Minnesota Workers' Compensation System Report

DEPARTMENT OF LABOR AND INDUSTRY

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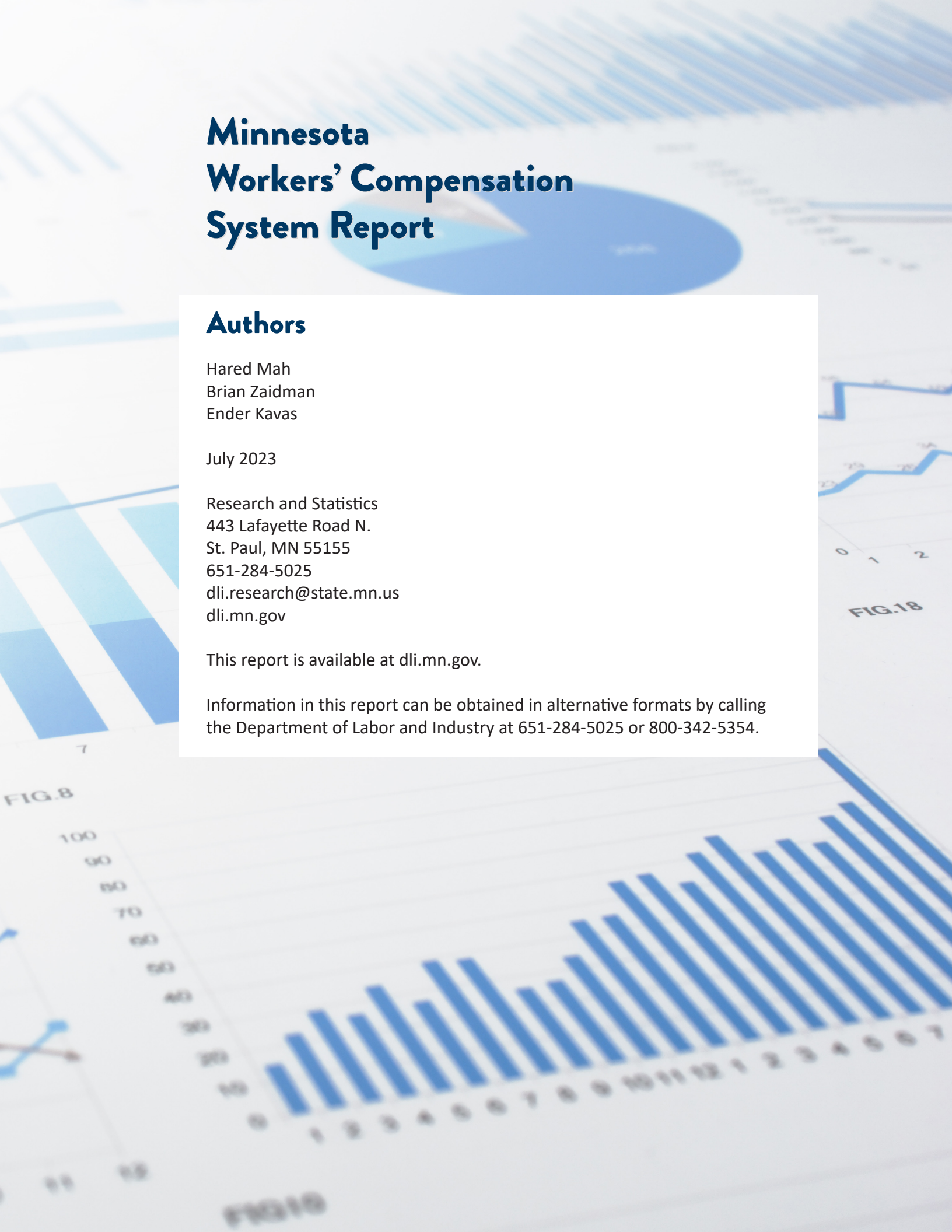

Executive summary

The 2023 Workers' Compensation System Report presents trend data from 2001 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 use available statistics to describe 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 2021 and filed through September 2022. Some of the statistics involve activities that took place in 2021 for workers' compensation claims that occurred in 2020 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

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 2021, the most recent injury-year, while some vocational rehabilitation statistics include data for 2022, the most recent plan-closure year. Claims resulting from injuries occurring in 2022 are still too recent to provide reliable measures of claim activity. 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 2022. The report also includes statistics reported by policy year or fiscal year.

Recent versions of this report present two faces: one for the whole workers' compensation system, including COVID-19 claims; and the other excluding the COVID-19 claims, showing a pattern similar to prior years. This report features a similar structure. 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]

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

Part 2: Claims, benefits and costs – overview

- There were 3.5 total paid claims per 100 full-time-equivalent (FTE) workers in 2021, down 52% from 7.4 claims in 2001. (The decline from 2001 to 2019 was 46%.) Total paid claims include indemnity and medical-only claims.
  - The estimated total claim rate for non-COVID-19 claims in 2021 was 3.2 paid claims per 100 FTE workers.
  - *The estimated total claim rate for COVID-19 claims was 0.4 paid claims per 100 FTE workers.*

- Adjusting for average wage growth, both medical and indemnity benefits per insured claim rose between 2001 and 2003, but showed little net change thereafter until 2020. Adjusted indemnity benefits per claim were 2% higher and medical benefits per claim were 17% lower in 2020 than in 2003. The average cost of a 2020 workers' compensation claim was $11,310 for medical and indemnity benefits combined (including vocational rehabilitation).

- Relative to total payroll, indemnity benefits were down 39% between 2001 and 2021, while medical benefits were down 49%. Medical and indemnity benefits (including vocational rehabilitation) amounted to $0.58 per $100 of payroll for 2021.

- 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.

- Due to a law change effective Jan. 1, 2023, the Minnesota Workers' Compensation Insurers Association (MWCIA) pure premium base rates for 2023 now include trend, loss development to ultimate and loss adjustment expenses. In the 2023 MWCIA *Minnesota Ratemaking Report*, the 2023 pure premium base rate change, including these new elements, is +5.7%. If the new elements were excluded from the advisory pure premiums, the 2023 rate change would have been -9.5%. With the new elements excluded, the average pure premium rate for 2023 is estimated to be 39% lower than in 2001.

- The total cost of Minnesota's workers' compensation system was an estimated $1.62 billion for 2021, or $0.93 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 44% over 20 years.

- In 2021, 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 (31%) and insurer expenses (30%).

Part 3: Claims, benefits and costs – detail

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

- Total disability benefits (temporary total disability benefits and permanent total disability benefits combined) per paid indemnity claim were largely stable from 2001 to 2021 for non-COVID-19 claims.
  - *When COVID-19 claims were included, there was a 24% decrease from 2019 to 2021.*

- Temporary partial disability benefits per paid indemnity claim fell 40% from 2001 to 2021 for non-COVID-19 claims.
  - *When COVID-19 claims were included, there was a 25% decrease from 2019 to 2021.*

- Permanent partial disability benefits per paid indemnity claim fell 69% from 2001 to 2021 for non-COVID-19 claims.
  - *When COVID-19 claims were included, there was a 38% decrease from 2019 to 2021.*

- Settlement benefits per indemnity claim rose 4% from 2001 to 2021 for non-COVID-19 claims.
  - *When COVID-19 claims were included, settlement benefits decreased 23% from 2019 to 2021. 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 20% of paid indemnity claims for injury-year 2001 to 24% for 2019, but decreased to 22% among non-COVID-19 indemnity claims in 2021 (Figure 4.1). There was a 15% decrease in the estimated number of workers who will receive vocational rehabilitation services for their injuries and illnesses in 2021.
  - *The 2021 vocational rehabilitation participation rate was 16% when COVID-19 indemnity claims were included.*

- After adjusting for average wage growth, the $9,060 average cost of vocational rehabilitation services for injury-year 2021 was 24% below the 2007 peak of $11,850.

- Vocational rehabilitation services accounted for an estimated 2.9% of total workers' compensation system cost for 2021.

- Fifty-seven percent of vocational rehabilitation participants reported a job at plan closure in 2022, down from 61% in 2019. The percentage of workers with a reported job had dipped to 56% in closure-year 2020.

Part 5: Disputes and dispute resolution

This report includes dispute-resolution statistics only about DLI proceedings.

- *There were very few disputes associated with COVID-19 claims — the dispute filing rate was 0.1% for COVID-19 claims in 2022 and 5% for non-COVID-19 claims.*

- There were 6,100 dispute filings received in 2022 among the four major dispute types – claim petitions, discontinuance disputes, medical requests and rehabilitation requests. This was about 500 more than 2021 and 1,000 more than 2020.

- The denial rate for 2021 non-COVID-19 claims was 24%. This was above the rate of 16% for 2020 and surpassed the highest rate of 17% recorded in the past 20 years.
    - *The rate of denial of filed indemnity claims, including COVID-19 claims, was 29% for 2021. This was above the rate of 23% for 2020. A large part of the 2021 increase in the denial rate was due to the influx of COVID-19 claims that began in 2020; the denial rate for COVID-19 claims was 39% in 2021.*

Among disputes filed at DLI the following was found.

- Between 2002 and 2022, due largely to resolutions of disputes reached though DLI's Alternative Dispute Resolution (ADR) outreach, the certification rate dropped from 62% to 54% for medical disputes and from 58% to 50% for vocational rehabilitation disputes.

- In 2022, 80% of the proceedings were mediations; the remaining 20% of the proceedings were rehabilitation and medical conferences.

- For medical and rehabilitation requests for assistance received in 2022, the median times from the request to the first scheduled conference date were 69 and 24 days, respectively. The time interval for medical requests has been increasing from 2013 to 2021, but decreased from 2021 to 2022. The interval for rehabilitation requests was close to the intervals for recent years, reflecting DLI's response to the 2013 law change requiring most rehabilitation conferences be scheduled within 21 days of the request.

- Ninety-seven percent of conferences and mediations in 2022 were conducted through teleconference.

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Part 1: Introduction

Nationwide, workers' compensation claim rates have declined since 2001. During the same period, indemnity claim costs increased at about the same rate as wages, but wage growth has outpaced indemnity claim costs in recent years, possibly exerting upward pressure on indemnity benefits.[3]

In Minnesota, a falling claim rate 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 2021 than in 2001. However, the economic fallout from COVID-19 impacted the workers' compensation system in Minnesota and the nation.

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.[4] Like other reports in the series, this report presents data from the most recently available 20-year window, beginning with 2001 for the present report. Its purpose is to use available statistics to describe the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

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 was effective for employees who contracted COVID-19 between April 8, 2020, and Dec. 31, 2021, and between Feb. 3, 2022, and Jan. 13, 2023. Employees were 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
- required to provide childcare to children of first responders and health care workers.

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[3]National Council on Compensation Insurance, "2023 State of the Line Guide," ncci.com/SecureDocuments/SOLGuide_2023.html#2023_State_of_the_Line_Guide.

[4]"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 2001 as the base year gives a 20-year observation window through 2021.

Impact of COVID-19

The report shows the effect of COVID-19 on claims, benefits and costs in 2020 and 2021. 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, occupation and remote work; and direct effects because of the influx of COVID-19 claims.

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 2020-2023 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.[5] 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.[6]

The injury-year and policy-year statistics that result from this technique are projections of what the actual numbers will be when all claims are complete and all data is reported. Therefore, the 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 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 and 2021, DLI decided to publish statistics for the most recent years in this report, despite the fluctuations in the data caused by COVID-19.

[5]Definitions in Appendix A.

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

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 reporting of additional COVID-19 claims for 2020 and 2021, nor does it expect significant changes to benefit payments and claims durations for the reported COVID-19 claims. Therefore, claims development estimates were calculated only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims.

Adjustment of cost data for wage growth

Some figures in this report present average or median costs per claim or per vocational rehabilitation plan over time. As wages and prices grow, a given cost in dollar terms represents a progressively smaller economic burden from one year to the next. If the total cost of indemnity and medical benefits grows at the same rate as wages, there is no net change in cost as a percentage of total payroll. Therefore, all costs per claim or per vocational rehabilitation plan are adjusted for average wage growth. The adjusted trends reflect the extent to which cost growth per claim or per vocational rehabilitation plan exceeds or falls short of average wage growth.[7]

This report includes statistics through injury-year 2021, 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 and 2021 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.

[7]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.[8] These factors led to changes in the estimates for workers' compensation claims rates for injury-years 2020 and 2021. 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 52%, indemnity claims by 17% and medical-only claims by 62% from 2001 to 2021 (Figure 2.1).
    - *Due to the influx of COVID-19 indemnity claims, there was a 32% increase in the indemnity claim rate from 2019 to 2021. This reversed the long-term downward trend in indemnity claim rate (the decline from 2001 to 2019 was 38%).*

- Adjusting for average wage growth, both medical and indemnity benefits per insured claim rose rapidly between 2001 and 2003, but showed little net change thereafter until 2020. In 2020, adjusted indemnity benefits per claim were 2% higher and medical benefits per claim were 17% lower than in 2003 (Figure 2.3).

- Relative to total payroll, indemnity benefits were down 39% between 2001 and 2021, while medical benefits were down 49% (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 then affected pure premium rates and system cost per $100 of payroll.

[8]The number of workers' compensation covered full-time-equivalent employees was estimated to be about 2,134,000 in 2020 and 2,179,000 in 2021, compared to 2,293,000 in 2019.

- Due to a law change effective Jan. 1, 2023, MWCIA pure premium base rates for 2023 now include trend, loss development to ultimate and loss adjustment expenses. In the 2023 MWCIA *Minnesota Ratemaking Report*, the 2023 pure premium base rate change, including these new elements, is +5.7%. If the new elements were excluded from the advisory pure premiums, the 2023 rate change would have been -9.5%. With the new elements excluded, the average pure premium rate for 2023 is estimated to be 39% lower than in 2001 (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 44% over a 20-year period (Figure 2.7).

- In 2021, 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 (31%) 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 3.5% annually and wage-adjusted cost per claim increased by less than 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.[9]

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

[9]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.

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

Insurance arrangements

Minnesota requires all employers to have workers' compensation insurance coverage. 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.

Rate setting

Minnesota is an open-rating state for workers' compensation, meaning rates are set by insurance companies rather than by a central authority. In determining their rates, insurance companies start with "pure premium rates" (also known as "advisory loss costs"). These rates represent expected losses (indemnity and medical) per $100 of payroll for some 600 payroll classifications. MWCIA — Minnesota's workers' compensation data service organization and rating bureau — annually calculates the pure premium rates for the next year from insurers' most recent pure premium (computed from prior pure premium rates and payroll) and indemnity and medical losses.[10] 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).[11]

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 and 2021 due to the influx of COVID-19 claims, claim rates declined nearly continually for the past 20 years (figure 2.1).

- In 2021, there were:
  - 1.3 paid indemnity claims per 100 FTE workers, down 17% from 2001. (The decline from 2001 to 2019 was 38%.) The estimated indemnity claim rate was 0.94 for non-COVID-19 claims and 0.33 for COVID-19 claims.

[10]MWCIA *Minnesota Ratemaking Report*: mwcia.org/Ratemaking-Report.

[11]In response to legislative and regulatory activity, MWCIA made significant changes to its calculation of advisory pure premium base rates effective Jan. 1, 2023. For the first time, the advisory rates for 2023 include trend, development to ultimate losses and loss adjustment expenses in the pure premium base rates it provides to the industry.

- 2.3 paid medical-only claims per 100 FTE workers, down 62% from 2001. (The decline from 2001 to 2019 was 49%.) The estimated medical-only claim rate was 2.2 for non-COVID-19 claims and 0.03 for COVID-19 claims.[12]
- 3.5 total paid claims per 100 FTE workers, down 52% from 2001. (The decline from 2001 to 2019 was 46%.) The estimated total claim rate was 3.2 for non-COVID-19 claims and 0.4 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 and 2021.
  - For non-COVID-19 claims in 2021, the indemnity claim rate was 0.94, which was 1% below the 2019 rate.
  - *When COVID-19 claims were included, there was a 32% increase in the indemnity claim rate from 2019 to 2021, which can be attributed to the influx of COVID-19 indemnity claims. There was also a 25% decrease in the medical-only claim rate, resulting in an 11% decrease in the total claim rate during this period.*

- Since 2009, indemnity claims have made up 23% to 24% of all paid claims, with medical-only claims constituting the remaining 76% to 77%.
  - *Due to the influx of COVID-19 claims, indemnity claims constituted 43% of all paid claims in 2020 and 36% of all paid claims in 2021. COVID-19 claims accounted for 26% of indemnity claims in 2021, compared to 39% in 2020. While 90% of COVID-19 claims in 2021 were for indemnity benefits, most claims for all other injuries and illnesses were medical-only claims.* [13]

- Since 2001, 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.[14]

- Because of the falling claim rate, the number of paid claims since 2001 has fallen despite the increase in the number of covered workers. From 2019 to 2021, due to COVID-19, the number of covered workers decreased, while the number of paid indemnity claims increased. However, the total number of paid claims (indemnity and medical-only) continued to decrease.
  - There were an estimated 27,500 paid indemnity claims in 2021, down 14% from 2001, but up 26% from 2019.

[12]The claim rates for COVID-19 claims were estimated using data from MWCIA (MWCIA CV-19 Collaborative Report MN Numbers 20-21).

[13]The indemnity claim count and percentage are from DLI data, while the numbers for medical-only claims and those comparing the indemnity and medical-only claims for COVID-19 claims come from MWCIA.

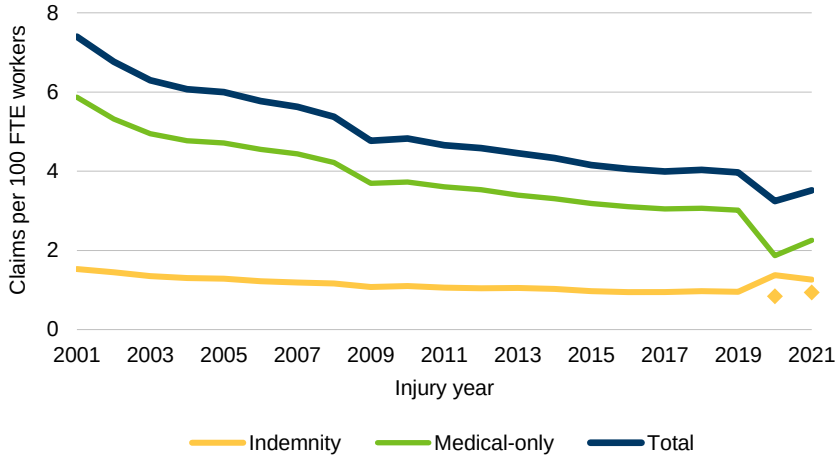
The increase in the medical-only claims rate from 2020 to 2021 could be related to increases in less-severe injuries in 2021 or reduced reporting of less-severe injuries in 2020 due to workers' inability or unwillingness to seek medical care during the early pandemic period.

[14]The Survey of Occupational Injuries and Illnesses (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.

- *Approximately 7,100 of these indemnity claims were COVID-19 claims.*[15]
- There were an estimated 76,700 total paid claims in 2021, down 51% from 2001. Despite the influx of COVID-19 indemnity claims, the total number of paid claims in 2021 was 16% lower than in 2019.

- The falling claim rate has led to decreases in benefits per $100 of payroll (Figure 2.4) and workers' compensation system cost per $100 of payroll (Figure 2.7).

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



Injury year	Indemnity claims	Medical-only claims	Total claims
2001	1.5	5.9	7.4
2019	1.0	3.0	4.0
2020	1.4	1.9	3.2
2021	1.3	2.3	3.5

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 and 2021. The diamond marker shows the indemnity claim rate for only non-COVID-19 paid indemnity claims in 2020 and 2021.

Insurance arrangements

The voluntary market share of the workers' compensation insurance market is lower than the low point reached in the mid-2000s. The 2020 and 2021 estimates were strongly affected by the COVID-19 pandemic. The COVID-19 pandemic caused a significant shift in data trends among paid indemnity claims from the voluntary market to self-insurance. Many of the workers covered by the COVID-19 presumption – first responders, corrections workers and health care workers – had self-insured employers.

- The voluntary market share of all paid indemnity claims was 60% in 2021, down from 73% in 2019 (figure 2.2). This also represents a decrease from the 73% mark reached in 2001 and the low point of 66% for 2004.
  - For non-COVID-19 paid indemnity claims, the voluntary market share was 73% in both 2020 and 2021.

[15]In 2022, there were approximately 10,100 COVID-19 paid indemnity claims, which was about 40% higher than the number of 2021 COVID-19 indemnity claims and almost as high as the number of 2020 COVID-19 claims.

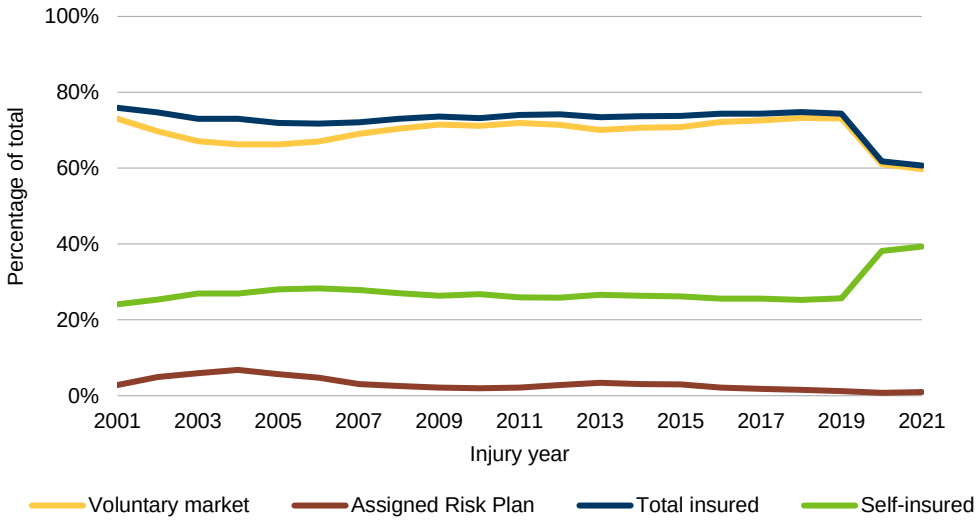
- The self-insured share of all paid indemnity claims, 39% for 2021, showed a significant increase from 26% in 2019. It has ranged from 25% to 27% since 2003; its low point was 24% for 2001.
  - For non-COVID-19 paid indemnity claims, the self-insured share was 27% in both 2020 and 2021.
  - *For COVID-19 paid indemnity claims, the self-insured share was 55% in 2020 and 72% in 2021.*

- The Assigned Risk Plan share of all paid indemnity claims was 0.9% in 2021, down from 1.2% in 2019. The Assigned Risk Plan share has generally ranged from 2% to 3% for the period shown, with a high point of 6.8% in 2004 and a low point of 0.8% in 2020.
  - For non-COVID-19 paid indemnity claims, the Assigned Risk Plan share was 1.3% in 2020 and 2021.

- 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.

- 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
2001	73.0%	2.9%	75.9%	24.1%
2004	66.2	6.8	73.0	27.0
2019	73.1	1.2	74.3	25.7
2020	61.0	.8	61.8	38.2
2021	59.7	.9	60.7	39.3

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

1. Data from DLI. Lines represent distribution of all paid indemnity claims (including COVID-19 claims) by insurance type.

Benefits per claim

Adjusting for average wage growth, both medical and indemnity benefits per insured claim rose rapidly between 2001 and 2003, but showed little net change thereafter until 2020 (Figure 2.3).

- For all claims combined, in 2020 relative to 2003:
  - average indemnity benefits were up 2%;
  - average medical benefits were down 17%; and
  - average total benefits were down 9%.[17]

- From 2001 to 2020: average indemnity benefits for all claims combined were up 10%; average medical benefits were up 2%; and average total benefits were up 6%. These increases were more modest compared to the increases from 2001 to 2019. This could be partly because COVID-19 claims had smaller indemnity and medical costs.[18]

- Statutory changes in the past few years concerning medical-service reimbursement and indemnity benefits have affected the benefit trends displayed in Figures 2.3 and 2.4.
  - 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 Diagnosis-Related Group (DRG) system based on Medicare's Inpatient Prospective Payment System. 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. The estimated cost-reduction amounts from the DRG system ranged from $8.1 to $14.5 million a year.[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. Using data that became available after the new Ambulatory Surgical Center Payment System (ASCPS) took effect, DLI estimated the new system reduced payments to ASCs by 25%, which would also lead to a reduction in overall medical costs.[20]

[17]The most recent data available from MWCIA is 2020.

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

[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. More information about inpatient payments following the adoption of the DRG system can also be found in the Workers' Compensation Research Institute (WCRI) Compscope Medical Benchmarks for Minnesota, 23rd edition, wcrinet.org/reports/compscope-medical-benchmarks-23rd-edition.

[20]"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.

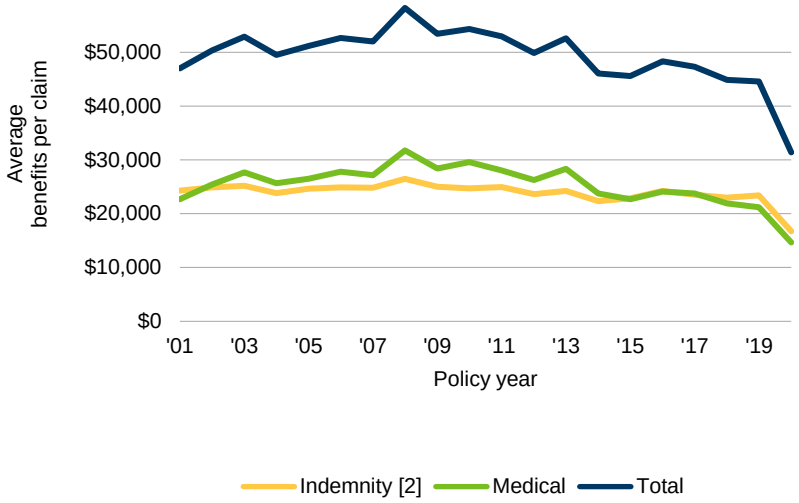
- For injuries on or after Oct. 1, 2018, indemnity benefit changes took effect that, by DLI's estimate, raised total indemnity benefits by 2.0% relative to what they otherwise would have been.[21]
- A new system for reimbursing hospitals for outpatient facility services also took effect Oct. 1, 2018, 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).

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

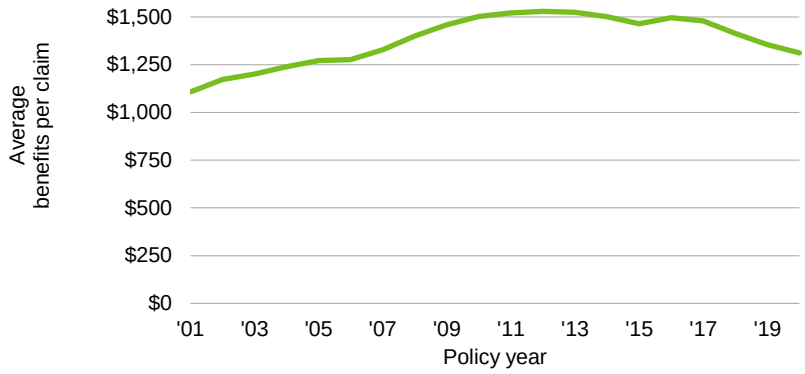
Figure 2.3. Average indemnity and medical benefits per insured claim, adjusted for average wage growth [1]

A: Indemnity claims



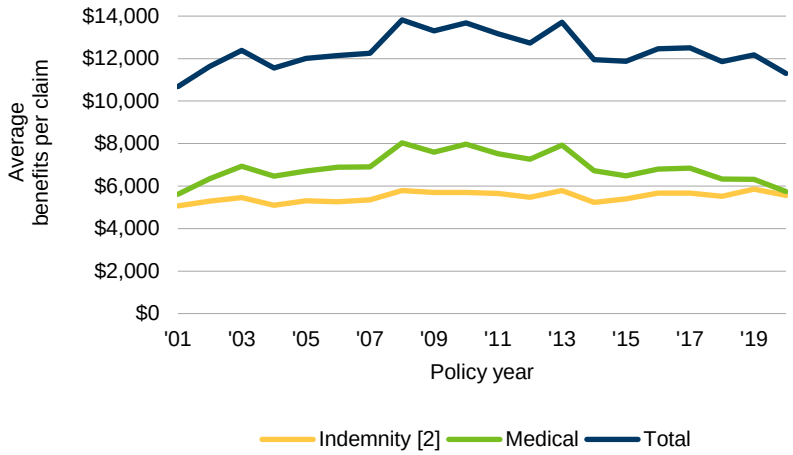
Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
2001	$24,300	$22,710	$47,010
2003	25,220	27,700	52,920
2018	22,980	21,920	44,900
2019	23,410	21,180	44,590
2020	16,740	14,660	31,400

B: Medical-only claims



Policy year	Medical benefits	Total benefits
2001	$1,110	$1,110
2003	1,200	1,200
2018	1,410	1,410
2019	1,360	1,360
2020	1,310	1,310

C: All claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
2001	$5,070	$5,610	$10,680
2003	5,450	6,930	12,390
2018	5,520	6,340	11,860
2019	5,860	6,320	12,170
2020	5,560	5,750	11,310

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 2021. The most recent year available is 2020.
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 2021 than in 2001 (Figure 2.4).

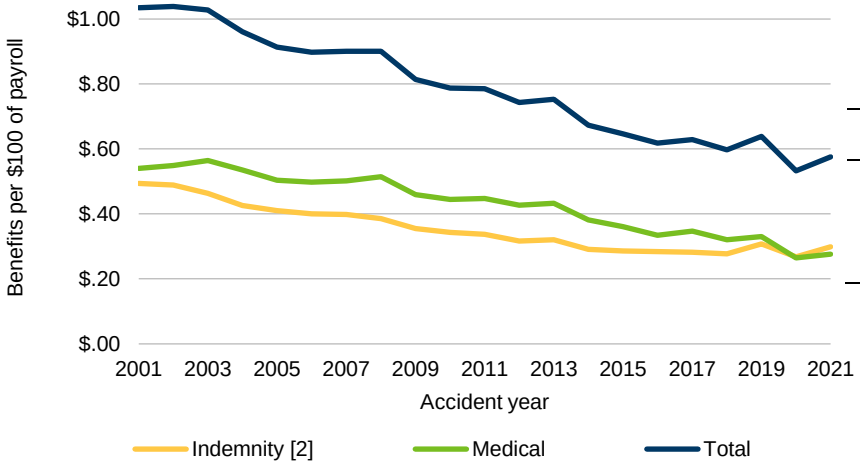
During the 21 years shown, relative to payroll, indemnity and medical benefits reached peaks in 2001 and 2003, respectively; both fell almost continually thereafter, except for some fluctuations in the past few years.

- In 2021 as compared to 2001, relative to payroll:
  - indemnity benefits were 39% lower;
  - medical benefits were 49% lower; and
  - total benefits were 44% lower.

- Despite fluctuations in the past few years due to the effects of COVID-19 on claim rates and benefits, these changes are the net result of a decreasing claim rate (Figure 2.1) and higher wage-adjusted indemnity and medical benefits per claim for all claims (Panel C in Figure 2.3).

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

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



Accident year	Indemnity benefits [2]	Medical benefits	Total benefits
2001	$.49	$.54	$1.03
2003	.46	.56	1.03
2019	.31	.33	.64
2020	.27	.26	.53
2021	.30	.28	.58

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

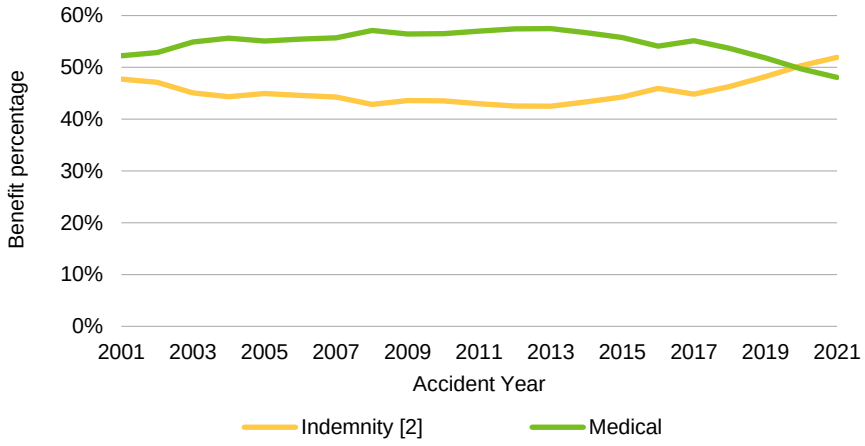
The medical share of total benefits rose from 2001 to 2013 but has fallen since 2013. The increase through 2013 occurred primarily from 2002 to 2008.

- Medical benefits rose from 52% of total benefits in 2001 to 58% in 2013, but fell back to 48% by 2021. From 2019 to 2021, the share of medical benefits fell from 52% to 48% because the majority of COVID-19 claims paid only indemnity benefits.

- Indemnity benefits fell from 48% of total benefits to 43% by 2013, but increased to 52% by 2021. The increase from 2019 (48%) to 2021 (52%) was a result of the influx of COVID-19 indemnity claims in 2020 and 2021.

- In 2020 and 2021, the indemnity share of total benefits exceeded the medical share of total benefits for the first time since 2001.

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



Accident year	Indemnity benefits [2]	Medical benefits
2001	47.8%	52.2%
2008	42.9	57.1
2013	42.5	57.5
2019	48.2	51.8
2020	50.3	49.7
2021	51.9	48.1

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

Pure premium rates

Pure premium rates have decreased substantially since 2001. However, in response to legislative and regulatory activity in 2021 and 2022, MWCIA made significant changes to its calculation of advisory pure premium base rates, which went into effect Jan. 1, 2023. Under the new legislation, the advisory pure premium base rates for 2023 include trend, development to ultimate losses and loss adjustment expenses. Prior to 2023, these elements were excluded from the rates published by MWCIA. Therefore, it is difficult to directly compare the 2023 pure premium base rates to those published prior to 2023.

The 2023 MWCIA pure premium base rate change, including the new elements of trend, loss development to ultimate and loss adjustment expenses, is +5.7%. If the new elements were to be excluded from the advisory pure premiums, the 2023 pure premium rate change would have been -9.5%.

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

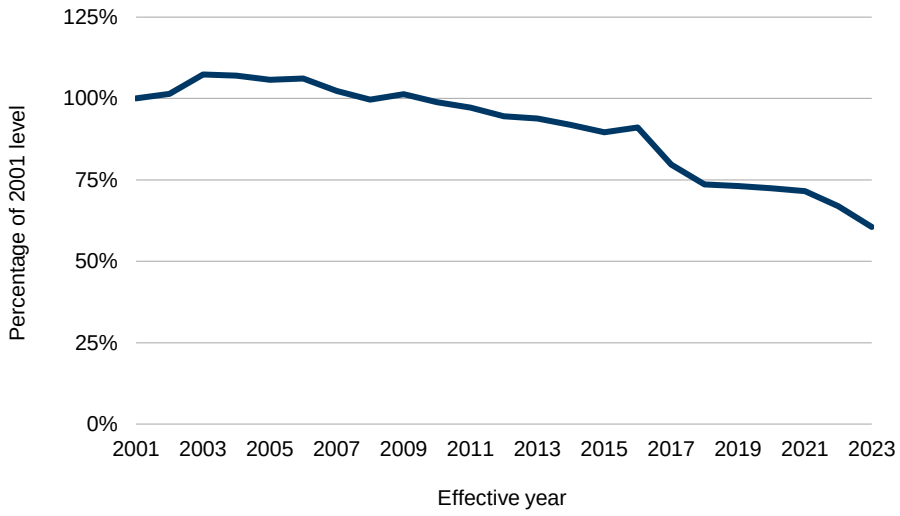
For this report, the -9.5% rate change has been used without the inclusion of the new elements to present trends that are more comparable to prior years. When the new elements are excluded from the advisory pure premiums:

- The 2023 average pure premium rate is down 39% from 2001. The rate fell 34% between 2016 and 2023 alone.[22]

- 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.[23]

- 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).

Figure 2.6. Average pure premium rate as percentage of 2001 [1]



Effective year	Percentage of 2001
2001	100.0%
2016	91.1
2021	71.5
2022	66.9
2023	60.5

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). The 2023 rate change used in this figure (-9.5%) includes experience and benefits only, and excludes the new elements of trend, development to ultimate losses and loss adjustment expenses.

System cost

The total cost of Minnesota's workers' compensation system per $100 of payroll has followed a cycle since 2001, with low points reached in 2001 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 $0.93 per $100 of payroll in 2021, well below the previous low point reached in 2010.

[22]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.

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

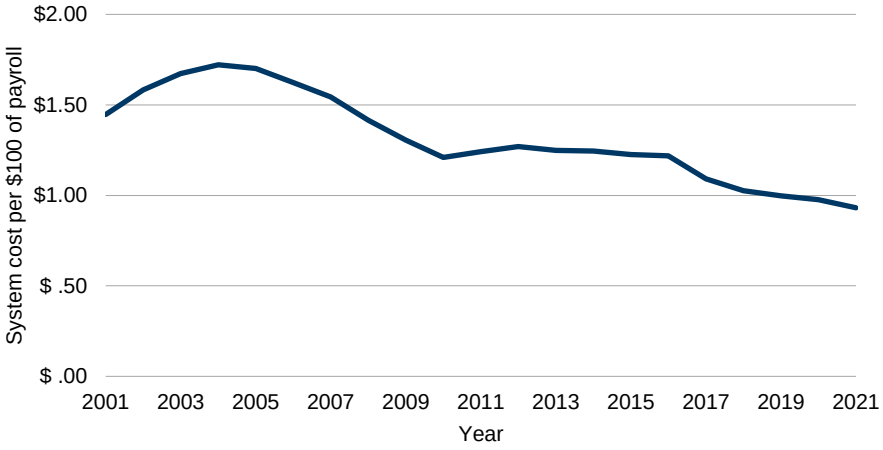
- The total cost of workers' compensation in 2021 was an estimated $1.62 billion.

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

- These figures partly reflect trends in 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.[24]

- The average system cost per $100 of payroll was $1.50 for 2002 to 2011, and $1.12 for 2012 to 2021 — two comparable cycles 10 years apart; this indicates a long-term downward trend with a 25% decrease between the two cycles. Extrapolated to 20 years, this would be a 44% decrease.[25] This is close to the average pure premium rate decrease of 39% for 2001 to 2023, 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]



		Cost per $100 of payroll
2001		$1.45
2004		1.72
2010		1.21
2012		1.27
2019	[2]	1.00
2020	[2]	.98
2021	[2]	.93

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

[24]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 (2020 data),* NASI, November 2022 (and prior reports), (nasi.org/wp-content/uploads/2022/11/2022-Workers-Compensation-Report-2020-Data.pdf), Table 15. Relevant data also appears in National Council on Compensation Insurance, "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.

[25]$(1 - .25)^2 - 1 = -.44$.

System cost components

Medical benefits represented the largest share of total workers' compensation system cost in 2021.

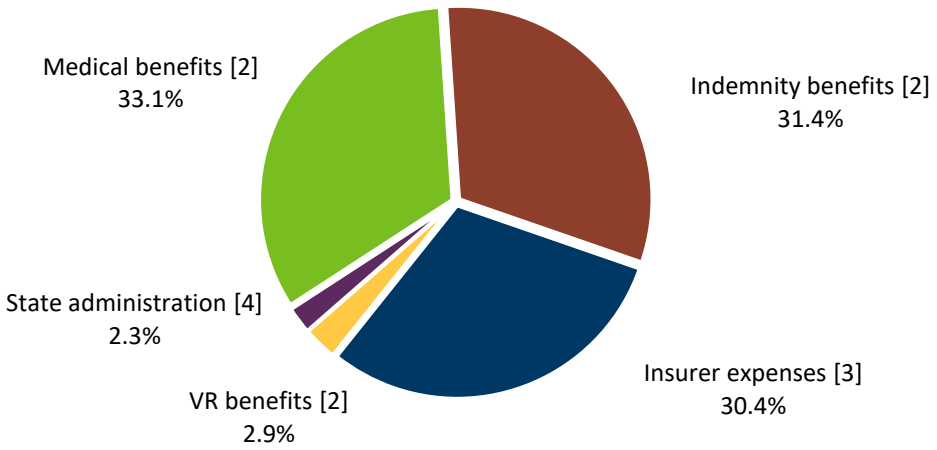
- In 2021, on a current-payment basis, medical benefits accounted for an estimated 33% of total system cost. This was followed closely by indemnity benefits other than vocational rehabilitation at 31% and insurer expenses at 30%. These shares remained largely unchanged from 2020.
  - Compared to 2019, the share of medical benefits was down from 35% and the share of indemnity benefits was up from 29%. The share of insurer expenses, vocational rehabilitation benefits and state administration remained the same as 2019.

- Total benefit payments accounted for 67% of total system cost.

- As shown in Figure 2.5, the indemnity and medical shares of total benefits have varied over time.
  - In 2020 and 2021, the indemnity share of total benefits exceeded the medical share of total benefits (for the first time since 2001) due to the effects of COVID-19.[26]

- As shown in Figure 3.13, state agency administrative cost has declined relative to payroll since 2001.

Figure 2.8. System cost components, 2021 [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'

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

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

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

- Combining the rates of change in the claim rate and benefits per claim (adjusted for average wage growth) gives an average annual rate of change of -3.4%. As expected, this is close to the average annual rate of change in benefits per $100 of payroll of -3.1% (see note 4 in Figure 2.9).

- The rate of change in the average pure premium rate (-2.2%) is somewhat less (in absolute terms) than the rate of change in benefits per $100 of payroll (-3.1%). An exact match is not expected because of different data sources and the fact that the pure premium rates reflect the computational methodology of MWCIA in addition to actual loss experience.

- The rate of change in system cost per $100 of payroll (-2.9%) is closer to the rate of change in benefits per $100 of payroll (-3.1%) than to the rate of change in the average pure premium rate (-2.2%). Exact correspondence is not expected because of differences in the measures (see note 7 in Figure 2.9).

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]	2001-2003	2019-2021	-3.5%
2.	Total benefits per total claim [3]	2001-2003	2018-2020	+0.1%
3.	Combined change in total claim rate and total benefits per total claim [4]			-3.4%
4.	Total benefits per $100 of payroll [5]	2001-2003	2019-2021	-3.1%
5.	Average pure premium rate [6]	2001-2003	2021-2023	-2.2%
6.	System cost per $100 of payroll [7]	2002-2011	2012-2021	-2.9%

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 + -3.5%) x (1 + 0.1%) - 1 = -3.4%. Since the growth in benefits per claim used in this calculation is adjusted for average wage growth, the combined average annual change of -3.4% 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 has computed the pure premium rate change every year by comparing historical pure premium (computed by applying historical pure premium rates to payroll) to total claim costs (or "benefits"). It is expected, in the long run, the pure premium rates will change at about the same rate as benefits per $100 of payroll (line 4). This relationship is only approximate because the two measures have different data sources and because the pure premium rates reflect MWCIA's computational methodology in addition to actual loss experience. To present trends that are more comparable to prior years, the measure of pure premium rate change used in this report (-9.5%) excludes the new elements of trend, loss development to ultimate and loss adjustment expenses, which are now included in the 2023 MWCIA pure premium rate change (+5.7%), as impacted by new legislation.
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, 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 also means values reported for earlier years have been updated in this report. The 2020 and 2021 data are presented separately for all claims, including COVID-19 claims and non-COVID-19 claims, to show how the pandemic has affected the statistics for these years. Other statistics in this part are reported by policy year or fiscal year.

Major findings

- Compared to 2001, the average amount of time an injured worker received total disability benefits was 12% longer in 2020 and 19% longer in 2021 for non-COVID-19 claims.
  - *When COVID-19 claims were included, total disability duration decreased 28% from 2019 to 2021 due to the significantly shorter duration of COVID-19 claims (Figure 3.3).*

- Compared to 2001, the average duration of temporary partial disability (TPD) fell 25% by 2020 and 16% by 2021 for non-COVID-19 claims.
  - *When COVID-19 claims were included, TPD duration increased 1% from 2019 to 2021 (Figure 3.3).*

- After adjusting for average wage growth, the following was found.
  - Settlement benefits per paid indemnity claim rose 4% from 2001 to 2021 for non-COVID-19 claims (Figure 3.9). 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 3.8).
    - *When COVID-19 claims were included, settlement benefits per paid indemnity claim decreased 23% from 2019 to 2021 (Figure 3.9). This decrease was largely due to the decrease in the proportion of claims with settlement benefits (Figure 3.2) because only a small number 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 2001 to 2019, but decreased 5% from 2019 to 2021 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 3.8).
    - *When COVID-19 claims were included, total disability benefits per paid indemnity claim fell 24% from 2019 to 2021 (Figure 3.9). 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 3.8).

- TPD benefits per paid indemnity claim fell 40% from 2001 to 2021 among non-COVID-19 claims (Figure 3.9). This decrease 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 25% decrease in TPD benefits per paid indemnity claim from 2019 to 2021.*
- Permanent partial disability (PPD) benefits per paid indemnity claim fell 69% from 2001 to 2021 for non-COVID-19 claims (Figure 3.9).
  - *When COVID-19 claims were included, there was a 38% decrease in PPD benefits per paid indemnity claim from 2019 to 2021.*
  - The long-term decrease in PPD benefits occurred primarily because PPD benefits became smaller relative to rising wages under the fixed PPD benefit schedule. 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) values for indemnity benefits per paid indemnity claim and per $100 of payroll closely follow their counterparts computed from Minnesota Workers' Compensation Insurers Association (MWCIA) data (Figures 3.10 and 3.11).

- The Special Compensation Fund assessment rate fell from 25.0% of paid indemnity benefits in 2001 to 11.9% in 2023 (Figure 3.14). This reflects decreasing liabilities under the supplementary and second-injury benefit programs and other factors (Figure 3.12).

Background

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

Benefit types

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

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

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

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

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

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

Counting claims and benefits: Insurance data and department data

The first figure in this part uses insurance data from MWCIA; two figures present DLI and MWCIA data side by side and all other figures use DLI data. 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 reporting of additional COVID-19 claims for 2020 and 2021, nor does it expect significant changes to benefit payments and claims durations for the reported COVID-19 claims. Therefore, claims development estimates were calculated only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims.

Costs supported by Special Compensation Fund assessment

DLI, through its Special Compensation Fund, levies an annual assessment on insurers and self-insured employers to finance: costs in DLI, the Office of Administrative Hearings (OAH), the Workers' Compensation Court of Appeals (WCCA), and other state agencies to administer the workers' compensation system; and certain benefits for which DLI is responsible.

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.

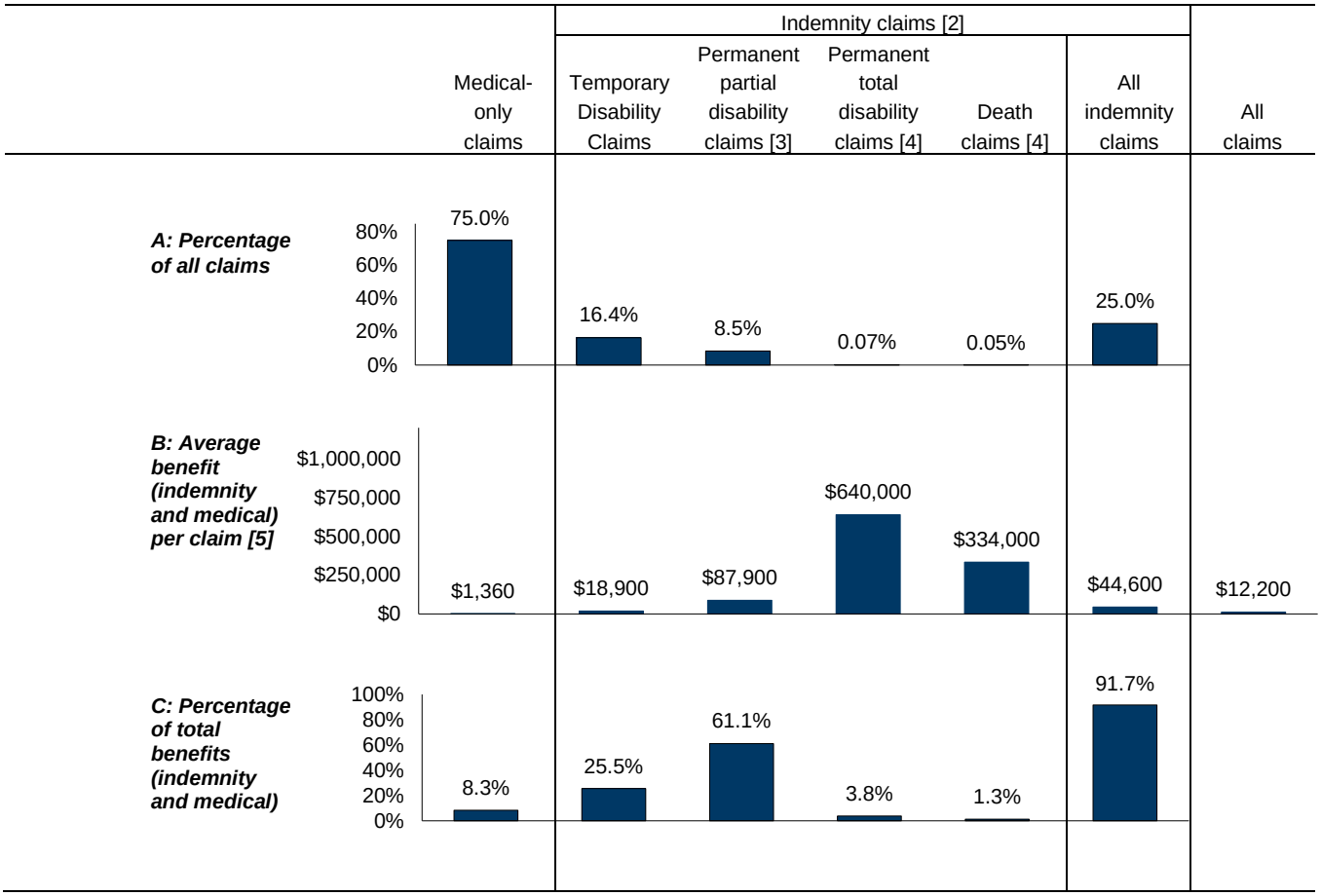
- PPD claims accounted for 61.1% of total benefits in 2019 (panel C in Figure 3.1) through a combination of moderately low frequency (panel A) and substantially higher-than-average benefits per claim (panel B).[27]

- 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 25% of all paid claims, but accounted for 92% of total benefits because they have far higher benefits, on average, than medical-only claims ($44,600 versus $1,360 for 2019). Medical-only claims accounted for 75% of claims, but only 8% of total benefits.

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

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 2019.
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 2015 to 2019 (see Appendix C).
5. Benefit amounts in panel B are adjusted for overall wage growth between 2019 and 2021.

Claims by benefit type

The majority of paid indemnity claims receive total disability benefits (TTD benefits and/or PTD benefits). Only a minority of paid indemnity claims receive PPD, TPD or settlement benefits (Figure 3.2). The proportion of claims with a settlement has shown a substantial increase since 2001, but has been fluctuating since 2018; the proportion with PPD benefits has fallen significantly since 2009 after rising gradually before that year; 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. *As the number of COVID-19 claims decreased*

in 2021, the proportion of claims with total disability benefits decreased while all other benefits increased relative to 2020.

- For non-COVID-19 paid indemnity claims in 2021, 84% received total disability benefits, while the proportion receiving other benefit types was estimated at: 13% for PPD benefits; 22% for settlement benefits; and 25% for TPD benefits. These percentages were consistent with pre-pandemic trends.
  - *When COVID-19 claims were included, an estimated 87% of all paid indemnity claims received total disability benefits in 2021. The proportion receiving the other benefit types shown was: 10% for PPD benefits; 16% for settlement benefits; and 20% for TPD benefits.*

- The percentage of claims with settlement benefits rose 12% from 2001 to 2018, but the trend's direction depends on whether COVID-19 are included, because only a small number of COVID-19 paid indemnity claims had settlement benefits.[28]
  - For non-COVID-19 claims in 2021, 22% of claims had settlements – an increase from 2020 and higher than the 2018 level.
  - *When COVID-19 claims were included, there was a decrease in claims with settlement benefits from 2019 to 2020, followed by an increase in 2021.*

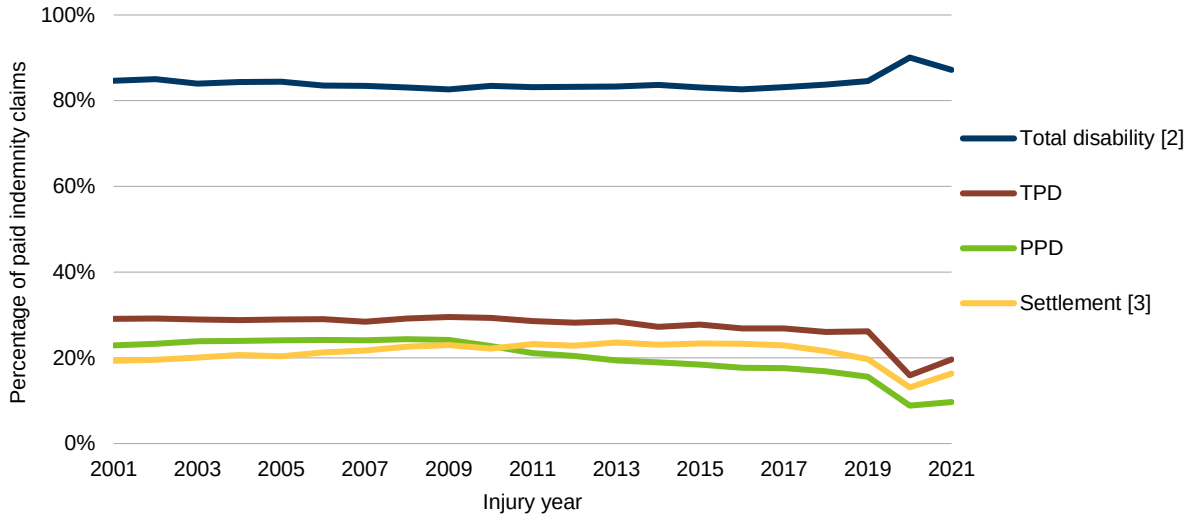
- The percentage of claims with PPD benefits has fallen substantially from 2001 to 2021.
  - For non-COVID-19 claims in 2021, the percentage of claims with PPD benefits was 13% – slightly below the 2020 value of 14%. There was a 44% decrease in the percentage of claims with PPD benefits from 2001 to 2021.
  - *When COVID-19 claims were included, the percentage of claims with PPD benefits dropped 43% from 2019 to 2020, but increased 9% from 2020 to 2021.*

- Except in 2020 and 2021, which include large numbers of COVID-19 claims, the percentage of claims with total disability benefits has remained stable throughout the period, with minimal yearly fluctuations.
  - For non-COVID-19 claims in 2021, the percentage of claims with total disability benefits was 84% – slightly below the 2020 value of 85%.
  - *When COVID-19 claims were included, there was a 3% increase from 2019 to 2021 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 2001.
  - For non-COVID-19 claims, the percentage of claims with TPD benefits was 25% in 2021, just above the 2020 value of 24%.
  - *When COVID-19 claims were included, there was a 39% decrease from 2019 to 2020, followed by a 23% increase from 2020 to 2021 because of the smaller number of COVID-19 claims in 2021 than in 2020.*

[28]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]
2001	84.6%	29.1%	22.9%	19.3%
2009	82.7	29.5	24.2	23.0
2017	83.2	26.8	17.6	22.9
2018	83.8	26.1	16.8	21.6
2019	84.6	26.2	15.6	19.7
2020	90.1	15.9	8.9	13.1
2020 non-COVID	84.8	23.9	14.1	20.6
2021	87.2	19.6	9.7	16.4
2021 non-COVID	83.5	24.8	12.9	21.8

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 and 2021 statistics include all paid indemnity claims, including COVID-19 claims. The non-COVID-19 percentages for 2020 and 2021 are not reflected in the figure but are shown separately in the above table.
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 18% from 2001 to 2009.[29] 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. Average duration of total disability benefits started to increase again in 2021. The TPD duration, declining since 2001, increased slightly from 2020 to 2021.

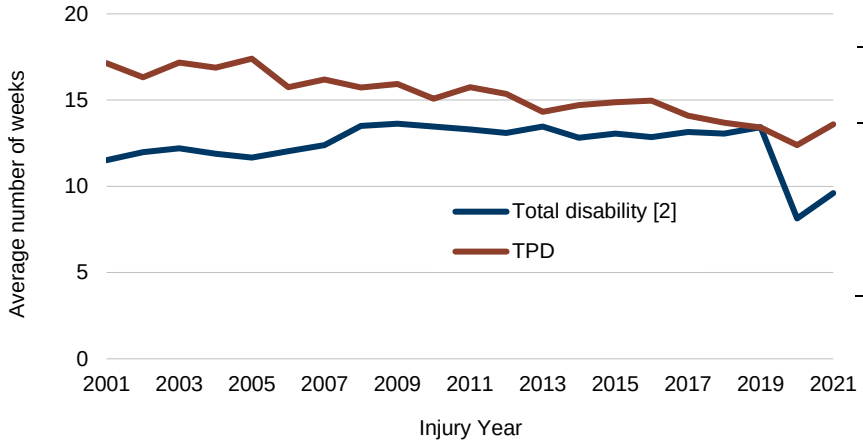
- For non-COVID-19 claims in 2021, the estimated average duration of total disability benefits was 13.7 weeks – up from 12.9 weeks in 2020 and consistent with earlier trends.

[29]The limit on TTD duration was raised from 104 weeks to 130 weeks under a law change effective Oct. 1, 2008 (see Appendix B). This accounts for about 5% of the 9% increase in average total disability duration from 2007 to 2008.

- *When COVID-19 claims were included, estimated total disability duration averaged 10 weeks for 2021, 16% below 2001. This reversed the upward trend from 2001 to 2019. Most of this decrease can be attributed to the significantly shorter duration of COVID-19 claims in 2020 and 2021. From 2019 to 2021, there was a 28% decrease in total disability duration.*

- For non-COVID-19 claims in 2021, estimated TPD duration averaged 14.4 weeks in 2021 – above the 2020 value of 12.9 weeks and 16% below 2001.
  - *When COVID-19 claims were included, TPD duration for 2021 claims averaged 13.6 weeks, 10% above the 2020 value and 21% below 2001.*

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



Injury year	Average weeks	
	Total disability [2]	TPD
2001	11.5	17.1
2008	13.5	15.7
2019	13.4	13.4
2020	8.1	12.4
2020 non-Covid	12.9	12.9
2021	9.6	13.6
2021 non-Covid	13.7	14.4

1. Developed statistics from DLI data (see Appendix C). The non-COVID-19 statistics for 2020 and 2021 are not reflected in the figure, but are shown separately in the data table.
2. Total disability includes TTD and PTD.

Weekly benefit payments

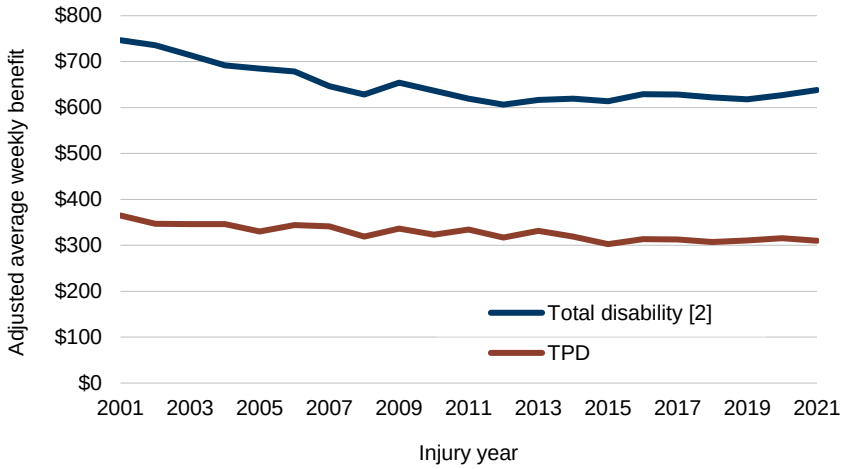
- After adjusting for average wage growth, the average weekly total disability payment decreased between 2001 and 2019, but increased from 2019 to 2021.
  - For non-COVID-19 claims, compared with 2001, adjusted average weekly total disability benefits fell 17% by 2019 and 22% by 2021.
  - *When COVID-19 claims were included, adjusted average weekly total disability benefits increased 3% from 2019 to 2021, which can be attributed to the higher weekly wages of many workers with COVID-19 claims.*

- TPD benefits declined between 2001 and 2021.
  - For non-COVID-19 claims, compared with 2001, TPD benefits fell 17% by 2021, consistent with the downward trend for earlier years.[30]
  - *When COVID-19 claims were included, there was no change in TPD benefits from 2019 to 2021.*

[30]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 occurred between 2001 and 2008.

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



Injury year	Total disability [2]	TPD
2001	$747	$365
2008	628	319
2019	618	310
2020	627	316
2020 non-COVID	591	312
2021	638	310
2021 non-COVID	586	304

1. Developed statistics from DLI data. Benefit amounts are adjusted for average wage growth between the respective year and 2021. See Appendix C. The non-COVID-19 values for 2020 and 2021 are not reflected in the figure, but are shown separately in the above table.
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 2001 to 2021.

- While the SAWW rose 83% during this period, the APIW rose 76% (Figure 3.5).

- The APIW is less than the SAWW because workplace injuries resulting in paid claims are more common in lower-wage jobs.

- Because of its relatively slow rate of increase, the APIW fell from 85% of the SAWW in 2001 to 81% in 2021 (Figure 3.5).[31] Because of accelerating wage growth in the low-wage sector in recent years, the gap between APIW and SAWW has been closing since 2020.

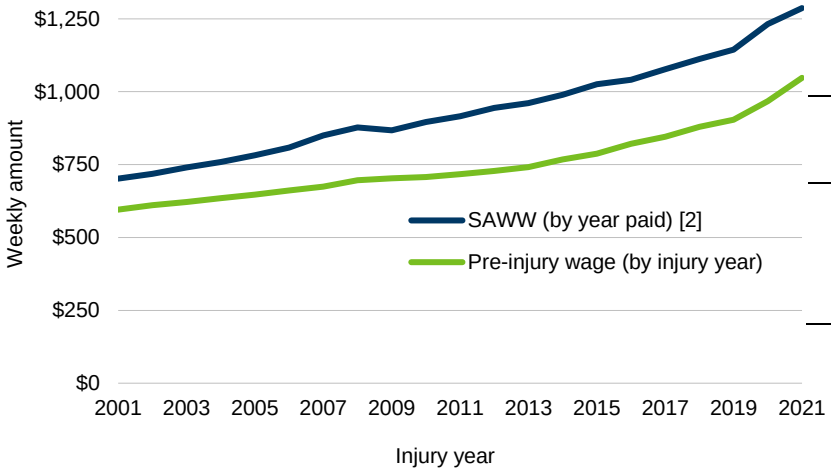
- Because average weekly benefits (Figure 3.4) are adjusted for growth in the SAWW, a change in the APIW relative to the SAWW will cause a change in these adjusted benefits, other things equal. The

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

decrease in the APIW relative to the SAWW explains about 36% of the estimated decrease in adjusted average weekly benefits for total disability, and 46% for TPD, for 2001 through 2021.[32]

- In 2021, wage-adjusted weekly total disability benefits averaged about $586 and weekly TPD benefits averaged about $304 for non-COVID-19 claims.
  - *For COVID-19 claims in 2021, wage-adjusted weekly total disability benefits averaged about $763 and weekly TPD benefits averaged about $396. Most COVID-19 indemnity claims were by workers included in the COVID-19 presumption, which covered first responders, corrections workers and health care workers, many of whom have higher weekly wages compared with all 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)	APIW as pctg. of SAWW
2001	$702	$596	84.8%
2011	916	717	78.2
2019	1,144	904	79.0
2020	1,232	968	78.6
2021	1,287	1,048	81.4

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

Average permanent partial disability rating

The trend in the average PPD rating helps to explain the trend in average PPD benefits in Figure 3.9. 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 been falling since 2001 but saw a slight increase after 2018.

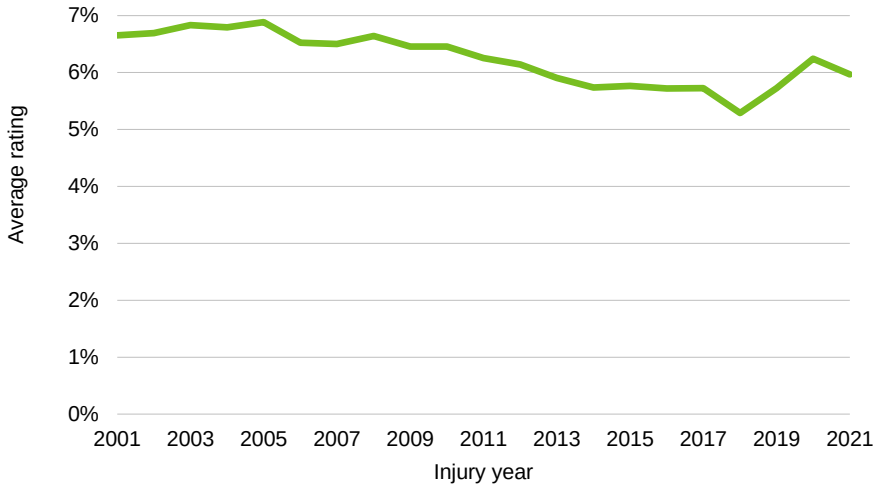
- The average PPD impairment rating was 6% for injury-year 2021. This represents a 10% decrease from 2001.[33]

[32]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.

[33]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.

- 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.[34]

Figure 3.6. Average permanent partial disability rating [1]



Injury year	Average PPD rating
2001	6.7%
2011	6.3
2019	5.7
2020	6.2
2021	6.0

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

Average level of permanent partial disability benefit schedule

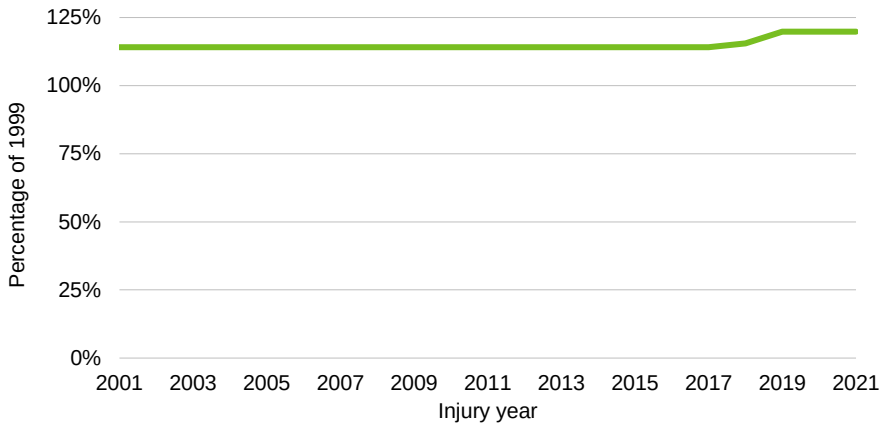
The trend in average PPD benefits in Figure 3.8 is also partly explained by the trend in the level of the PPD benefit schedule. This benefit schedule is fixed in statute but has been raised twice since 1998. These schedule increases affect the benefits paid to workers injured on or after the effective date of the increase.

- The PPD benefit schedule was raised in 2000 by an estimated 14.1% and in 2018 by 5%.

- As a result of these changes, the benefit schedule was higher by an estimated 5.7% for injury-year 2021 than for injury-year 2001 (see note 1 in Figure 3.7).

[34]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 because more claims are in lower brackets in the schedule with lower benefit amounts per rating point.

Figure 3.7. Average level of permanent partial disability benefit schedule as percentage of 1999 [1]



Injury year	Pctg. of 1999
2001	114.1%
2018	115.5
2019	119.8
2020	119.8
2021	119.8

1. The increase in 2019 reflects the 2018 law change that raised PPD benefits by a uniform 5% throughout the benefit schedule, effective for injuries on or after Oct. 1, 2018.

Average benefits by type

Settlement benefits are far higher on average where they are paid than total disability, TPD and PPD benefits (Figure 3.8). 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 2021 claims, are subject to change as the claims mature.

- For non-COVID-19 claims in injury-year 2021, settlement benefits averaged about $46,490 per claim where they were paid. In comparison, total disability benefits averaged about $8,010, TPD benefits $4,370 and PPD benefits $6,190.
  - *When COVID-19 claims were included, the average for total disability benefits was lower – about $6,140, while the averages for settlement benefits, TPD benefits and PPD benefits were almost the same as non-COVID-19 claims.*

- After adjusting for average wage growth, the following was found.
  - Average total disability benefits were largely stable from 2001 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 and 2021, the trend was more consistent with earlier years.
    - *When COVID-19 claims were included, there was an overall 26% decline from 2019 to 2021, but a 20% increase from 2020 to 2021. The decline from 2019 was driven largely by the short average benefit duration of COVID-19 claims.*
  - Average TPD benefits fell 33% from 2001 to 2021 (same as the decrease from 2001 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 (51%) from 2001 to 2018, but rose slightly after 2018. This decrease occurred primarily because the statutory PPD benefit schedule changed only once during that period, with an overall increase of 5.7% (Figure 3.7). In contrast, the SAWW increased by 83% from 2001 to 2021 (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 3.6, the average PPD rating fell roughly 21% from 2001 to 2018.[35] This would produce a decrease in the average PPD benefit (unadjusted for wage growth) of roughly the same percentage.[36] The net effect of this decrease and the 5.7% increase in the benefit schedule (Figure 3.7) would be a predicted decrease in average unadjusted benefits of roughly 16%.[37]
- Actual average PPD benefits, unadjusted for average wage growth, decreased 22% from 2001 to 2018.
- This decrease is only a part of the 51% decrease in average PPD benefits from 2001 to 2018 as adjusted for average wage growth shown in Figure 3.8. 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 58% from 2001 to 2018.
- The increase in average PPD benefits from 2018 to 2021 corresponds to the rise in the average PPD rating and the PPD benefit schedule after 2018.[38]

➢ The average wage growth adjusted settlement payment decreased 8% from 2001 to 2021. Settlement benefits depend in part on the value of benefits the worker might receive without a settlement. Settlement benefits can include payments for medical and vocational rehabilitation benefits in addition to total disability, TPD and PPD benefits.[39]

[35]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.

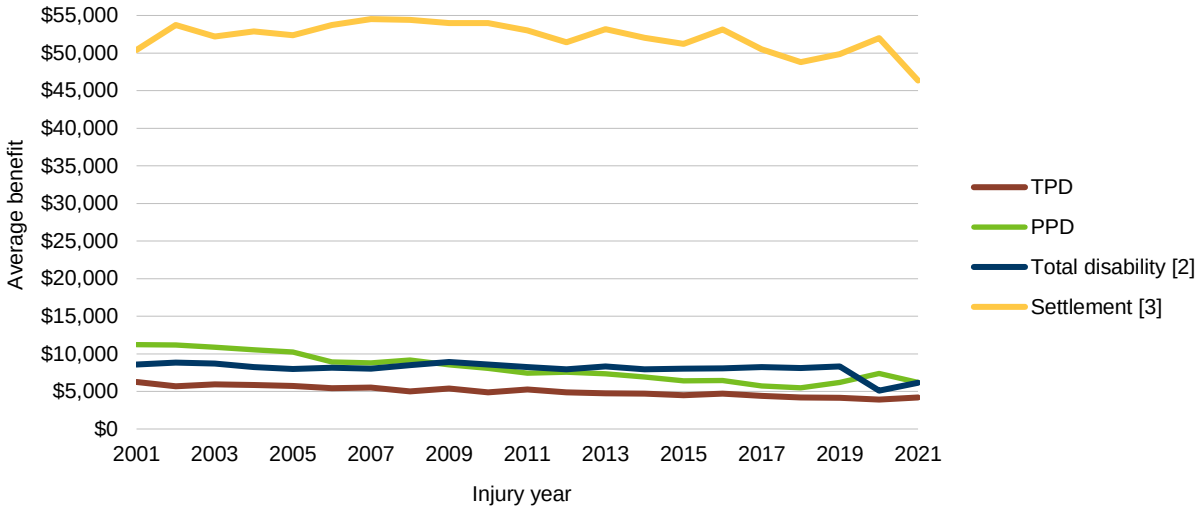
[36]See the last bullet on p. 30 and note 34 on that page.

[37](1 - .205 [the more exact decrease in the average rating]) x (1 + .057) = .84, or a 16% 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.

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

[39]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 3.8. Average benefit by type *per claim with that benefit type*, adjusted for wage growth [1]



Injury year	Total disability [2]	TPD	PPD	Settlement [3]
2001	$8,590	$6,250	$11,220	$50,430
2005	7,980	5,740	10,240	52,390
2011	8,240	5,260	7,430	53,000
2017	8,260	4,410	5,740	50,520
2018	8,120	4,200	5,480	48,790
2019	8,300	4,160	6,180	49,850
2020	5,100	3,910	7,380	51,980
2020 Non-Covid	7,610	4,030	7,390	53,060
2021	6,140	4,210	6,190	46,350
2021 Non-Covid	8,010	4,370	6,190	46,490

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 2021. The 2020 and 2021 values reflect average benefit amounts for all claims, including COVID-19. The non-COVID-19 average benefit values for 2020 and 2021 are not reflected in the figure, but are shown separately in the above table.
2. Total disability includes TTD and PTD.
3. Settlement includes indemnity, medical and vocational rehabilitation components.

Benefits by type per indemnity claim

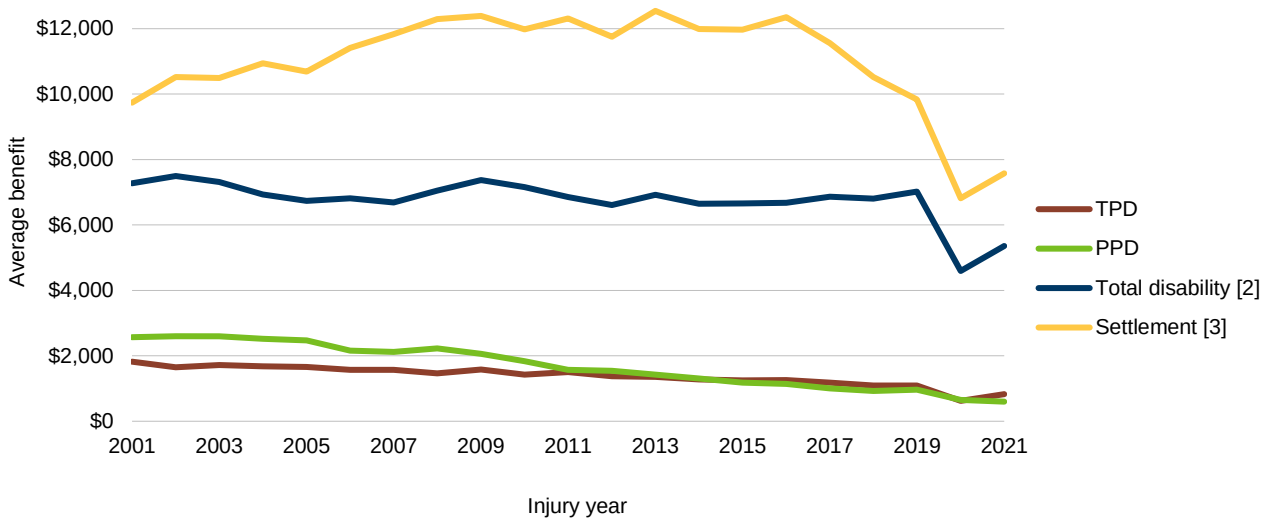
Per paid indemnity claim, settlement benefits are far higher than total disability, TPD or PPD benefits (Figure 3.9). With respect to trends, after adjusting for average wage growth, average benefits per paid indemnity claim followed widely divergent paths. These are all developed statistics; reported values for recent years, especially for 2020 and 2021 claims, are subject to change as the claims mature.

Note, Figure 3.9 differs from Figure 3.8 in that it shows the average benefit of each type per paid indemnity claim rather than per claim with that type of benefit. Figure 3.9 reflects the percentage of indemnity claims with each benefit type (Figure 3.2) and Figure 3.8 shows the average benefit amount per claim with that benefit type. For example, the $7,580 average settlement benefits per paid indemnity claim for 2021 (Figure 3.9) is about equal to the percentage of indemnity claims with settlement benefits (16.4%, Figure 3.2) multiplied by the average settlement benefit where paid ($46,350, Figure 3.8).

- The table presented in Figure 3.9 provides the average indemnity benefits for all 2020 and 2021 indemnity claims, including COVID-19 claims, and below them, 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 difference 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 2001 to 2019 and for 2020 to 2021 for non-COVID-19 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 3.8), 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 24% from 2019 to 2021.*
  - Compared to 2001, TPD benefits per indemnity claim fell 40% by 2021 for non-COVID-19 claims.
    - *When COVID-19 claims were included, the decrease from 2001 to 2021 was larger (55%). From 2019 to 2021 there was a 25% 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 3.8).
  - PPD benefits per indemnity claim fell 69% from 2001 to 2021 for non-COVID-19 claims.
    - *When COVID-19 claims were included, the decrease from 2001 to 2021 was larger (77%). From 2019 to 2021 there was a 38% 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 3.8) and, to a lesser degree, from a decrease in the percentage of claims with these benefits (Figure 3.2).
  - Settlement benefits per non-COVID-19 indemnity claim rose 4% from 2001 to 2021.
    - *When COVID-19 claims were included, settlement benefits decreased 23% from 2019 to 2021. This was driven largely by the decrease in the proportion of claims with settlement benefits in 2020 and 2021, because only a handful of COVID-19 paid indemnity claims involved settlement benefits.*

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



Injury year	Total disability [2]	TPD	PPD	Settlement [3]
2001	$7,270	$1,820	$2,570	$9,740
2005	6,740	1,660	2,470	10,690
2009	7,370	1,590	2,060	12,390
2018	6,800	1,100	920	10,520
2019	7,020	1,090	960	9,830
2020	4,590	620	650	6,820
2020 non-Covid	6,450	960	1,040	10,910
2021	5,350	820	600	7,580
2021 non-Covid	6,690	1,090	800	10,120

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 2021. The non-COVID-19 values for 2020 and 2021 are not reflected in the figure, but are shown separately in the above table
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 2001 through 2021, 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.[40]

- Both data sources show a generally stable trend in wage-adjusted indemnity benefits per indemnity claim since 2001, with some yearly fluctuations.

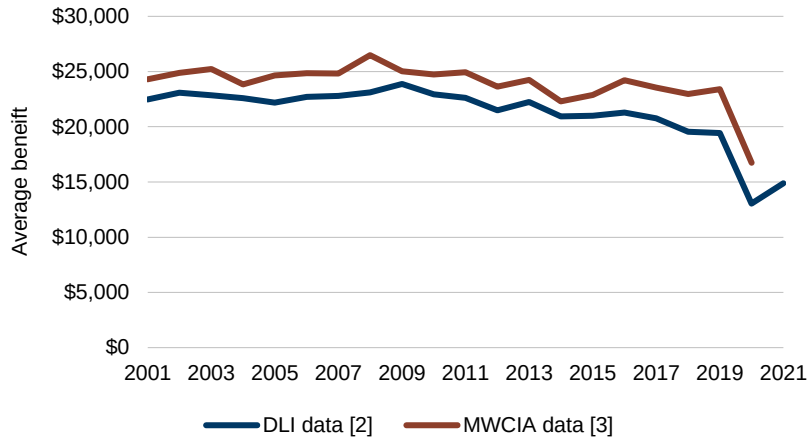
[40]As shown in Figure 4.4, the average cost of vocational rehabilitation has been somewhat above $2,000 per paid indemnity claim (adjusted for wage growth) since 2001. From 2001 to 2020, the MWCIA number in Figure 3.10 exceeded the DLI number by an average of $2,335. Another possible factor is the MWCIA figure excludes self-insured employers while the DLI figure includes them, although the effect of this difference is uncertain.

- For non-COVID-19 claims, indemnity benefits per indemnity claim were $19,365 in 2021 – more consistent with the earlier trends.
- *When COVID-19 claims were included, DLI data shows a significant decrease in wage-adjusted indemnity benefits per indemnity claim, from $19,440 in 2019 to $14,880 in 2021.*

- It is uncertain why the MWCIA figure seems to fluctuate more than the DLI figure. One possible explanation is the MWCIA figure is based on payments plus claim-specific reserves, while the DLI figure is based on payments alone.[41]

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

Figure 3.10. 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]
2001	$22,480	$24,300
2018	19,560	22,980
2019	19,440	23,410
2020	13,040	16,740
2020 non-COVID	19,726	
2021	14,880	
2021 non-COVID	19,365	

1. Benefit amounts are adjusted for average wage growth between the respective year and 2021 (see Appendix C). The non-COVID-19 value for 2020 and 2021 DLI data are not reflected in the figure but are shown separately in the above table.
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 2021.

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.

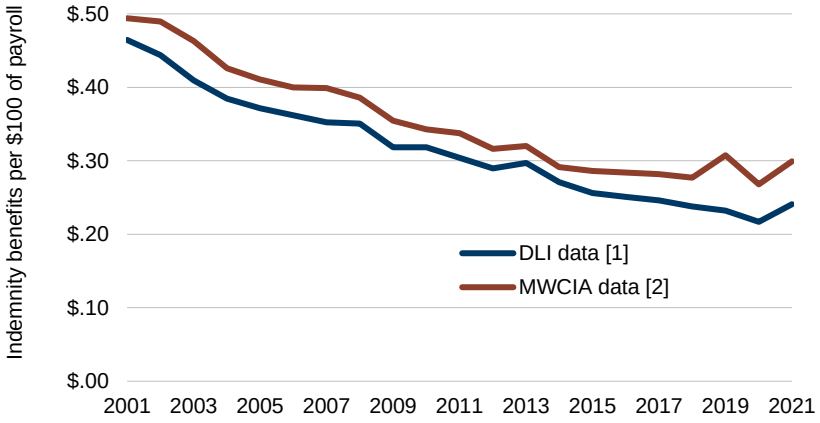
- Since 2001, the DLI figure has ranged from 94% in 2001 to 81% in 2021 of the MWCIA figure.

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

- As with average indemnity benefits per paid indemnity claim (Figure 3.10), much of the difference between the DLI and MWCIA numbers is because the MWCIA figure includes vocational rehabilitation service costs while the DLI number does not.[42]

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

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



Injury year	DLI data [1]	MWCIA data [2]
2001	$.46	$.49
2002	.44	.49
2019	.23	.31
2020	.22	.27
2020 non-COVID	.20	
2021	.24	.30
2021 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 and second-injury benefit costs

DLI produces an annual projection of supplementary benefit and second-injury benefit reimbursement costs as they would exist without future settlement activity. The total annual cost is projected to fall by 65% during the next 10 years and to disappear by 2060.

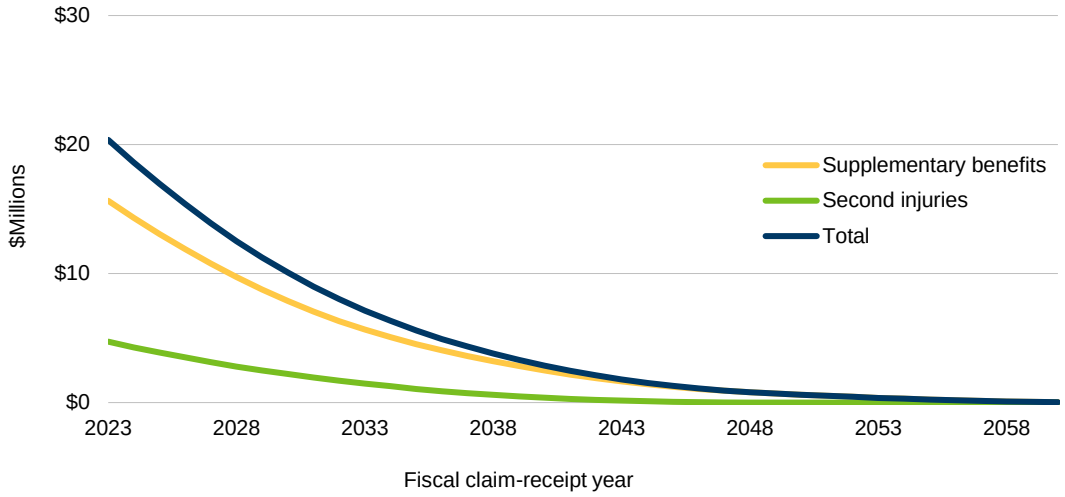
- The 2023 projected cost of $20.4 million consists of roughly $15.6 million for supplementary benefits and $4.7 million for second-injury benefits.[43]
- Without settlements, supplementary benefit claims are projected to continue until 2060 and second-injury benefit claims until 2045.

[42]The data in Figure 2.8 indicates the vocational rehabilitation component of total system cost is about 8.4% of the combined vocational rehabilitation and indemnity (without vocational rehabilitation) components (2.9% / (31.4% + 2.9%) = 8.4%). This accounts for a majority of the average 11.4% difference between the DLI and MWCIA numbers in Figure 3.11 for the period shown. Another possible factor is the MWCIA figure excludes self-insured employers while the DLI figure includes them, although the effect of this difference is uncertain.

[43]Because complete data for supplementary benefit and second-injury benefit claims was not available in the Work Comp Campus database, 2023 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 $1.6 million in fiscal-year 2021.

Figure 3.12. Projected cost of supplementary and second-injury reimbursement claims [1]



Fiscal year of claim receipt	Projected amount claimed ($millions)		
	Supplementary benefits	Second injuries	Total
2023	$15.6	$4.7	$20.4
2025	13.1	3.9	17.0
2030	7.9	2.2	10.1
2035	4.5	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.

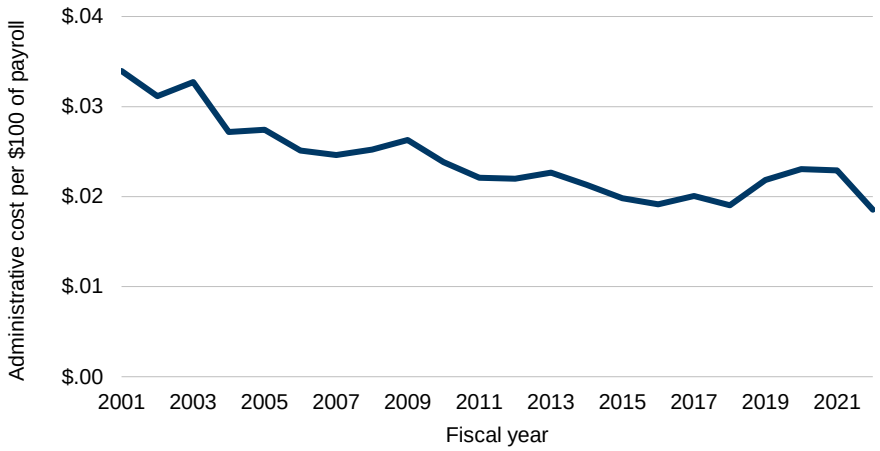
- In fiscal-year 2022, state agency administrative cost (see note 1 in Figure 3.13) was 1.9 cents per $100 of payroll.

- 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.

- The increase in administrative cost from 2018 to 2021 primarily reflected the expenditure for the Workers' Compensation Modernization Program, or Work Comp Campus.[44]

- Administrative cost for 2022 was $32.2 million. As indicated in Figure 2.8, state administration accounted for about 2.3% of total workers' compensation system cost in 2021.

Figure 3.13. Net state agency administrative cost per $100 of payroll [1]



Fiscal year	State agency admin. cost per $100 of payroll
2001	$.034
2019	.022
2020	.023
2021	.023
2022	.019

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

- The rate fell from 25.0% for 2001 to 11.9% for 2023. Primarily, this reflects the continuing decreases in supplementary benefit and second-injury benefit reimbursement costs (Figure 3.12) and, to a lesser degree, the decreasing trend in state agency administrative costs relative to total covered payroll (Figure 3.13).

- The sharp decrease in the assessment rate for fiscal-year 2019 primarily reflects an increase in the reported assessment base rather than a decrease in the assessment itself. The increase in the base

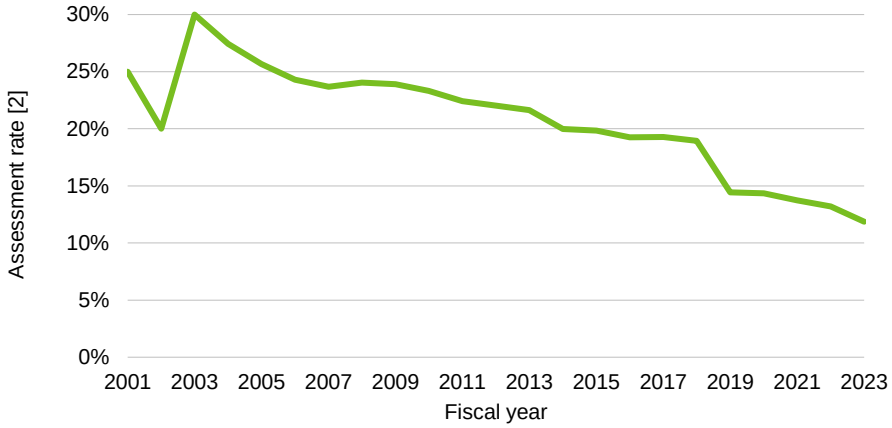
[44]"Campus" stands for Claims Access and Management Platform User System. Campus expenditures, funded by the workers' compensation assessment, were $3.6 million in 2019, $8.9 million in 2020 and $5.7 million in 2021, as compared with $0.2 million in 2018.

reflects some insurers erroneously including medical benefits in their reported base, which is supposed to include paid indemnity benefits only.[45]

- The fluctuations of the assessment rate between 20% and 30% from 1999 to 2003 reflected DLI responses to legislative actions.[46]

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

Figure 3.14. Special Compensation Fund assessment rate [1]



Fiscal year assessment is due	Assessment rate [2]
2001	25.0%
2002	20.0
2003	30.0
2018	18.9
2019	14.4
2020	14.4
2022	13.2
2023	11.9

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.

[45]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 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.

[46]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 3.14). 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 services in Minnesota's workers' compensation system. Some of the statistics are presented by the year of the worker's injury or illness; others are presented by the year of the vocational rehabilitation plan closure, the period from Oct. 1 through Sept. 30 of the indicated year. The economic effects of the COVID-19 pandemic affected results for many workers receiving these services during 2020 and 2021.

Major findings

- Participation in vocational rehabilitation rose from 20% of paid indemnity claims for injury-year 2001 to 24% for 2019, but decreased to 22% among non-COVID-19 indemnity claims in 2021 (Figure 4.1).
  - There was a 15% decrease in the estimated number of workers who will receive vocational rehabilitation services for their injuries and illnesses in 2021 compared with the number in 2019 (4,500 and 5,300, respectively).
  - *The 2021 vocational rehabilitation participation rate was 16% when COVID-19 indemnity claims are included. Only 62 workers with 2021 COVID-19 claims had vocational rehabilitation services.*

- After adjusting for average wage growth, the $9,060 average cost of vocational rehabilitation services for injury-year 2021 was 24% below the 2007 peak of $11,850 (Figure 4.4).

- Vocational rehabilitation services accounted for an estimated 2.9% of total workers' compensation system cost for 2021 (Figure 2.8).

- The average time from injury to the start of vocational rehabilitation services fell from 7.7 months for injury-year 2001 to 5.0 months for 2021 (Figure 4.8).

- The percentage of vocational rehabilitation plans closed with a plan completion decreased from 55% in closure-year 2005 to 45% in 2022 (Figure 4.10). During the prior 10 years, the average percentage of plans closed by completion was 48%.

- The percentage of plan closures resulting from claim settlement increased from 26% in 2005 to 34% in 2022, while the percentage closing by agreement of the parties increased slightly, from 17% in 2005 to 18% in 2022 (Figure 4.10).
  - Plan closures in 2021 were an outlier compared to recent statistics, with 26% of closures due to a settlement and 21% due to closure by agreement.

- The percentage of vocational rehabilitation participants with a reported job at plan closure dropped from 61% in 2019 to 56% in 2020 and increased to 57% of workers employed at plan closure in 2022 (Figure 4.12).

  - Forty percent of vocational rehabilitation participants returned to work with their pre-injury employer in 2022, below the prior 10-year average of 42%.
  - Seventeen percent of vocational rehabilitation participants worked for a new employer at plan closure in 2022, the same as the prior 10-year average.

- During the 2020 through 2022 closure years, 77% of the workers returned to a job with a wage at least 95% of their pre-injury wage (Figure 4.14).

- For vocational rehabilitation participants who returned to work at a different employer in closure-year 2022, the average ratio of the return-to-work wage to the pre-injury wage was 96%, an increase from 78% in 2009 (Figure 4.15). For workers returning to the same employer, the average ratio was 100%.

Background

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

Vocational rehabilitation is the third type of workers' compensation benefit, supplementing indemnity and medical benefits. Vocational rehabilitation services are provided to injured workers who need help in returning to suitable gainful employment because of their injuries.[47]

Vocational rehabilitation services include the following:

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

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

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

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

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

The vocational rehabilitation eligibility process typically begins when the insurer files a disability status report (DSR) to notify DLI it is referring the injured worker to a QRC for a consultation or requesting a waiver of services. The insurer is required to file the DSR within 14 days of becoming aware temporary total disability is likely to exceed 13 weeks, 90 days after the injury if the employee has not returned to work or 14 days after receiving a consultation request from the employee. Although the insurer typically refers the employee for a consultation via the DSR, the employee or employer may request a consultation and DLI can also order a consultation. A QRC in DLI's VRU may also provide a consultation if the insurer denies the employee's injury or condition is work-related and the employee has disputed the denial.

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

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

Annual changes in hourly vocational rehabilitation service charges through 2012 were limited to the lesser of the percentage increase in the statewide average weekly wage (SAWW) or 2%. The 2013 workers' compensation law change increased the annual change in hourly charges to the lesser of the percentage increase in the SAWW or 3%, effective Oct. 1, 2013. The maximum hourly fee levels for QRCs and for job-development and job-placement services, effective Oct. 1, 2021, through Sept. 30, 2022, were $115.91 and $92.83, respectively. These rates changed to $119.39 and $95.61, respectively, for Oct. 1, 2022, through Sept. 30, 2023.

The 2013 law change also defined job-development services and limited these services: to 20 hours a month for up to 13 weeks; to 26 weeks by agreement between the injured worker and employer; or by order of DLI or the 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 insurer can agree to pay for additional weeks of service. Injured workers with earlier dates of injury have no limit on their job-development services.

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

process to six hours a month. This includes in-person meetings with the worker and any placement vendor to determine job goals, review why the current job search has been unsuccessful and set strategies to overcome obstacles to employment.

Data sources and time period covered

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

The trend statistics in this chapter reported by injury-year or plan-closure year are developed (projected) to a uniform maturity as described in Appendix C. Vocational rehabilitation plan-closure years cover plan closures in the period from Oct. 1 through Sept. 30 of the indicated year. Among the claims in plan-closure year 2022, 41% had injuries in 2021 and 28% had injuries in 2020.

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 vocational rehabilitation services due to their ongoing symptoms leading to extended time loss. However, the number of these cases is not yet known.

Participation

The vocational rehabilitation participation rate remained between 20% and 25% from 2001 to 2019, and the rate dropped below 20% in 2020 and 2021 (Figure 4.1). The COVID-19 pandemic led to a drop in the utilization rate in 2020 and 2021.

- The COVID-19 pandemic had a significant effect on the statistics for vocational rehabilitation services for workers injured in 2021. A projected 4,500 of the estimated 27,500 workers with indemnity claims for injury-year 2021 are expected to receive vocational rehabilitation services, 16% of the claims. This is a slightly higher rate than in 2020, when 15% of the 29,400 workers with indemnity claims are expected to receive vocational rehabilitation services. In contrast, 24% of the 21,900 workers with indemnity claims from 2019 are expected to receive vocational rehabilitation services.

- Among non-COVID-19 indemnity claims with 2021 dates of injury, the vocational rehabilitation participation rate was 22%, slightly below the average percentage of 24% for 2015 through 2019.

- 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. Few of these workers require vocational rehabilitation services to return to work. Workers with COVID-19 indemnity claims accounted for 26% of estimated indemnity claims in 2021, but only 1% of the claims with vocational rehabilitation services. Only 62 of the 7,101 workers with 2021 COVID-19 indemnity claims have received vocational rehabilitation services; 125 workers with COVID-19 indemnity claims in 2020 have received vocational rehabilitation services.

Participation and injury severity

Vocational rehabilitation 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.

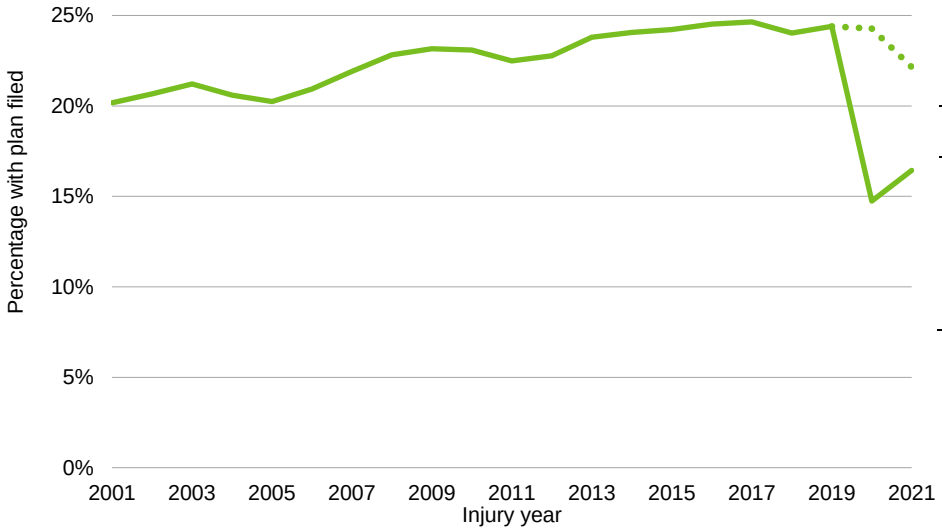
For workers with indemnity claims closed between October 2020 and September 2022 the following was found.

- Vocational rehabilitation participation ranged from 9% for workers with no more than three months of temporary total disability (TTD) benefits to 92% for workers with more than 12 months of TTD benefits (Figure 4.2).

- Vocational rehabilitation participation ranged from 12% for workers without PPD benefits (and no settlement agreement) to 75% for workers with PPD ratings of 20% or more (Figure 4.3).[48] Vocational rehabilitation participation was 56% for workers with a settlement and no PPD benefits.

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

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

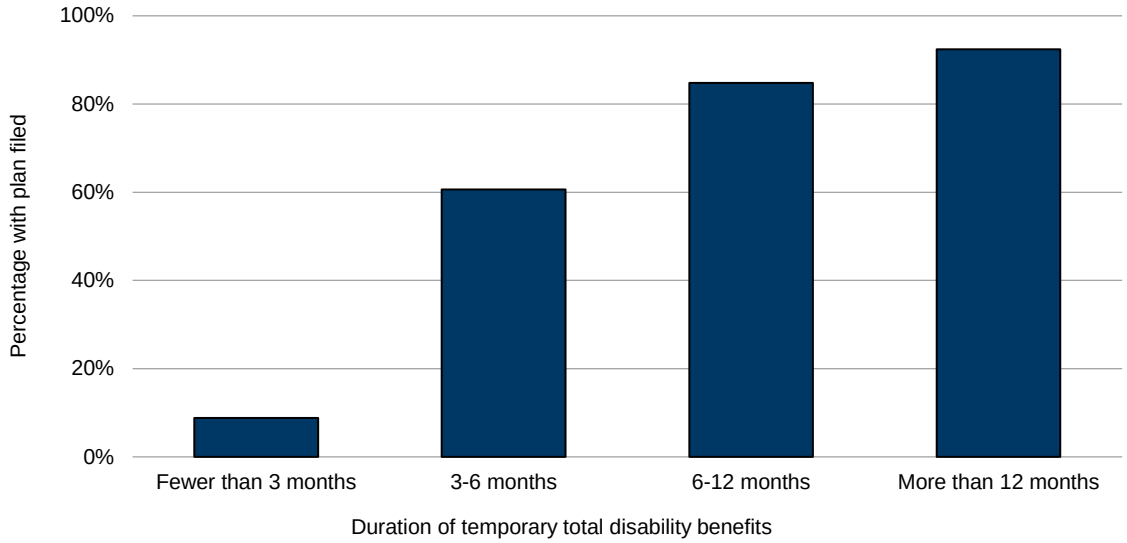


Injury year	Percentage with plan
2001	20.2%
2010	23.1
2019	24.4
2020	14.7
2020 non-COVID	24.3
2021	16.4
2021 non-COVID	22.1

1. Developed statistics from DLI data (See Appendix C)
2. Line shows estimated amount for all indemnity claims, including COVID-19 claims. Dotted line shows values for non-COVID-19 claims only.

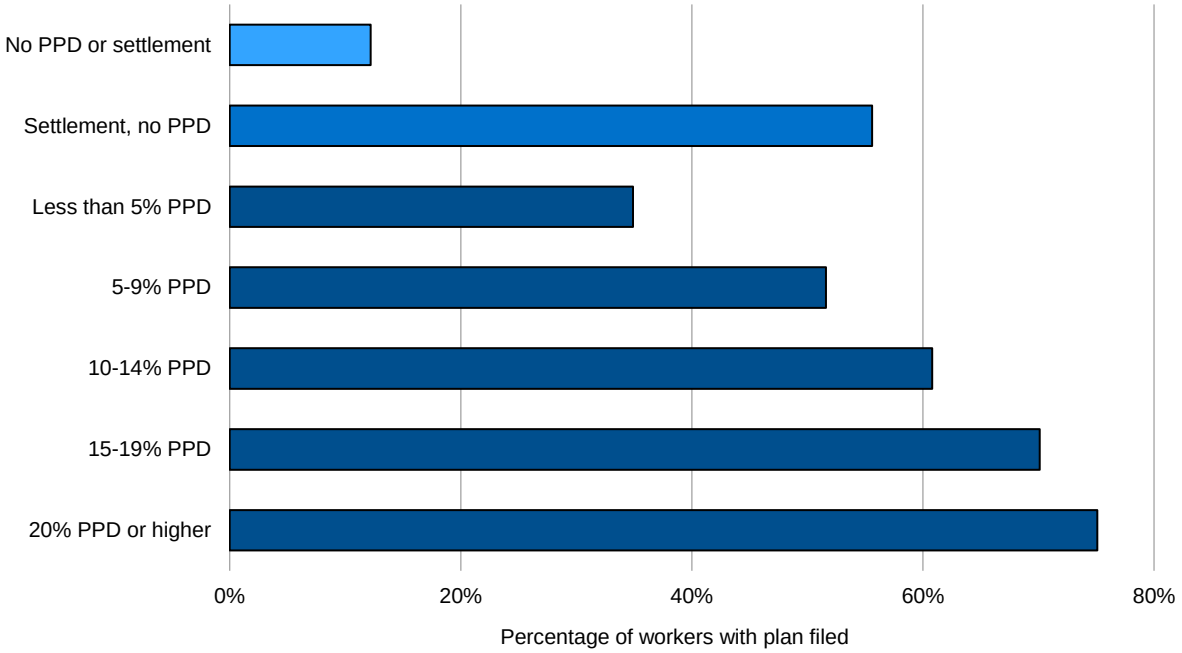
[48]A settlement might have included consideration for PPD benefits. Some of the workers with a PPD benefit may also have received a settlement that included consideration for additional PPD.

Figure 4.2. Percentage of paid indemnity claims with a VR plan filed by TTD duration, claim-closure years 2020-2022 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 2020-2022 combined [1]



1. Data from DLI. 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 vocational rehabilitation services peaked in 2007 but has fallen since then.[49] 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 2021 claims should be considered preliminary because of the uncertain effects of the COVID-19 pandemic and the resultant changes in the labor market. The initial values for 2021 injuries are developed with increases based, for the most part, on annual changes from years prior to 2020.

- The adjusted average cost of $9,060 for 2021 was 9% lower than the 2020 adjusted average cost and 24% below the adjusted average cost peak of $11,850 in 2007.

- The adjusted median cost of $5,650 for 2021 was $550 below the median for 2020. The median service cost in 2021 was 15% below the median peak of $6,980 in 2008.

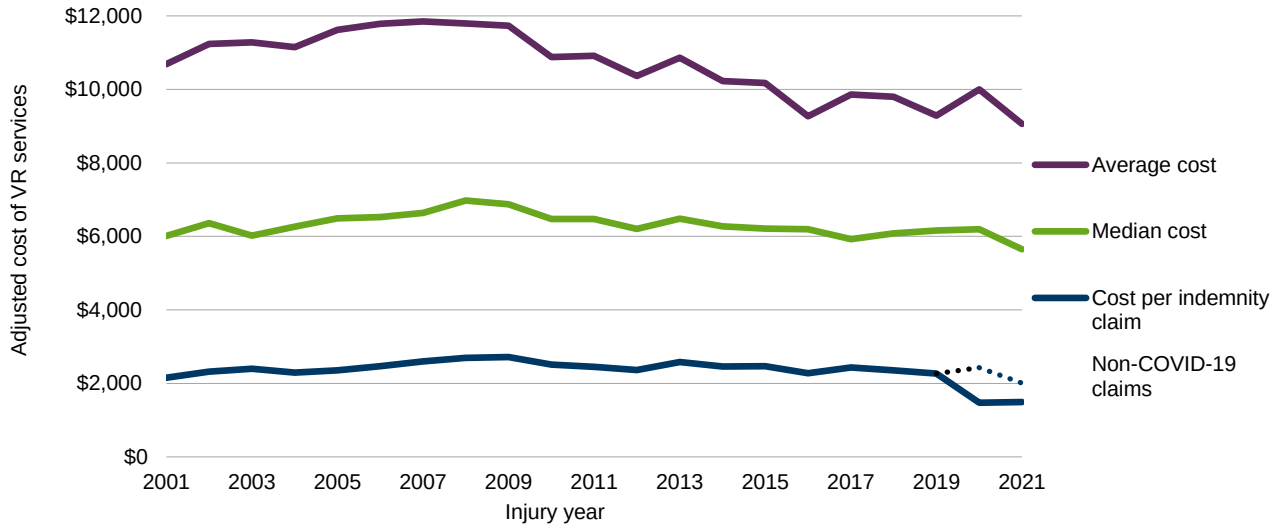
- The average costs are about 60% higher than the median costs because a small percentage of injured workers have vocational rehabilitation services of more than $30,000. This raises the average cost, while the median is more representative of claims with vocational rehabilitation services. Among plans closed between October 2021 and September 2022, 6% had adjusted costs higher than $30,000.

- The adjusted total cost of vocational rehabilitation services for injury-year 2021 is estimated at $40.9 million. This is a 6% decrease from the adjusted 2020 total of $43.4 million. As shown in Figure 2.8, vocational rehabilitation accounts for an estimated 2.9% of total workers' compensation system cost for payment-year 2021.

- Estimated adjusted vocational rehabilitation service cost per indemnity claim (counting claims with and without plans) was $1,490 for 2021 claims. This value is 34% below the 2019 value of $2,270, 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. The total vocational rehabilitation service cost per 2021 indemnity claim is estimated at $2,010 using only non-COVID-19 claims, 11% below the adjusted 2019 value.

[49]The vocational rehabilitation service costs indicated here are those reported by QRCs to DLI on the plan-closure form. These costs do not always represent the amounts actually paid (see pp. 42-43).

Figure 4.4. Vocational rehabilitation service costs, adjusted for wage growth [1] [2]



Injury year	Average cost	Median cost	Cost per indemnity claim
2001	$10,690	$6,010	$2,160
2007	$11,850	$6,640	$2,600
2019	$9,290	$6,160	$2,270
2020	$10,000	$6,200	$1,470
2020 non-COVID			$2,430
2021	$9,060	$5,650	$1,490
2021 non-COVID			$2,010

1. Developed statistics from DLI data. Costs are adjusted for average wage growth between the respective year and 2021.
2. Line shows estimated amount for all indemnity claims, including COVID-19 claims. The dotted line shows values for non-COVID-19 claims only.

Cost by service type

For plans closed in closure-year 2022 (October 2021 through September 2022), 95% of total vocational rehabilitation cost was for services provided by QRCs and QRC firms, and 5% was for services provided by vendor placement firms.

Figure 4.5 provides a different breakdown of costs, showing the average, median and total unadjusted costs for closure-year 2022 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 61% of total plan costs. The medical management services subgroup accounted for 69% of the plan service costs. This subgroup includes medical management, functional capacity evaluation, and work hardening or adjustment.

- The placement subgroup, which includes job-seeking skills training, job development, job placement and job placement follow-up, accounted for 16% of plan services. Only 26% of the plans included placement subgroup services. Vendor placement firms accounted for 42% of the placement subgroup service costs.

Figure 4.5. Vocational rehabilitation cost by service or expense type group, plan-closure year 2022 [1]

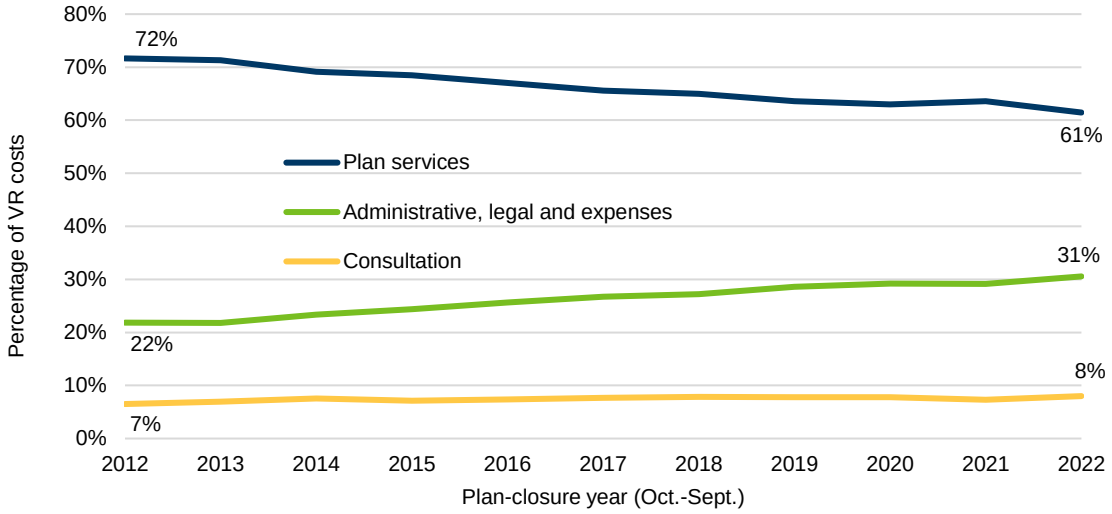
Service or expense type	Average	Median	Sum	Percentage of total costs
Consultation	$ 730	$ 680	$ 3,780,000	8%
Plan services	$ 5,590	$ 3,380	$ 29,054,510	61%
Administrative, legal and expenses	$ 2,780	$ 1,900	$ 14,447,960	31%
Total plan costs	$ 9,090	$ 6,210	$ 47,282,860	100%

As a percentage of total cost for vocational rehabilitation services, plan services have decreased by 11 percentage points between closure-years 2012 and 2022 (Figure 4.6).[50]

- Administrative costs and expenses, which includes administrative costs, legal expenses and other expenses, have increased by nine percentage points, while consultation costs have remained nearly constant. As shown in Figure 4.6, these changes have been gradual over the entire period, although there was a three percentage point decrease in plan services from 2021 to 2022.

- 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 69% of plan services in closure-year 2022. During this period, placement subgroup service costs decreased from 32% to 16% of all plan services.

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



[50]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.

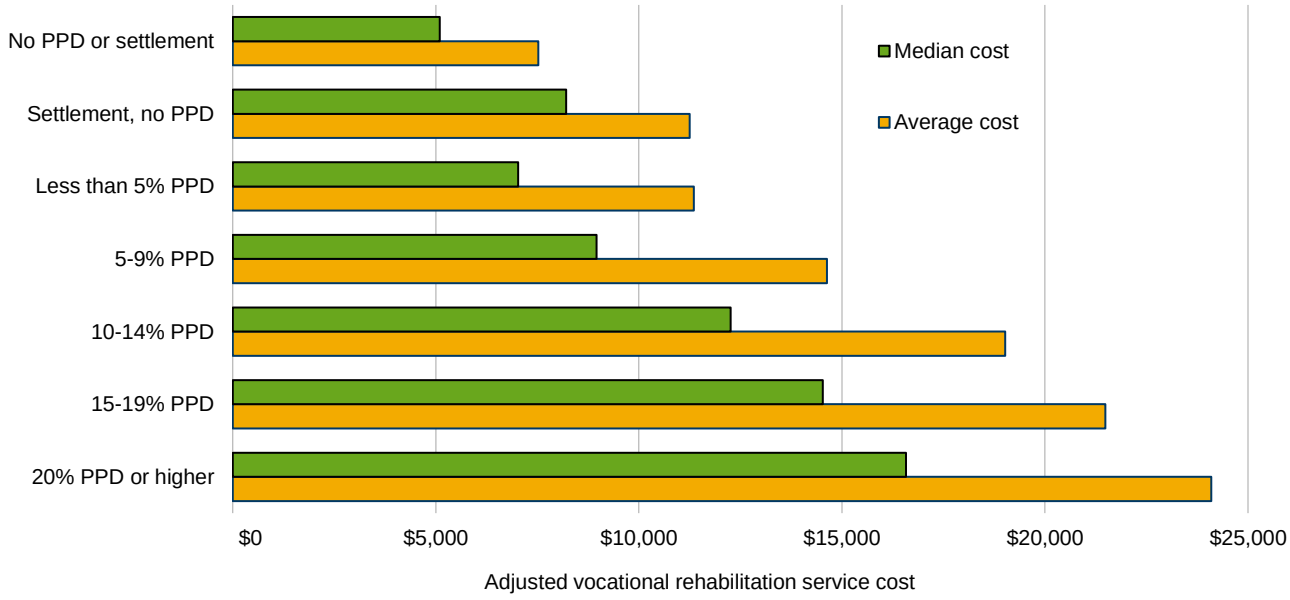
Cost and injury severity

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

- For plan-closure years 2020 to 2022, participants with higher PPD ratings had progressively higher vocational rehabilitation costs. For workers with PPD ratings of 15% or more, the average cost of vocational rehabilitation services was more than double the cost for workers with PPD ratings of 5% or less.

- For workers with a settlement but no reported PPD rating, their average vocational rehabilitation service cost was $11,250, similar to the vocational rehabilitation service costs for workers with PPD ratings of less than 5%.

Figure 4.7. Vocational rehabilitation service cost by PPD rating and settlement status, adjusted for wage growth, plan-closure years 2020-2022 combined [1,2]



1. Data from DLI. Costs are adjusted for average wage growth between the year of injury and 2021. Plan-closure years start in October and end in September of the indicated year.
2. 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 category extends to all values up to the next category's start value.

Timing of services

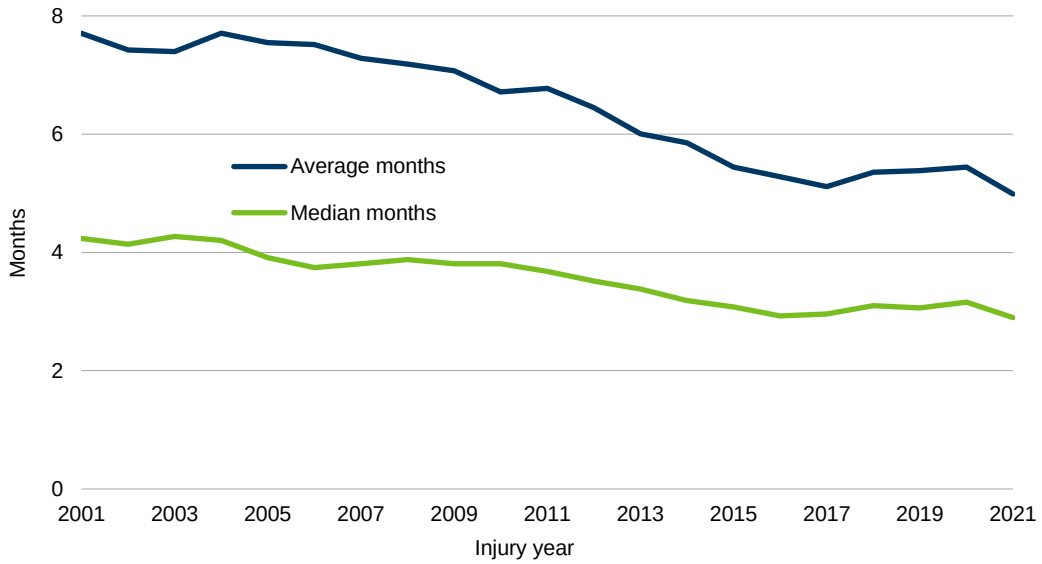
Prompt service provision is closely linked to successful vocational rehabilitation outcomes. The average time from injury to the start of vocational rehabilitation services has decreased by almost three months since 2000 and two months since 2006. The rehabilitation consultation is considered the start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

- The estimated average time from the date of injury to the start of vocational rehabilitation services was 5.0 months for injury-year 2021, 8% below the 2020 average and down 35% from 2001. The estimated median time was 2.9 months for 2021, down 32% from 2001.

- Among plans closed in closure-year 2022, 47% of plans started services within three months of injury and 73% started within six months.

- Among vocational rehabilitation participants with plans closed in 2022, those who began services within three months of injury, as compared to those starting more than a year after their injury, had:
  - 20% lower average service costs ($9,840 versus $12,340);
  - 20% shorter average service durations (13.3 months versus 16.6 months);
  - 4% higher average wages upon returning to work; and
  - slightly better chances of returning to work at plan closure (58% versus 54%).

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



Injury year	Average months	Median months
2001	7.7	4.2
2019	5.4	3.1
2020	5.4	3.2
2021	5.0	2.9

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

Service duration

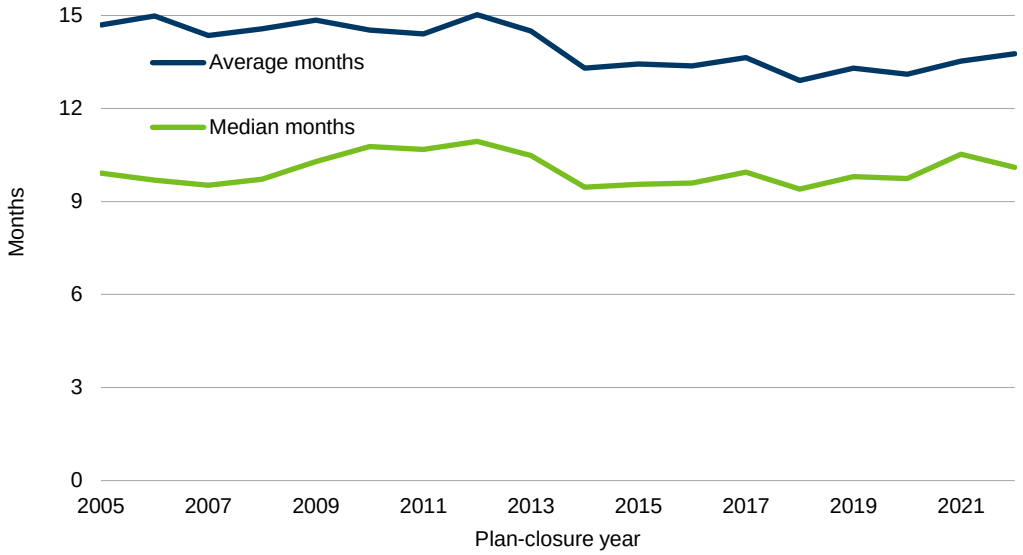
Average vocational rehabilitation service duration — measured by the time between the initial consultation and plan closure — has dropped by more than one month since closure-year 2012.

- The estimated average service duration peaked at 15.0 months in 2012 and decreased to 12.9 months in 2018. The estimated average of 13.8 months for closure-year 2022 is more than half a month longer than the estimate for 2020 closures.

- The estimated median service durations remained below 10 months from 2014 through 2020. The 2022 estimated median of 10.1 months is 0.4 months shorter than the 2020 median.

- Among plans closed in 2021, average service duration was: 11.0 months for workers who returned to work with their pre-injury employer; 17.2 months for workers who went to a different employer; and 16.1 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	14.7	9.9
2012	15.0	10.9
2020	13.1	9.7
2021	13.5	10.5
2022	13.8	10.1

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 closure-year 2011, estimated results for completions in 2020 and later 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.

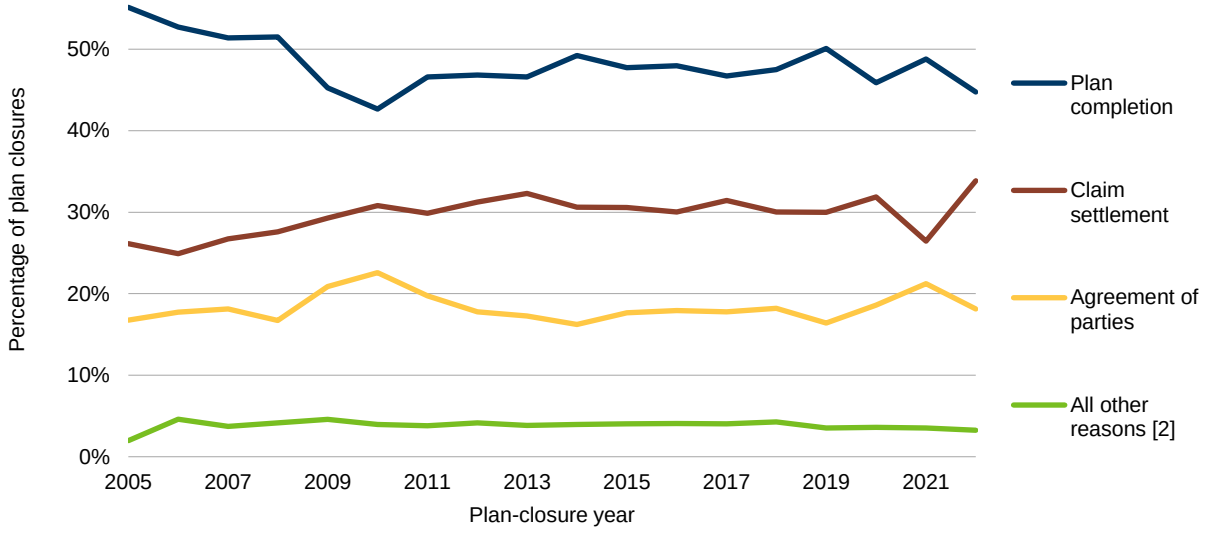
- The proportion of plans closed with completion of services reached 50% in 2019 and 49% in 2021 before falling to 45% in 2022 (Figure 4.10).

- The proportion of plans closed by claim settlement dropped from 32% in 2020 to 26% in 2021 before rebounding to 34% in 2022.

- The proportion of plans closed by agreement of the parties moved counter to settlements from 2020 to 2022, increasing from 19% in 2020 to 21% in 2021 and then deceasing to 18% of closures in 2022.

- 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	55.1%	26.1%	16.8%	2.0%
2010	42.7	30.8	22.6	3.9
2020	45.9	31.9	18.6	3.6
2021	48.8	26.4	21.2	3.5
2022	44.8	33.9	18.1	3.2

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.
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 2022 closures, the highest average adjusted plan costs were for plans closed with a settlement ($12,230) and the lowest were for completed plans ($7,290). Closures by agreement of the parties fell between these two values.

Figure 4.11. Plan cost by reason for plan closure, plan-closure year 2022 [1]

1. Plan costs were adjusted to 2021 wage levels according to the worker's date of injury. Plan-closure year 2022 started Oct. 1, 2021, and ended Sept. 30, 2022.
2. See note 2 in Figure 4.10.

Return-to-work status

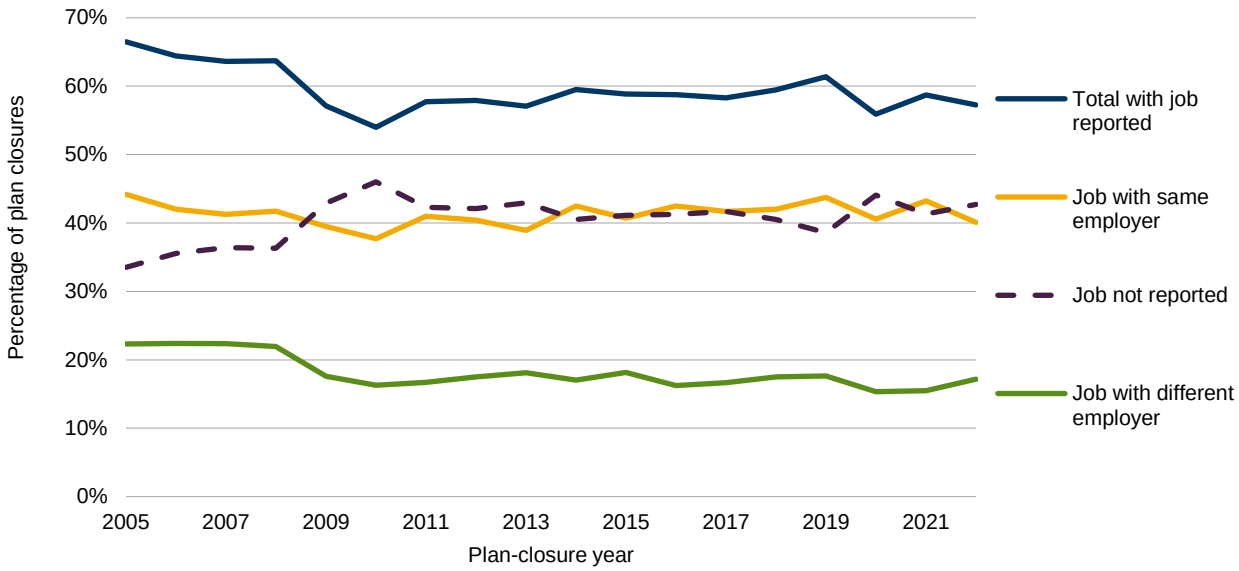
The goal of vocational rehabilitation is to return injured workers to a job related to the employee's former employment or to a job in another work area that produces an economic status as close as possible to what the employee would have enjoyed without disability. Returning to work is affected by many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

- The estimated percentage of vocational rehabilitation participants with a job reported at plan closure was slightly lower in 2022 than in 2021. The decrease in 2022 was because of a three-percentage point drop in workers returning to the same employer, coupled with a one-percentage point increase in workers returning to a different 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 because a job is reported at closure for almost all workers who complete their plans, but for only a minority of others.

- For plan closures in 2022, the average cost of vocational rehabilitation services for participants returning to work with their pre-injury employer ($6,720) was 53% of the vocational rehabilitation cost of workers going to a different employer ($12,540) and 62% of the cost for workers not returning to work at plan closure ($10,770).

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	16.3	54.0	46.0
2020	40.6	15.3	55.9	44.1
2021	43.2	15.5	58.7	41.3
2022	40.1	17.2	57.3	42.7

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

Return-to-work status and plan duration

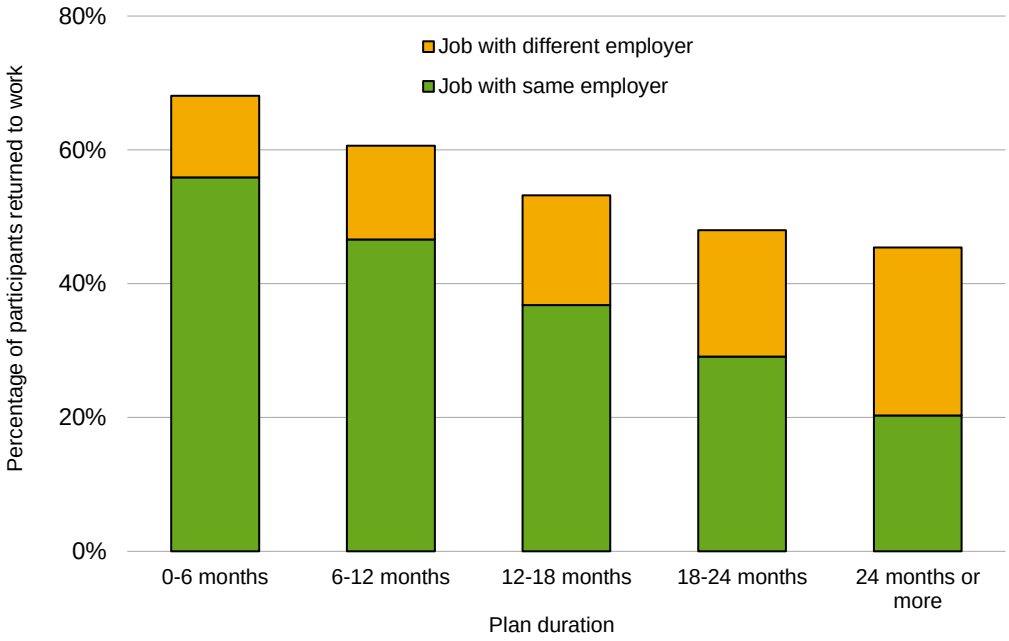
The percentage of vocational rehabilitation participants with a reported return to work decreases with plan duration (Figure 4.13).

- For plan closures in 2020 to 2022 combined, the percentage of workers with a reported return to work ranged from 68% for plans lasting no more than six months to 45% for plans lasting 24 months or longer.

- The percentage of workers returning to their pre-injury employer was 56% for the shortest plans and 20% for the longest plans.

- The percentage of workers finding a job with a different employer was 12% for the shortest plans and 25% for the longest plans.

Figure 4.13. Return-to-work status by plan duration, plan-closure years 2020-2022 combined [1]



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

Return-to-work status and placement services

The placement subgroup services include job-seeking skills training, job development, job placement and job placement follow-up. QRCs provide these services to help injured workers return to their pre-injury employer and placement vendors provide these services to help injured workers find work with a different employer. Twenty-eight percent of the workers with plans closed during between October 2019 and September 2022, received services in the placement subgroup.

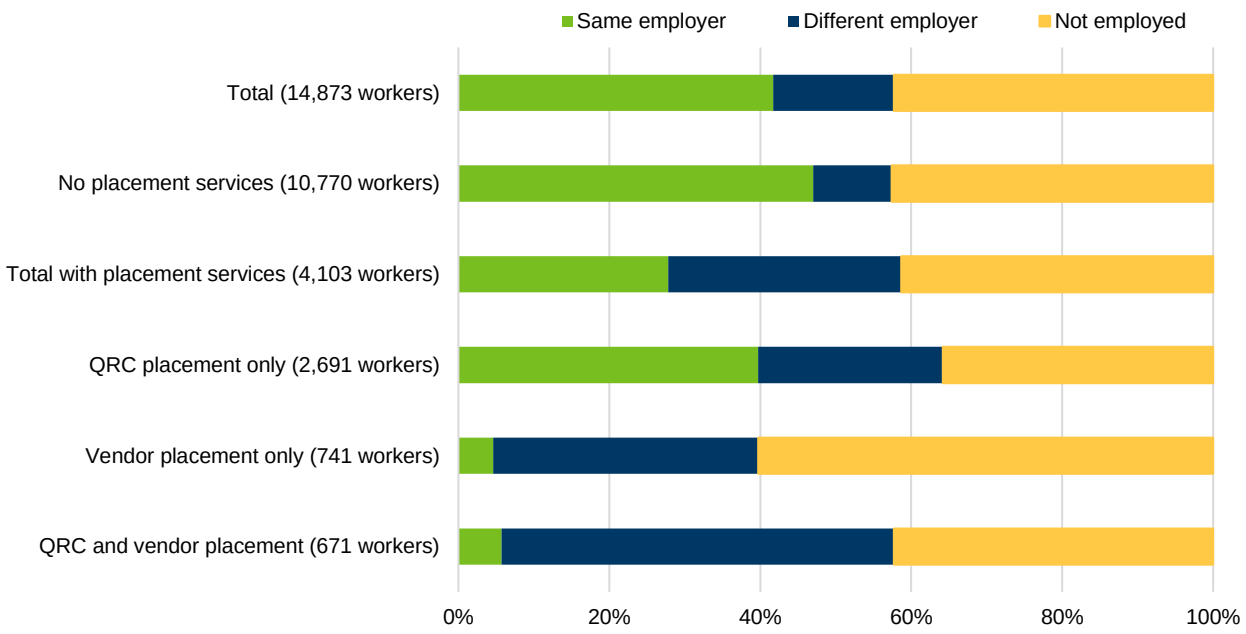
As shown in Figure 4.14, 31% of the workers receiving placement services returned to work with a different employer, compared with 10% among workers not receiving job placement services. Among the workers with placement services, 28% returned to work with their pre-injury employer. However, there are noticeable differences in the return-to-work outcomes among the different placement service providers.

- As expected, more workers receiving placement services only from QRC firms returned to the pre-injury employer than to a new employer. In contrast, less than 10% of the workers receiving placement services from vendors returned to their pre-injury employer.

- While 35% of the workers receiving placement services only from vendors found employment with a different employer, 60% of the workers were not employed at plan closure. This was primarily due to the closure of 80% of these plans by settlement or agreement.

- Workers receiving placement services from both QRC firms and placement vendors had the highest rate of placement with a new employer, 52%.

Figure 4.14. Return-to-work outcomes by placement services provider type, plan-closure years 2020-2022 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 vocational rehabilitation participants returning to work, the return-to-work wage, on average, is slightly less than the pre-injury wage, but this varies widely (Figure 4.15).

- Among workers returning to work, their median pre-injury wage was $950 and their median return-to-work wage was $850.

- For plan closures in 2020 to 2022 combined, 78% of participants returning to work earned more than 95% of their pre-injury wage, but 14% earned less than 80% of their pre-injury wage.

- Return-to-work wage recovery was related to injury severity as measured by PPD rating. For plan closures in closure-years 2020 to 2022 combined, workers without a PPD payment or a settlement agreement[51] had an average wage ratio of 100% of their pre-injury wage, while workers with PPD ratings of 15% or higher who returned to work had an average wage ratio of 91%.

- Average return-to-work wage rates also vary with plan duration. For 2020 to 2022 closures, the average return-to-work wage ratio was 100% for vocational rehabilitation plans of fewer than 12 months duration, 97% for plans between 12 and 18 months, and 92% for plans with longer service durations.

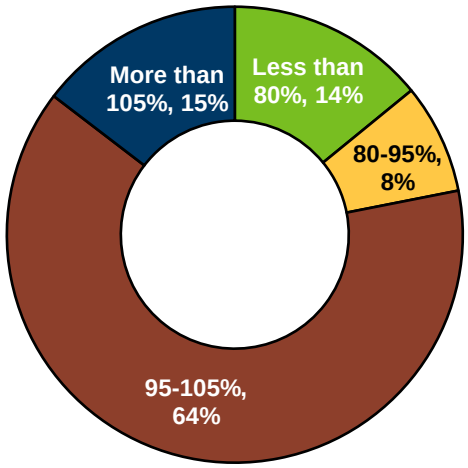
[51]Injured workers with settlements are excluded from this group because PPD benefits are often in dispute when settlements occur.

- The percentage of workers returning to wages of less than 80% of their pre-injury wage was also dependent on the workers' pre-injury wage. Only 2% of the workers earning $200 or less reported return-to-work wages of less than 80% and the percentage increased to 19% among workers earning more than $1,500 weekly.

- Conversely, the percentage of workers returning to wages of more than 105% of their pre-injury wage was also dependent on workers' pre-injury wage. Only 4% of the workers earning more than $1,500 weekly reported return-to-work wages of more than 105% of pre-injury wage and the percentage increased to 34% among workers earning $200 or less.

Figure 4.15. Ratio of return-to-work wage to pre-injury wage for participants returning to work, plan-closure years 2020-2022 combined [1]

Average wage ratio: 98% Median wage ratio: 100%



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

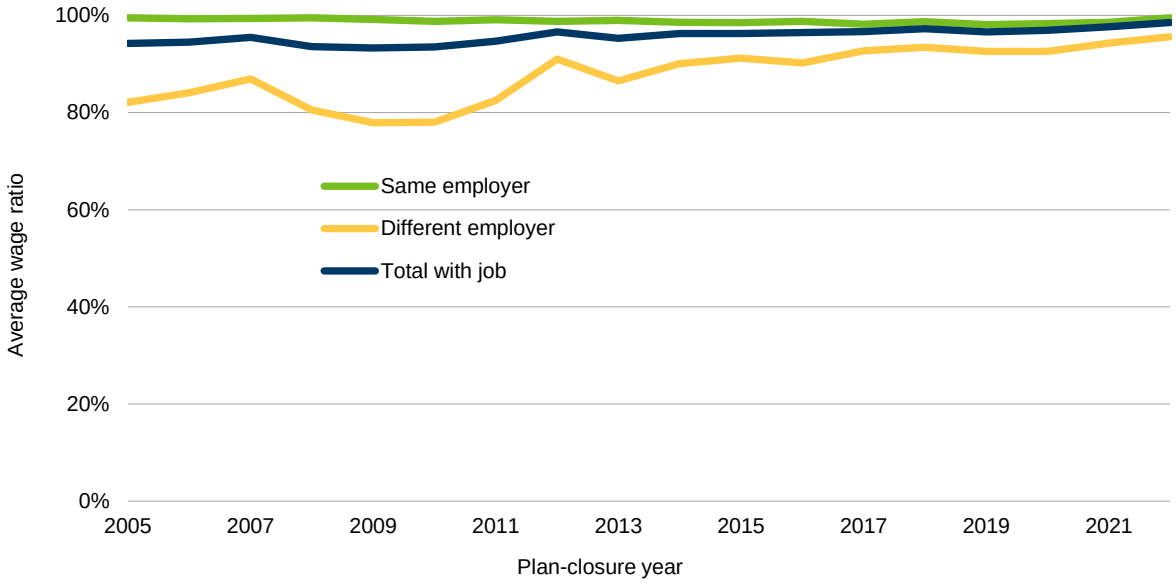
Return-to-work wages: Trend

Among vocational rehabilitation participants returning to work at plan completion, the ratio of the return-to-work wage to the pre-injury wage changed little between 2005 and 2022 for those returning to their pre-injury employer (Figure 4.16). 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 2022.

- For workers returning to their pre-injury employer, the average wage ratio was between 98% and 100% from 2005 to 2022.
- For workers going to a different employer, the wage ratio was 96% for closures in 2022; this was 18 percentage points higher than the low point of 78% reached in 2009. The 2022 closure-year average was also slightly higher than the 2021 average.
- 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-years 2021 and 2022 may reflect both increasing post-pandemic wages and a greater range of job opportunities due to labor market shortages.[52]

Figure 4.16. 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	99.5%	82.1%	94.2%
2009	99.2	77.9	93.3
2020	98.3	92.6	96.9
2021	98.6	94.3	97.6
2022	99.5	95.6	98.5

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.

[52]These trends are monitored by the Minnesota Department of Employment and Economic Development. Some recent *Minnesota Economic Trends* articles about these topics are "Minnesota Wage Distribution Analysis: Article Two" mn.gov/deed/newscenter/publications/trends/december-2022/wage-distribution2.jsp, "Post-Pandemic Recession Wage and Inflation Growth: Comparisons Across Industries and States" mn.gov/deed/newscenter/publications/trends/december-2022/post-pandemic.jsp and "The Great Resignation in Minnesota" mn.gov/deed/newscenter/publications/trends/march-2023/great-resignation.jsp.

Part 5: Dispute resolution

This part of the report presents data concerning workers' compensation disputes and only Department of Labor and Industry (DLI) dispute-resolution activities.

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.[53] 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 2022.

Major findings

- *There were very few disputes associated with COVID-19 claims — the dispute filing rate was 0.1% for COVID-19 claims in 2022 and 5.0% for non-COVID-19 claims (Figure 5.2).*

- DLI received about 6,100 dispute filings in 2022 among the four major dispute types – claim petitions, discontinuance disputes, and medical and rehabilitation requests for assistance. This was about 500 more than in 2021 and 1,000 more than in 2020 (Figure 5.3).

- The denial rate for non-COVID-19 claims in 2021 was 24%, which exceeded the 16% rate observed in 2020 and surpassed the highest rate, 17%, recorded in the past 20 years (Figure 5.4).
  - *The denial rate of filed indemnity claims, with COVID-19 claims included, was 29% for 2021. This was above the rate of 23% for 2020. A large part of the 2021 increase in denial rate was due to the influx of COVID-19 claims that began in 2020; the denial rate for COVID-19 claims was 39% in 2021.*

- Between 2002 and 2022, the certification rate dropped from 62% to 54% for medical disputes and from 58% to 50% for vocational rehabilitation disputes at DLI (Figure 5.5).[54] A majority of noncertifications of medical and rehabilitation disputes occurred because the issues were resolved (Figures 5.6 and 5.7).

- In 2022, 80% of the proceedings were mediations; the remaining 20% of proceedings were rehabilitation and medical conferences (Figures 5.11 and 5.12).

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

[54]See the description of the DLI dispute certification process on p. 62.

- For medical and rehabilitation requests for assistance received in 2022, the median times from the request to the first scheduled DLI conference date were 69 and 24 days, respectively. The time interval for medical requests for assistance has been increasing since 2013, with the exception of 2022. The interval for rehabilitation requests for assistance was close to the intervals for recent years, reflecting DLI's response to the 2013 law change requiring that most rehabilitation conferences be scheduled within 21 days of the request (Figure 5.10). When a rehabilitation conference is scheduled past the 21st day, that is typically to accommodate the schedules of the participating attorneys.

- Seven percent of DLI scheduled proceedings in 2022 required interpreters, an increase from 6% in 2016 (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 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.

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

Dispute certification: In a medical or vocational rehabilitation dispute, DLI must certify a dispute exists and informal intervention did not resolve the dispute before an attorney may charge for services.[55] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

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 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 vocational rehabilitation disputes for other reasons.[56] The DLI specialist usually attempts to bring the parties to agreement during the conference. If agreement is reached, the specialist issues an "order on agreement." If agreement is not reached,

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

[56]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. 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.

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 about 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.[57] 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 outreach to the parties and the scheduling of litigation proceedings. Sometimes the party initiating a dispute or an appeal of a decision-and-order withdraws the dispute or the appeal. Sometimes the parties agree informally. Disputes often settle by means of a stipulation for settlement, which may be reached while the dispute is being litigated at DLI or OAH. If approved by a compensation judge, then an award on stipulation is issued. An award on stipulation may occur in any type of dispute, but occurs most commonly in claim petition disputes.

[57]Minn. Stat. § 176.239.

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.[58] These obligations and procedures may include alternative dispute-resolution. If a collective bargaining agreement meets conditions in the law, the agreement must be recognized as valid and binding by DLI, 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.

The UCWCP aims to provide efficient and non-adversarial dispute resolution, quality medical and rehabilitative care, prompt payment of appropriate indemnity benefits[59] and prompt and safe return to union work, with the goal of minimizing losses for employers and employees.

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

During calendar-year 2022, UCWCP provided intervention for 85 cases, fully resolving the issues in 61 of the disputes. Twenty-five disputes went to facilitation, 17 of which reached full agreement. Among the 37 disputes using mediation: 36 reached full agreement. Five disputes used arbitration; four reached full agreement and one was 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 database systems. While editions of the system report published prior to 2022 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 60% of each year's disputes. The COVID-19 pandemic affected dispute filing statistics. There were very few disputes associated with COVID-19 claims from injury-years 2020 through2022 (Figure 5.2).[60] This is because the average claim duration for COVID-19 claims was very short

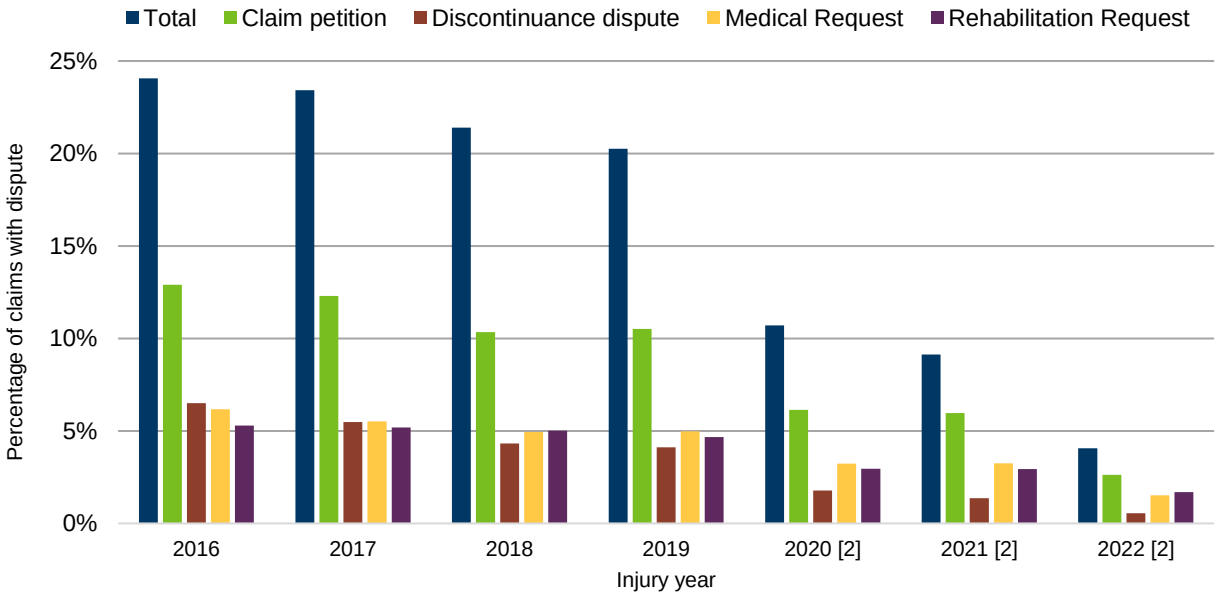
[58]Minn. Stat. § 176.1812.

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

[60]The numbers in Figure 5.2 are not developed; they show the number of disputes filed by Dec. 31, 2022, for workers injured in 2020, 2021 and 2022. Therefore, the number of disputes shown for 2021 claims have an extra year of maturity compared with 2022 claims.

(Figure 3.3) and especially short relative to the time needed to schedule and hold conferences. Moreover, COVID-19 claims are expected to decline over time as infection rates decline nationwide.

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.

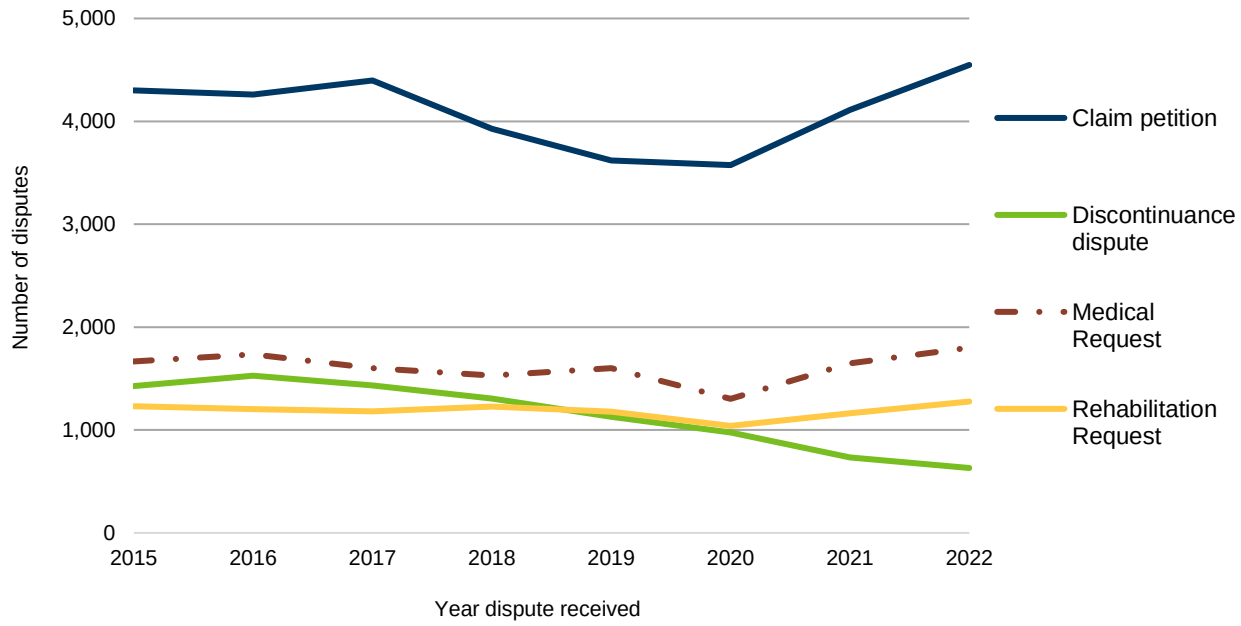
Figure 5.2. Dispute filing by COVID-19 status

	Number of disputes [1]		Dispute rate [2]	
Injury year	COVID-19 claims	Non-COVID-19 claims	COVID-19 claims	Non-COVID-19 claims
2020	76	2,463	0.7%	14.4%
2021	18	1,883	0.3%	10.2%
2022	9	878	0.1%	5.0%

1. The number of disputes filed by Dec. 31, 2022, for workers injured in 2020 through 2022.
2. Dispute rate per 100 indemnity claims of that claim type.

Without the ability to develop dispute activity, examination of dispute filings by filing year provides insights into dispute activity. The number of dispute filings for the four major types of disputes — claim petitions, discontinuance disputes, medical requests and rehabilitation requests — decreased by 5.4% from 2016 to 2022 (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 16% (about 776 filings) from 2017 to 2019, then increased by 29% (927 filings) from 2019 to 2022. The onset of the COVID-19 pandemic in 2020 did not appear to substantially affect claim petition filings.

Discontinuance disputes decreased by 43% from 2018 to 2021, and dropped 14% from 2021 to 2022. This decrease in reported discontinuance disputes might have been affected by implementation of the new OAH database and the lack of available data.

The number of medical requests decreased from 2019 to 2020, but has been increasing since 2021 to a level higher than in 2016. Rehabilitation requests followed a similar pattern, except the 2022 increase was not as steep.

Denial of primary liability

When an employer or insurer takes the position that the claimed injury is not covered for workers' compensation benefits, that is a denial of primary liability. Dispute-resolution activities at DLI and OAH take place for injuries both with and without primary liability denials.

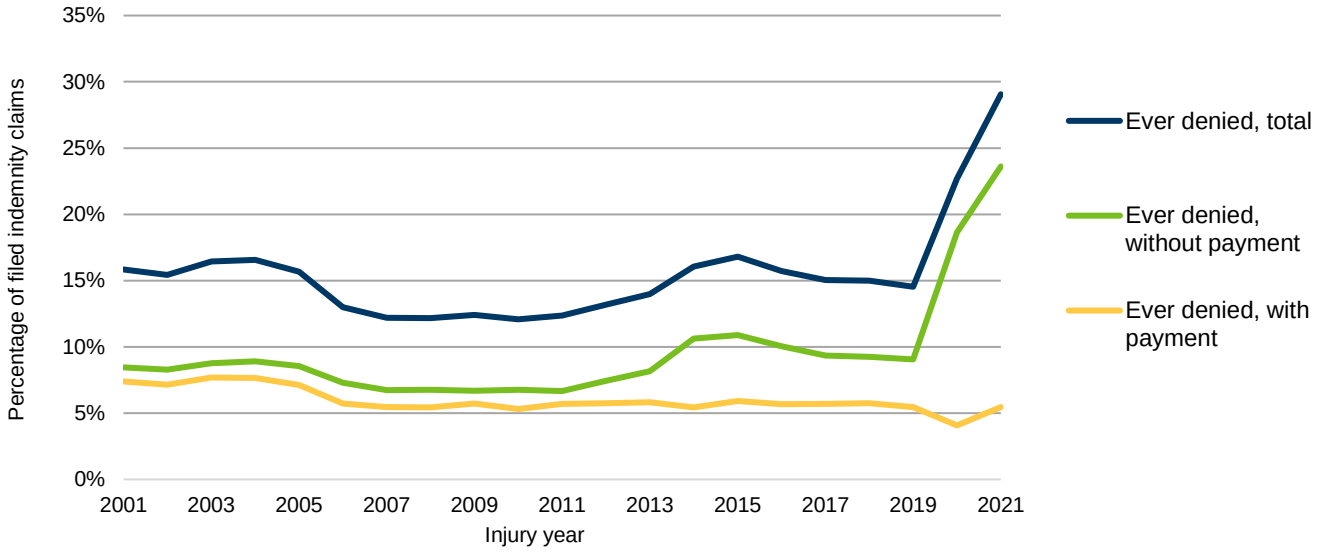
COVID-19 claims appear to have affected the 2020 and 2021 denial rates (Figure 5.4).[61] Although the COVID-19 presumption enabled many first responders, corrections workers and health care workers to receive workers'

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

compensation benefits, the denial rate for COVID-19 claims was 39%, significantly higher than the 24% rate for non-COVID-19 claims in 2021.

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 COVID-19 episodes, denials were rarely challenged by workers, so very few workers had both a denial and a benefit payment. Only 4% of the COVID-19 claims with a denial had an indemnity benefit payment, compared with 29% among non-COVID-19 claims with a denial in 2021.

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
2001	8.5%	7.4%	15.9%	46.7%
2017	9.3%	5.7%	15.0%	37.9%
2019	9.0%	5.5%	14.5%	37.6%
2020	18.7%	4.1%	22.8%	22.8%
2020 non-COVID-19	11.3%	5.0%	16.3%	30.6%
2021	23.6%	5.4%	29.1%	18.7%
2021 non-COVID-19	17.2%	7.2%	24.4%	29.4%

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 for assistance (if a dispute certification request was not filed). In 2022, DLI's Alternative Dispute Resolution (ADR) specialists made certification decisions about 1,200 medical dispute filings and 912 rehabilitation dispute filings.

The percentage of medical and rehabilitation requests for assistance that are certified as disputes are lower than 15 years ago, although they have been increasing since 2017 (Figure 5.5). Between 2002 and 2017, the percentage of medical disputes certified decreased from 62% to 47%. The percentage of medical disputes

certified has increased since 2017 to 54% in 2022. Among rehabilitation requests, the percentage certified decreased from 58% in 2002 to 30% in 2017, then increased to 50% in 2022.

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 2022, 74% 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 2002 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 62% in 2021, before jumping up to 68% in 2022. 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 requests for assistance certified

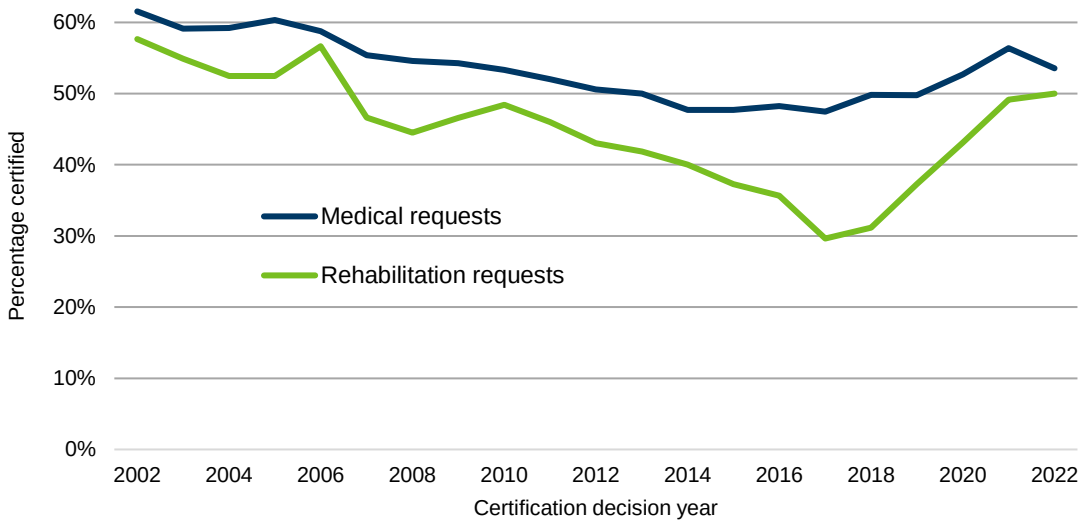
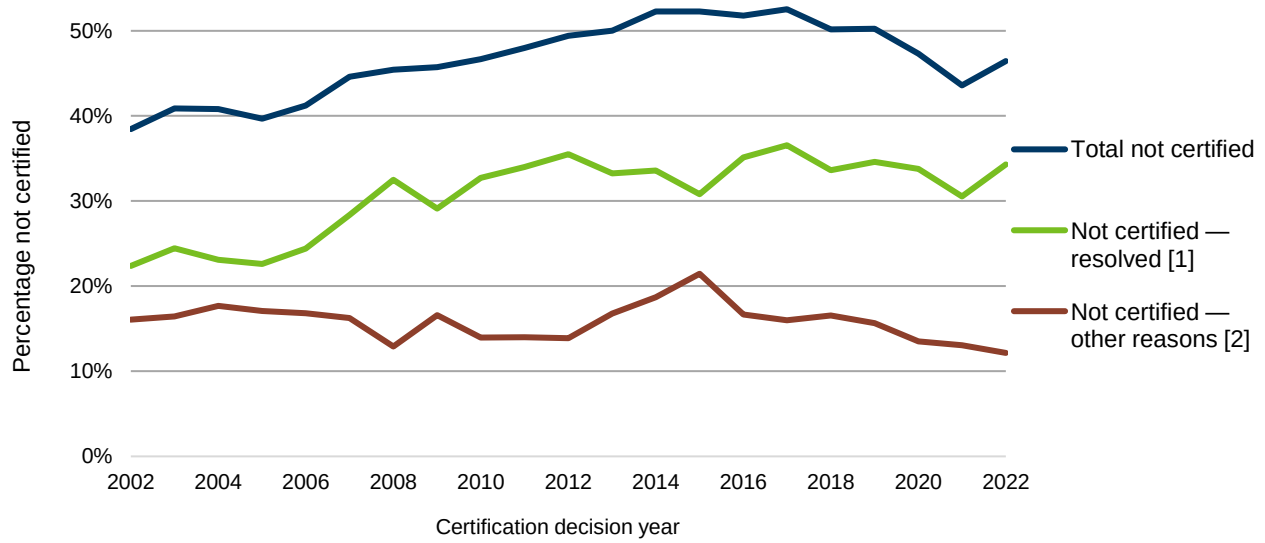
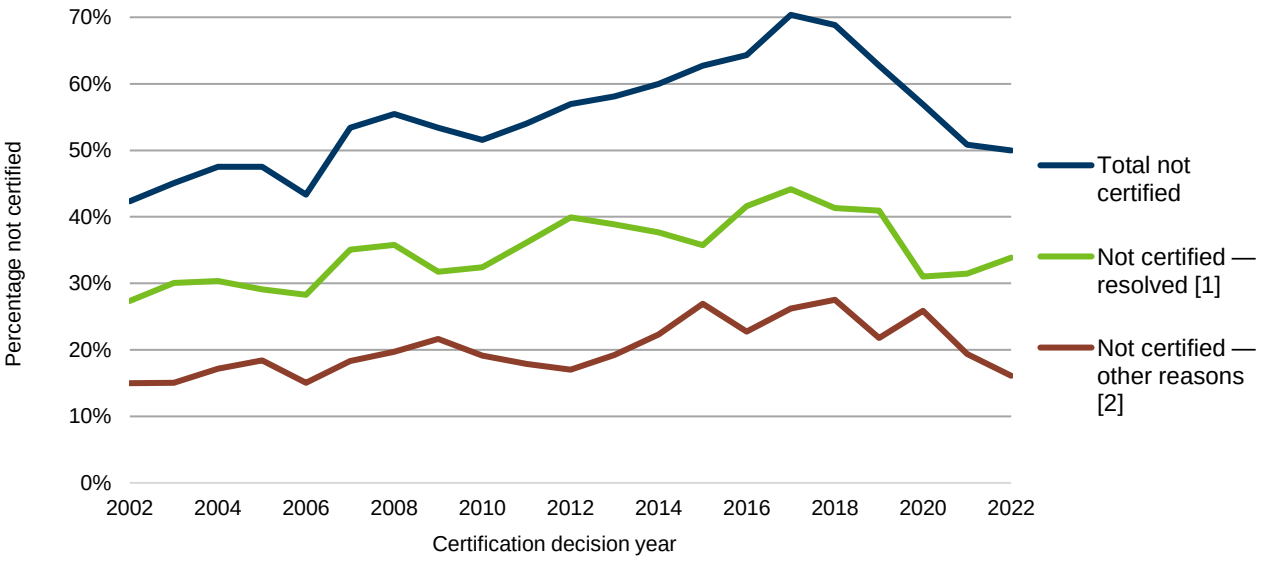


Figure 5.6. Noncertification of medical disputes



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. § 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 2022; 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.

Second opinion consultations were the most common issue. Requests for injections, imaging, office visits and physical therapy were the other top medical service requests, while office or clinic visits and surgery were the most common reimbursement issues.

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 plan duration followed by consultation and eligibility for services.

Figure 5.8. Medical issues at DLI administrative conferences, disputes filed in 2022

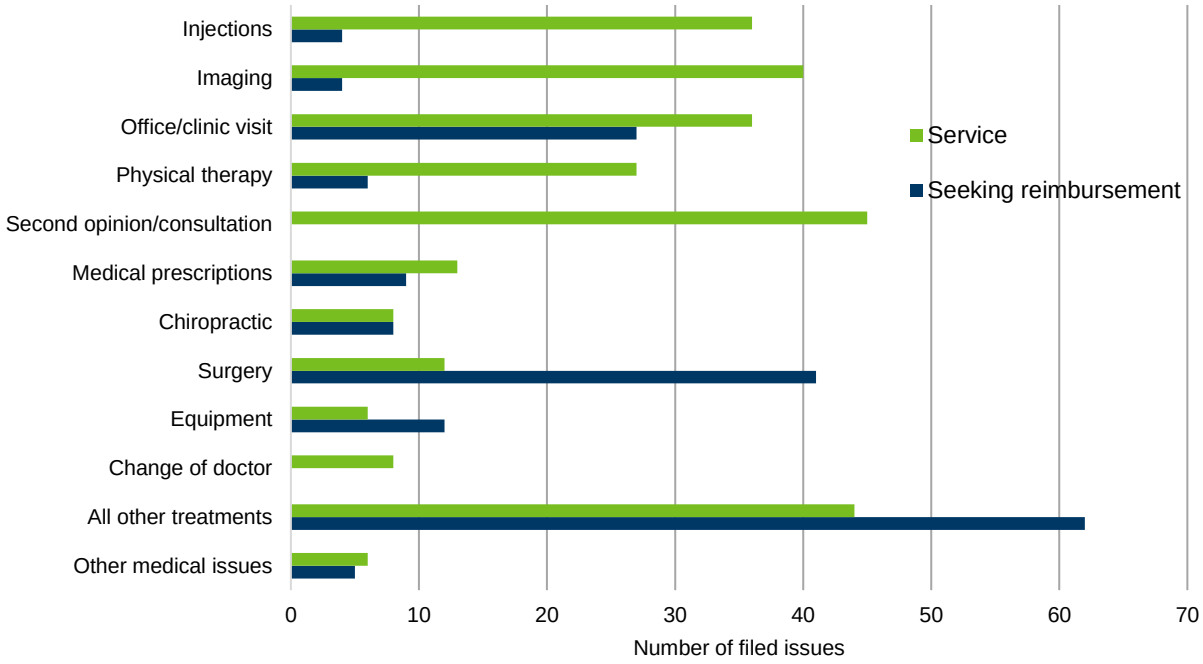
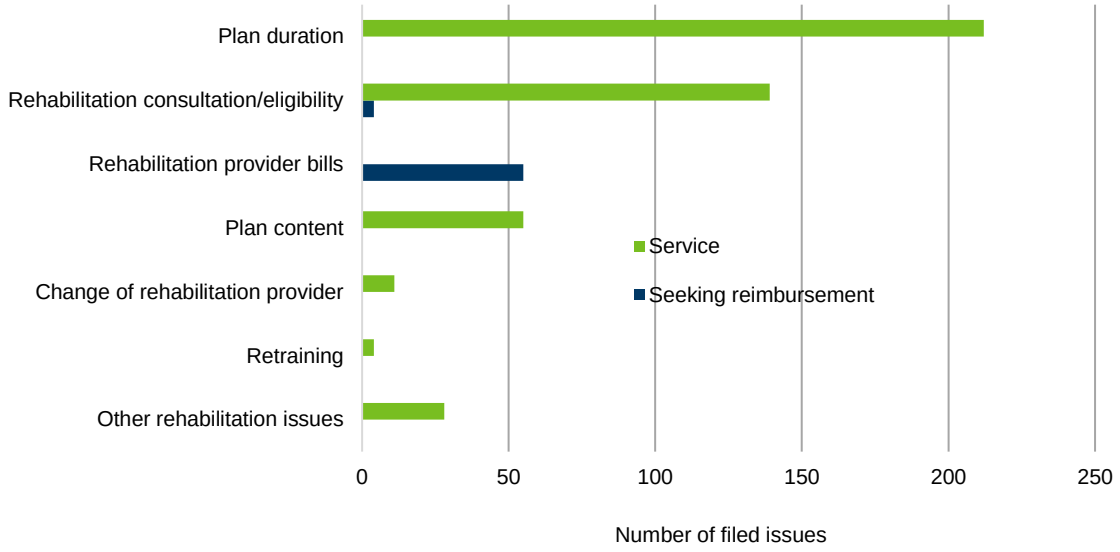


Figure 5.9. Rehabilitation issues at DLI administrative conferences, disputes filed in 2022

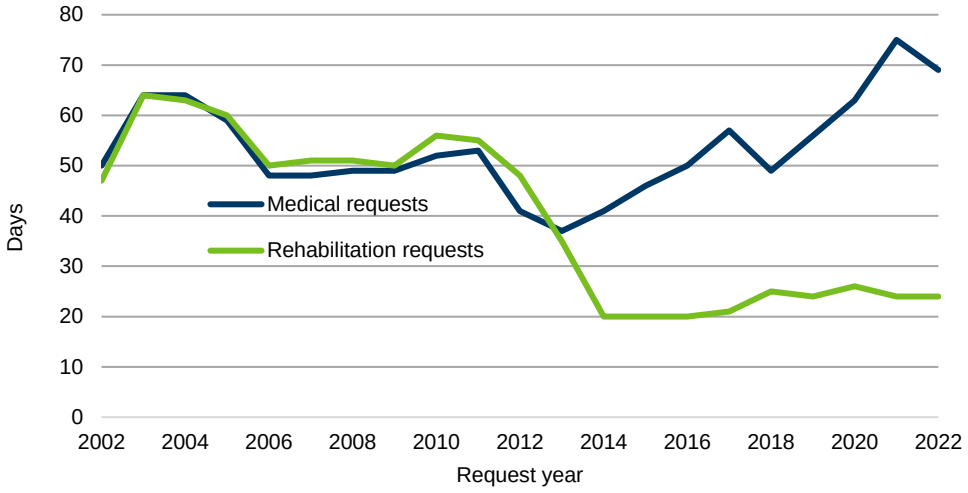


Time to first conference for medical and rehabilitation requests at DLI

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 69 days in 2022. 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 24 days in 2022. 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).[62] Giving priority to scheduling rehabilitation conferences delayed the timing of medical conferences.

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

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
2002	50	47
2013	37	35
2017	57	21
2019	56	24
2020	63	26
2021	75	24
2022	69	24

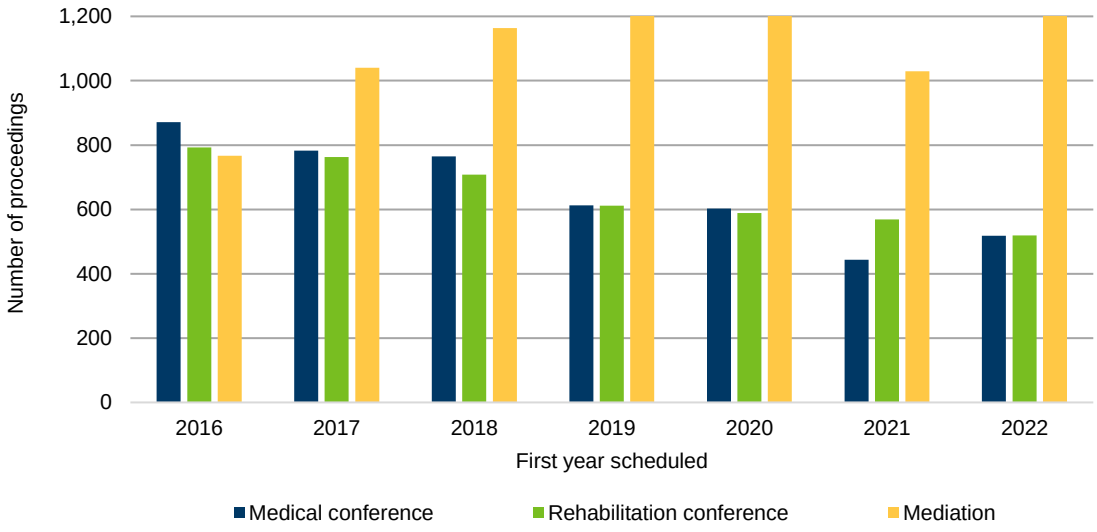
Dispute proceedings at DLI

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 32% of the scheduled conferences in 2016 to 55% in 2022. In 2021, the number of rehabilitation conferences scheduled surpassed the number of medical conferences for the first time, but the two were equal in 2022.

Figure 5.11. Scheduled proceedings at DLI

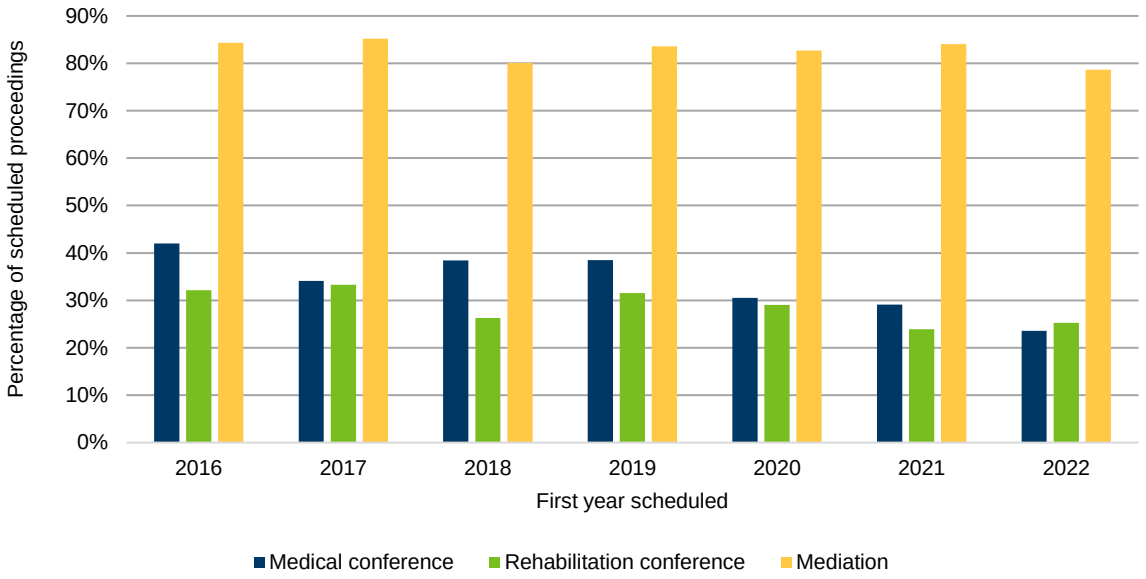


1. The first year scheduled is used because a proceeding can be rescheduled into another year.

Proceedings

More than half of scheduled medical and rehabilitation conferences did not ultimately take place, often due to resolution of the disputes without the need for a conference. For the period of 2016 to 2021, more than 80% of scheduled mediations were held (Figure 5.12), which is expected because these are specifically requested by the parties. Some of the disputes originally scheduled as conferences became mediations either at the request of the parties or encouragement by the arbitrator. The number of DLI proceedings that were held increased from 1,258 in 2016 to 1,460 in 2019. It declined to 1,130 proceedings in 2021, but increased to 1,263 in 2022.

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

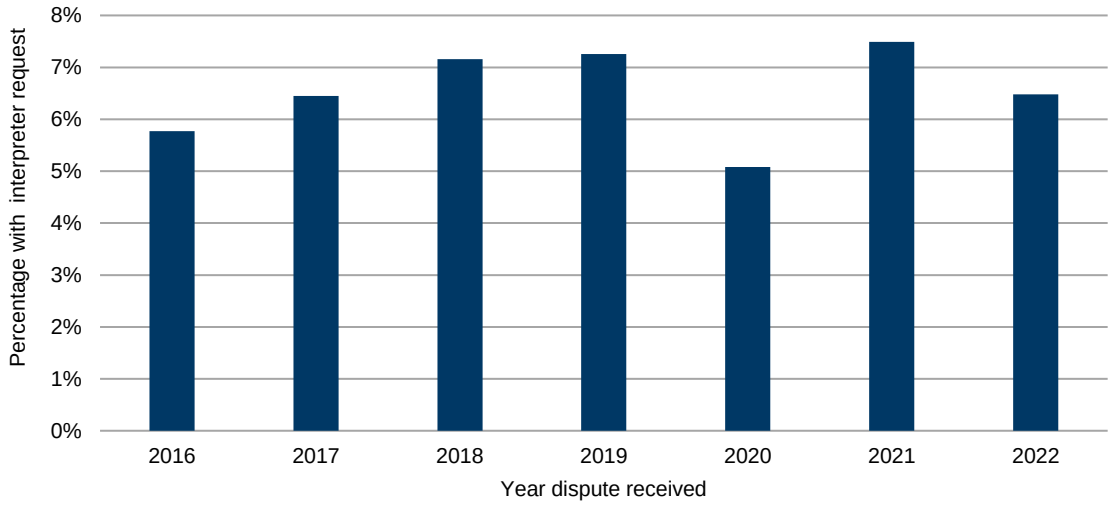
Location of proceedings

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 and 2022, 95% to 97% 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 four years, with 86% of the requests for Spanish interpreters. Somali interpreter requests were the second most common, with 6% of the requests.

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

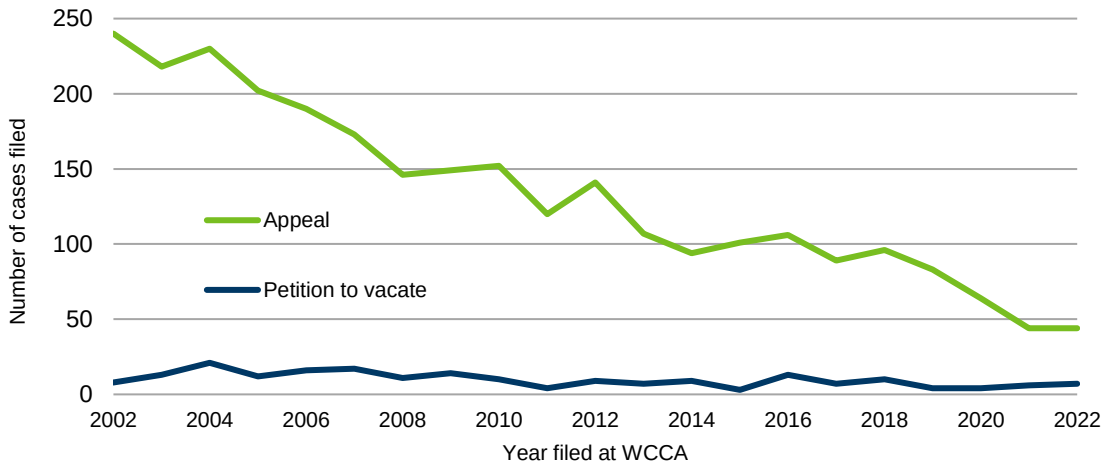


Workers' Compensation Court of Appeals activity

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

Figure 5.14 shows the number of cases filed at WCCA from 2002 through 2022 and the reason for filing. The number of decisions has been trending downward, falling from a high of 251 cases in 2004 to 51 cases in 2022. This decrease has been due to the number of appeals filed; petitions to vacate have varied between three and 13 filings since 2011.

Figure 5.14. Number of WCCA cases filed and case type by year filed

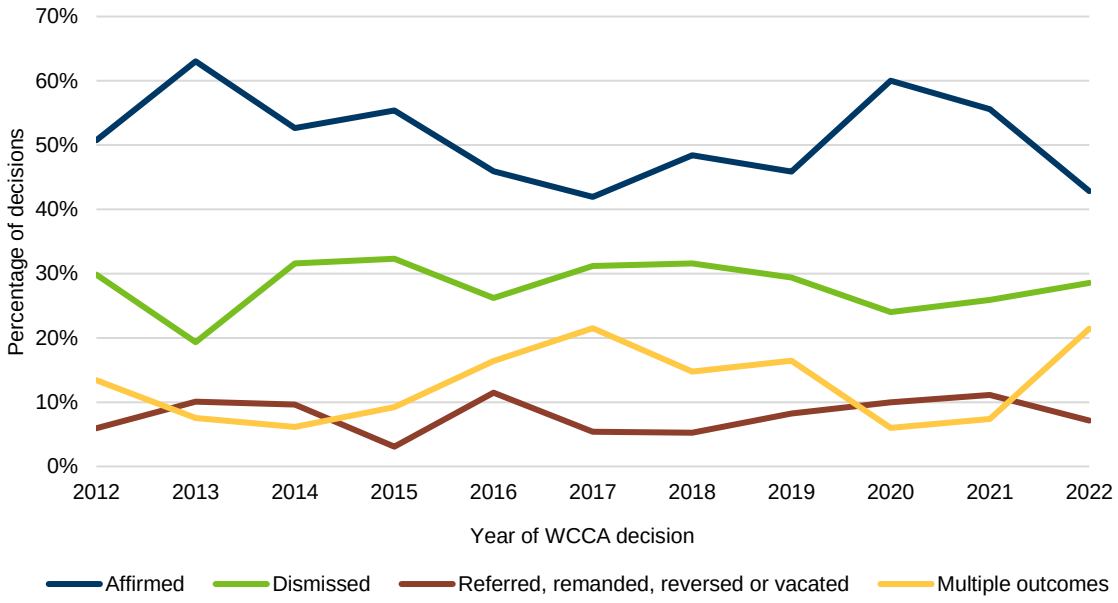


Filing party information is available for recent years. For 2022, employees filed 55% of the appeals and 71% of the petitions to vacate. Both percentages were slightly below the values for 2021.

The median number of days from WCCA filing to the argument date was 119 days for WCCA decisions filed in 2022, with a median of 78 days from the argument date to the decision filing date. The median number of days from WCCA filing to the WCCA decision was 190 days for 2022 decisions, slightly less than the 198 days for 2021 decisions.

The percentage distribution of WCCA decisions have remained relatively constant despite the number of decisions decreasing by more than half, from 134 in 2021 to 56 in 2022. WCCA affirmed 43% of the cases in 2022, below the 51% average for the 2012 to 2022 period. It dismissed 29% of the cases in 2022, close to the 2012 to 2022 average of 28% dismissals. The percentage of decisions with multiple outcomes increases to 21% in 2022, which was the second-highest value in the entire period examined.

Figure 5.15 Trends in WCCA decisions



Appendix A

Glossary

The following terms are used in this report.[63]

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[64]; 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.[65] 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

[63]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.

[64]As indicated on p. 62, 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.

[65]See the discussion of DLI administrative conferences on pp. 62-63 (including note 58) 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 than the voluntary market rates.

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

Claim petition — a form by which the injured worker contests a denial of primary liability or requests an award of indemnity benefits or, in some cases, medical or rehabilitation benefits. In response to a claim petition, the 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).[66] 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.[67] 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 plan-closure year.[68] The reported numbers develop both because of the time necessary for claims to mature and, in the case of some Department of Labor and Industry data, because of reporting lags.

Diagnosis-related group (DRG) payment system — Minnesota's payment system for workers' compensation hospital inpatient facility services, effective for services provided on or after Jan. 1, 2016.

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

[67]See note 68.

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

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 (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.[69] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

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

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

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

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

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

Hearing — a formal proceeding about a disputed issue or issues in a workers' compensation claim, conducted at the 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[70] 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, the Department of Labor and Industry has determined payment levels, separately for small and large hospitals (those with up to 100 beds and more than 100 beds, respectively), relative to Medicare to produce the same overall payment amounts as under the prior system.

Indemnity benefit — a benefit to the injured or ill worker or survivors to compensate for wage loss, functional impairment or death. Indemnity benefits include: temporary total disability, temporary partial disability, permanent partial disability and permanent total disability benefits; supplementary

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

benefits; dependents' benefits; and, in the insurance industry accounting, vocational rehabilitation benefits.

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

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

Intervention — an instance in which the Department of Labor and Industry provides information or assistance to prevent a potential dispute from developing into an actual one or communicates with the parties (outside of a conference or mediation) to resolve a dispute or determine whether a dispute should be certified. (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.) 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 — a wage-replacement benefit paid if the worker sustains a severe work-related injury specified in law or if the worker, because of a work-related injury or illness in combination with other factors, is permanently unable to secure gainful employment, provided that, for injuries on or after Oct. 1, 1995, the worker has a permanent partial disability rating of at least 13% to 17%, depending on age and education. The benefit is equal to two-thirds of the worker's gross pre-injury wage, subject to minimum and maximum weekly amounts, and is paid at the same intervals as wages were paid before the injury. For injuries on or after Oct. 1, 1995, weekly benefits are subject to a minimum of 65% of the statewide average weekly wage. The maximum weekly benefit amount is indicated in Appendix B. For injuries from Oct. 1, 1995, to Sept. 30, 2018, benefits end at age 67 under a rebuttable presumption of retirement. For injuries on or after Oct. 1, 2018, benefits end at age 72 or, if the injury is after age 67, after five years of benefits have been paid. Cost-of-living adjustments are described in this appendix.

Petition to discontinue benefits — a document by which the insurer requests a formal hearing to allow a discontinuance of wage-loss benefits (temporary total disability, temporary partial disability or unadjudicated permanent total disability). The hearing is conducted at the 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 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 and second-injury benefit 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 (2021) 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 dispute — a dispute about a vocational rehabilitation issue, such as whether the employee should be evaluated for eligibility, whether the employee is eligible, whether certain plan provisions are appropriate or whether the employee is cooperating with the plan.

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

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

Workers' Compensation Court of Appeals (WCCA) — an executive branch body that hears appeals of workers' compensation findings-and-orders from the 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 estimated this would increase overall PPD benefits by 14%. In addition, the PPD award may be paid as a lump sum, computed with a discount rate not to exceed 5%. Previously, PPD benefits were only payable in installments at the same interval and amount as the employee's temporary total disability benefits.

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

2005 law change

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

Jurisdiction in medical disputes: The monetary limit on Department of Labor and Industry jurisdiction in medical disputes was raised from $1,500 to $7,500.

2008 law change

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

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

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

2011 law change

The following provisions took effect Aug. 1, 2011.

Scheduling of proceedings at the 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 about the issues concerned.

2013 law change

The following provisions took effect for injuries on or after Oct. 1, 2013.[71]

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.

[71]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.

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

2015 law change

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

Diagnosis-related Group (DRG) system for hospital inpatient services: Minnesota changed its system for paying for workers' compensation hospital inpatient facility services from a charge-based system to one based on Medicare's Inpatient Prospective Payment System (IPPS). This system is often called a DRG system because payment is based primarily on the diagnosis-related group, which categorizes the major diagnosis and principal procedures performed. For non-catastrophic cases at non-Critical-Access Hospitals, the payment is 200% of the Medicare level, not to exceed the charged amount. DLI estimated that in its first year, the new system reduced inpatient hospital cost by 9% to 16%, total medical cost by 1.3% to 2.3% and total workers' compensation system cost by 0.5% to 0.8% relative to what they would otherwise have been.[72]

Minnesota's DRG statute also has a set of provisions regarding bill payment and denial.[73]

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.

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

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

The following provisions took effect for 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.

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

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

Hospital Outpatient Fee Schedule (HOFS): Payment for certain hospital outpatient facility services was changed to be based on portions of Medicare's Outpatient Prospective Payment System (OPPS) that relate to major surgical procedures and emergency department visits. As provided by statute, DLI set the payment levels under the new system, separately for small and large hospitals (those with up to 100 beds and with more than 100 beds, respectively), so that estimated outpatient payments would be the same under the old and new systems.[74]

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

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

2023 law change

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

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

Article 3. Permanent partial disability schedule – amends the permanent partial disability schedule in chapter 176, resulting in increased payments to injured workers with permanent impairments. The amendment also requires the Workers' Compensation Advisory Council in 2026 and every other year thereafter to consider the adequacy of compensation for permanent impairment.

Article 4. Hospital outpatient fee schedule – amends chapter 176 to provide for reductions to the hospital outpatient fee schedule over a period of three years. Repeals the provision describing the criteria that must be met for the reductions to occur.

Article 5. Post-traumatic stress disorder study – requires the commissioner of the Department of Labor and Industry to conduct a study identifying systemic or regulatory changes that may improve the experience and outcomes of employees with work-related post-traumatic stress disorder. Includes a $500,000 appropriation for

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

the commissioner to contract with a third-party to complete part or all of the study and hire additional staff members to support.

Article 6. Housekeeping – amends chapter 176 to make various technical changes.

Appendix C

Data sources and estimation procedures

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

Developed statistics: Many statistics in this report are by accident year or policy year (insurance data) or by injury year or vocational rehabilitation plan-closure year (Department of Labor and Industry (DLI) data). For any given accident, policy, injury or vocational rehabilitation plan-closure year, these statistics grow, or "develop," over time because of claim maturation and reporting lags.[75] 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 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

[75]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.

Part 4, the injury-year statistics are at a 10-year maturity and the vocational rehabilitation plan-closure year statistics are at a seven-year maturity. In Part 5, the rate of claim denial by injury-year is at 35-year maturity.

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

COVID-19 and developed statistics: 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 reporting of additional COVID-19 claims for 2020 and 2021, nor does it expect significant changes to benefit payments and claims durations for the reported COVID-19 claims. Therefore, claims development estimates were calculated only for the non-COVID-19 claims and combined with the reported, non-developed values for COVID-19 claims. Development of measures for COVID-19 claims will be added to the results for future reports.

Adjustment of cost data for wage growth: For reasons explained in Part 1, all costs in this report that are expressed per claim or per vocational rehabilitation plan are adjusted for average wage growth. The cost number for each year is multiplied by the ratio of the 2021 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 2021 wage-dollars.

Figure 2.1: The developed number of non-COVID-19 paid indemnity claims for injury-year 2021 (in the numerator of the indemnity claim rate) is 20,400 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2022, 18,400 for non-COVID-19 claims, multiplied by the appropriate development factor, 1.108. In this manner, the non-COVID-19 numbers are developed to a uniform maturity. The reported, non-developed number of COVID-19 paid indemnity claims – 7,100 – is then added to the developed non-COVID-19 number to get the combined total number of paid indemnity claims, which is 27,500 (rounded to the nearest hundred) for injury-year 2021. 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).[76] 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.

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

Figure 2.3: Claim and loss data is from supplementary tables to MWCIA's *2023 Minnesota Ratemaking Report*. This data comes from insurance company reports about claim and loss experience for individual policies for the voluntary market and the Assigned Risk Plan. The reported losses include paid losses plus case-specific reserves. Data is developed to a 10th-report basis using the development factors in the *Minnesota Ratemaking Report,* which produces statistics at an average maturity of 10.5 years from the injury date; the statistics are then adjusted for average wage growth.

Figures 2.4 and 2.5: These figures are based on paid losses, because paid losses are more stable from year to year than are paid losses plus case reserves. The data is from financial reports to 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 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 2020 is available from MWCIA. The 2021 figure was estimated by applying the ratio of deductible credits to written premium for the prior two years to the 2021 premium figure. When the actual amount becomes available for 2021, that year's total cost figure will be revised.

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

Total workers' compensation covered payroll is computed as the sum of insured payroll, from MWCIA, and self-insured payroll, from WCRA. Insured payroll was not yet available for 2021. 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.[77] A major issue is that both paid benefits and total system cost (primarily the latter) vary substantially from year to year, causing major variation in the ratio of the two. 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 67.3% as the ratio of total paid benefits to total system cost.

The indemnity, medical and vocational rehabilitation components of the 67.3% were then computed using the relative totals of these payments for 2021. Vocational rehabilitation benefits (counted separately here from indemnity benefits) are not directly available on a payment-year basis, so a payment-year version of these benefits was estimated from the injury-year series used for Figure 4.3. The portion of total system cost not accounted for by benefit payments, 32.7%, 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 2.3% of total system cost, leaving an estimated 30.4% 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 2019.

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.

[77] 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.

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.