatively brief nature of the course of the illness for most workers.

- After adjusting for average wage growth, the following was found.
  - Total disability benefits per indemnity claim were relatively stable from 2000 to 2019 and 2020 for non-COVID claims. The trend in total disability benefits per indemnity claim largely followed the trend in the average amount of these benefits where they were paid (Figure 3.9), given the relatively flat trend in the proportion of indemnity claims with these benefits (Figure 3.2).
    - *When COVID-19 claims were included, total disability benefits per indemnity claim fell 30% from 2019 to 2020.*
  - Compared to 2000, TPD benefits per indemnity claim fell 36% by 2019 and 41% by 2020 for non-COVID-19 claims.
    - *When COVID-19 claims were included, the decrease from 2000 to 2020 was larger (63%). From 2019 to 2020 there was a 41% decrease in TPD benefits per indemnity claim.*
    - The long-term decline in TPD benefits per indemnity claim is attributable to declines in the percentage of indemnity claims with these benefits (Figure 3.2) and in adjusted average TPD benefits where these were paid (Figure 3.9).
  - PPD benefits per indemnity claim fell 63% from 2000 to 2019 and 2020 for non-COVID-19 claims.
    - *When COVID-19 claims were included, the decrease from 2000 to 2020 was larger (77%). From 2019 to 2020 there was a 40% decrease in PPD benefits per indemnity claim.*
    - The long-term decline in average PPD benefits per indemnity claim resulted primarily from a decrease in adjusted average PPD benefits where these were paid (Figure 3.9) and, to a lesser degree, from a decrease in the percentage of claims with these benefits (Figure 3.2).
  - Settlement benefits per indemnity claim rose 8% from 2000 to 2019 and 17% from 2000 to 2020 for non-COVID-19 claims. The long-term increase in settlement benefits per indemnity claim resulted from an increase in the proportion of claims with these benefits (Figure 3.2) and an increase in adjusted average settlement benefits where they were paid (Figure 3.9).
    - *When COVID-19 claims were included, settlement benefits decreased 31% from 2019 to 2020. This was driven largely by the decrease in the proportion of claims with settlement benefits in 2020, because only a handful of COVID-19 paid indemnity claims involved settlement benefits.*

Figure 3.10. Average benefit by type *per paid indemnity claim*, adjusted for wage growth [1]



Injury year	Total disability [2]	TPD	PPD	Settlement [3]
2000	$6,490	$1,680	$2,290	$9,220
2010	6,800	1,350	1,770	11,670
2018	6,500	1,090	880	10,600
2019	6,600	1,080	880	9,990
2020	4,580	630	530	6,870
Non-COVID	6,490	980	840	10,810

1. Developed statistics from DLI data (see Appendix C). An indemnity claim may have more than one type of benefit paid. Benefit amounts are adjusted for average wage growth between the respective injury-year and 2020. The non-COVID-19 values for 2020 are indicated by the diamond markers on the graph.
2. Total disability includes TTD and PTD.
3. Settlement includes indemnity, medical and vocational rehabilitation components.

Indemnity benefits per claim, DLI and MWCIA data

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

- From 2000 through 2019, the MWCIA figure has exceeded the DLI figure. This is largely because the MWCIA figure includes vocational rehabilitation benefits while the DLI figure does not.[41]

- Both data sources show a generally stable trend in wage-adjusted indemnity benefits per indemnity claim since 2002, with some yearly fluctuations.
  - For non-COVID-19 claims, indemnity benefits per indemnity claim were $19,470 – more consistent with the earlier trends.

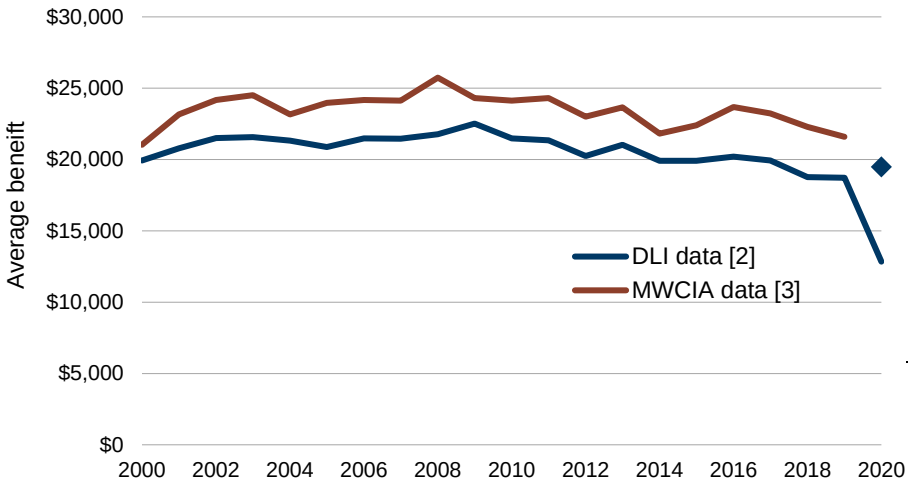
[41]As shown in Figure 4.4, the average cost of vocational rehabilitation has been somewhat above $2,000 per paid indemnity claim (adjusted for wage growth) since 2001. From 2001 to 2019, the MWCIA number in Figure 3.11 exceeded the DLI number by an average of $2,771. Another possible factor is that the MWCIA figure excludes self-insured employers while the DLI figure includes them, although the effect of this difference is uncertain.

- *When COVID-19 claims were included, DLI data shows a significant decrease in wage adjusted indemnity benefits per indemnity claim from $18,730 in 2019 to $12,840 in 2020.*

- It is uncertain why the MWCIA figure seems to fluctuate more than the DLI figure. One possible explanation is that the MWCIA figure is based on payments plus claim-specific reserves, while the DLI figure is based on payments alone.[42]

- The agreement between the data sources lends credibility to both.

Figure 3.11. Average indemnity benefits per paid indemnity claim, adjusted for wage growth, DLI and MWCIA data [1]



	DLI data (by injury year) [2]	MWCIA data (by policy year) [3]
2000	$19,940	$21,030
2002	21,500	24,170
2018	18,770	22,300
2019	18,730	21,600
2020	12,840	
Non-COVID	19,470	

1. Benefit amounts are adjusted for average wage growth between the respective year and 2020 (see Appendix C). The non-COVID-19 value for 2020 DLI data is indicated by the diamond marker on the graph.
2. Developed statistics from DLI data (see Appendix C). Includes insured and self-insured employers. In DLI reporting, benefits paid under a stipulation for settlement are not divided into indemnity and medical components. Consequently, all settlement benefits are included with indemnity benefits in the DLI data here. Indemnity benefits in DLI reporting exclude vocational rehabilitation service costs.
3. From Figure 2.3, Panel A. Includes insured employers only (including those in the Assigned Risk Plan). In MWCIA reporting, insurers are instructed to divide settlement benefits into indemnity and medical components. Indemnity benefits in MWCIA reporting include vocational rehabilitation service costs. Not yet available for 2020.

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

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

- Since 2000, the DLI figure has ranged from 70% to 96% of the MWCIA figure.[43]

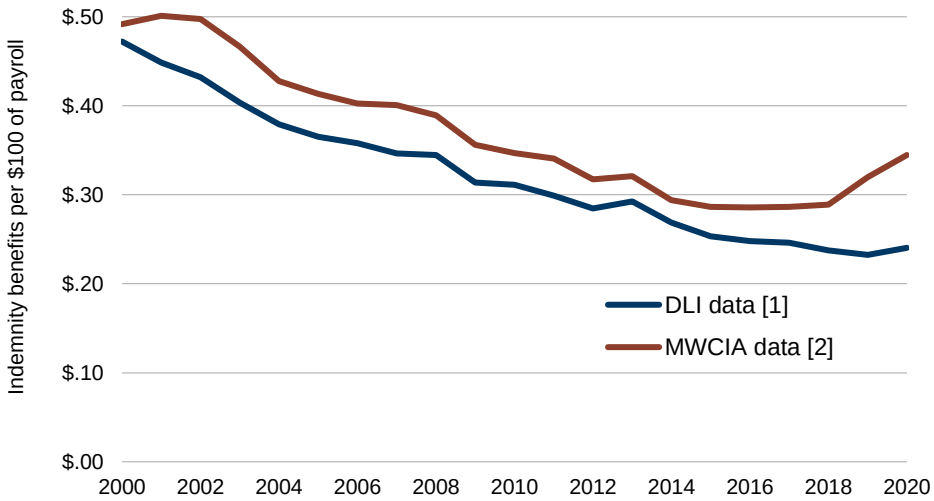
[42]Claim-specific reserves are funds an insurer sets aside to cover anticipated future costs of particular claims.

[43]This range is larger than the range presented in last year's report. This is because last year's report presented data only through 2016, whereas the current report presents data through 2020.

- As with average indemnity benefits per paid indemnity claim (Figure 3.11), much of the difference between the DLI and MWCIA numbers is because the MWCIA figure includes vocational rehabilitation service costs while the DLI number does not.[44]

- Again, the general agreement between the data sources lends credibility to both.

Figure 3.12. Indemnity benefits per $100 of payroll, DLI and MWCIA data



Injury year	DLI data [1]	MWCIA data [2]
2000	$.47	$.49
2002	.43	.50
2018	.24	.29
2019	.23	.32
2020	.24	.34
Non-COVID	.23	

1. Indemnity benefits are developed statistics from DLI data; payroll data is from several sources (see Appendix C). Includes insured and self-insured employers. In DLI reporting, benefits paid under a stipulation for settlement are not divided into indemnity and medical components. Consequently, all settlement benefits are included with indemnity benefits in the DLI data here. Indemnity benefits in DLI reporting exclude vocational rehabilitation service costs.
2. From Figure 2.4. Includes insured employers in the voluntary market only. In MWCIA reporting, insurers are instructed to divide settlement benefits into indemnity and medical components. Indemnity benefits in MWCIA reporting include vocational rehabilitation service costs.

Supplementary benefit and second-injury costs

DLI produces an annual projection of supplementary benefit and second-injury benefit reimbursement costs as they would exist without future settlement activity. The total annual cost is projected to fall by 63% during the next 10 years and to disappear by 2060.

- The 2022 projected cost of $22 million consists of roughly $17 million for supplementary benefits and $5 million for second-injury benefits.[45]

- Without settlements, supplementary benefit claims are projected to continue until 2060 and second-injury benefit claims until 2045.

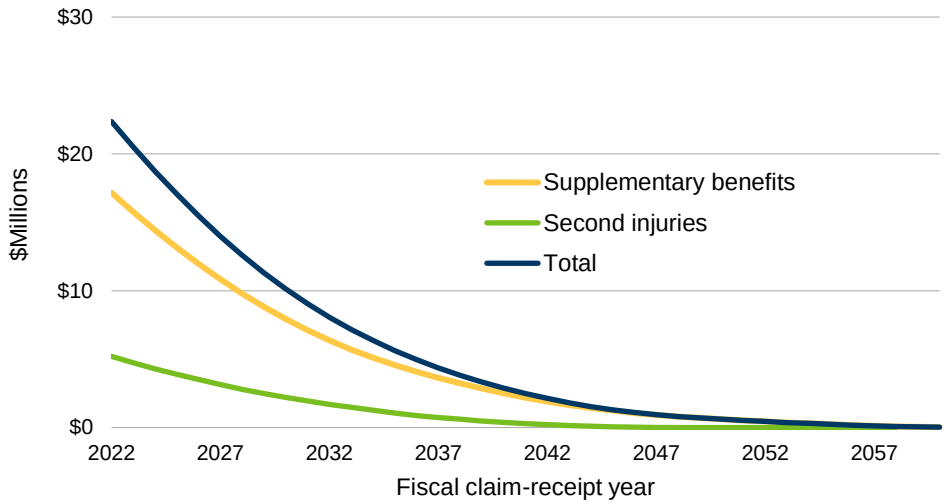
[44]The data in Figure 2.8 indicates the vocational rehabilitation (VR) component of total system cost is about 8.2% of the combined VR and indemnity (without VR) components (2.8% / (31.5% + 2.8%) = 8.2%). This accounts for a majority of the average 13.0% difference between the DLI and MWCIA numbers in Figure 3.12 for the period shown. Another possible factor is that the MWCIA figure excludes self-insured employers while the DLI figure includes them, although the effect of this difference is uncertain.

[45]As complete data for supplementary benefit and second-injury benefit claims was not available in the Work Comp Campus database, 2022 cost numbers were projected using the data through fiscal claim-receipt year 2020 available from the Informix database.

- Claim settlements will reduce future projections of these liabilities. Settlements amounted to $2 million in fiscal-year 2020.

- The cost of supplementary and second-injury benefits for calendar-year 2020, $19.7 million including settlements, came to 1.3% of total workers' compensation system cost.[46]

Figure 3.13. Projected cost of supplementary and second-injury reimbursement claims [1]



Fiscal claim receipt	Projected amount claimed ($millions)		
	Supplementary benefits	Second injuries	Total
2022	$17.2	$5.2	$22.4
2025	13.2	3.9	17.0
2030	7.9	2.2	10.1
2035	4.6	1.1	5.6
2050	.6	.0	.6

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

State agency administrative cost

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

- In fiscal-year 2021, state agency administrative cost (see note 1 in Figure 3.14) was 2.5 cents per $100 of payroll.

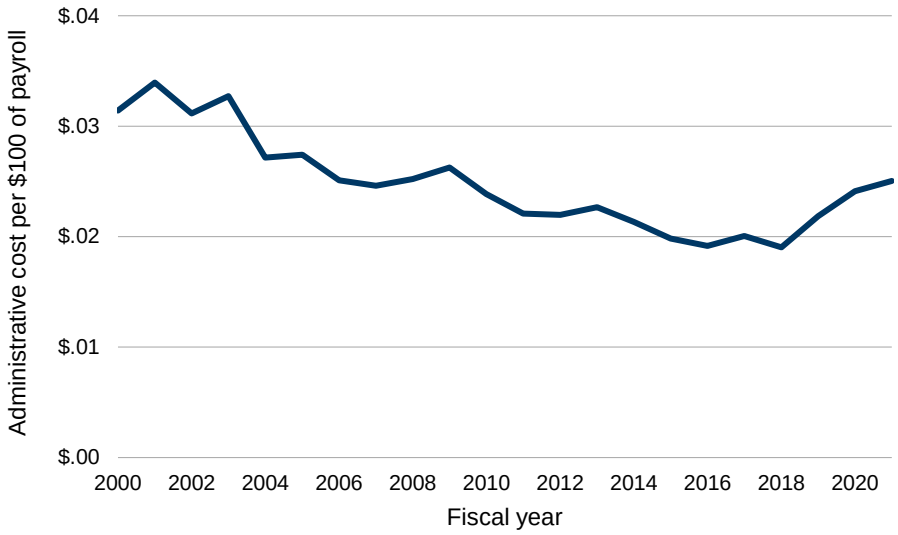
- The main factor in the decline of administrative cost relative to covered payroll over time has been the steady increase in payroll itself, as administrative cost has been relatively stable during the past two decades.

[46]The cost of supplementary and second-injury benefits for calendar-year 2020 accurately represents what DLI paid for both programs, but was significantly affected by internal staffing shortages and Campus deficiencies. The percentage of system cost was calculated with techniques similar to those for Figure 2.8 to reduce the effects of annual fluctuations in total system cost.

- The increase in administrative cost from 2019 to 2021 primarily reflected the beginning of substantial expenditure for the Workers' Compensation Modernization Program, or Work Comp Campus.[47]

- Administrative cost for 2021 was $38.3 million. As indicated in Figure 2.8, state administration accounted for about 2.5% of total workers' compensation system cost in 2020.

Figure 3.14. Net state agency administrative cost per $100 of payroll [1]



Fiscal year	State agency admin. cost per $100 of payroll
2000	$.031
2018	.019
2019	.022
2020	.024
2021	.025

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

Special Compensation Fund assessment rate

The Special Compensation Fund assessment rate has fallen by more than half since 2000.

- The rate fell from 30.0% for 2000 to 13.2% for 2022. Primarily, this reflects the continuing decreases in supplementary benefit and second-injury benefit reimbursement costs (Figure 3.13) and, to a lesser degree, the decreasing trend in state agency administrative costs relative to total covered payroll (Figure 3.14).

- The sharp decrease in the assessment rate for fiscal-year 2019 primarily reflects an increase in the reported assessment base rather than a decrease in the assessment itself. The increase in the base reflects some insurers erroneously including medical benefits in their reported base, which is supposed to include paid indemnity benefits only.[48]

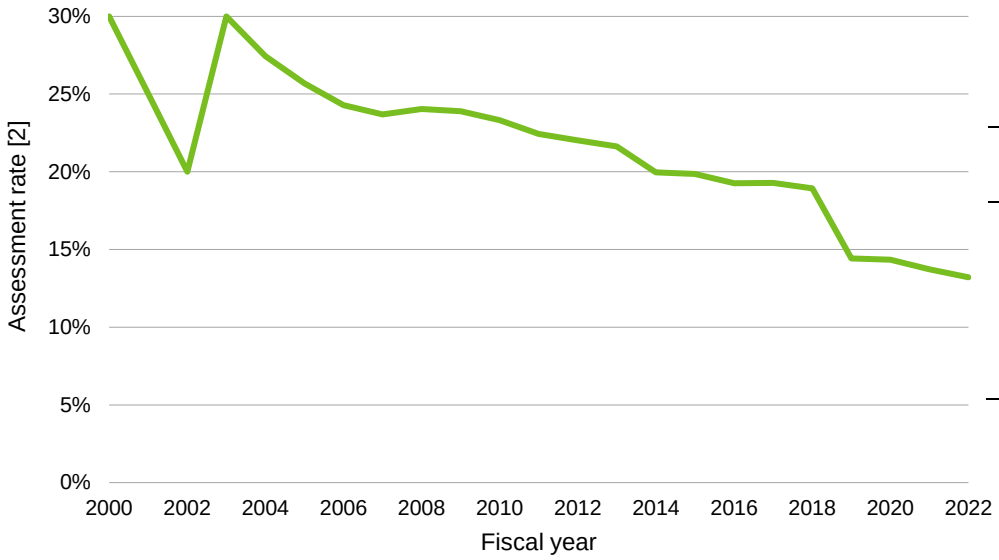
[47]"Campus" stands for Claims Access and Management Platform User System. Campus expenditures, funded by the workers' compensation assessment, were $3.6 million in 2019, $8.9 million in 2020 and $5.7 million in 2021, as compared with $0.2 million in 2018.

[48]Through payment-year 2016, DLI required insurers to report paid medical benefits as a separate item in the annual "Workers' Compensation Report of Benefits Paid." Beginning with payment-year 2017, DLI dropped medical benefits from the report; however, some insurers erroneously added these benefits to their reported paid indemnity benefits. Between the two payment-years, reported

- The fluctuations of the assessment rate between 20% and 30% from 1999 to 2003 reflected DLI responses to legislative actions.[49]

- At its highest, the assessment rate was 31% for fiscal-years 1988 through 1992 (before the period shown in Figure 3.15).

Figure 3.15. Special Compensation Fund assessment rate [1]



Fiscal year assessment is due	Assessment rate [2]
2000	30.0%
2002	20.0
2003	30.0
2018	18.9
2019	14.4
2020	14.4
2021	13.7
2022	13.2

1. Data from DLI.
2. The assessment rate is the percentage of paid indemnity benefits collected as the assessment. The graph shows an assessment rate of 25% for 2001, reflecting the 30% and 20% rates for the two halves of that year. For assessments due through fiscal-year 2003, DLI determined the assessment rate in advance of the assessment and applied that rate to paid indemnity benefits for insurers and self-insurers to determine the assessment due. Beginning with assessments due in fiscal-year 2004, DLI determines the total assessment amount to be collected and then allocates this amount between insurers and self-insurers (as groups) according to their relative shares of total indemnity benefits paid. The insurer share is then allocated among insurers according to their pure premium and the self-insurer share is allocated among self-insurers according to their paid indemnity benefits. The assessment rate shown here for 2004 and later years is the total assessment divided by total indemnity benefits paid.

indemnity increased by 17.8%. This contributed the majority of the 23.8% decrease in the nominal assessment rate for assessments due in fiscal-year 2019. The remainder of the decrease resulted from a drop of 10.3% in assessment liabilities between the two years.

[49]The 2000 Legislature transferred $325 million of surplus from the Assigned Risk Plan to the Special Compensation Fund for the purpose of settling liabilities of the supplementary benefit and second-injury benefit programs. The legislative action also mandated a decrease in the assessment rate by Jan. 1, 2001, of at least 30% from the rate in effect on Jan. 1, 2000 (Minn. Laws 2000, ch. 447, secs. 24-27) (see note 2 in Figure 3.15). DLI reduced the rate from 30% to 20% effective July 1, 2000, for assessments due in the second half of fiscal-year 2001. The 2002 Legislature directed that the remaining balance of the transferred amount be transferred to the state general fund as of July 1, 2003. The transferred amount was $265 million. DLI raised the assessment rate to 30% for assessments due in fiscal-year 2003.

Part 4: Vocational rehabilitation

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

Major findings

- Participation in vocational rehabilitation rose from 19% of paid indemnity claims for injury-year 2000 to 24% for 2019 but decreased to 21% among non-COVID-19 indemnity claims (Figure 4.1). There was a 22% decrease in the estimated number of workers who will receive VR services for their injuries and illnesses in 2020.
    - *The 2020 VR participation rate was 14% when COVID-19 indemnity claims are included.*

- After adjusting for average wage growth, the $9,360 average cost of VR services for injury-year 2020 was 21% below the 2007 peak of $11,800 (Figure 4.4).

- VR services accounted for an estimated 2.8% of total workers' compensation system cost for 2020 (Figure 2.8).

- The average time from injury to the start of VR services fell from 8.2 months for injury-year 2000 to 5.3 months for 2017 and is estimated at 5.4 months for the past three years (Figure 4.8).

- The percentage of VR plans closed with a plan completion increased from 46% in closure-year 2020 to 49% in 2021 (Figure 4.10). During the prior 10 years, the average percentage of plans closed by completion was 47%.

- The percentage of plan closures resulting from claim settlement dropped from 32% in 2020 to 27% in 2021, while the percentage closing by agreement of the parties increased from 19% in 2020 to 21% in 2021 (Figure 4.10).

- Sixty percent of VR participants reported a job at plan closure in 2021, just above the 10-year average of 59% (Figure 4.12). The percentage with a reported job had dipped to 57% in closure-year 2020.

- During the 2019 through 2021 closure years, 71% of the workers returned to a job with a wage at least 96% of their pre-injury wage (Figure 4.14).

- For VR participants who returned to work at a different employer in closure-year 2021, the average ratio of the return-to-work wage to the pre-injury wage was 95%, an increase from 78% in 2009. For workers

returning to the same employer, the average ratio was 97%, which has not significantly changed since 2005 (Figure 4.15).

Background

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

Vocational rehabilitation is the third type of workers' compensation benefit, supplementing indemnity and medical benefits. VR services are provided to injured workers who need help in returning to suitable gainful employment because of their injuries.[50]

VR services include the following:

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

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

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

Registered placement vendors are approved to provide job-development and job-placement services under an approved VR plan. They help injured workers to secure suitable employment through a series of activities, including teaching job-seeking skills and assisting with preparation of resumes, cover letters and job applications. Placement vendors also contact prospective employers to identify jobs, arrange interviews, discuss employment incentives and to conduct labor market surveys.

The VR eligibility process begins when the insurer files a disability status report (DSR) to notify DLI it is referring the injured worker to a QRC for a VR consultation or requesting a waiver of VR services. The insurer must file the DSR within 14 days of becoming aware that temporary total disability is likely to exceed 13 weeks, 90 days after

[50]Minnesota Statutes § 176.102, subdivision 1(b), and Minnesota Rules, part 5220.0100, subpart 34.

the injury if the employee has not returned to work or 14 days after receiving a consultation request from the employee. Although the insurer typically refers the employee for a consultation via the DSR, the employee or employer may request a consultation and DLI can also order a consultation. A QRC in DLI's VRU may also provide a consultation if the insurer denies that the employee's injury or condition is work-related and the employee has disputed the denial.

A QRC conducts a consultation with the employee to determine if the employee is eligible to receive VR services. A VR plan is developed if the QRC determines the employee is qualified for VR services.

VR plan costs reported to DLI include charges for services by QRCs and vendors and direct costs of certain other services, such as vocational testing. VR plan costs also include the costs of planning and facilitating other services, such as functional capacity evaluations, technical or academic skills improvement, retraining and on-the-job training. The direct costs of these other services, such as tuition, have traditionally been paid directly by the insurer and not reported as a plan cost to DLI. Due to recent case law involving interpreter expenses, reporting those service costs as part of the VR plan may occur in the future.

Annual changes in hourly VR service charges through 2012 were limited to the lesser of the percentage increase in the statewide average weekly wage (SAWW) or 2%. The 2013 workers' compensation law change increased the annual change in hourly charges to the lesser of the percentage increase in the SAWW or 3%, effective Oct. 1, 2013. The maximum hourly fee levels for QRCs and for job-development and job-placement services, effective Oct. 1, 2020, through Sept. 30, 2021, were $112.53 and $90.13, respectively. These rates changed to $115.91 and $92.83, respectively, for Oct. 1, 2021, through Sept. 30, 2022.

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

Rule amendments effective Sept. 24, 2018, eliminated the $10 an hour fee reduction for lengthy and costly VR plans and adjusted the hourly rate to maintain cost neutrality. The rule change also increased the amount of professional time QRCs can work with injured workers to enhance the job search process, including job development, to six hours a month.

Data sources and time period covered

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

The trend statistics in this chapter reported by injury-year or plan-closure year are developed (projected) to a uniform maturity as described in Appendix C. VR plan-closure years cover the period from Oct. 1 through Sept. 30 of the indicated year.

The changeover to the Work Comp Campus online portal in November 2020 and the impact of the COVID-19 pandemic also led to disruptions in reporting, which may have affected some of the reported results for the

most recent years. Additionally, some of the workers with COVID-19 claims may qualify for VR services due to their ongoing symptoms leading to extended time loss. However, the number of these cases is not yet known.

Participation

The VR participation rate increased by six percentage points from 2000 to 2013, and the rate was unchanged from 2013 through 2019 (Figure 4.1). The COVID-19 pandemic led to a drop in the utilization rate in 2020.

- The COVID-19 pandemic had a significant effect on the use of vocational rehabilitation services for workers injured in 2020. A projected 4,100 of the estimated 30,000 workers with indemnity claims for injury-year 2020 are expected to receive VR services, 14% of the claims. In contrast, 5,300 of the 22,100 indemnity claims from 2019 are expected to receive VR services. This is a decrease of 22% in the number of workers expected to receive VR services.

- The VR participation rate — the percentage of paid indemnity claims with a VR plan filed — increased from 19% in 2000 to 23% in 2008, and it had remained in the 23% to 25% range until 2020. Among non-COVID-19 indemnity claims with 2020 dates of injury, the VR participation rate was 21%.
  - *When COVID-19 claims were included, the VR participation rate for 2020 decreased to 13.7%.*

- The participation rate dropped because of the short duration of COVID-19 indemnity claims, most of which had a disability duration of two weeks or fewer. These workers did not require VR services to return to work. Workers with COVID-19 indemnity claims accounted for 38% of estimated indemnity claims in 2020, but only 3% of the claims with VR services.

Participation and injury severity

VR participation increases with injury severity, as measured by the amount of time the injured worker has been off the job and by the worker's degree of permanent partial disability (PPD). Some workers may receive a settlement instead of a PPD rating when the degree of impairment is in dispute.

For workers with indemnity claims closed between October 2019 and September 2021 the following was found.

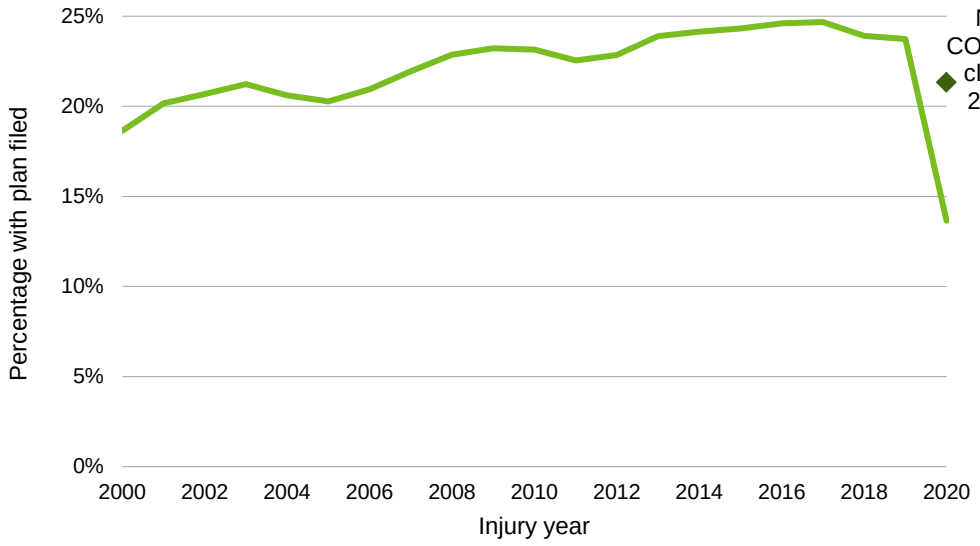
- VR participation ranged from 10% for workers with no more than three months of temporary total disability (TTD) benefits to 95% for workers with more than 12 months of these benefits (Figure 4.2).

- VR participation ranged from 13% for workers without PPD benefits (and no settlement agreement) to 73% for workers with PPD ratings of 20% or more (Figure 4.3).[51] VR participation was 46% for workers with a settlement and no PPD benefits.

- For workers with both a PPD percentage and a settlement, the VR participation rate was 75%.

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

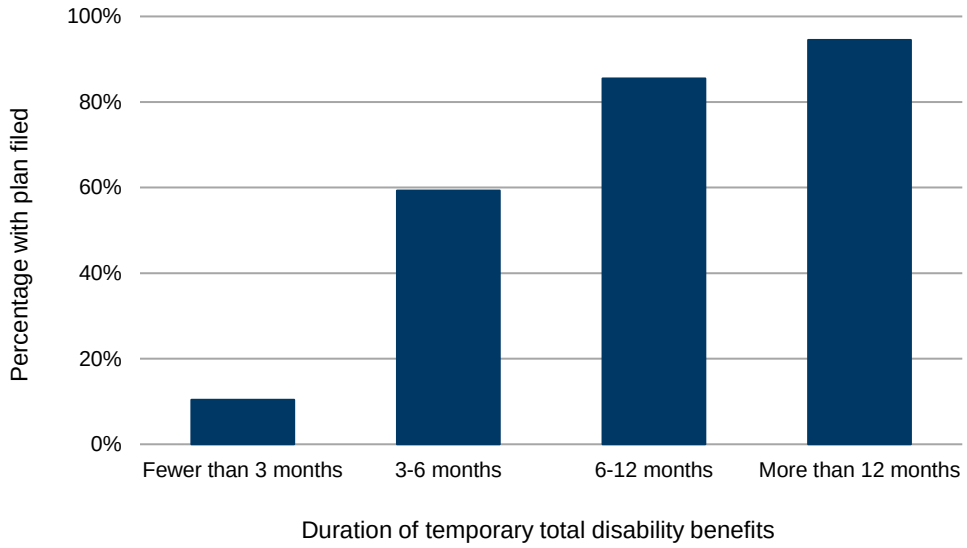
Figure 4.1. Percentage of indemnity claims with a vocational rehabilitation plan filed [1]



Injury year	Percentage with plan
2000	18.6%
2005	20.3
2010	23.1
2018	23.9
2019	23.7
2020	13.7

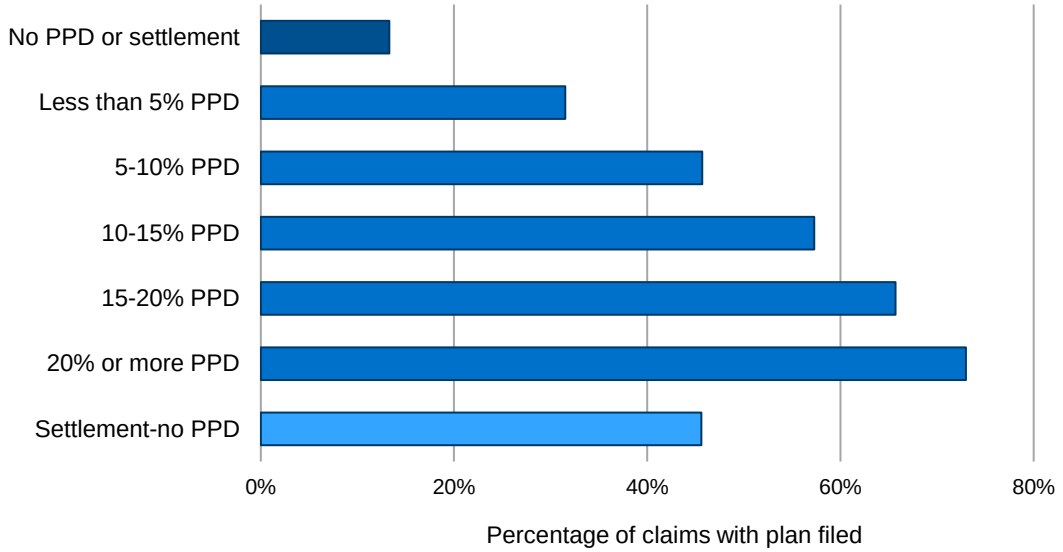
1. Developed statistics from DLI data (see Appendix C).

Figure 4.2. Percentage of paid indemnity claims with a VR plan filed by TTD duration, claim-closure years 2019-2021 combined [1]



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

Figure 4.3. Percentage of paid indemnity claims with a VR plan filed by permanent partial disability and settlement status, claim-closure years 2019-2021 combined [1]



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

Cost of vocational rehabilitation services

Adjusted for average wage growth, the average cost of VR services peaked in 2007 but has fallen since then.[52] These cost figures are estimates developed for 10 years of maturity, allowing for cost comparisons for the past 20 injury years.

The estimated mean and median costs for 2020 claims should be considered preliminary because of the uncertain effects of the COVID-19 pandemic and the resultant changes in the labor market. The pandemic led to a reduction of in-person meetings among QRCs and injured workers, employers and medical providers, possibly shifting expenses associated with travel time. Therefore, the initial values for 2020 injuries are developed with increases based, for the most part, on annual changes from years prior to 2020.

- The adjusted average cost of $9,360 for 2020 was unchanged from the previous year and 21% below the peak of $11,800 in 2007.

- The adjusted median cost of $5,720 for 2020 was $320 below the median for 2019. The median service costs in 2020 was 18% below the median peak of $6,980 in 2008.

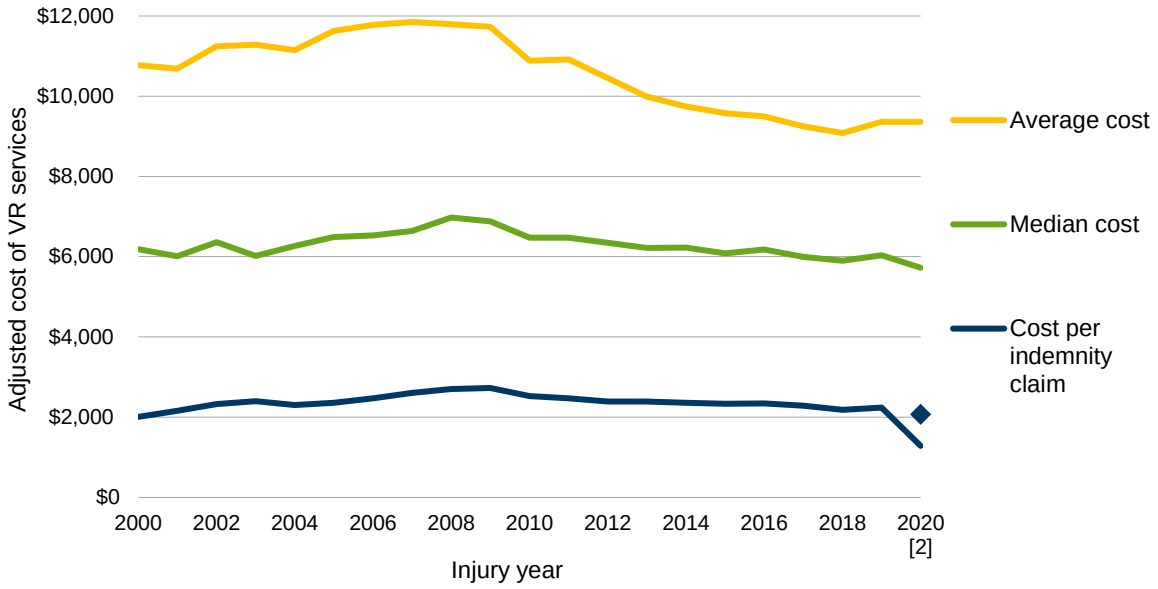
- The average costs are about 50% higher than the median costs because a small percentage of injured workers have VR services of more than $50,000. This raises the average cost, while the median is more representative of most claims with VR services.

[52]The VR service costs indicated here are those reported by QRCs to DLI on the plan-closure form. These costs do not always represent the amounts actually paid (see pp. 40-41).

- The adjusted total cost of VR services for injury-year 2020 is estimated at $38.5 million. This is a 22% decrease from the adjusted 2019 total of $49.5 million, and the same decrease as the number of workers receiving VR services. As shown in Figure 2.8, VR accounts for an estimated 2.8% of total workers' compensation system cost for payment-year 2020.

- Estimated adjusted VR service cost per indemnity claim (counting claims with and without plans) was $1,280 for 2020 claims. This value is 42% below the 2019 value of $2,240, which was consistent with costs for previous years. The cost per indemnity claim was affected by the large number of workers with COVID-19 indemnity claims who returned to work within two weeks of their illness date. When the total VR service cost per indemnity claim is estimated using only non-COVID-19 claims, the cost per claim increases to $2,060, 8% below the adjusted 2019 average.

Figure 4.4. Vocational rehabilitation service costs, adjusted for wage growth [1]



Injury year	Average cost	Median cost	Cost per indemnity claim
2000	$10,770	$6,190	$2,010
2007	$11,850	$6,640	$2,600
2010	$10,880	$6,480	$2,520
2018	$9,080	$5,900	$2,180
2019	$9,360	$6,040	$2,240
2020 [2]	$9,360	$5,720	$1,280

1. Developed statistics from DLI data. Costs are adjusted for average wage growth between the respective year and 2020.
2. Line shows estimated amount for all indemnity claims, including COVID-19 claims in 2020. The estimated cost was $2,060 for non-COVID-19 claims in 2020 (diamond marker).

Cost by service type

For plans closed in closure-year 2021 (October 2020 through September 2021), 92% of total VR cost was for services provided by QRCs and QRC firms, and 8% was for services provided by vendor placement firms.

Figure 4.5 provides a different breakdown of costs, showing the average, median and total costs for closure-year 2021 plans by service or expense type. Costs can be divided into consultation, plan services, and administrative costs and expenses. Plan services includes services by both QRCs and placement vendors. The table shows unadjusted dollar values for the reported plan costs and service or expense types.

- Median costs are much lower than the average costs because a few plans with very high costs affect the mean value while the median is more representative of typical plan costs.

- Plan services by QRCs and placement vendors accounted for 63% of total plan costs; within plan services, two-thirds of the costs are from medical management services. The medical management service subgroup includes medical management, functional capacity evaluation and work hardening or adjustment.

- The placement services subgroup, which includes job-seeking skills training, job development, job placement and job placement follow-up, accounted for 18% of the plan services. Only 29% of the plans included placement services. Vendor placement services accounted for 55% of the placement service costs.

Trends in the distribution of plan costs indicate plan services have decreased by eight percentage points between closure-years 2012 and 2021 (Figure 4.6).[53]

- Administrative costs and expenses, which includes administrative costs, legal expenses and other expenses, have increased by seven percentage points, as consultation costs have remained nearly constant. As shown in Figure 4.6, these changes have been gradual over the entire period, with little change from 2020 to 2021.

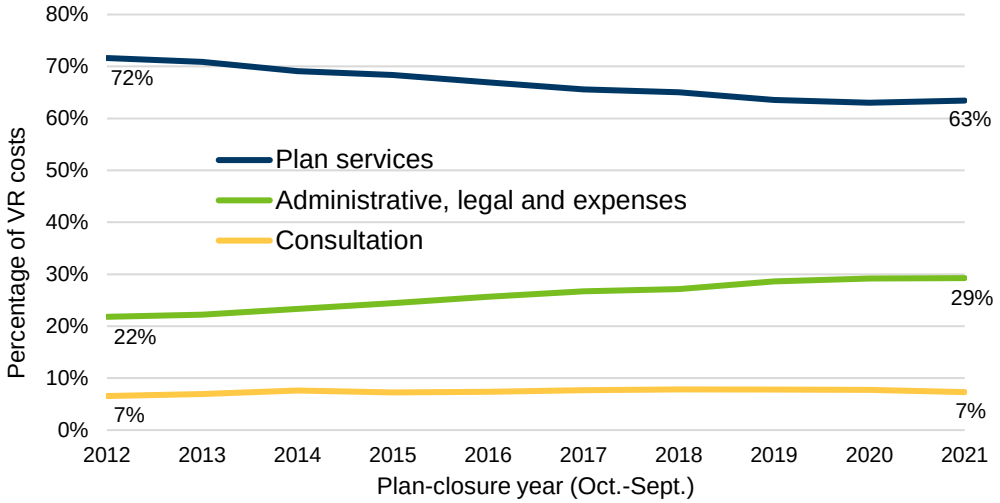
- Within these cost groups, some subgroups have different trends. Costs for the medical management subgroup increased from 50% of plan services in closure-year 2012 to 67% of plan services in closure-year 2021. During this period, placement services costs decreased from 31% to 18% of all plan services.

Figure 4.5. Vocational rehabilitation cost by service or expense type group, plan-closure year 2021 [1]

Service or expense type	Average	Median	Sum	Percentage of total costs
Consultation	$ 640	$ 570	$ 3,101,000	7%
Plan services	$ 5,580	$ 3,360	$ 26,894,250	63%
Administrative, legal and expenses	$ 2,570	$ 1,730	$ 12,408,080	29%
Total plan costs	$ 8,800	$ 5,900	$ 42,403,720	100%

[53]Values shown in Figure 4.6 are rounded; the percentage point differences are based on unrounded values. The trend starts in 2012 because this is when QRCs consistently used the R-8 Notice of Rehabilitation Plan Closure form with the cost breakdown needed for this analysis.

Figure 4.6. Percentage of vocational rehabilitation costs by expense type group [1]



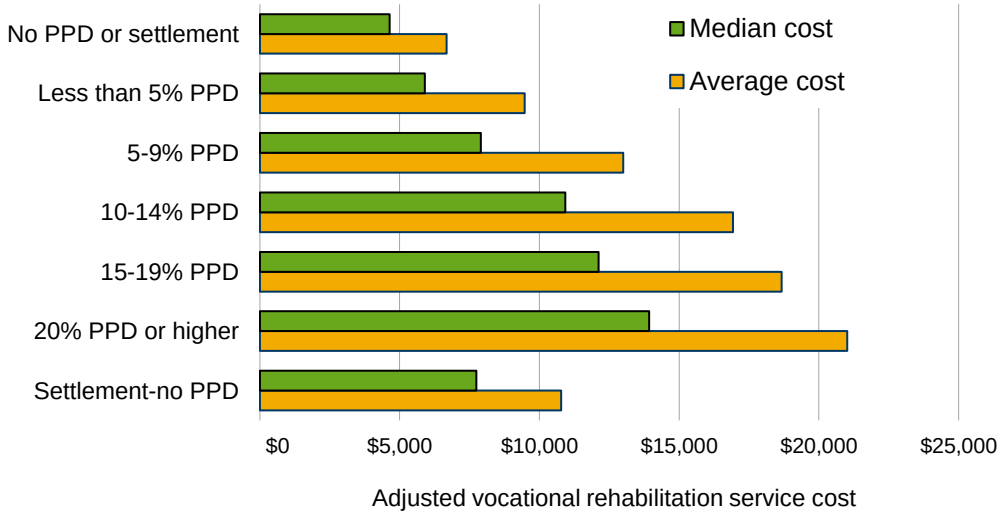
Cost and injury severity

VR service costs increase with injury severity as measured by PPD rating, reflecting increases in service contact hours and in the types of services.

- For plan-closure years 2019 to 2021, participants with higher PPD ratings had progressively higher VR costs. For workers with PPD ratings of 15% or more, the average cost of VR services was more than double the cost for workers with PPD ratings of 5% or less.

- For workers with a settlement but no reported PPD rating, their average VR service cost was $10,800.

Figure 4.7. Vocational rehabilitation service cost by PPD rating and settlement status, adjusted for wage growth, plan-closure years 2019-2021 combined [1]



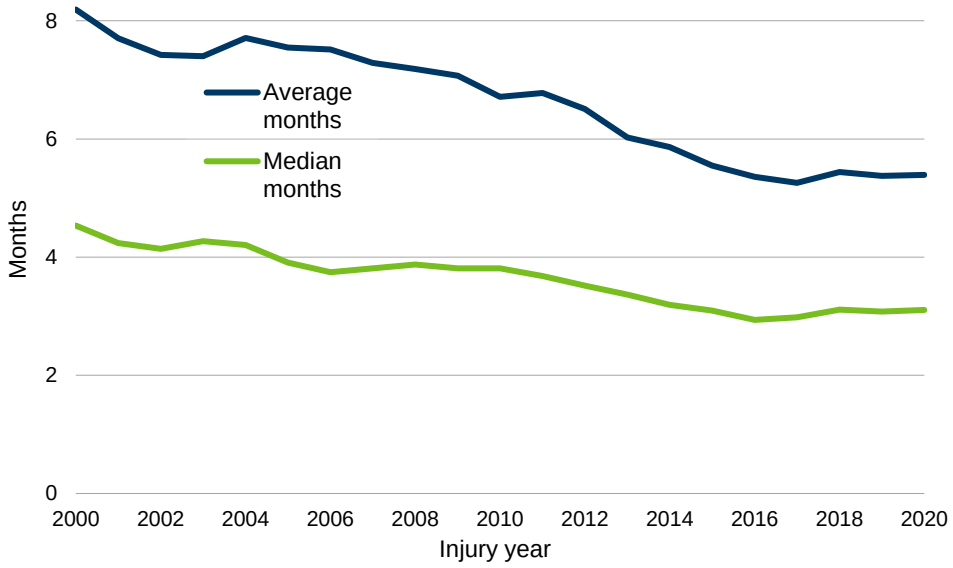
1. Data from DLI. Costs are adjusted for average wage growth between the year of injury and 2020. Plan-closure years start in October and end in September of the indicated year. Some of the workers with a PPD benefit may also have received a settlement that included consideration for additional PPD. The upper range of each PPD category extends to all values up to the next category's start value.

Timing of services

Prompt service provision is closely linked to successful VR outcomes. The average time from injury to the start of VR services has decreased by almost three months since 2000 and two months since 2006. The rehabilitation consultation is considered the start of VR services for this measure.

- The estimated average time from the date of injury to the start of VR services was 5.4 months for injury-year 2020, unchanged from the previous two years and down 34% from 2000; the estimated median time was 3.1 months for 2020, unchanged from the previous two years and down 32% from 2000.
- The time from injury to the start of services has leveled off since 2016.
- Among plans closed in 2021, 47% of workers with VR started within three months of injury and 75% started within six months.
- Among VR participants with plans closed in 2021, those who began services within three months of injury, as compared to those starting more than a year after their injury, had:
  - 15% lower average VR service costs ($9,590 versus $11,280);
  - 16% shorter average service durations (13.6 months versus 16.2 months); and
  - Slightly better chances of returning to work at plan closure (60% versus 56%).

Figure 4.8. Time from injury to start of vocational rehabilitation services [1]



Injury year	Average months	Median months
2000	8.2	4.5
2018	5.4	3.1
2019	5.4	3.1
2020	5.4	3.1

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

Service duration

VR service duration — measured by the time between the initial consultation and plan closure — has increased and then fallen since 2005.

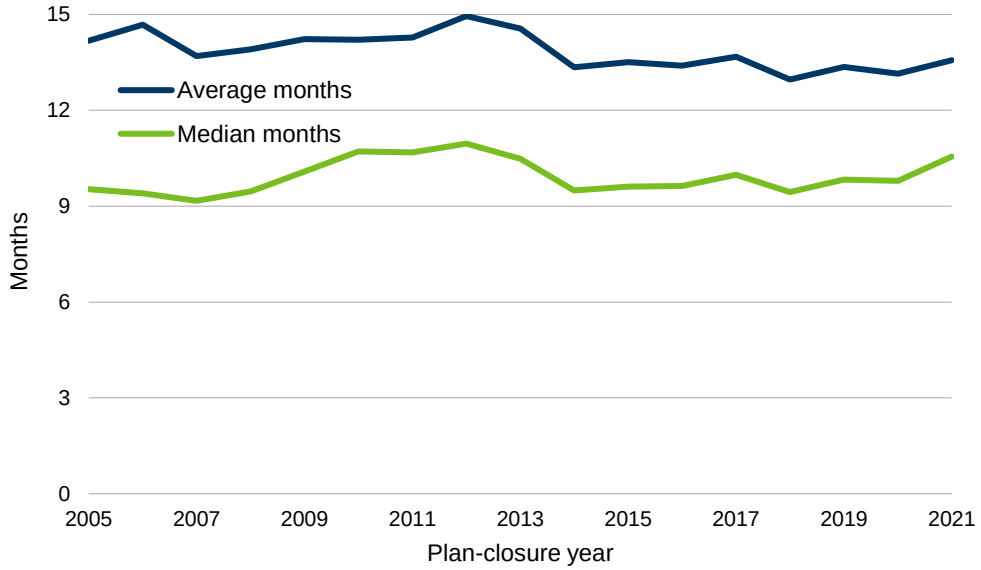
- The estimated average service duration peaked at 14.9 months in 2012 and decreased to 13.0 months in 2018. The estimated average of 13.6 months for plans closed in the 2021 closure year is half a month longer than the estimate for 2020 closures.

- The estimated median service durations have remained near 10 months since 2014. The 2021 estimated median of 10.5 months is the longest median value since 2013.

- The relatively high average service durations for 2008 through 2013 suggest an effect of the Great Recession. The increases in the 2021 closure-year estimates are likely the result of effects of the COVID-19 pandemic on labor markets from October 2000 through September 2021. COVID-19 cases peaked during the fall of 2020 and receded after vaccinations became widely available.

- Among plans closed in 2021, average service duration was: 10.6 months for participants who returned to work with their pre-injury employer; 16.8 months for those who went to a different employer; and 16.5 months for workers who had their plans closed without a reported return to work.

Figure 4.9. Vocational rehabilitation service duration [1]



Plan-closure year	Average months	Median months
2005	14.2	9.5
2012	14.9	11.0
2019	13.4	9.8
2020	13.1	9.8
2021	13.6	10.5

1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury-year 1998, to be sufficiently mature. Plan-closure years start in October and end in September of the indicated year. See Appendix C.

Reason for plan closure

While the trends for plan closure reasons have stabilized since 2011, estimated results for completions in 2020 and 2021 indicate possible effects of the economic disruption caused by the COVID-19 pandemic. Workers may have had difficulty finding suitable employment and some workers may have been more willing to settle their claims.

- The proportion of plans closed with completion of services reached 50% in 2019 and dropped to 46% in 2020 before rebounding to 49% in 2021. (Figure 4.10).

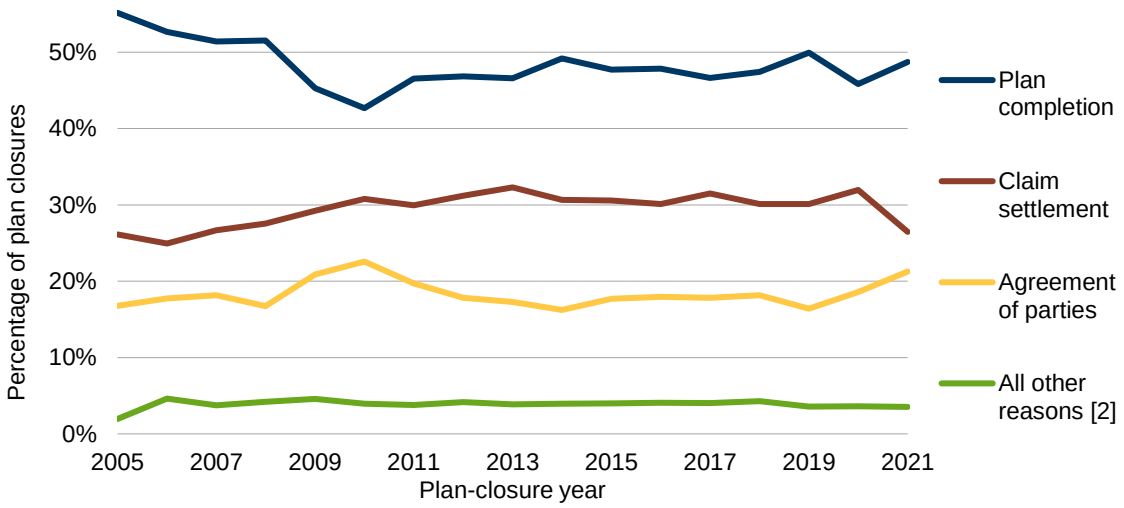
- The proportion of plans closed by claim settlement varied between 30% and 32% between 2009 and 2020. The percentage dropped to 27% in 2021.

- The decreased proportion of VR plans closed because of claim settlement is consistent with the decrease in the percentage of paid indemnity claims with settlements (See Part 3, Figure 3.2).

- The proportion of plans closed by agreement of the parties remained in range of 17% to 18% for 2012 to 2018, then dipped to 16% in 2019 before increasing to 19% in 2020 and to 21% in 2021.

- A return to work is reported for most participants who complete their plans (97% for 2021 closures) but for only a minority of workers whose plans close for any other reason (22%).

Figure 4.10. Reason for plan closure [1]

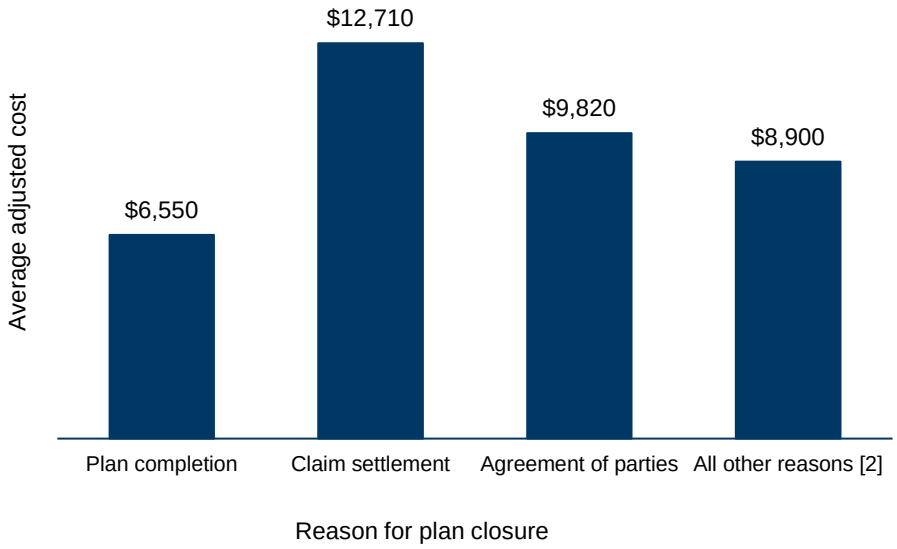


Plan-closure year	Plan completion	Claim settlement	Agreement of parties	All other reasons [2]
2005	55.2%	26.1%	16.8%	2.0%
2010	42.7	30.8	22.6	4.0
2019	49.9	30.1	16.4	3.6
2020	45.8	32.0	18.6	3.6
2021	48.7	26.5	21.3	3.5

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

- Plan costs vary by reason for closure (Figure 4.11). For 2021 closures, the highest average adjusted plan costs were for plans closed with a settlement ($12,710) and the lowest were for completed plans ($6,550). This variation occurs mainly because of differences in the type and duration of services provided.[54]

Figure 4.11. Plan cost by reason for plan closure, plan-closure year 2021 [1]



1. Plan costs were adjusted to 2020 wage levels according to the worker's date of injury. Plan-closure year 2021 started Oct. 1, 2020, and ended Sept. 30, 2021.
2. See note 2 in Figure 4.10.

Return-to-work status

The goal of VR is to return injured workers to a job related to the employee's former employment or to a job in another work area that produces an economic status as close as possible to what the employee would have enjoyed without disability. Returning to work is affected by many factors, including VR services, the job market, injury severity, worker job skills and education, availability of job modifications and claim litigation.

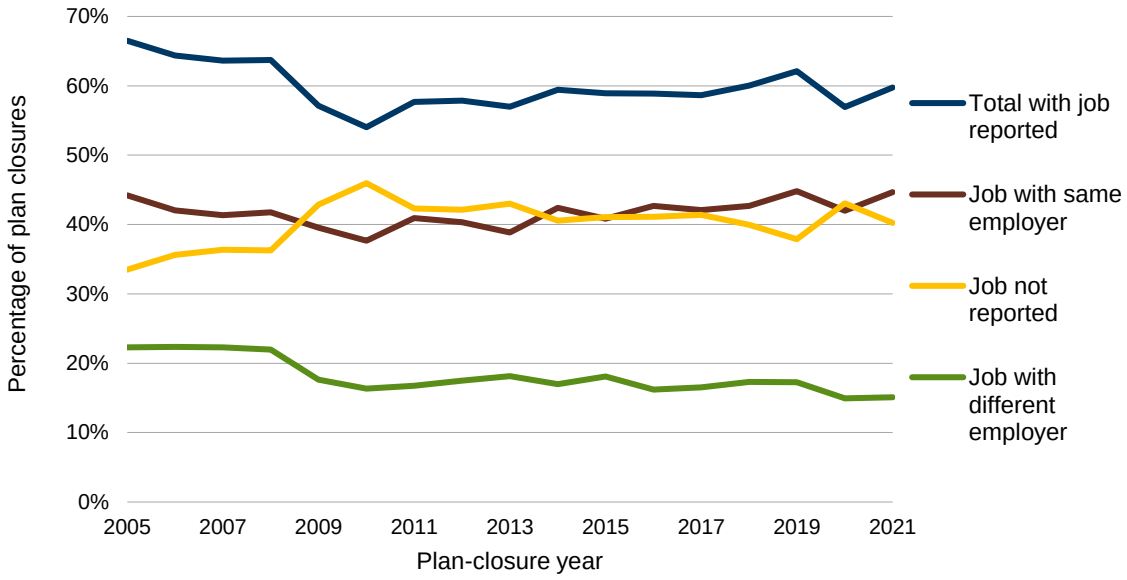
- The estimated percentage of VR participants with a job reported at plan closure was lower in 2020 than any year since 2010 and then climbed in 2021, probably because of the changes in economic conditions and the effect on businesses caused by the COVID-19 pandemic. The increase in 2021 was mainly because of an increase in workers returning to the same employer (Figure 4.12).

- The percentage of participants with a job reported at plan closure closely parallels the percentage of plans closed because of completion (Figure 4.10). This is expected since a job is reported at closure for almost all workers who complete their plans, but for only a minority of others.

[54]This is shown by separate DLI analysis.

- For plan closures in 2021, the average cost of VR services for participants returning to work with their pre-injury employer ($6,370) was 45% of the cost of workers going to a different employer ($14,060) and 54% of the service cost for workers not returning to work at plan closure ($11,800).

Figure 4.12. Return-to-work status [1]



Plan-closure year	Job with same employer	Job with different employer	Total with job reported	Job not reported
2005	44.2%	22.3%	66.5%	33.5%
2010	37.7	16.4	54.0	46.0
2019	44.8	17.3	62.1	37.9
2020	42.0	14.9	56.9	43.1
2021	44.7	15.1	59.8	40.2

1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury-year 1998, to be sufficiently mature. Plan-closure years start in October and end in September of the indicated year. See Appendix C.

Return-to-work status and plan duration

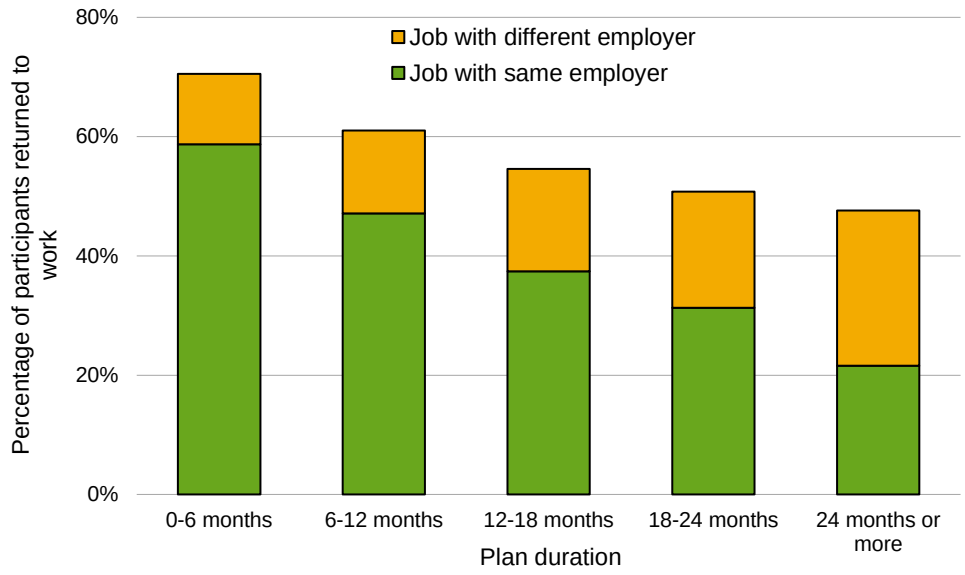
The percentage of VR participants with a reported return to work decreases with plan duration (Figure 4.13).

- For plan closures in 2019 to 2021 combined, the percentage of workers with a reported return to work ranged from 71% for plans lasting no more than six months to 48% for plans lasting 24 months or longer.

- The percentage of workers returning to their pre-injury employer was 59% for the shortest plans and 22% for the longest plans.

- The percentage of workers finding a job with a different employer was 12% for the shortest plans and 26% for the longest plans.

Figure 4.13. Return-to-work status by plan duration, plan-closure years 2019-2021 combined [1]



1. Data from DLI. Plan-closure years start in October and end in September of the indicated year.

Return-to-work wages

Distribution

For VR participants returning to work, the return-to-work wage, on average, is slightly less than the pre-injury wage, but this varies widely (Figure 4.14).

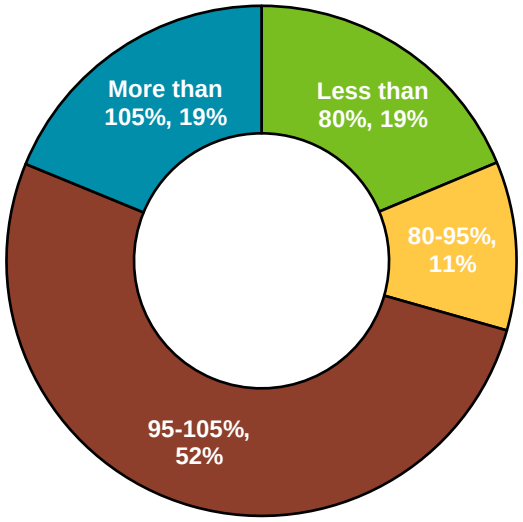
- For plan closures in 2019 to 2021 combined, 71% of VR participants returning to work earned more than 95% of their pre-injury wage, but 19% earned less than 80% of their pre-injury wage.

- Return-to-work wage recovery was related to injury severity as measured by PPD rating. For plan closures in 2019 to 2021 combined, workers without a PPD payment or a settlement agreement[55] had an average wage ratio of 103% of their pre-injury wage, while workers with PPD ratings of 15% or higher who returned to work had an average wage ratio of 93%.

- Average return-to-work wage rates also vary with plan duration. For 2019 to 2021 closures, the average return-to-work wage ratio was 104% for VR plans of fewer than 12 months duration, 98% for plans between 12 and 18 months, and 91% for plans with longer service durations.

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

Figure 4.14. Ratio of return-to-work wage to pre-injury wage for participants returning to work, plan-closure years 2019-2021 combined [1]



Average wage ratio: 96%

Median wage ratio: 100%

1. Data from DLI.
2. Plan-closure years start in October and end in September of the indicated year.

Return-to-work wages: trend

Among VR participants returning to work at plan completion, the ratio of the return-to-work wage to the pre-injury wage changed little between 2005 and 2021 for those returning to their pre-injury employer (Figure 4.15). For workers going to a different employer, the ratio declined in 2008 and 2009 but recovered in later years, reaching a new high value in 2021.

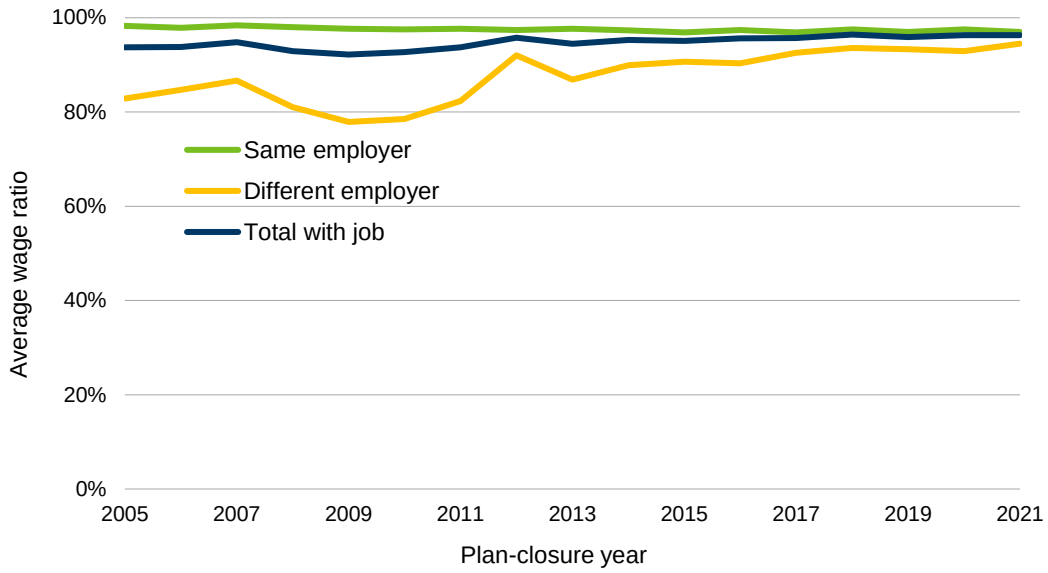
- For workers returning to their pre-injury employer, the average wage ratio was between 97% and 98% from 2005 to 2021.

- For workers going to a different employer, the wage ratio was 95% for closures in 2021; this was 17 percentage points higher than the low point of 78% reached in 2009 and the highest value this measure has reached since tracking started.

- The dip in the wage ratio for 2008 to 2011 for those going to a different employer suggests an effect of the Great Recession.

- The increase in the wage ratio for workers returning to work in closure-year 2021 may reflect both increasing post-pandemic wages and a greater range of job opportunities due to labor market shortages.

Figure 4.15. Average ratio of return-to-work wage to pre-injury wage by employer type [1]



	Average ratio of return-to-work wage to pre-injury wage		
Plan-closure year	Same employer	Different employer	Total with job
2005	98.3%	82.9%	93.7%
2009	97.7	77.9	92.2
2019	97.0	93.3	95.9
2020	97.6	92.9	96.3
2021	97.0	94.5	96.3

1. Developed statistics from DLI data. The statistics by plan-closure year begin with 2005 to allow the data concerned, which begins with injury-year 1998, to be sufficiently mature. Plan-closure years start in October and end in September of the indicated year. See Appendix C.

Part 5: Dispute resolution

This part of the report presents data concerning workers' compensation disputes and Department of Labor and Industry (DLI) dispute-resolution activities. Workers' Compensation System Reports through 2016 also included data about dispute resolution at the Office of Administrative Hearings (OAH). In March 2018, OAH implemented a new court case-management system (C-Track). DLI implemented a new workers' compensation data system (Work Comp Campus[56]) in November 2020. These systems replaced the one DLI and OAH had previously shared. Because of the separate systems, this report, like last year's, excludes data concerning OAH dispute-resolution activities. As DLI and OAH work together to enhance data-sharing between the two new systems, future reports may include OAH dispute-resolution statistics.

The Campus implementation has required a new system of reporting, tracking and coding dispute-related information and calculating dispute statistics. This year's report reflects the changes during this period of transition, resulting in some discontinuities in the statistics.

Some statistics in this part are by year of injury; these are usually "developed" statistics.[57] Statistics about dispute-resolution filings and timelines are displayed by the year the dispute was filed. Some statistics are by the year an action occurred and are presented through 2021.

Major findings

- *There were very few disputes associated with COVID-19 claims — the dispute filing rate was 0.5% for COVID-19 claims in 2020 and 11.8% for non-COVID-19 claims (Figure 5.2).*

- DLI received about 7,600 dispute filings in 2021 among the four major dispute types – claim petitions, discontinuance disputes, medical requests and rehabilitation requests. This was the same number as in 2019 and 500 more than in 2020 (Figure 5.3).

- The denial rate for non-COVID-19 claims was 17%. This was above the rate of 15% for 2019 and equal to the rate of 17% in 2015, the previous high rate in the past 20 years (Figure 5.4).
    - *The denial rate of filed indemnity claims, with COVID-19 claims included, was 23% for 2020. This was substantially above the rate of 15% for 2019. A large part of the 2020 increase was due to the influx of COVID-19 claims; the denial rate for COVID-19 claims was 28%.*

[56]"Campus" stands for Claims Access and Management Platform User System.

[57]See "Developed statistics" on p. 2.

- Between 2000 and 2021, the certification rate for medical and vocational rehabilitation disputes at DLI combined dropped from 63% to 51% (Figure 5.3).[58] A majority of noncertifications of medical and rehabilitation disputes occurred because the issues were resolved (Figures 5.4 and 5.5).

- In 2021, 48% of the scheduled DLI proceedings were mediations, but 72% of the completed proceedings were mediations; the remaining 38% were administrative conferences (Figures 5.6 and 5.7).

- For medical and rehabilitation requests received in 2021, the median times from the request to the first scheduled DLI conference date were 72 and 25 days, respectively. The time interval for medical requests has been increasing since 2013. The interval for rehabilitation requests was close to the intervals for recent years, reflecting DLI's response to the 2013 law change requiring that most rehabilitation conferences be scheduled within 21 days of the request (Figure 5.8).

- Eight percent of DLI scheduled proceedings in 2021 required interpreters, an increase from 5% in 2015 (Figure 5.13).

Background

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

Types of disputes

Most disputes in Minnesota's workers' compensation system concern one or more of the three types of benefits and services the system provides: monetary benefits; medical services; and vocational rehabilitation services.

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

These disputes are typically filed by the injured worker and handled by DLI and OAH in the following ways.

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

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

[58]See the description of DLI dispute certification process on p. 58.

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

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

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

Dispute resolution activities and proceedings

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

Dispute resolution at DLI

DLI carries out a variety of dispute-resolution activities.

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

Dispute certification — In a medical or vocational rehabilitation dispute, DLI must certify a dispute exists and informal intervention did not resolve the dispute before an attorney may charge for services.[59] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

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

Administrative conference — DLI conducts administrative conferences about medical or vocational rehabilitation (VR) issues presented on a medical or rehabilitation request unless it has referred the issues to OAH or the issues have otherwise been resolved. DLI refers medical disputes other than those about fee levels to OAH if they involve more than $7,500 at the time of dispute filing, and it may refer medical or VR disputes for other reasons.[60] The DLI specialist usually attempts to bring the parties to agreement during the conference. If

[59]Minnesota Statutes § 176.081, subdivision 1(c).

[60]Minn. Stat. § 176.106. In 2005, the Legislature increased the monetary limit on DLI jurisdiction in medical disputes from $1,500 to $7,500. In 2013, the Legislature removed this limit for disputes about medical fees, effective May 17, 2013. Also, DLI usually refers medical disputes to OAH if surgery is involved, and it may refer medical or VR disputes if litigation is pending at OAH or the issues are

agreement is reached, the specialist issues an "order on agreement." If agreement is not reached, the specialist issues a "decision-and-order." A party may appeal a DLI decision-and-order or order on agreement by requesting a *de novo* hearing at OAH.

Dispute resolution at OAH

OAH performs the following dispute-resolution activities.

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

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

Administrative conference — With some exceptions, OAH conducts administrative conferences about issues presented on a medical or rehabilitation request that have been referred from DLI (see above). In some cases, medical and rehabilitation request disputes referred from DLI are heard in a formal hearing (see below). OAH also conducts administrative conferences where requested by the claimant in a dispute about discontinuance of wage-loss benefits.[61] If agreement is not reached at the conference, the OAH judge issues a decision-and-order. A party may appeal an OAH decision-and-order by requesting a *de novo* formal hearing at OAH.

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

Dispute resolution by the parties

Often the parties in a dispute reach agreement outside of the dispute-resolution process at DLI or OAH, although this is often spurred by DLI or OAH initiatives, such as the scheduling of proceedings. Sometimes the party initiating a dispute or an appeal of a decision-and-order withdraws the dispute or the appeal. Sometimes the parties agree informally, sometimes without notifying DLI or OAH. Disputes often settle by means of a stipulation for settlement, which may be reached while the dispute is at DLI or OAH. The stipulation for

unusually complex. Primary liability disputes are outside of administrative conference jurisdiction and must be filed on a claim petition, which leads to a settlement conference or hearing at OAH.

[61]Minn. Stat. § 176.239.

settlement is usually incorporated into an award on stipulation issued by an OAH judge. An award on stipulation may occur in any type of dispute but occurs most commonly in claim petition disputes.

Dispute resolution in the Union Construction Workers' Compensation Program

The 1995 workers' compensation law change authorized employers and employees, through collective bargaining agreements, to establish certain obligations and procedures relating to workers' compensation in their workplaces.[62] These obligations and procedures may include (among others) alternative dispute-resolution. If a collective bargaining agreement meets conditions in the law, the agreement must be recognized as valid and binding by DLI, OAH, the Workers' Compensation Court of Appeals (WCCA) and the Minnesota Supreme Court. The Union Construction Workers' Compensation Program (UCWCP) was created under this process and has been operating since 1997; it includes alternative dispute-resolution as one of its features. From 2014 to 2018, an annual average of 291 paid indemnity claims were involved in UCWCP. This accounted for about 13% of annual paid indemnity claims in the construction industry for that period.[63]

The UCWCP aims to provide efficient and non-adversarial dispute resolution, quality medical and rehabilitative care, prompt payment of appropriate indemnity benefits[64] and prompt and safe return to union work, with the goal of minimizing losses for employers and employees.

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

During calendar-year 2021, UCWCP provided intervention for 38 cases, fully resolving the issues in 30 of the disputes. Fifty disputes went to facilitation, 47 of which reached full agreement. Among the 31 disputes using mediation, 28 reached full agreement. Eleven disputes used arbitration; five reached full agreement and six were either resolved or withdrawn prior to the proceeding.

Dispute filings and rates

At this time, it is uncertain how much of the changes in the reported measures are due to changes in the dispute-resolution activity itself, changes due to variations in the number of filed claims – including COVID-19 claims and the decrease in non-COVID-19 claims in 2020, changes due to how disputes are filed and recorded, and changes due to the database changes at OAH and DLI and the communication between the two agencies. While previous editions of the system report have included developed estimates, the combination of these effects creates uncertainty about these values and estimates of ultimate dispute rates would be too unreliable to publish.

The undeveloped dispute rates (Figure 5.1) will almost always show a decreasing trend because of decreasing claim maturity. Claim petitions account for about 70% of each year's disputes. Most noticeable is the increased

[62]Minn. Stat. § 176.1812.

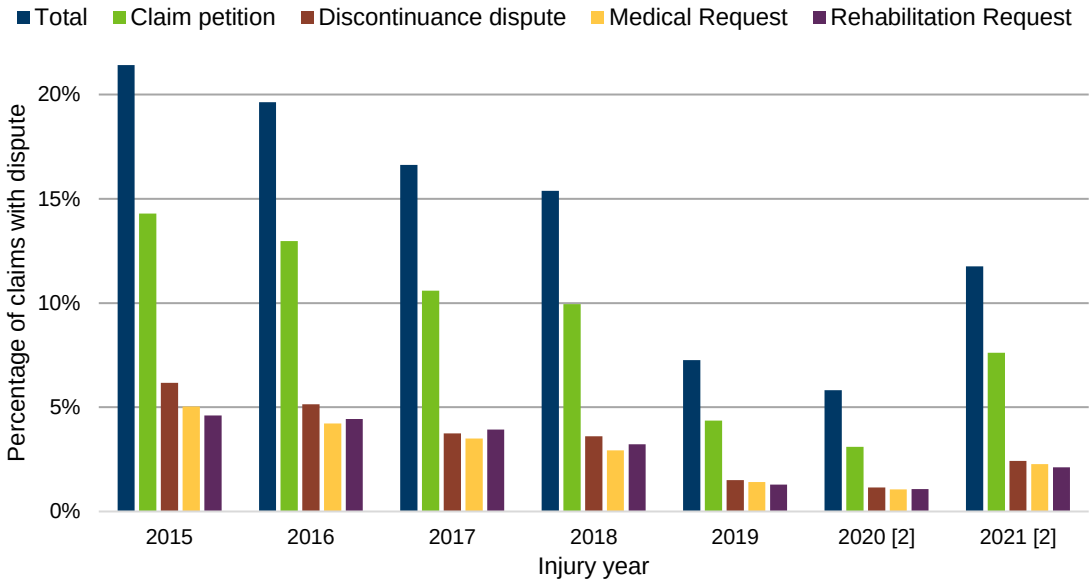
[63]More information is available at ucwcp.com.

[64]The indemnity benefits provided must be those in Minnesota law.

number of disputes for the least-mature injury year, 2021, which has higher percentages of claims with all four dispute types than each of the two previous years.

The COVID-19 pandemic affected dispute filing statistics. There were very few disputes associated with COVID-19 claims in 2020 and 2021 (using year of injury, Figure 5.2).[65] This is because the average claim duration for COVID-19 claims was very short (Figure 3.3) and especially short relative to the time needed to schedule and hold conferences. Many COVID-19 claims did not receive medical treatment, which generates many disputes.[66]

Figure 5.1. Percentage of indemnity claims with filed disputes [1]



1. Percentages are not developed to a constant maturity. Claim petitions are a percentage of all filed indemnity claims. All other disputes values are percentages of paid indemnity claims.
2. Displayed values are for all claims, including COVID-19 claims.

Figure 5.2. Dispute filing by COVID-19 status

	Number of disputes [1]		Dispute rate [2]	
Injury year	COVID-19 claims	Non-COVID-19 claims	COVID-19 claims	Non-COVID-19 claims
2020	60	1,986	0.5%	11.8%
2021	5	821	0.2%	6.8%

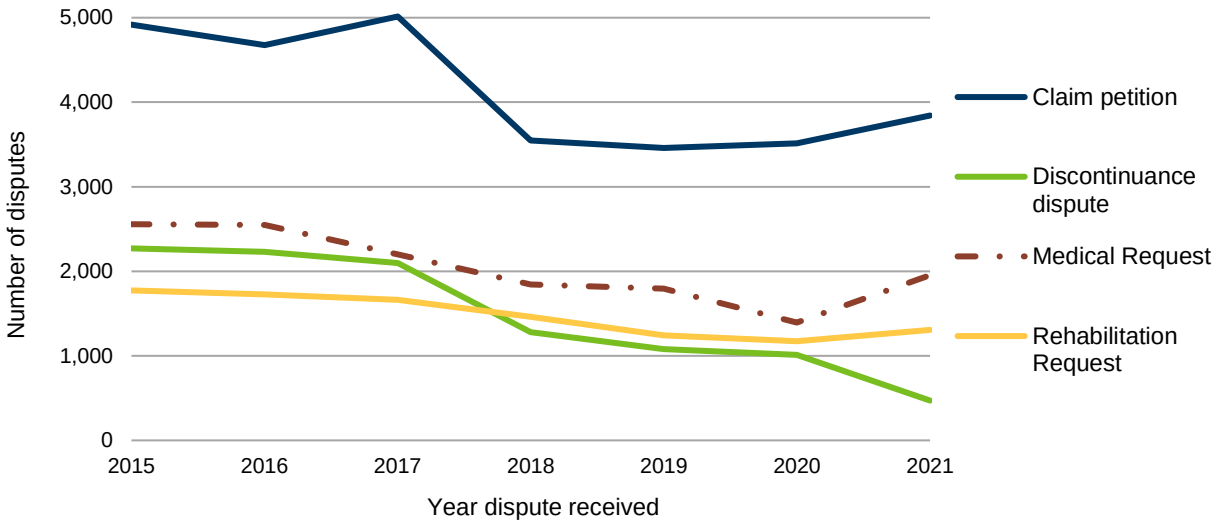
1. The number of disputes filed by Dec. 31, 2021, for workers injured in 2020 and 2021.
2. Dispute rate per 100 indemnity claims of that claim type.

[65]The numbers in Figure 5.2 are not developed; they show the number of disputes filed by Dec. 31, 2021, for workers injured in 2020 and 2021. Therefore, the number of disputes shown for 2020 claims have an extra year of maturity compared with 2021 claims.

[66]NCCI and MWCIA (among other insurance rating bureaus), "COVID-19's Impact on Workers Compensation, A Multi-Bureau Collaboration," 2022. mwcia.org/Media/Default/PDF/Navigation/COVID-19_Insights.pdf.

Without the ability to develop dispute activity, examination of dispute filings by filing year provides insights into dispute activity. The number of disputes filings for the four major types of disputes — claim petitions, discontinuance disputes, medical requests and rehabilitation requests — decreased by 34% from 2015 to 2021 (Figure 5.3).

Figure 5.3. Number of dispute filings and requests by type



The number of claim petition filings in the DLI claims database decreased by 29% (about 1,500 filings) from 2017 to 2018, then increased by 10% (300 filings) from 2020 to 2021. The onset of the COVID-19 pandemic in 2020 did not appear to substantially affect claim petition filings.

Discontinuance disputes decreased by half from 2017 to 2019 and dropped by another 54% from 2020 to 2021. This decrease in reported discontinuance disputes might have been affected by implementation of the new OAH database and the lack of data available. The drop from 2020 might also be a result of the short average durations of COVID-19 claims and there were fewer non-COVID-19 claims active in 2020 and 2021 available to file discontinuance disputes.

The number of medical requests decreased from 2016 through 2020, then increased in 2021 to a level higher than in 2018. Rehabilitation requests followed a similar pattern, except the 2021 increase was not as steep.

Denial of primary liability

COVID-19 claims appear to have affected the 2020 denial rates (Figure 5.4).[67] Although the COVID-19 presumption enabled many first responders, corrections workers and health care workers to receive workers' compensation benefits, the denial rate for COVID-19 claims was 28%, significantly higher than the 17% rate for non-COVID-19 claims.

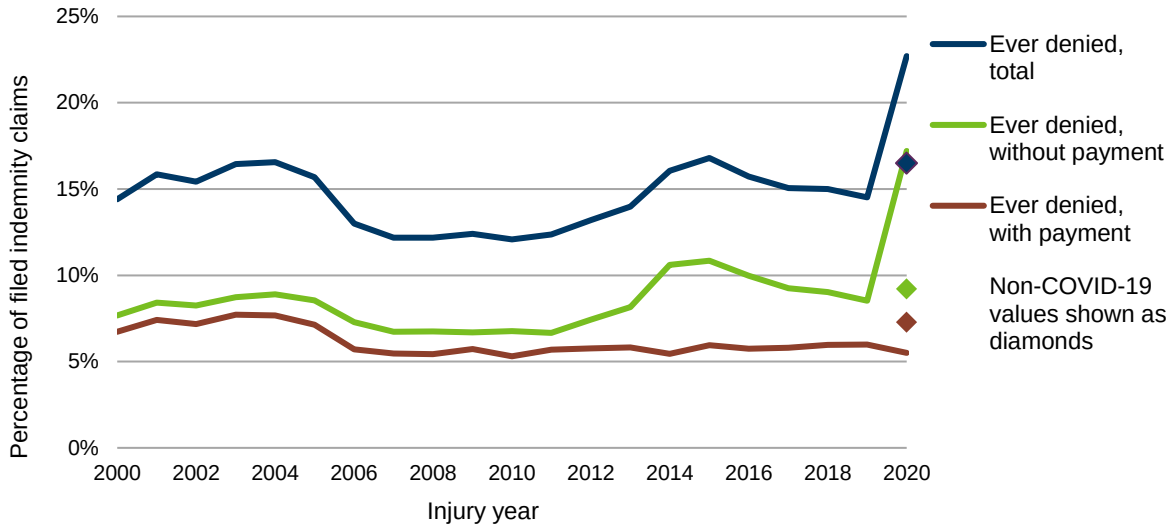
Including COVID-19 claims leads to large increases in the percentage of claims for indemnity benefits with a denial and in the percentage of claims denied without any indemnity paid. Because of the short duration of most

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

COVID-19 episodes, denials were rarely challenged by workers, so very few workers had both a denial and a benefit payment. Only 8% of the COVID-19 claims with a denial had an indemnity benefit payment, compared with 44% among non-COVID-19 claims with a denial.

Among non-COVID-19 claims (shown with a diamond marker in Figure 5.4), the estimated percentages for 2020 claims were slightly higher than the 2019 values.

Figure 5.4. Denial rates for filed indemnity claims [1]



1. Developed statistics from DLI data (see Appendix C). Filed indemnity claims are claims for indemnity benefits, including claims paid and claims never paid. Denied claims include claims denied and never paid, claims denied but eventually paid and claims initially paid but later denied.

	Percentage of filed indemnity claims ever denied			
Injury year	Without payment	With payment	Total	Pctg. of denied filed indemnity claims ever paid
2000	7.7%	6.7%	14.4%	46.7%
2018	9.0%	6.0%	15.0%	39.8%
2019	8.5%	6.0%	14.5%	41.2%
2020	17.2%	5.5%	22.7%	24.2%
2020 Non-COVID-19	9.2%	7.3%	16.5%	44.2%

Dispute certification

The certification process is triggered by the filing of a dispute certification request for medical or rehabilitation issues or a medical or rehabilitation request (if a dispute certification request was not filed). In 2021, DLI's Alternative Dispute Resolution (ADR) specialists made certification decisions about 1,470 medical dispute filings and 870 rehabilitation dispute filings.

The percentage of medical and rehabilitation requests that are certified as disputes are lower than 15 years ago, although they have been increasing since 2017 (Figure 5.5). Between 2001 and 2017, the percentage of medical disputes certified decreased from 60% to 47%. The percentage of medical disputes certified has increased since 2017 to 54% in 2021. Among rehabilitation requests, the percentage certified decreased from 55% in 2001 to 30% in 2017, then increased to 46% in 2021.

The increase in noncertification of medical disputes since 2001 has resulted entirely from an increase in the percentage not certified because the issues were resolved (Figure 5.6). In 2021, 67% of medical requests not certified were resolved by ADR intervention during the certification process.

In contrast with medical disputes, the increase in noncertification of rehabilitation disputes between 2001 and 2017 has resulted from increases in both the percentage not certified because the issues resolved and the percentage not certified for other reasons (Figure 5.7). Most of the noncertified medical requests were resolved by ADR intervention. The percentage of noncertified rehabilitation requests resolved by intervention during the certification process dipped from 65% in 2019 to 56% in 2020, before jumping up to 70% in 2021. It is likely that disruptions associated with the onset of the COVID-19 pandemic affected the resolution process.

Figure 5.5. Percentage of medical and rehabilitation disputes certified

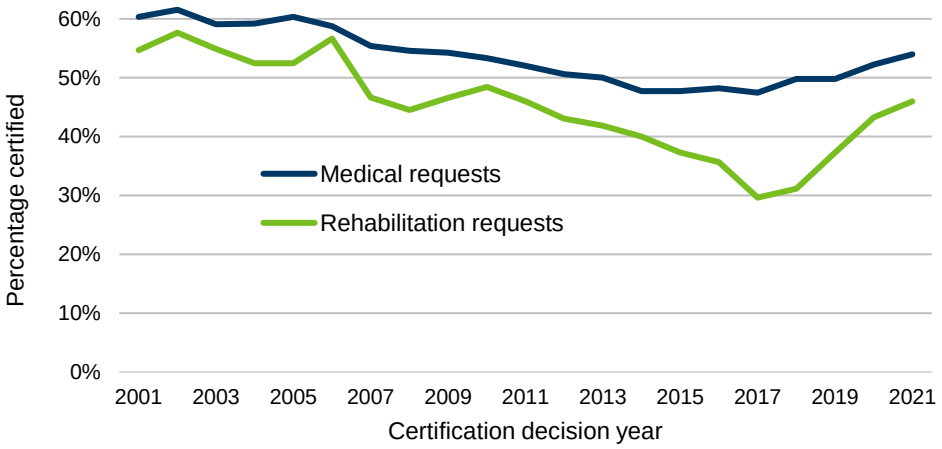
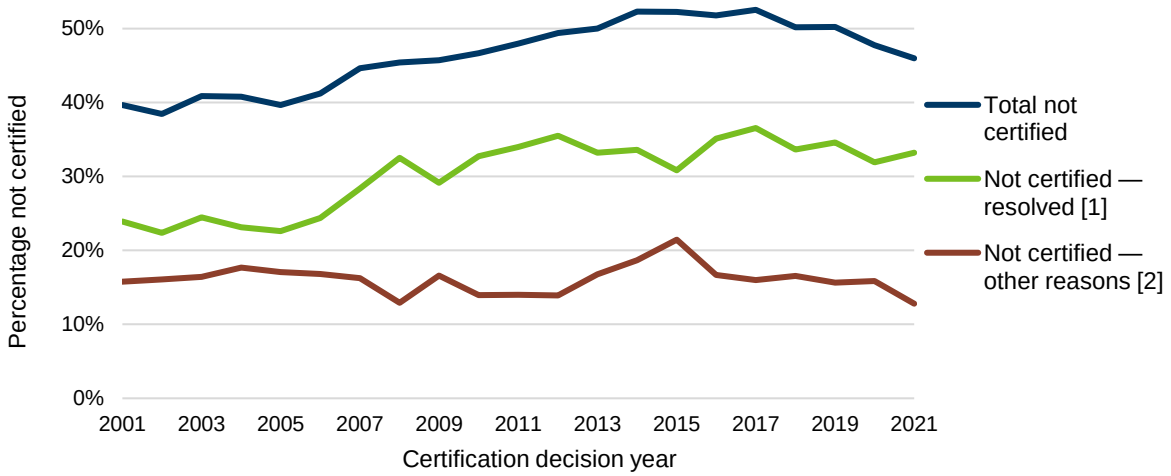
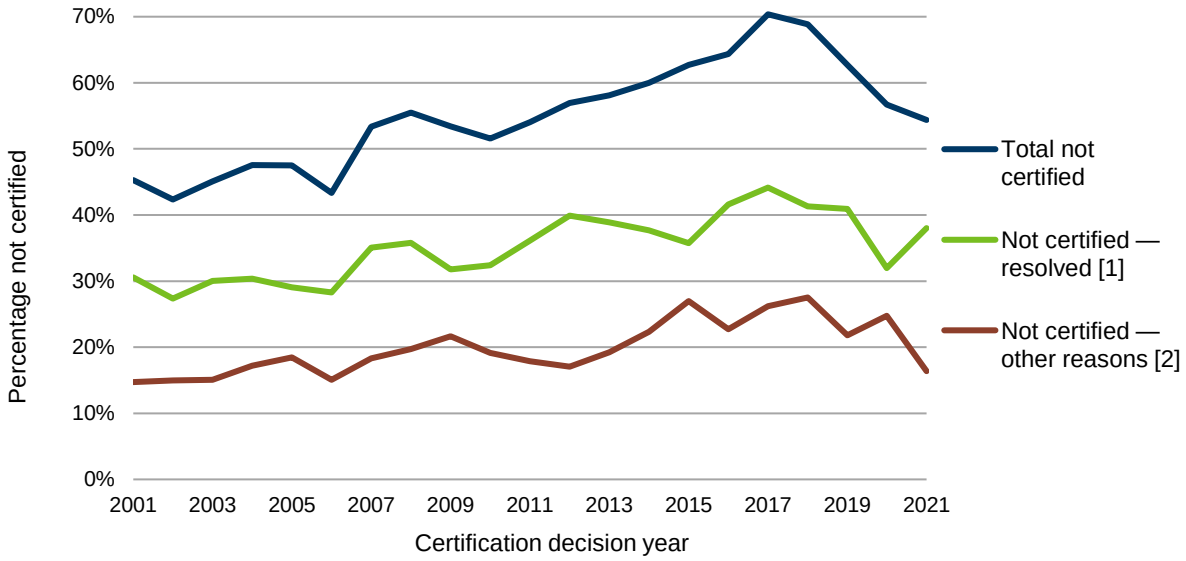


Figure 5.6. Noncertification of medical disputes



1. The resolution here could be the result of efforts by a DLI specialist or of the insurer indicating it intended from the start to approve or to pay for the services as requested.
2. Other reasons include: the insurer needs additional time or information to decide its position; the same issues are already scheduled for a proceeding at DLI or OAH; the injured worker's claim is subject to the provisions of a collective bargaining "carve-out" agreement (Minn. Stat. § 176.1812) and an administrative conference is currently deemed unnecessary; or a medical issue hasn't previously been submitted to the internal dispute-resolution procedure of a certified managed care plan.

Figure 5.7. Noncertification of rehabilitation disputes



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

Dispute issues at DLI

Disputes can include multiple issues on each request.

Figure 5.8 shows the distribution of medical issues for disputes filed in 2021 and Figure 5.9 shows the distribution for rehabilitation issues. The issues are classified into those asking for a service and those concerning payment for services already provided.

Medical office or clinic visits were the most common issue, with the requests nearly equally divided between service-seeking and reimbursement disputes. Requests for injections, imaging, office visits and physical therapy were the top medical service requests, while office or clinic visits and surgery were the most common reimbursement issues. As shown in the figure, detailed information was not available for many issues, which were labeled simply as "other medical treatment."

Nearly 90% of the rehabilitation issues were service-related; almost all reimbursement issues involved rehabilitation provider bills. The most common rehabilitation service issues were disputes about consultation and eligibility for services and disputes about services taking too much time.

Figure 5.8. Medical issues at DLI administrative conferences, disputes filed in 2021

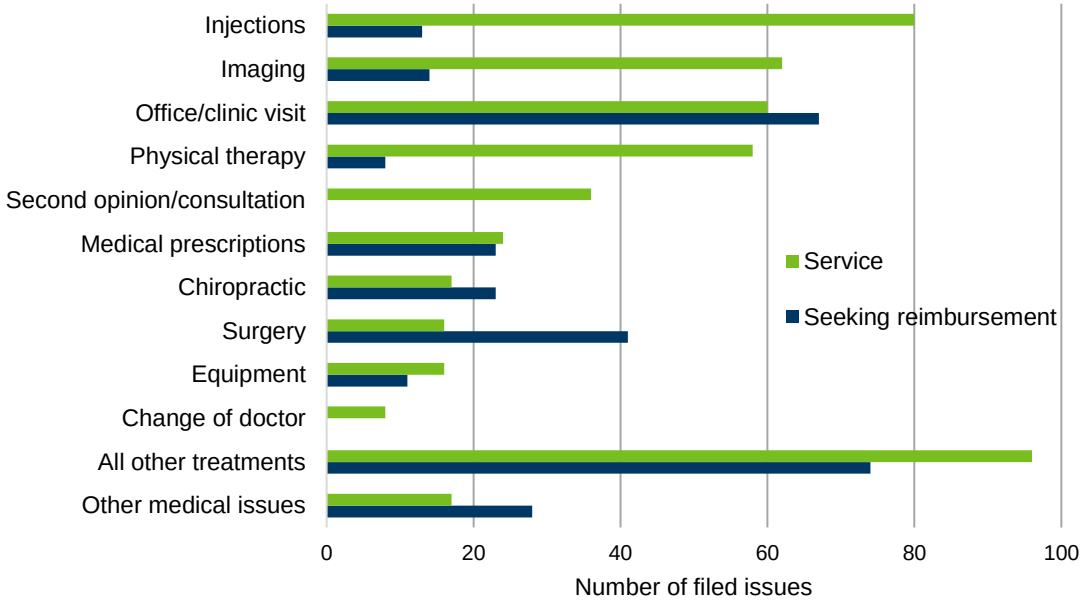
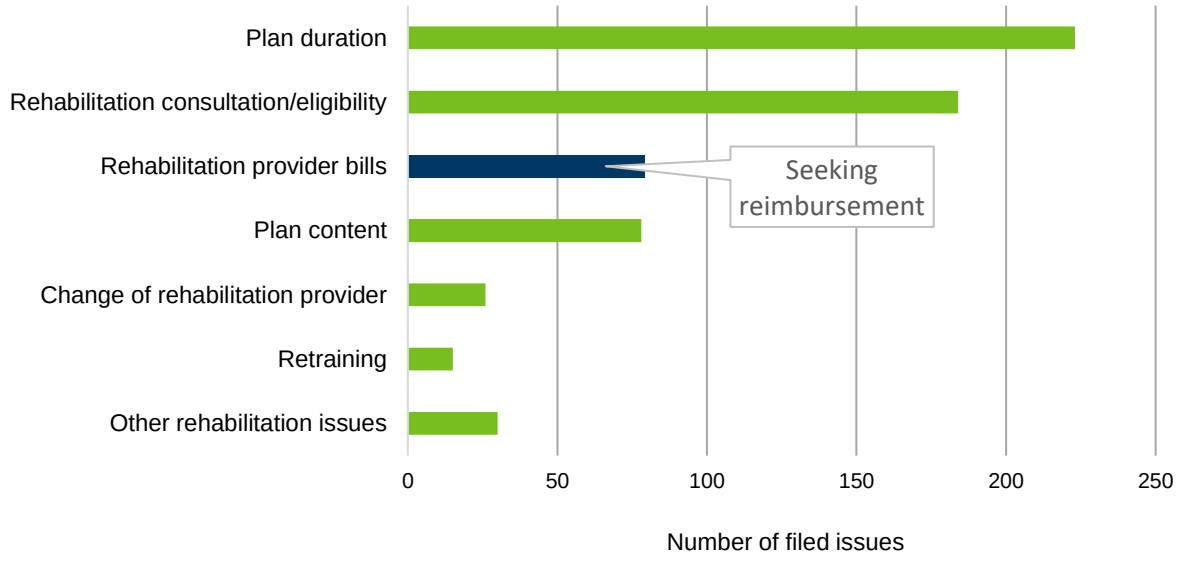


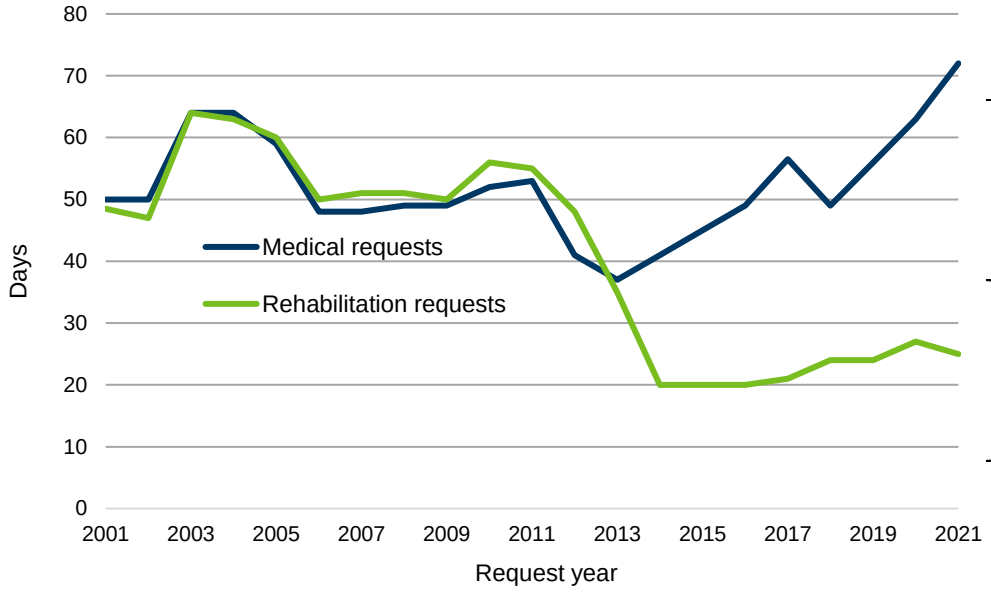
Figure 5.9. Rehabilitation issues at DLI administrative conferences, disputes filed in 2021



Time to first conference for medical and rehabilitation requests at DLI

The time from medical and rehabilitation requests to the first scheduled conference at DLI have diverged in recent years (Figure 10). For medical requests, the median time to the first scheduled conference dropped from 64 days in 2004 to 37 days in 2013, and then increased to 72 days in 2021. For rehabilitation requests, the median time to the first scheduled conference dropped from 64 days in 2003 to 20 days in 2014 and has since increased to 25 days in 2021. These changes were in response to the 2013 law change requiring rehabilitation conferences to take place within 21 days of the request (unless the only issue is the amount of payment for services already provided or there is good cause).[68] Giving priority to scheduling rehabilitation conferences delayed the timing of medical conferences.

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



Year request received	Median days from request to first scheduled conference: Medical requests	Median days from request to first scheduled conference: Rehabilitation requests
2001	50	49
2013	37	35
2014	41	20
2019	56	24
2020	63	27
2021	72	25

Dispute proceedings at DLI

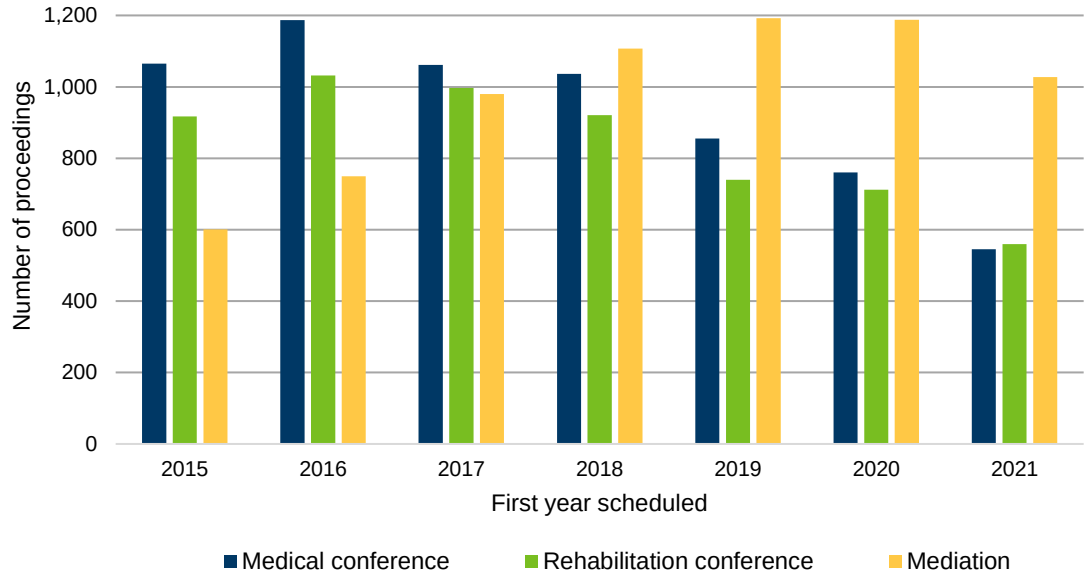
DLI ADR schedules and conducts administrative conferences for certified disputes and for mediations. DLI mediations can be about claim petition issues and medical and rehabilitation disputes pending at DLI.

Scheduled proceedings

Figure 5.11 shows the trend in the number of scheduled proceedings at DLI. Since 2016, there has been a decreasing number of medical and rehabilitation conferences scheduled, while the number of mediations has increased. Mediations increased from 23% of the scheduled conferences in 2015 to 48% in 2021. In 2021, the number of rehabilitation conferences scheduled surpassed the number of medical conferences for the first time.

[68]See the description of the 2013 law change in Appendix B.

Figure 5.11. Scheduled proceedings at DLI

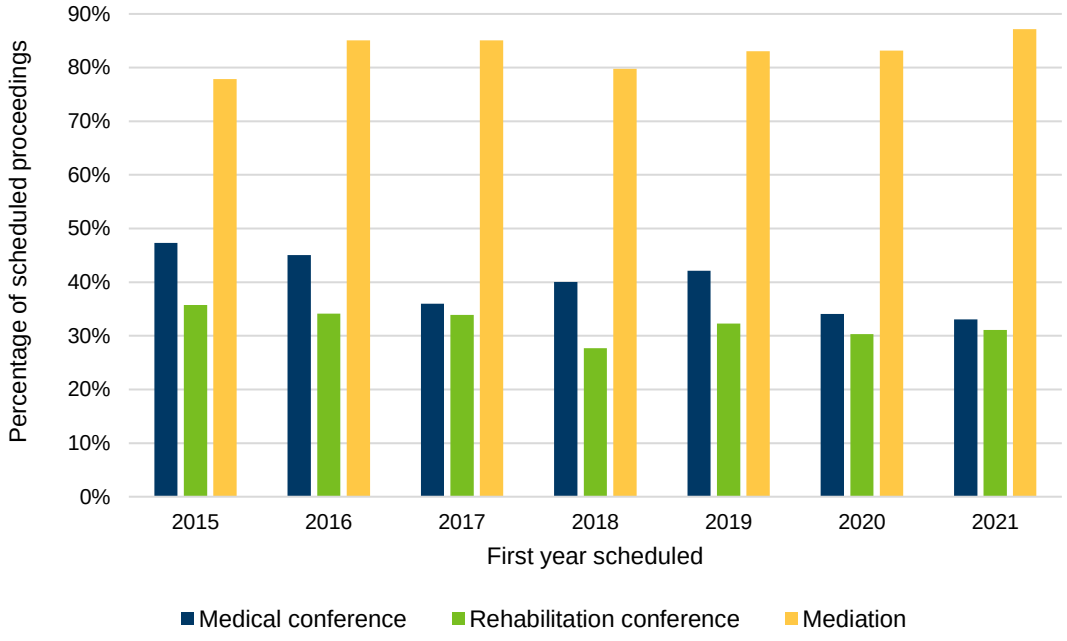


1. The first year scheduled is used because a proceeding can be rescheduled into another year.

Completed proceedings

More than half of scheduled medical and rehabilitation conferences are not completed, while more than 80% of scheduled mediations are held (Figure 5.12). Some of the disputes originally scheduled as conferences became mediations. The number of completed DLI proceedings increased from 1,300 in 2015 to nearly 1,600 in 2019 and has since declined to 1,250 proceedings in 2021.

Figure 5.12. Percentage of DLI scheduled proceedings completed



1. The first year scheduled is used because a proceeding can be rescheduled into another year.

Characteristics of dispute proceedings at DLI

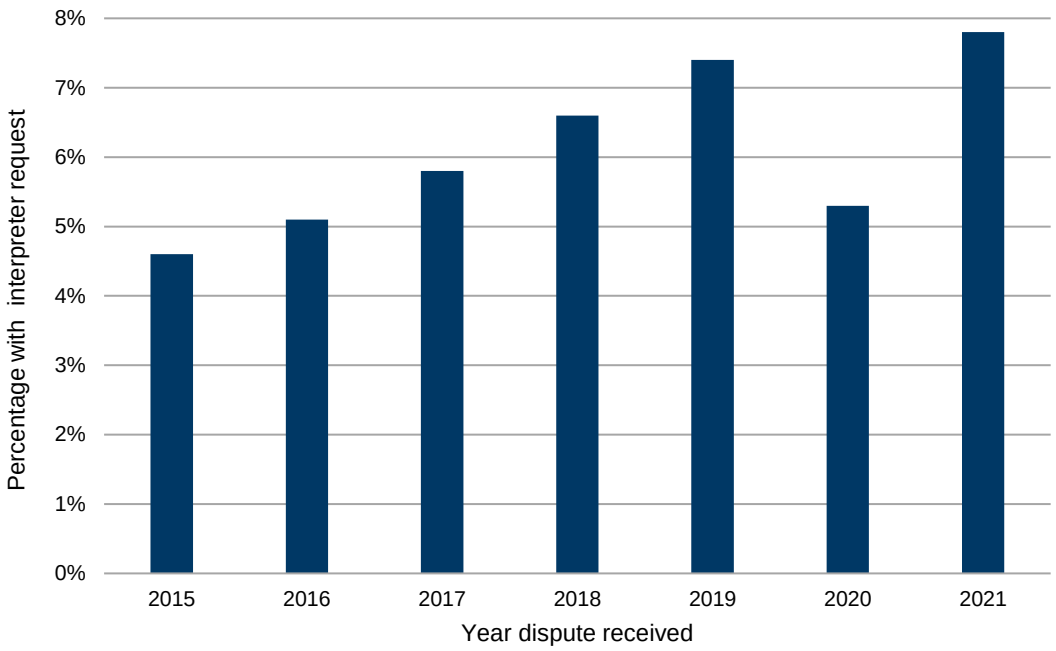
Location of proceedings

All conferences and mediations scheduled prior to 2020 were scheduled for a physical location, almost always a conference room at a DLI office. In 2021, 95% of the proceedings were scheduled as teleconferences.

Requests for interpreters

In recent years, an increasing percentage of workers scheduled for conferences and mediations have requested interpreters, with a dip in 2020 when the COVID-19 pandemic affected dispute-resolution behavior (Figure 5.13). There were requests for interpreters in 20 different languages in the past three years, with 84% of the requests for Spanish interpreters. Somali interpreter requests were the second most common, with 7% of the requests.

Figure 5.13. Percentage of scheduled DLI proceedings with an interpreter requested



Appendix A

Glossary

The following terms are used in this report.[69]

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

Administrative conference — An expedited, informal proceeding where parties present and discuss viewpoints in a dispute. With some exceptions, administrative conferences are conducted for medical and vocational rehabilitation disputes presented on a medical or rehabilitation request;[70] they are also conducted for disputes about discontinuance of wage-loss benefits presented by a claimant's request for administrative conference. Medical and rehabilitation conferences are conducted at either the Department of Labor and Industry (DLI) or the Office of Administrative Hearings (OAH) depending on whether DLI has referred the issues concerned to OAH.[71] Discontinuance conferences are conducted at OAH. If agreement is achieved at the conference, an "order on agreement" is issued, which is binding unless appealed. If agreement is not achieved, the DLI specialist or OAH judge issues a "decision-and-order," also binding unless appealed. A party may appeal a DLI or OAH decision-and-order or order on agreement by requesting a *de novo* hearing at OAH.

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

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

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

[70]As indicated on p. 59, some issues presented on a medical or rehabilitation request are heard in a formal hearing at the Office of Administrative Hearings rather than in an administrative conference.

[71]See the discussion of DLI administrative conferences on p. 58 (including note 60) for types of medical and vocational rehabilitation disputes referred to OAH.

administrative services. The Department of Commerce sets the ARP premium rates, which are different from the voluntary market rates.

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

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

Cost-of-living adjustment — An annual adjustment of temporary total disability, temporary partial disability, permanent total disability or dependents' benefits computed from the annual change in the statewide average weekly wage (SAWW).[72] The percent adjustment is equal to the proportion by which the SAWW in effect at the time of the adjustment differs from the SAWW in effect one year earlier, not to exceed a statutory limit. For injuries from Oct. 1, 1995, through Sept. 30, 2013, the cost-of-living adjustment was limited to 2% a year and was delayed until the fourth anniversary of the injury. For injuries on or after Oct. 1, 2013, the cost-of-living adjustment is limited to 3% a year and delayed until the third anniversary of the injury.

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

Developed statistics — Estimates of the values of claim statistics (for example, number of claims, average claim cost, dispute rate, vocational rehabilitation participation rate) at a given claim maturity. Developed statistics are relevant for accident-year, policy-year, injury-year and vocational rehabilitation plan-closure year data.[73] They are obtained by applying development factors, based on historical rates of development of the statistic in question, to tabulated numbers.

Development — The change over time in a claim statistic (for example, number or cost of claims) for a particular accident year, policy year, injury year or vocational rehabilitation (VR) plan-closure year.[74] The reported numbers develop both because of the time necessary for claims to mature and, in the case of Department of Labor and Industry data, because of reporting lags.

Diagnosis-related group (DRG) payment system — Minnesota's payment system for workers' compensation hospital inpatient facility services, effective for services provided on or after Jan. 1, 2016. It is based on Medicare's Inpatient Prospective Payment System (IPPS). In the IPPS, a hospitalization is categorized – by principal diagnosis and primary treatment performed – into a Diagnosis-related Group

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

[73]See note 74.

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

(DRG) and payment is determined mainly from the DRG. For hospitals that are not Medicare-designated Critical Access Hospitals, Minnesota's DRG system provides for payment at 200% of the Medicare level, not to exceed the charged amount, or 75% of charges in catastrophic (high-cost) cases. For Critical Access Hospitals, payment is 100% of charges. As of Oct. 1, 2022, the threshold for catastrophic cases was total charges of $268,774.

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

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

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

Dispute certification — A process required by statute in which, in a medical or rehabilitation dispute, the Department of Labor and Industry (DLI) must certify a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services.[75] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

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

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

[75]Minn. Stat. § 176.081, subdivision 1(c).

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

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

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

Hearing — A formal proceeding about a disputed issue or issues in a workers' compensation claim, conducted at the Office of Administrative Hearings (OAH). After the hearing, the judge issues a "findings-and-order," which is binding unless appealed to the Workers' Compensation Court of Appeals. OAH conducts formal hearings about disputes presented on claim petitions and other petitions where resolution through a settlement conference is not possible. OAH also conducts hearings about some discontinuance disputes (those presented on an *Employee's Objection to Discontinuance* form or a petition to discontinue benefits), disputes referred by the Department of Labor and Industry (DLI) because they do not seem amenable to less formal resolution, disputes about proposed surgery[76] and disputes about miscellaneous issues, such as attorney fees. Finally, OAH conducts *de novo* formal hearings when requested by a party to an administrative conference decision-and-order from DLI or OAH or a nonconference decision-and-order from DLI.

Hospital Outpatient Fee Schedule (HOFS) — Minnesota's payment system for certain workers' compensation hospital outpatient facility services, effective for services provided on or after Oct. 1, 2018. It is based primarily on those portions of Medicare's Outpatient Prospective Payment System that relate to major surgical procedures and emergency department (ED) visits. For cases with major procedures, payment is based on the procedure regardless of other services provided. For cases with ED or clinic visits and no major procedures, payment is based on the ED or clinic visit and other services provided. Under statute, DLI has determined payment levels, separately for small and large hospitals (those with up to 100 beds and more than 100 beds, respectively), relative to Medicare to produce the same overall payment amounts as under the prior system. DLI calculated that in 2018 small hospitals were reimbursed at 472% of the Medicare rate and large hospitals at 251%. At the time, for cases with ED or clinic visits and not major procedures, these percentages applied to the ED or clinic visit only.

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

Indemnity claim — A claim with paid indemnity benefits. Most indemnity claims involve more than three days of total or partial disability, since this is the threshold for qualifying for temporary total or

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

temporary partial disability benefits, which are paid on most of these claims. Indemnity claims typically include medical costs in addition to indemnity costs.

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

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

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

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

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

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

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

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

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

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

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

Permanent partial disability (PPD) — A benefit that compensates for permanent functional impairment resulting from a work-related injury or illness. The benefit is based on the worker's impairment rating, which is a percentage of whole-body impairment determined on the basis of health care providers' assessments according to a rating schedule in rules. The PPD benefit is calculated under a schedule specified in law, which assigns a benefit amount per rating point with higher ratings receiving proportionately higher benefits. The scheduled amounts per rating point were fixed for injuries from 1984 through September 2000, but were raised in the 2000 law change for injuries on or after Oct. 1, 2000, and in the 2018 law change for injuries on or after Oct. 1, 2018. The PPD benefit is paid after temporary total disability (TTD) benefits have ended. For injuries from October 1995 through September 2000, it is paid at the same rate and intervals as TTD until the overall amount is exhausted. For injuries on or after Oct. 1, 2000, the PPD benefit may be paid in this manner or as a lump sum, computed with a discount rate not to exceed 5%.

Permanent total disability (PTD) — A wage-replacement benefit paid if the worker sustains a severe work-related injury specified in law or if the worker, because of a work-related injury or illness in combination with other factors, is permanently unable to secure gainful employment, provided that, for injuries on or after Oct. 1, 1995, the worker has a PPD rating of at least 13% to 17%, depending on age and education. The benefit is equal to two-thirds of the worker's gross pre-injury wage, subject to minimum and maximum weekly amounts, and is paid at the same intervals as wages were paid before the injury. For injuries on or after Oct. 1, 1995, weekly benefits are subject to a minimum of 65% of the statewide average weekly wage. The maximum weekly benefit amount is indicated in Appendix B. For injuries from Oct. 1, 1995, to Sept. 30, 2018, benefits end at age 67 under a rebuttable presumption of retirement. For injuries on or after Oct. 1, 2018, benefits end at age 72 or, if the injury is after age 67, after five years of benefits have been paid. Cost-of-living adjustments are described in this appendix.

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

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

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

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

Pure premium rates — Rates of expected indemnity and medical losses a year per $100 of covered payroll, also referred to as "loss costs." Pure premium rates are determined annually by the Minnesota Workers' Compensation Insurers Association (MWCIA) for approximately 560 insurance classes in the voluntary market. They are based on insurer "experience" and statutory benefit changes. "Experience" refers to actual losses relative to pure premium for the most recent report periods. The pure premium rates are published with documentation in the annual *Minnesota Ratemaking Report* subject to approval by the Department of Commerce. From 2016 to 2020, MWCIA has gradually increased the maturity level of the losses reflected in the pure premium rates.

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

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

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

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

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

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

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

Statewide average weekly wage (SAWW) — The average wage used by insurers and the Department of Labor and Industry to adjust certain workers' compensation benefits. This report uses the SAWW to adjust average benefit amounts for different years so they are all expressed in constant (2019) wage dollars. The SAWW, from the Department of Employment and Economic Development, is the average weekly wage of nonfederal workers covered under unemployment insurance.

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

Temporary partial disability (TPD) — A wage-replacement benefit paid if the worker is employed with earnings that are reduced because of a work-related injury or illness. (The benefit is not payable for the first three calendar-days of total or partial disability unless the disability lasts, continuously or intermittently, for at least 10 days.) The benefit is equal to two-thirds of the difference between the worker's gross pre-injury wage and gross current wage, subject to a maximum weekly amount, and is paid at the same intervals as wages were paid before the injury. An additional limit is that the weekly TPD benefit plus the employee's weekly wage earned while receiving TPD benefits may not exceed 500% of the SAWW. For injuries from Oct. 1, 1992, through Sept. 30, 2018, TPD benefits are limited to a total of 225 weeks and to the first 450 weeks after the injury (with an exception for approved retraining). For injuries on or after Oct. 1, 2018, benefits are limited to a total of 275 weeks and to the first 450 weeks after the injury (with an exception for approved retraining). The maximum weekly benefit amount is indicated in Appendix B. Cost-of-living adjustments are described in this appendix.

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

injuries on or after Oct. 1, 2008, after 130 weeks of TTD have been paid (with an exception for approved retraining). Minimum and maximum weekly benefit provisions are described in Appendix B. Cost-of-living adjustments are described in this appendix.

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

Vocational rehabilitation (VR) plan — A plan for VR services developed by a qualified rehabilitation consultant (QRC) in consultation with the employee and the employer and/or insurer. The plan is developed after the QRC determines the injured worker to be eligible for VR services. It is filed with the Department of Labor and Industry and provided to the affected parties. The plan indicates the vocational goal, the services necessary to achieve the goal and their expected duration and cost.

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

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

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

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

Appendix B

Workers' compensation law changes

Some workers' compensation law changes enacted since 2000 are relevant for this report. This appendix summarizes those law changes. Law changes that do not significantly affect the trends in this report are not considered.

2000 law change

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

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

Temporary total disability (TTD), temporary partial disability (TPD) and permanent total disability (PTD) maximum benefit — The maximum weekly TTD, TPD and PTD benefit was raised from $615 to $750. (This maximum was raised again in 2008 and 2013; see below.)

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

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

2005 law change

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

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

2008 law change

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

Temporary total disability (TTD), temporary partial disability (TPD) and permanent total disability (PTD) maximum benefit — The maximum weekly TTD, TPD and PTD benefit was raised from $750 to $850. (This maximum was raised again in 2013; see below.)

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

2011 law change

The following provisions took effect Aug. 1, 2011.

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

2013 law change

The following provisions took effect for injuries on or after Oct. 1, 2013.[77]

Temporary total disability (TTD), temporary partial disability (TPD) and permanent total disability (PTD) maximum benefit — The maximum weekly TTD, TPD and PTD benefit was raised from $850 to 102% of the statewide average weekly wage (SAWW). The SAWW in effect for injuries in each year beginning Oct. 1 is the SAWW reflecting wages paid during the year ending the prior Dec. 31.

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

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

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

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

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

2015 law change

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

[77]Other statutory changes have occurred since 2013 (other than the 2015 change regarding inpatient hospital payments described below), but they do not significantly affect the trends in this report.

Diagnosis-Related Group (DRG) System for hospital inpatient services — Minnesota changed its system for paying for workers' compensation hospital inpatient facility services from a charge-based system to one based on Medicare's Inpatient Prospective Payment System (IPPS). This system is often called a "DRG" system because payment is based primarily on the diagnosis-related group, which categorizes the major diagnosis and principal procedures performed. For non-catastrophic cases at non-Critical-Access Hospitals, the payment is 200% of the Medicare level, not to exceed the charged amount. DLI estimated that in its first year, the new system reduced inpatient hospital cost by 9% to 16%, total medical cost by 1.3% to 2.3% and total workers' compensation system cost by 0.5% to 0.8% relative to what they would otherwise have been.[78]

Minnesota's DRG statute also has a set of provisions regarding bill payment and denial.[79]

2018 law change

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

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

PPD benefit schedule — The PPD benefit schedule was raised by a uniform 5% for all impairment ratings.

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

The following provisions took effect for medical services provided on or after Oct. 1, 2018.

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

Hospital Outpatient Fee Schedule (HOFS) — Payment for certain hospital outpatient facility services was changed to be based on portions of Medicare's Outpatient Prospective Payment System (OPPS) that relate to major surgical procedures and emergency department (ED) visits. As provided by statute, DLI set the payment levels under the new system, separately for small and large hospitals (those with up to 100 beds and with more than 100 beds, respectively), so that estimated outpatient payments would be the same under the old and new systems.[80]

2020 and 2022 COVID-19 related law – On April 8, 2020, a new law stated that certain employees who contract COVID-19 are presumed to have an occupational disease covered by the Minnesota workers' compensation law.

[78]DLI, *Minnesota Workers' Compensation DRG Evaluation Report,* January 2018, pp. 25-27.

[79]See Glossary (Appendix A) for details.

[80]See Glossary (Appendix A) for details.

The law originally sunset May 1, 2021, but was extended to sunset Dec. 31, 2021. It was then revived and reenacted on Feb. 3, 2022, with a new sunset of Jan. 13, 2023. Employees are entitled to the presumption if they contract COVID-19 while employed in one of these occupations:

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

Appendix C

Data sources and estimation procedures

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

Developed statistics — Many statistics in this report are by accident year or policy year (insurance data) or by injury year or vocational rehabilitation (VR) plan-closure year (Department of Labor and Industry (DLI) data). For any given accident, policy, injury or VR plan-closure year, these statistics grow, or "develop," over time because of claim maturation and reporting lags.[81] This affects a range of statistics, including claims, costs, dispute rates, attorney fees and others. Statistics from the DLI database develop constantly as the data is updated from insurer reports received daily. With the insurance data, insurers submit annual reports to the Minnesota Workers' Compensation Insurers Association (MWCIA) giving updates about prior accident and policy years along with initial data about the most recent year. If the DLI and insurance statistics were reported without adjustment, trend data would give invalid comparisons because the statistics would be progressively less mature from one year to the next, especially for the most recent years.

MWCIA uses a standard insurance industry technique to produce "developed statistics." In this technique, the reported numbers are adjusted to reflect expected development between the current report and future reports. The adjustment uses "development factors" derived from historical rates of growth (from one report to the next) in the statistic in question. The result is a series of statistics developed to a constant maturity, for example, to a "tenth-report" basis. The developed insurance statistics in this report were computed by DLI Research and Statistics using tabulated numbers and associated development factors from the MWCIA. Research and Statistics has adapted this technique to DLI data. It tabulates statistics at regular intervals from the DLI database, computes development factors representing historical development for given injury years and then derives developed statistics by applying the development factors to the most recent tabulated statistics. In this manner, the annual numbers in any given time series are developed to a uniform maturity.

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

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

Therefore, all developed statistics are estimates and are revised each year using updated data. DLI periodically reviews the developed statistics to determine their stability over time and their suitability for publication. However, to show the impact of COVID-19 in 2020, which was a destabilizing factor, DLI decided to publish statistics for the most recent years in this report.

COVID-19 and developed statistics — Due to the influx of COVID-19 claims in 2020, computing developed statistics for COVID-19 indemnity claims is a near-impossible task at this time, because these claims are unlikely to follow the pattern of claims from previous years. DLI does not expect significant reporting of 2020 COVID-19 episodes in future years, nor does it expect significant changes to benefit payments and claims durations. Therefore, only 2020 non-COVID-19 claims were developed and then added to the undeveloped 2020 COVID-19 claims.

Adjustment of cost data for wage growth — For reasons explained in Part 1, all costs in this report that are expressed per claim or per vocational rehabilitation plan are adjusted for average wage growth. The cost number for each year is multiplied by the ratio of the 2020 statewide average weekly wage (SAWW) to the SAWW for that year, using the SAWW reflecting wages paid during the respective year. Thus, the numbers for all years represent costs expressed in 2020 wage-dollars.

Figure 2.1 — The developed number of non-COVID-19 paid indemnity claims for injury-year 2020 (in the numerator of the indemnity claim rate) is 18,700 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2021, 16,870 for non-COVID-19 claims, multiplied by the appropriate development factor, 1.106. In this manner, the non-COVID-19 numbers are developed to a uniform maturity. The reported, non-developed number of COVID-19 paid indemnity claims – 11,300 – is then added to the developed non-COVID-19 number to get the combined total number of paid indemnity claims, which is 30,000 (rounded to the nearest hundred) for injury-year 2020. For reasons explained in Part 1, COVID-19 claims are not developed.

The number of full-time-equivalent (FTE) workers covered by workers' compensation is estimated as total nonfederal unemployment insurance (UI) covered employment from the Department of Employment and Economic Development (DEED) multiplied by average annual hours per employee (from the annual *Survey of Occupational Injuries and Illnesses,* conducted jointly by the U.S. Bureau of Labor Statistics and state labor departments) divided by 2,000 (annual hours per full-time worker).[82] Nonfederal UI-covered employment is used because there is no direct data about workers' compensation-covered employment.

Figure 2.2 — Market-share percentages are taken from undeveloped counts of paid indemnity claims from the DLI database. Using undeveloped rather than developed claim counts has little effect on the percentages, because the number of indemnity claims develops at nearly the same rate for the different insurance arrangements.

Figure 2.3 — Claim and loss data is from supplementary tables to the MWCIA's *2022 Minnesota Ratemaking Report.* This data comes from insurance company reports on claim and loss experience for individual policies for the voluntary market and the Assigned Risk Plan. The reported losses include paid losses plus case-specific reserves. Data is developed to a 10th-report basis using the development factors in the *Minnesota Ratemaking*

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

Report, which produces statistics at an average maturity of 10.5 years from the injury date; the statistics are then adjusted for average wage growth.

Figures 2.4 and 2.5 — Figures 2.4 and 2.5 are based on paid losses, because paid losses are more stable from year to year than are paid losses plus case reserves. The data is from financial reports to the MWCIA by voluntary market insurers only. Paid losses are developed to a uniform maturity of 30 years (a "30th-report basis") using development factors computed from year-to-year loss development data supplied by MWCIA. Payroll data for Figure 2.4 is from insurer reports of policy experience.

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

Figure 2.7 — For insured employers, total cost is computed as written premium adjusted for deductible credits, minus paid policy dividends. Written premium and paid dividends for the voluntary market are obtained from the Department of Commerce. Written premium for the Assigned Risk Plan (ARP) is obtained from AON Risk Services, the plan administrator. (There are no policy dividends in the ARP.)

Written premium is adjusted upward by the amount of premium credits granted with respect to policy deductibles to reflect that portion of cost for insured employers that falls below deductible limits. Deductible credit data through policy-year 2019 is available from MWCIA. The 2020 figure was estimated by applying the ratio of deductible credits to written premium for the prior two years to the 2020 premium figure. When the actual amount becomes available for 2020, that year's total cost figure will be revised.

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

Total workers' compensation covered payroll is computed as the sum of insured payroll, from MWCIA, and self-insured payroll, from WCRA. Insured payroll was not yet available for 2020. This figure was extrapolated from actual figures using the trend in nonfederal UI-covered payroll (from DEED) and the trend in the relative insured and self-insured shares of total pure premium (from WCRA).

Figure 2.8 — The percentages in this figure were derived from payment-year data to avoid significant issues that would arise with injury-year (or accident-year) data.[83] A major issue is that both paid benefits and total system

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

cost (primarily the latter) vary substantially from year to year, causing major variation in the ratio of the two. Therefore, the percentages in this figure were derived by averaging data over time.

Data about benefits and state agency administrative cost came from DLI, MWCIA, the Minnesota Insurance Guaranty Association and the Minnesota Self-Insurers' Security Fund. Total system cost was calculated as indicated in connection with Figure 2.7. The percentage of cost going to insurer expenses was calculated as a residual as described below.

Because written premium — the primary element in system cost — relates to policies originating in a given year, it is paid during that year and the year following. Therefore, the ratio of benefits to system cost was computed using system cost for the year prior to the benefit payment year. An analysis of the data reveals this ratio varies through approximately an 11-year cycle. To minimize annual fluctuation, an average over this cycle was used. To further reduce annual fluctuation, an average of averages was used, corresponding to the 11-year cycles ending with the most recent year and the prior two years. This yielded the ratio 67.6% as the ratio of total paid benefits to total system cost.

The indemnity, medical and vocational rehabilitation (VR) components of the 67.6% were then computed using the relative totals of these payments for 2020. VR benefits (counted separately here from indemnity benefits) are not directly available on a payment-year basis, so a payment-year version of these benefits was estimated from the injury-year series used for Figure 4.3. The portion of total system cost not accounted for by benefit payments, 32.4%, was then allocated between state agency administrative expenses and insurer expenses. State agency administrative expenses (using the same numbers as for Figure 3.14) were estimated to account for 2.5% of total system cost, leaving an estimated 29.9% attributable to insurance expenses (for insurers and self-insurers).

Figure 3.1 — Statistics are derived in the same manner as for Figure 2.3, with one modification. Figure 3.1 presents data by claim type. For permanent total disability (PTD) and death cases, the number of claims and their average cost fluctuate widely from one policy-year to the next because of small numbers of cases. Therefore, to produce more meaningful comparisons among claim types, PTD and death claims and losses were estimated by applying respective percentages of claims and losses (relative to the total) during the most recent five years to total claims and losses for 2018.

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

Figure 3.14 — Administrative cost is computed to capture that portion of the workers' compensation assessment (see "Special Compensation Fund" in Appendix A) that pays for state administration. Consequently, administrative cost is computed as the total of costs other than workers' compensation benefits that are paid for by the assessment or other revenues with which it is combined, minus those other revenues.

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

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