Minnesota
Workers' Compensation System Report, 2000

Research and Statistics
Minnesota Department of Labor and Industry

Minnesota Workers' Compensation System Report, 2000

by
David Berry (principal)
Carolyn MacDonald
Grant Martin
Brian Zaidman

January 2002

Research and Statistics

443 Lafayette Road N.
St. Paul, MN 55155-4307
651-284-5025
dli.research@state.mn.us
www.doli.state.mn.us/research.html

This report is available on the Research and Statistics website at www.doli.state.mn.us/rsreport.htlm. Copies are also available from the Department of Labor and Industry at 1-800-342-5354. Information in this report can be obtained in alternative formats by calling the Department of Labor and Industry at 1-800-342-5354 or TTY at (651) 297-4198.

Executive Summary

The Minnesota workers' compensation system has seen a period of stability in the latter part of the 1990s, with claim rates and costs at historically low levels since 1984. The last two years of data, however, show an increase in cost related to longer durations of wage-replacement benefits. Whether this is a minor fluctuation or the beginning of longer trend remains to be seen.

This report, part of an annual series, presents data from 1984 through 2000 on several aspects of Minnesota's workers' compensation system—claims and costs, vocational rehabilitation, and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota.

Major Findings

Claims and Costs: Overview

- Claim rates fell during most of the 1990s. Current figures indicate 8.2 paid claims per 100 full-time-equivalent (FTE) workers in 1999, and 1.7 paid indemnity claims per 100 FTE workers in 1999 and 2000.

- Following a half-decade of decline, total system cost per $100 of payroll leveled off at $1.37 in 1999 and 2000. This is down 45 percent from the average for 1989-1994.

- Indemnity costs—measured per claim[1] and relative to payroll—increased in 1999 and 2000. This followed steep decreases in indemnity and medical costs—per claim and relative to payroll—during the early 1990s and a period of gentler decreases or leveling off later in the decade.

[1] All cost figures in the report are adjusted for wage growth. The exception is costs expressed relative to payroll, which do not need this adjustment.

Indemnity Claims and Costs: Detail

- Among paid indemnity claims in 2000:

  › 85 percent received total disability benefits (temporary or permanent);
  › 30 percent received temporary partial disability benefits;
  › 21 percent received permanent partial disability benefits;
  › 15 percent received stipulated benefits.

  The percentages with temporary partial, permanent partial, and stipulated benefits fell in varying degrees during the 1990s.

- The average durations of total disability and temporary partial disability benefits were 10 and 18 weeks in 2000. These durations were stable from 1995 through 1998 but were up 13 to 14 percent between 1998 and 2000.

- Driven primarily by the increase in duration, average indemnity benefits per indemnity claim rose 7 percent between 1998 and 2000. The 2000 figure, $10,600, is still low by historical standards.

Vocational Rehabilitation

- Following a period of major fluctuation resulting from a law change, court decisions, and DLI administrative initiatives, vocational rehabilitation (VR) began a period of relative stability in 1997.

- About 17 percent of paid indemnity claimants injured in 2000 (about 5,300 individuals) received VR services, an increase from 15 percent for 1997.

- The total cost of VR services was about $19.7 million in 2000, about 2 percent of total workers' compensation system cost.

- The average cost of VR services declined 10 percent between 1998 and 2000.
- Three-quarters of VR participants have a job at the time of plan closure, a majority of these with their pre-injury employer.

Disputes and Dispute Resolution

- The incidence of all types of disputes, after peaking in 1991, declined rapidly in the early 1990s but changed relatively little during the second half of the decade.
- The rate of denial of filed indemnity claims, after increasing in the 1980s, has remained between 14 and 16 percent since 1991.
- The percentage of paid indemnity claims with claimant attorney fees decreased from 17 percent in 1991 to 12 percent in 2000.
- For 2000, total attorney fees were roughly 16 percent of indemnity benefits and 6 percent of total workers' compensation system cost.

Contents

(Continued)

Figures

1

Introduction

For much of the past one and a half decades, high workers' compensation costs were a major concern both in Minnesota and in most of the nation. During the early and middle 1990s, through cost-control measures by employers and insurers and law changes in most states, costs fell nationwide. In Minnesota, a combination of employer and insurer efforts and law changes in 1992 and 1995 produced major cost reductions during the first half of the 1990s, followed by a period of stability in the latter part of the decade.

The most recent two years of data, however, show an increase in cost driven by longer durations of wage-replacement benefits. Only future data will indicate whether this is a short-term fluctuation or the beginning of a longer trend.

This report, part of an annual series, presents data from 1984 through 2000 on several aspects of Minnesota's workers' compensation system—claims and costs, vocational rehabilitation, and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota.

To enhance readability, this year's report is presented in a new format featuring a more selective presentation of data and a bullet-point text format emphasizing current developments.

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

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

Some important points to keep in mind throughout the report:

Developed statistics. Most statistics in this report are presented by injury year or insurance policy year.[1] An issue with such 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 are "developed" as needed to a uniform maturity so that the statistics are comparable over time. The technique uses "development factors" (projection factors) based on observed data for older claims. Appendix C gives more detail.

2000 law change. The benefit changes enacted by the 2000 Legislature (see Appendix B) took effect for injuries on or after Oct. 1, 2000; therefore, those changes do not appreciably affect the data in this report.

Economic slowdown. The current economic slowdown may affect the workers' compensation system. Some effect may be present in statistics in this report, to the extent that claims from 2000 and earlier remained open after the slowdown began. However, the full effect of the slowdown will only be present in future reports.

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

2

Claims and Costs: Overview

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

Major Findings

- Claim rates fell during most of the 1990s. The most recent figures indicate 8.2 paid claims per 100 full-time-equivalent (FTE) workers in 1999, and 1.7 paid indemnity claims per 100 FTE workers in 1999 and 2000. (Figure 2.1)
- After a half-decade of decline, total system cost per $100 of payroll leveled off at $1.37 for 1999 and 2000; this is down 45 percent from an average of $2.51 for 1989-1994. (Figure 2.2)
- After falling by nearly half during the middle and late 1990s, pure premium rates increased for 2002. The 2002 rates are up 1.4 percent from 2001. (Figure 2.4)
- Indemnity and medical costs—measured per claim[2] and relative to payroll—declined steeply during the early 1990s but fell more slowly or leveled off later in the decade. Indemnity costs—per claim and relative to payroll—increased in 1999 and 2000. (Figures 2.5, 2.7-2.9)

Background

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

[2] Adjusted for wage growth.

Workers' Compensation Benefits and Claim Types

Workers' compensation provides three basic types of benefits:

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

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

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

Claims with indemnity benefits are called ***indemnity claims***; these claims typically have medical benefits also. The remainder of claims are called ***medical-only claims*** because they only have medical benefits.

Insurance Arrangements

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

Rate-Setting

Minnesota is an open-rating state for workers' compensation, meaning that rates are set by

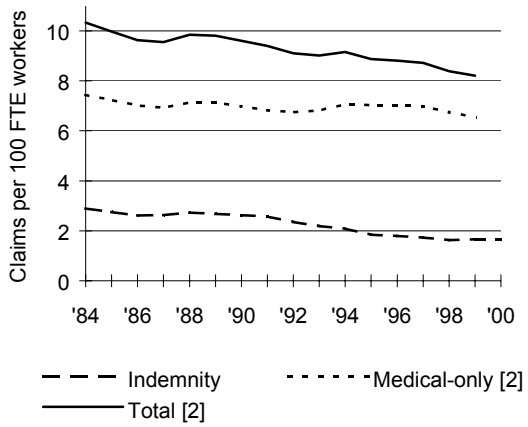
insurance companies rather than by a central authority. In determining their rates, insurance companies start with "pure premium rates" calculated every year by Minnesota's workers' compensation data service organization and rating bureau, the Minnesota Workers' Compensation Insurers Association (MWCIA).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

Claim Rates

Claim rates fell during most of the 1990s.

- In 1999, there were 8.2 paid claims per 100 FTE workers, down 15 percent from 1990.
- In 1999 and 2000, there were 1.7 paid indemnity claims per 100 FTE workers, down 37 percent from 1990. Most of the decrease was during the early 1990s.
- The medical-only claims rate fell only slightly during the 1990s, to 6.5 per 100 FTE workers in 1999.
- Indemnity claims made up 20 percent of total paid claims in 1999, down from 27 percent for 1991. Most of the decrease was between 1991 and 1995.

Figure 2.1 Paid Claims Per 100 Full-Time-Equivalent Workers, Injury Years 1984-2000 [1]



Injury Year	Indemnity Claims	Medical-Only Claims	Total Claims
1984	2.9	7.4	10.3
1990	2.6	7.0	9.6
1998	1.6	6.8	8.4
1999	1.7	6.5	8.2
2000	1.7	[2]	[2]

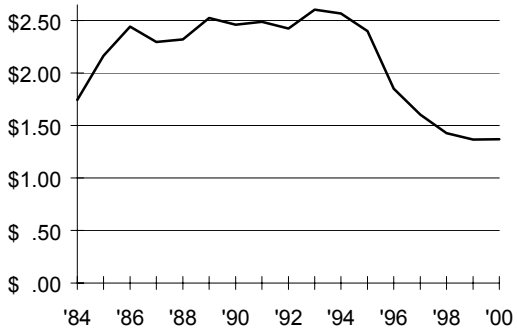
1. Developed statistcs from DLI data and other sources (see Appendix C).
2. Not available at time of publication.

System Cost

The cost of Minnesota's workers' compensation system fell dramatically relative to payroll during the mid-1990s.

- System cost per $100 of payroll was $1.37 in 2000, the same as in 1999 and down 45 percent from the average of $2.51 for 1989-1994.
- The total cost of the workers' compensation system in 2000 was an estimated $1.07 billion, up from $1.00 billion in 1999 (not adjusted for inflation).
- These figures reflect benefits (indemnity, medical, and vocational rehabilitation) plus other costs such as claims adjustment, litigation, and taxes and assessments. The figures are computed primarily from actual premium for insured employers (allowing for costs under deductible limits) and pure premium for self-insured employers (see Appendix C).

Figure 2.2 System Cost per $100 of Payroll, 1984-2000 [1]



	Cost per $100 of Payroll
1984	$1.74
1990	2.46
1994	2.57
1999	1.37
2000	1.37

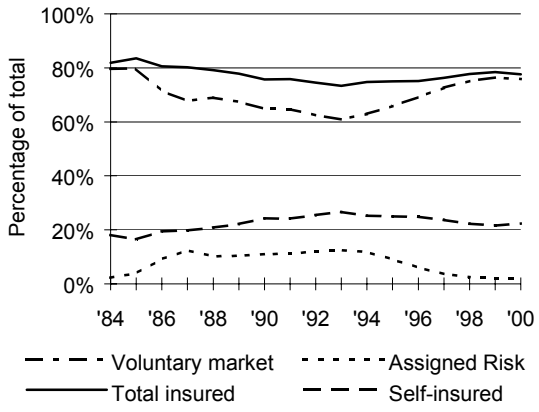
1. Data from several sources. Includes insured and self-insured employers.

Insurance Arrangements

The voluntary market gained market share in the mid-1990s.

- The voluntary market share of paid indemnity claims rose from 61 percent in 1993 to 76 percent in 1999 and 2000.
- During the same period, the Assigned Risk Plan share fell from 12 percent to 2 percent and the self-insured share fell from 27 percent to 22 percent.
- These shifts are at least partly due to declining insurance rates (Figure 2.4).
- When market share is measured by pure premium (not shown here), the trends are nearly identical.

Figure 2.3 Market Shares of Different Insurance Arrangements as Measured by Paid Indemnity Claims, Injury Years 1984-2000 [1]



Injury Year	Voluntary Market	Assigned Risk Plan	Total Insured	Self-Insured
1984	79.6%	2.3%	81.8%	18.2%
1993	60.9	12.4	73.3	26.7
1999	76.4	2.0	78.4	21.6
2000	75.8	1.8	77.6	22.4

1. Data from DLI.

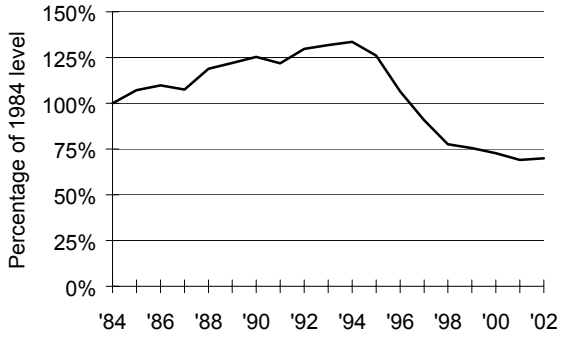
Pure Premium Rates

Pure premium rates fell steeply in the mid-1990s.

- Between 1994 and 2002, pure premium rates fell by nearly half, from 134 percent of their 1984 level to 70 percent.
- The 2002 level is up 1.4 percent from 2001.
- The decreases during the 1990s reflect a combination of the 1992 and 1995 law changes and other factors, including safety programs, more active medical treatment, better management of claims and costs, and more effective return-to-work programs.[3]
- Insurers in the voluntary market use the pure premium rates in determining their own rates, which in turn affect total system cost (Figure 2.2).

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

Figure 2.4 Pure Premium Rates as Percentage of 1984 Level, 1984-2000 [1]



Effective Year	Percentage of 1984
1984	100.0%
1994	133.6
2000	72.7
2001	69.0
2002	70.0

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

Benefit Cost Relative to Payroll

Indemnity and medical costs fell sharply relative to payroll in the early 1990s and have been stable since 1995.

- Total benefit cost per $100 of payroll was $1.03 in 2000, unchanged from 1999. The indemnity component was up slightly from 1999, but the medical component was down.
- Relative to payroll, total benefit cost in 2000 was half its peak value in 1990. The indemnity and medical figures for 2000 were down 58 percent and 38 percent, respectively, from their peaks.
- Most of the decreases occurred in the early 1990s; costs were stable relative to payroll from 1995 to 2000.
- These figures ultimately drive the pure premium rate trend in Figure 2.4.[4]

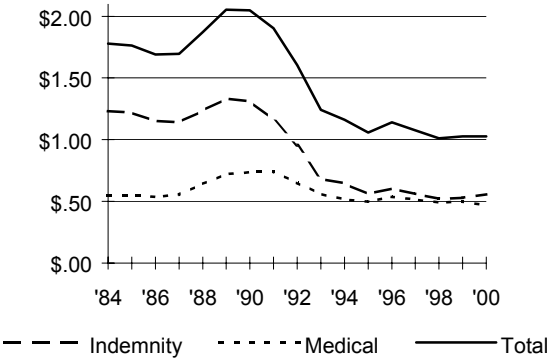
Indemnity and Medical Shares

The indemnity share of total benefit cost fell steadily from the mid-1980s to the mid-1990s, to a point almost equal to the medical share. However, the indemnity share turned back upward in 2000.

- Reflecting the data in Figure 2.5, indemnity cost was 54 percent of total benefit cost in 2000, up from 52 percent in 1999.
- The indemnity share fell from 70 percent in 1984 to 53 percent in 1995 and was stable until the 2000 increase.

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

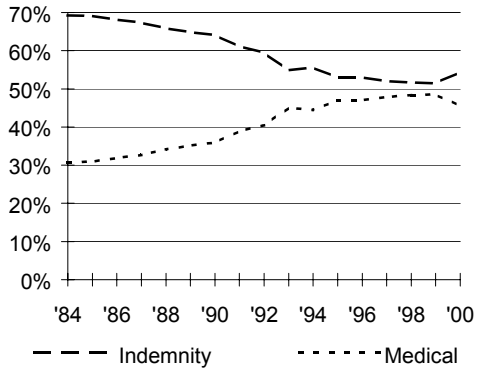
Figure 2.5 Benefit Cost per $100 of Payroll in the Voluntary Market, Accident Years 1984-2000 [1]



Accident Year	Indemnity Cost	Medical Cost	Total Benefit Cost
1984	$1.23	$.55	$1.78
1989	1.33	.72	2.05
1990	1.31	.74	2.05
1999	.53	.50	1.03
2000	.56	.47	1.03

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

Figure 2.6 Indemnity and Medical Cost Shares in the Voluntary Market, Accident Years 1984-2000 [1]



Accident Year	Indemnity Cost	Medical Cost
1984	69.2%	30.8%
1995	52.9	47.1
1999	51.5	48.5
2000	54.4	45.6

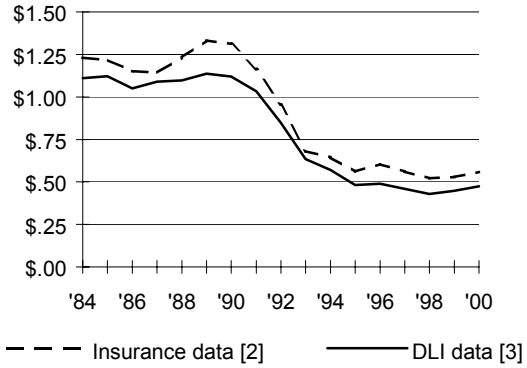
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan, and supplementary and second-injury benefits.

Indemnity Cost Relative to Payroll: Insurance and DLI Data

Insurance and DLI data closely corroborate each other on indemnity cost relative to payroll.

- While the DLI figures are consistently less than the insurance figures,[5] the two trends follow each other closely.
- The 2000 DLI figure, $.47 per $100 of payroll, is up slightly from 1998 and 1999, showing about the same amount of change as the insurance figures for the same period.

Figure 2.7 Indemnity Cost per $100 of Payroll, Injury Years 1984-2000: Insurance and DLI Data [1]



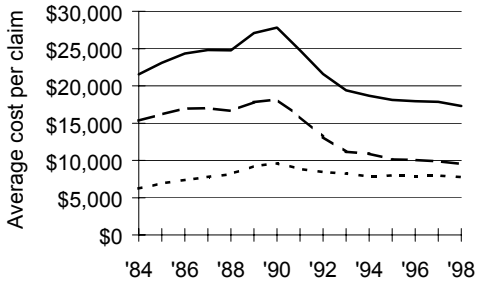
Injury Year [1]	Insurance Data [2]	DLI Data [3]
1984	$1.23	$1.11
1989	1.33	1.14
1998	.52	.43
1999	.53	.45
2000	.56	.47

1. Injury year in the DLI data corresponds to accident year in the insurance data.
2. From Figure 2.5. Excludes self-insured employers, the Assigned Risk Plan, and supplementary and second-injury benefits. Includes vocational rehabilitation benefits.
3. Developed statistics (see Appendix C). Includes self-insured employers, the Assigned Risk Plan, and supplementary and second-injury benefits. Excludes vocational rehabilitation benefits.

[5] This may occur because the two data sources have different inclusions and exclusions (see notes in Figure 2.7) or because the insurance data are projected to a greater maturity.

Figure 2.8 Average Indemnity and Medical Costs of Insured Claims, Adjusted for Wage Growth, Policy Years 1984-1998 [1]

A: Indemnity Claims



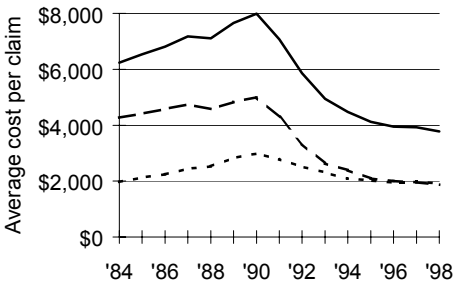
Policy Year	Indemnity Cost	Medical Cost	Total Cost
1984	$15,300	$6,200	$21,500
1990	18,200	9,600	27,800
1997	9,900	8,000	17,900
1998	9,500	7,800	17,300

Indemnity Medical Total

B: Medical-Only Claims

Policy Year	Medical Cost	Total Cost
1984	$319	$319
1991	523	523
1997	479	479
1998	481	481

C: All Claims



Policy Year	Indemnity Cost	Medical Cost	Total Cost
1984	$4,270	$1,960	$6,230
1990	5,000	2,980	7,980
1997	1,960	1,970	3,930
1998	1,870	1,910	3,780

Indemnity Medical Total

1. Developed statistics from MWCIA data (see Appendix C). Includes the Assigned Risk Plan; excludes self-insured employers. Costs are adjusted for average wage growth between the respective year and 2000.

Benefit Costs per Claim

Adjusted for wage growth, average claim costs fell sharply during the early 1990s and continued a gradual decline through 1998.

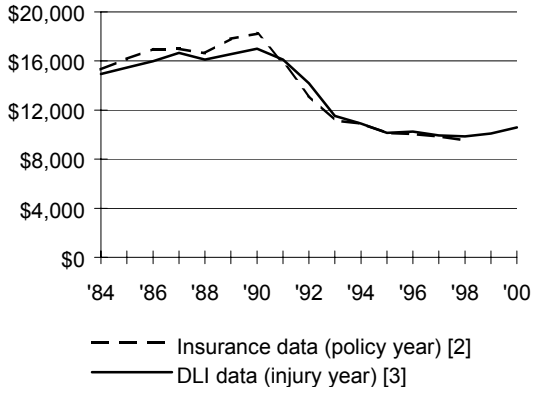
- For all claims combined, in 1998 relative to 1990:
  - › average total cost was done 53 percent;
  - › average indemnity cost was down 63 percent;
  - › average medical cost was down 36 percent.
- The average total cost of all claims combined was down 4 percent in 1998 from 1997, with both indemnity and medical costs contributing to the decrease.
- The decreases in benefit costs relative to payroll (Figure 2.5) are driven by the decreases in average claim costs (Figure 2.8) and decreases in claim rates (Figure 2.1).

Indemnity Cost of Indemnity Claims: Insurance and DLI Data

DLI data show an increase in the average indemnity cost of indemnity claims between 1998 and 2000, adjusted for wage growth. For earlier years, the insurance and DLI data corroborate each other closely.

- The 2000 DLI figure is up 5 percent from 1999 and 7 percent from the low point in 1998. Given the small change in the indemnity claims rate (Figure 2.1), this increase accounts for the increase in indemnity cost relative to payroll between 1998 and 2000 (Figure 2.7).
- For 1990-1998, the insurance and DLI numbers differ by an average of 3 percent.

Figure 2.9 Average Indemnity Cost of Indemnity Claims, Adjusted for Wage Growth, 1984-2000: Insurance and DLI Data [1]



Policy or Injury Year	Insurance Data [2]	DLI Data [3]
1984	$15,300	$14,900
1990	18,200	17,000
1998	9,500	9,900
1999	[4]	10,100
2000	[4]	10,600

1. Claim costs are adjusted for average wage growth between the respective year and 2000.
2. From Figure 2.8. Excludes self-insured employers, supplementary benefits, and second-injury claims. Includes the Assigned Risk Plan and vocational rehabilitation benefits.
3. Developed statistics (see Appendix C). Includes self-insured employers, the Assigned Risk Plan, supplementary benefits, and second-injury claims. Excludes vocational rehabilitation benefits.
4. Not yet available.

3

Indemnity Claims and Costs: Detail

This chapter presents additional data on indemnity claims and costs. These more detailed figures lie behind the indemnity claim and cost data in Chapter 2.

Major Findings

- Among paid indemnity claims in 2000:
  - › 85 percent received total disability benefits (temporary or permanent);
  - › 30 percent received temporary partial disability benefits;
  - › 21 percent received permanent partial disability benefits;
  - › 15 percent received stipulated benefits.

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

- The average durations of total disability and temporary partial disability benefits were 10 and 18 weeks in 2000. These durations were stable from 1995 through 1998 but were up 13 to 14 percent between 1998 and 2000. (Figure 3.3)

- After adjusting for wage growth, average weekly total disability and temporary partial disability benefits have been steady since the mid-1990s. (Figure 3.4)

- Driven primarily by the increase in duration, average indemnity benefits per indemnity claim (adjusting for wage growth) rose 7 percent between 1998 and 2000. The 2000 figure, $10,600, is still low by historical standards. (Figures 3.5, 3.6)

Background

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

Benefit Types

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

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

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

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

Stipulated benefits. Indemnity and/or medical benefits specified in a claim settlement—"stipulation for agreement"— among the affected parties. A stipulation usually occurs in

a dispute, and stipulated benefits are usually paid in a lump-sum.

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

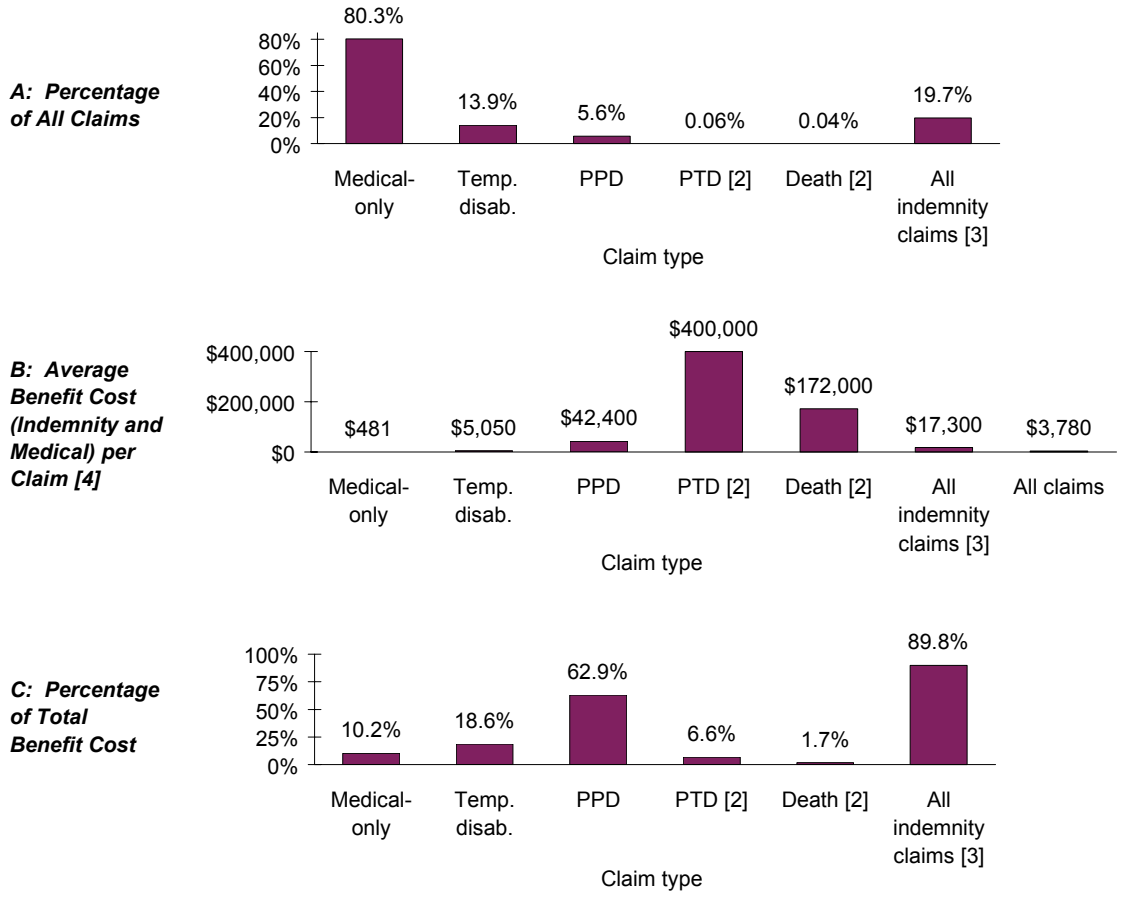
Counting Claims and Benefits: Insurance Data and Department Data

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

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

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

Figure 3.1 Benefit Cost by Claim Type for Insured Claims, Policy Years 1984-1998 [1]



1. Developed statistics from MWCIA data (see Appendix C).
2. Because of annual fluctuations, data for PTD and death claims are averaged over several years (see Appendix C).
3. Indemnity claims consist of all claim types other than medical-only.
4. Costs in Panel B are adjusted for average wage growth between 1998 and 2000.

Benefit Cost by Claim Type

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

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

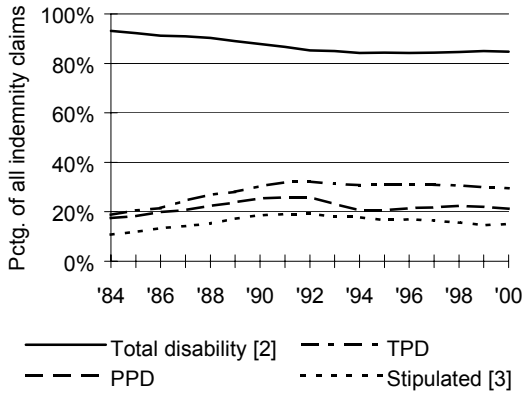
- PPD claims accounted for 63 percent of total benefit cost in 1998 (Panel C of Figure 3.1) because of a combination of moderate frequency (Panel A) and higher than average cost per claim (Panel B).
- Other claim types contributed smaller amounts to total benefit cost because of low frequency (PTD and death claims) or low average cost (medical-only claims).
- Indemnity claims were 20 percent of all paid claims, but accounted for 90 percent of total benefit cost because they are far more expensive than medical-only claims ($17,300 vs. $481).

Claims by Benefit Type

The percentages of paid indemnity claims with different types of benefits have been steady or slightly declining since the mid-1990s.

- The 1995-2000 period saw slight declines in the percentages with TPD and stipulated benefits and little change in the percentages with total disability and PPD benefits.
- The decrease in the percentage of claims with PPD benefits between 1992 and 1994 resulted from the introduction of the new PPD rating schedule in July 1993.[6]
- The decrease in the percentage of claims with stipulated benefits after 1992 is probably related to a declining dispute rate (Chapter 5, Figure 5.1).
- The 1984-1992 period experienced substantial increases in the percentages of claims with TPD, PPD, and stipulated benefits, and a decrease in the percentage with total disability benefits.

Figure 3.2 Percentages of Paid Indemnity Claims With Selected Types of Benefits, Injury Years 1984-2000 [1]



Injury Year	Total Disab.[2]	TPD	PPD	Stipu-lated [3]
1984	93.1%	18.8%	17.5%	10.7%
1992	85.2	32.2	25.9	19.2
1995	84.3	31.1	20.6	16.6
1999	85.0	29.9	22.0	14.6
2000	84.7	29.5	21.3	15.0

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

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

Benefit Duration

The average durations of total disability and TPD benefits show signs of increasing in the last one to two years.

- After a period of stability beginning in 1995, total disability duration turned upward in 1999 and TPD duration did the same in 2000. Relative to 1998, total disability and TPD duration are up 14 percent and 13 percent respectively.
- These increases in duration affect indemnity costs (Figures 2.5, 2.7, 2.9, 3.5, 3.6). They will eventually affect pure premium rates and system cost (Figures 2.2, 2.4).
- The current economic slowdown may be behind some of the duration increase for 1999 and 2000, to the extent that some of the claims for those years remained open after the slowdown began.
- The average durations of total disability and TPD benefits reached low points in 1995 after several years of decline.

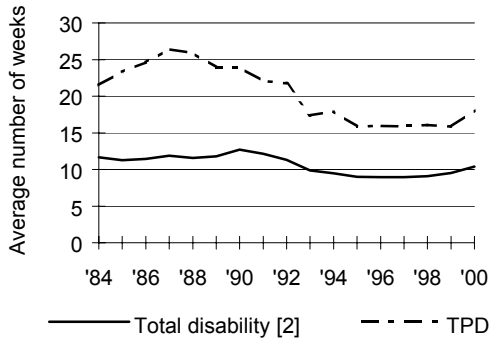
Weekly Benefits

Average weekly TPD benefits have been generally steady since the mid-1990s after adjusting for wage growth. Average weekly total disability benefits have declined slightly since 1996.

- Average weekly total disability and TPD benefits have been generally steady since 1993. This means these weekly benefits have grown at the same rate as overall wage levels.
- Average weekly total disability and TPD benefits fell from 1984 through 1993. This was primarily because pre-injury wages (the basis for weekly benefits) grew more slowly than overall wage levels.[7]

[7] *Minnesota Workers' Compensation System Report, 1999,* DLI Research and Statistics, February 2001.

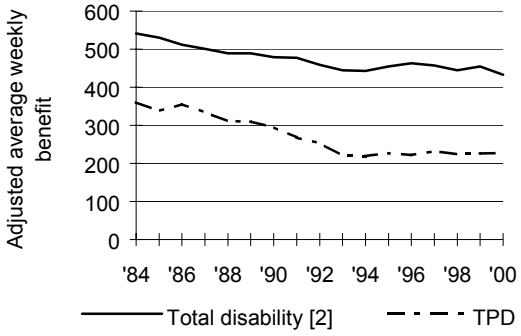
Figure 3.3 Average Duration of Wage-Replacement Benefits in Weeks, Injury Years 1984-2000 [1]



Injury Year	Total Disab.[2]	TPD
1984	11.7	21.5
1987	11.9	26.4
1990	12.7	23.9
1995	9.0	15.9
1998	9.1	16.1
1999	9.5	15.8
2000	10.4	18.1

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

Figure 3.4 Average Weekly Wage-Replacement Benefits, Adjusted for Wage Growth, Injury Years 1984-2000 [1]



Injury Year	Total Disab. [2]	TPD
1984	$542	$360
1993	444	220
1996	463	222
1999	455	226
2000	432	228

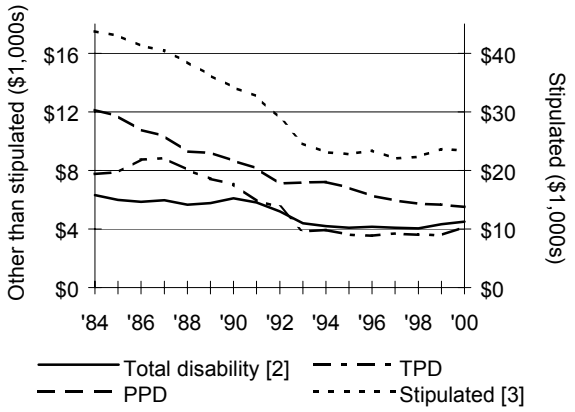
1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2000.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.

Average Indemnity Benefits by Type

After a period of stability since the mid-1990s, average total disability, TPD, and stipulated benefit amounts have increased in the last two years after adjusting for average wage growth. The most recent figures for all benefit types are still at or near their historical lows since 1984.

- Relative to 1998, the adjusted average amounts of total disability, TPD, and stipulated benefits for 2000 are up by 11 percent, 14 percent, and 5 percent, respectively.
- The increases for total disability and TPD benefits reflect increased benefit duration (Figure 3.3), since average weekly benefit amounts have been stable (Figure 3.4).
- The recent decreases in adjusted average PPD amounts are part of a long-term trend. Average PPD benefits fell steadily from 1984 through 2000 primarily because most PPD benefits were paid under a benefit schedule that remained fixed.[8] With rising wages, PPD benefits fell by comparison, which is reflected in the adjusted average benefit amounts.

Figure 3.5 Average Indemnity Benefit by Type Per Claim with that Benefit Type, Adjusted for Wage Growth, Injury Years 1984-2000 [1]



Injury Year	Total Disab.[2]	TPD	PPD	Stipulated [3]
1984	$6,310	$7,750	$12,120	$43,750
1995	4,080	3,610	6,820	22,780
1998	4,040	3,600	5,730	22,360
1999	4,320	3,580	5,650	23,640
2000	4,490	4,120	5,500	23,380

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2000.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.
3. Includes indemnity and medical components.

[8]The 2000 law change raised PPD benefit levels for injuries on or after Oct. 1, 2000 (see Appendix B).

Indemnity Benefits per Indemnity Claim

After a relatively low period during the late 1990s, average indemnity benefits per indemnity claim are up in 2000 after adjusting for wage growth. The primary cause is an upturn in total disability and TPD benefits per indemnity claim resulting from duration increases.

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

- Indemnity benefits per indemnity claim in 2000 are up by 7 percent from 1998. These numbers (last column of Figure 3.6) are the DLI numbers in Figure 2.9.

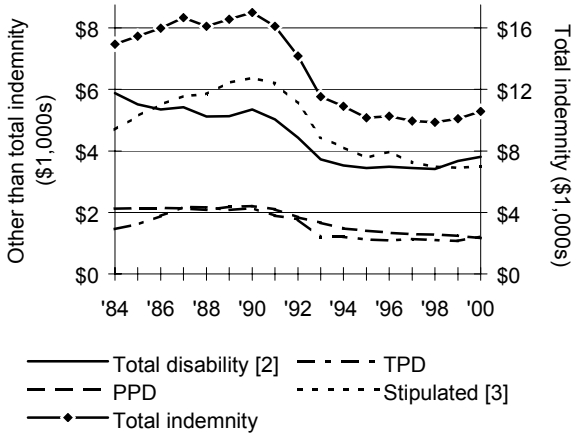
- This increase reflects increases in total disability and TPD benefits per indemnity claim of 11 percent and 14 percent, respectively, between 1998 and 2000. The latter increases are a result of higher average benefit amounts (Figure 3.5) given stable or somewhat decreasing percentages of indemnity claims with these benefits (Figure 3.2). The increased total disability and TPD benefit amounts, in turn, reflect duration increases (Figure 3.3).

- PPD benefits per indemnity claim were down in 2000 from 1998 and 1999. This is part of a long-term trend, discussed in relation to Figure 3.5.

- Stipulated benefits per indemnity claim in 2000 were about the same as in the prior two years, and the lowest since 1984.

- In 2000, total disability and stipulated benefits per indemnity claim were about three times as great as TPD and PPD benefits per indemnity claim.

Figure 3.6 Average Indemnity Benefit by Type Per Indemnity Claim, Adjusted for Wage Growth, Injury Years 1984-2000 [1]



Injury Year	Total Disab. [2]	TPD	PPD	Stipu-lated [3]	Total Indem. [4]
1984	$5,880	$1,450	$2,120	$4,690	$14,930
1990	5,350	2,140	2,210	6,380	16,990
1995	3,440	1,120	1,400	3,780	10,150
1998	3,410	1,100	1,280	3,490	9,860
1999	3,670	1,070	1,240	3,450	10,080
2000	3,800	1,210	1,170	3,500	10,580

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2000.
2. Total disability includes TTD and PTD benefits. TTD and PTD are not distinguished in the DLI database.
3. Includes indemnity and medical components.
4. Because some benefit types are not shown, total indemnity benefits are greater than the sum of the benefit types shown.

4

Vocational Rehabilitation

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

Major Findings

- After a period of major fluctuation resulting from a law change, court decisions, and DLI administrative initiatives, VR began a period of relative stability in 1997. (Figure 4.1)

- About 17 percent of paid indemnity claimants injured in 2000 (about 5,300 individuals) received VR services. This represents a gradual increase from 15 percent for 1997. (Figure 4.1)

- The total cost of VR services was about $19.7 million in 2000; this is about 2 percent of total workers' compensation system cost. (Figure 4.2)

- Adjusted for average wage growth, the average cost of VR services declined 10 percent between 1998 and 2000. (Figure 4.2)

- About three quarters of VR participants have a job at the time of plan closure, a majority of these with their pre-injury employer. (Figure 4.6)

- The average VR participant returning to work receives a wage about the same as their pre-injury wage, but this varies widely among individuals. (Figure 4.7)

Background

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

VR services include—

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

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

Time Period Covered

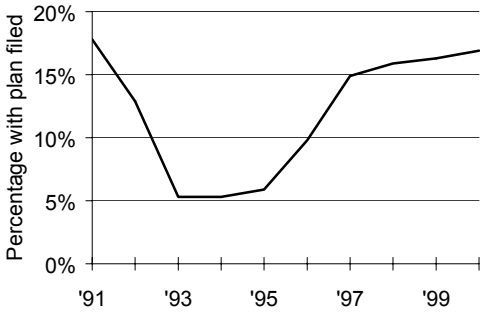
Most of the data in this chapter come from VR plan closure forms filed with DLI. Because the VR system experienced major changes in the early and middle 1990s, only the closure data from 1998 through 2000 are used. Earlier plan closure data are strongly affected by changes over time in the types of injured workers receiving services.

Participation Rate

During the last decade, the percentage of indemnity claimants receiving VR services varied widely, reflecting a law change, court decisions, and DLI initiatives. A period of relative stability began in 1997.

- About 17 percent of paid indemnity claimants injured in 2000—about 5,300 individuals—had received VR services as of October 2001, when data were compiled for this report.
- The VR participation rate increased gradually from 1997 to 2000.

Figure 4.1 Percentage of Paid Indemnity Claims With a VR Plan Filed, Injury Years 1991-2000 [1]



Injury Year	Percentage with Plan
1991	17.8%
1993	5.3
1997	14.9
1999 [2]	16.3
2000 [2]	16.9

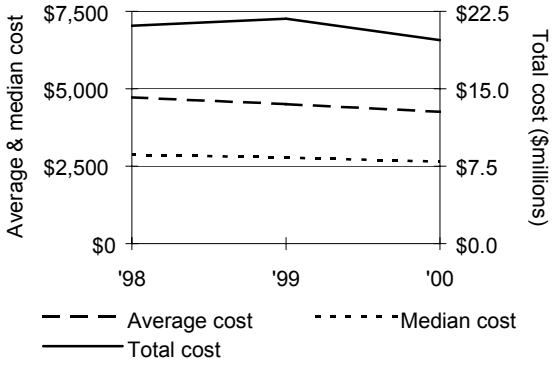
1. Data from DLI.
2. Preliminary.

Cost

After adjusting for wage growth, the average cost of VR services declined steadily since 1998.

- Average cost in 2000 was down 5 percent from 1999 and 10 percent from 1998. Median cost also declined slightly.
- In 2000, total VR cost was about $20 million, roughly 2 percent of total workers' compensation system cost.
- Total VR cost in 2000 was down 7 percent from 1998.

Figure 4.2 VR Plan Costs, Adjusted for Wage Growth, Plan-Closure Years 1998-2000 [1]



Plan-Closure Year	Average Cost	Median Cost	Total Cost ($Millions)
1998	$4,720	$2,870	$21.1
1999	4,500	2,780	21.8
2000	4,260	2,640	19.7

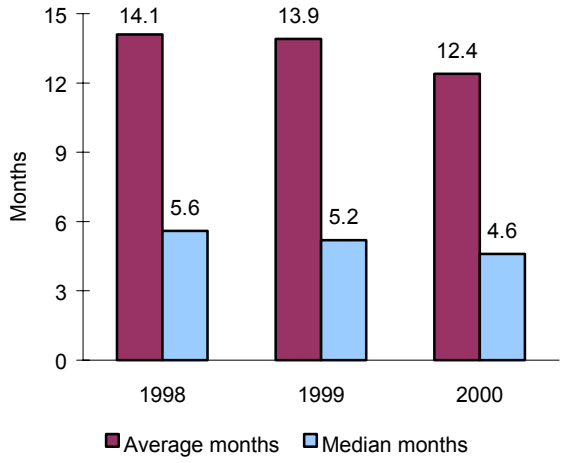
1. Data from DLI. Costs are adjusted for average wage growth between the respective year and 2000.

Timing of Services

Since 1998, the average time between the injury and the start of VR services has steadily declined.

- From 1998 to 2000, the average time from injury to start of services declined 12 percent. The median time also declined.

Figure 4.3 Time from Injury to Start of VR Services, Plan-Closure Years 1998-2000 [1]



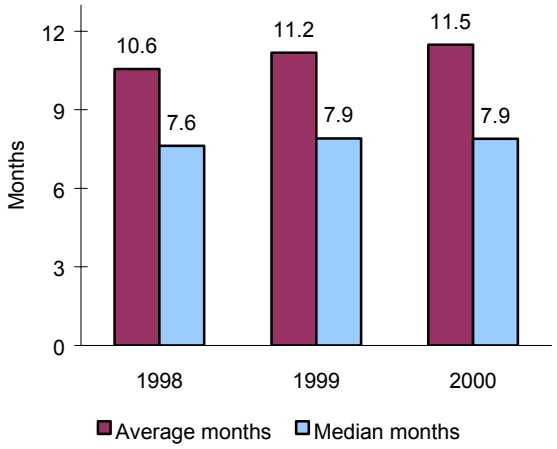
1. Data from DLI .

Service Duration

VR service duration has increased slightly since 1998.

- Average service duration increased 8 percent from 1998 to 2000. However, median duration was unchanged.
- VR service duration was shortest for participants returning to work with the pre-injury employer and longest for participants not returning to work.
- Injured workers who began services later after the injury had, on average, longer service durations.

Figure 4.4 VR Service Duration, Plan-Closure Years 1998-2000 [1]



1. Data from DLI.

Services Provided

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

- Of the three services reported separately to DLI, only placement services are used to a significant degree. Twenty-nine percent of plans reported this service in 2000.
- On-the-job training and retraining are used in small numbers of cases.

Figure 4.5 Provision of Specific Services, Plan-Closure Years 1998-2000 [1]

Plan-Closure Year	Number and Percentage of Plans Indicating Service		
	On-the-Job Training	Retraining	Placement Services
1998	29	76	1,561
	0.6%	*1.7%*	*34.9%*
1999	15	64	1,554
	0.3%	*1.3%*	*31.9%*
2000	18	60	1,354
	0.4%	*1.3%*	*29.2%*

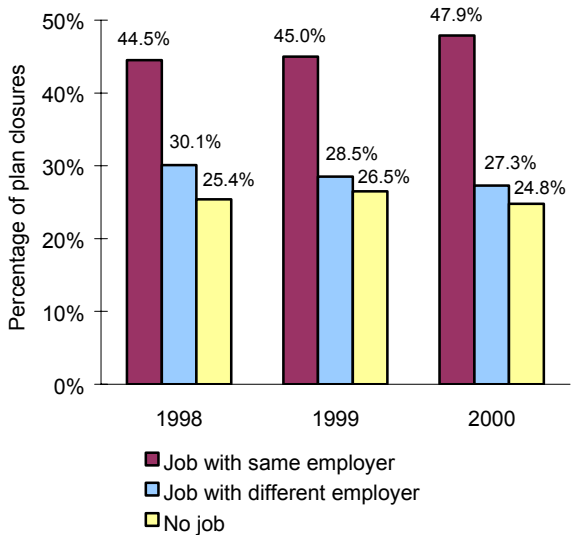
1. Data from DLI.

Return-to-Work Outcomes

Between 1998 and 2000, the percentage VR participants returning to work with the pre-injury employer increased. The percentage going to work with a different employer decreased. The percentage with no job at closure—about 25 percent—showed little change.

- The proportion of VR participants returning to work with their pre-injury employer was higher for those who started services sooner after their injury.

Figure 4.6 Return-to-Work Outcomes, Plan-Closure Years 1998-2000 [1]



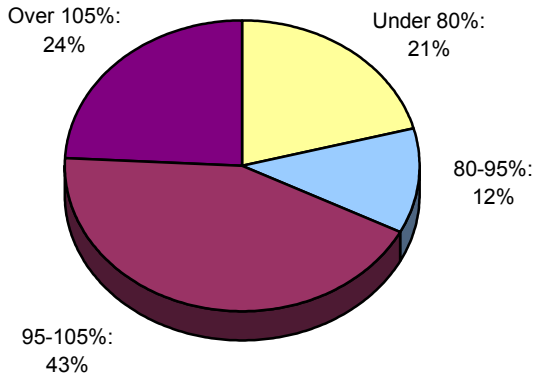
1. Data from DLI.

Return-to-Work Wages

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

- In 2000, about two-thirds of participants returning to work received a wage of at least 95 percent of their pre-injury wage. About one third made less than 95 percent of their pre-injury wage, with most of those earning less than 80 percent of their pre-injury wage.
- The average return-to-work wage ratio was higher among participants who returned to their pre-injury employer (106 percent) than among those who returned to a different employer (94 percent).
- Participants with shorter service durations had a higher average wage ratio than those with longer service durations.

Figure 4.7 Ratio of Return-to-Work Wage to Pre-Injury Wage for Participants Returning to Work, Plan-Closure Year-1998-2000 [1]



Average: 102%
Median: 100%

1. Data from DLI.

Reasons for Plan Closure

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

- The 1998-2000 period saw an increase in the proportion of plans closed because of completion or agreement of the parties, and a decrease in the proportion closed by a decision and order.

Figure 4.8 Reason for Plan Closure, Plan-Closure Years 1998-2000 [1]

Plan-Closure Year	Plan Completed	Claim Settlement	Decision and Order	Agreement of Parties
1998	63.5%	21.4%	5.2%	9.9%
1999	63.7	23.7	2.2	10.4
2000	65.6	20.9	1.1	12.4

1. Data from DLI.

5

Disputes and Dispute Resolution

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

Major Findings

- The incidence of all types of disputes, after peaking in 1991, declined rapidly in the early 1990s but changed relatively little during the second half of the decade. (Figure 5.1)
- Claim petition disputes—usually over primary liability and benefit issues—are the most common type of dispute. (Figure 5.2)
- The rate of denial of filed indemnity claims, after increasing in the 1980s, has remained between 14 and 16 percent since 1991. (Figure 5.3)
- The percentage of paid indemnity claims with claimant attorney fees decreased from 17 percent in 1991 to 12 percent in 2000. (Figure 5.9)
- For 2000, total attorney fees were roughly 16 percent of indemnity benefits and 6 percent of total workers' compensation system cost. (Figure 5.10)

Background

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

Types of Disputes

Disputes in Minnesota's workers' compensation system generally occur over five types of issues:[9]

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

Dispute Resolution Process

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

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

Customer Assistance Activities

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

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

Mediation. A mediation occurs when all parties agree to participate and may be used to deal with

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

any type of dispute. The mediator, a CA specialist, works to facilitate agreement among the parties and formally records its terms.

Administrative conference and "nonconference decision-and-orders." An administrative conference is an expedited, informal proceeding where parties present and discuss viewpoints in a dispute. CA conducts administrative conferences on rehabilitation issues and on medical issues involving $1,500 or less. If agreement is not achieved, the CA specialist issues a "decision and order." If CA believes a dispute under its jurisdiction does not require a conference, it may issue a "nonconference decision and order."

Office of Administrative Hearings Activities

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

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

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

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

Data Issues

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

Counting Disputes

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

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

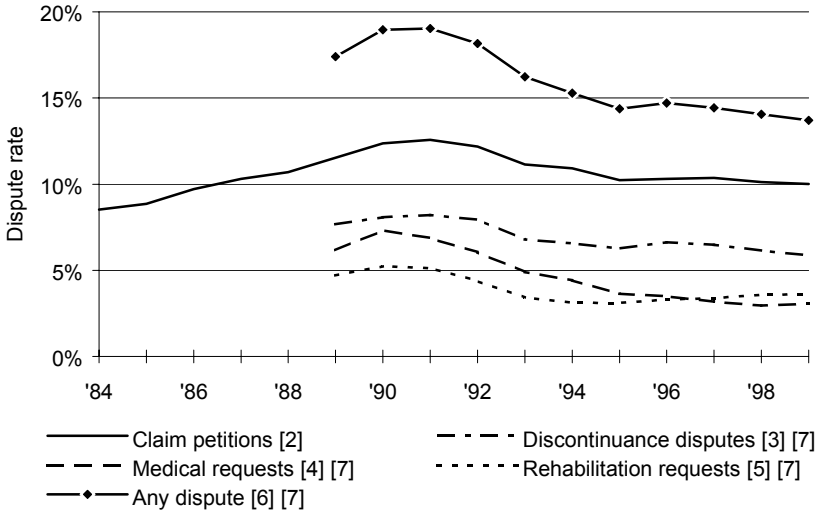
Discontinuance disputes. These disputes are most often initiated by a claimant's *Request for Administrative Conference* in response to the insurer's declared intention to discontinue temporary total or temporary partial benefits. They may also be presented on the claimant's *Objection to Discontinuance*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

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

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

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

Figure 5.1 Incidence of Disputes, Injury Years 1984-1999 [1]



Injury Year	Dispute Rate				
	Claim Petitions [2]	Discontinuance Disputes [3]	Medical Requests [4]	Rehabilitation Requests [5]	Any Dispute [6]
1984	8.5%	[7]	[7]	[7]	[7]
1989	11.5	7.7%	6.2%	4.7%	17.4%
1990	12.4	8.1	7.3	5.2	19.0
1991	12.6	8.2	6.9	5.1	19.0
1995	10.2	6.3	3.6	3.1	14.4
1998	10.1	6.2	2.9	3.6	14.1
1999	10.0	5.9	3.0	3.6	13.7

1. Developed statistics from DLI data. 2000 data are not presented because they are not yet sufficiently reliable. (See Appendix C.)
2. Percentage of filed indemnity claims with claim petitions. (Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.)
3. Percentage of paid wage-loss claims with discontinuance disputes.
4. Percentage of paid indemnity claims with *Medical Requests.*
5. Percentage of paid indemnity claims with *Rehabilitation Requests.*
6. Percentage of filed indemnity claims with any disputes.
7. Not available before 1989.

Dispute Rates

The incidence of all dispute types fell significantly during the early 1990s but changed relatively little during the second half of the decade.

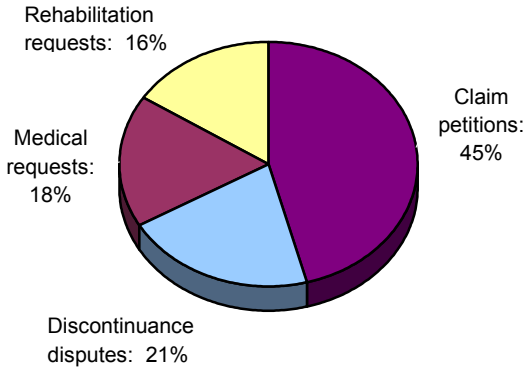
- The 1999 total dispute rate was 13.7 percent, down by more than a quarter from 1990 but only slightly down from 1995.
- By far the largest relative decrease was shown by *Medical Requests,* which in 1999 were down 58 percent from 1990 and 16 percent from 1995.
- The increase in the rate of *Rehabilitation Requests* after 1995 may be attributable to increased participation in vocational rehabilitation after that year (Figure 4.1).
- Preliminary data for 2000 suggest a possible upturn in the overall dispute rate, driven by claim petitions and discontinuance disputes.
- Multiple disputes on individual claims are common. For injury year 1999, 36 percent of claims with disputes had two or more disputes.

Dispute Types

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

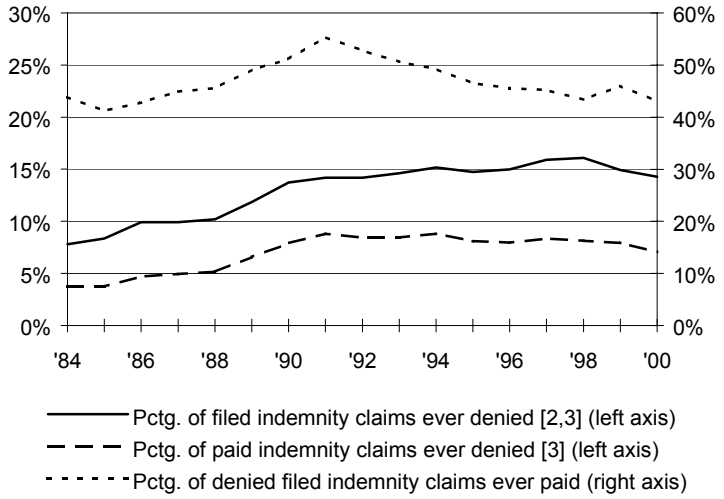
- Discontinuance disputes are the next most common, making up almost a quarter of disputes.
- Medical requests and rehabilitation requests are somewhat less frequent, 18 percent and 16 percent respectively.

Figure 5.2 Dispute Types as Share of Total, Disputes Filed in 2000 [1]



1. Data from DLI.

Figure 5.3 Indemnity Claim Denial Rates, Injury Years 1984-2000 [1]



Injury Year	Filed Indemnity Claims [2] Total	Filed Indemnity Claims [2] Pctg. Ever Denied [3]	Paid Indemnity Claims Total	Paid Indemnity Claims Pctg. Ever Denied [3]	Pctg. of Denied Filed Indemnity Claims Ever Paid
1984	43,400	7.8%	40,100	3.7%	43.8%
1991	47,200	14.2	42,000	8.8	55.4
1998	38,100	16.1	32,700	8.1	43.3
1999	39,300	14.9	34,000	7.9	46.0
2000	39,800	14.3	34,600	7.1	43.1

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

Denials

Denials of primary liability are of interest because they frequently generate disputes. Denial rates have been stable for the last decade.

- The denial rate among filed indemnity claims has been between 14 and 16 percent since 1991.
- The denial rate among paid indemnity claims has been near 8 percent since 1991, although the 2000 rate is slightly down from 1991.
- Denial rates rose steeply in the late 1980s.
- Among filed indemnity claims that were denied, the proportion ever paid has ranged from 41 percent to 55 percent, with the highest rates occurring in the early 1990s.

Dispute Resolution Proceedings

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

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

Figure 5.4 Dispute Resolution Activities, Fiscal Year 2001 [1]

DLI Customer Assistance	
Resolutions of potential disputes [2]	10,400
Noncertifications [3]	885
Mediation awards	336
Administrative conference orders and agreements	615
Nonconference decision-and-orders	26
Office of Administrative Hearings	
Settlement conferences	3,250
Administrative conferences	1,930
Hearings	750
Workers' Compensation Court of Appeals	
Hearings	200

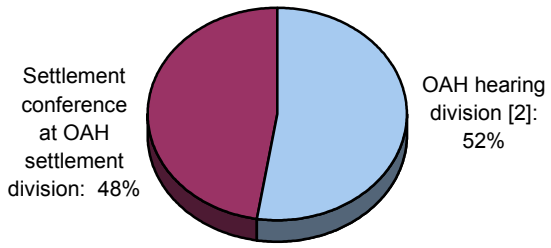
1. Data from DLI, OAH, and the Workers' Compensation Court of Appeals.
2. Potential disputes are cases in which a party to a dispute contacts CA before approaching an attorney.
3. These are cases in which CA determined a medical or rehabilitation dispute to be "not certified" after it intervened and resolved the dispute or determined that there was no dispute.

Resolution of Claim Petition Disputes

Roughly equal numbers of claim petition disputes are resolved at settlement conferences and formal hearings.

- Slightly under half of claim petition disputes filed during 1996-1998 were resolved through settlement conferences in the OAH settlement division; the remainder were resolved in the hearing division—usually through hearings but sometimes through settlement conferences.
- Of claim petition disputes filed during 1996-1998, OAH *initially* referred more than 85 percent to a settlement conference; those not resolved in that venue went to hearings.

Figure 5.5 Resolution of Claim Petition Disputes: Venue of Last Proceeding for Disputes Filed 1996-1998 [1]



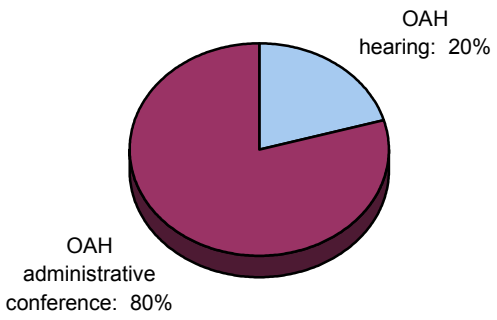
1. Data from DLI. Appeals of hearing decisions are not included. The 1996-1998 period is used to allow the data to be sufficiently mature.
2. Includes primarily hearings but also some settlement conferences.

Resolution of Discontinuance Disputes

About 80 percent of discontinuance disputes are resolved in administrative conferences and the remainder at formal hearings.

- The initial venue for discontinuance disputes is determined by the types of dispute documents filed by the employee and insurer.
- Some cases resolved at hearings are on appeal from an administrative conference decision.

Figure 5.6 Resolution of Discontinuance Disputes: Last Proceeding for Disputes Filed 1997-1999 [1]



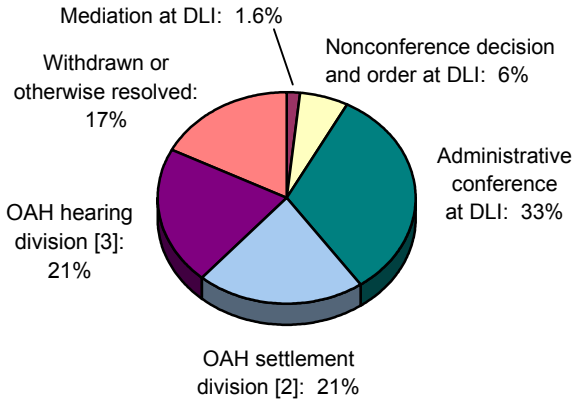
1. Data from DLI. Appeals of hearing decisions are not included. The 1997-1999 period is used to allow the data to be sufficiently mature.

Resolution of Medical Disputes

About a third of medical disputes are resolved in administrative conferences at DLI. Substantial proportions of medical disputes are also resolved in administrative conferences, settlement conferences, and formal hearings at OAH.[10]

- All venues but mediation include some cases previously dealt with but not resolved in other venues.
- The last five years have seen a large increase in the use of administrative conferences to resolve medical disputes, with a corresponding decrease in nonconference decision-and-orders. This is at least partly due to changing preferences of the disputants.

Figure 5.7 Resolution of Medical Disputes: Final Venue for Disputes Filed 1997-1999 [1]



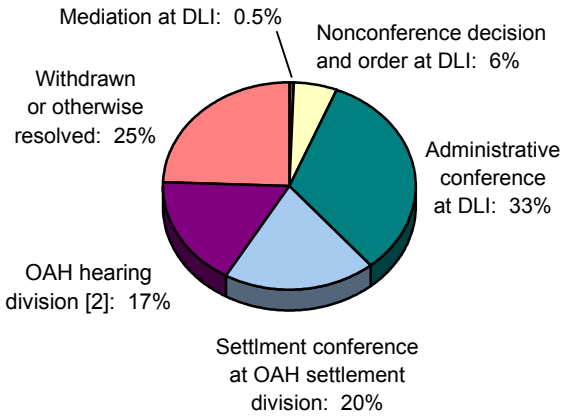
1. Data from DLI. Limited to disputes filed on *Medical Request* form. Appeals of hearing decisions are not included. The 1997-1999 period is used to allow the data to be sufficiently mature.
2. Includes settlement conferences and administrative conferences.
3. Includes hearings and settlement conferences.

Resolution of Rehabilitation Disputes

As with medical disputes, about a third of rehabilitation disputes are resolved in administrative conferences at DLI, with substantial proportions of cases also resolved in settlement conferences or formal hearings at OAH.[11]

- All venues but mediation include some cases previously dealt with in other venues.
- As with medical disputes, the last five years have seen a large increase in the use of administrative conferences to resolve rehabilitation disputes, with a corresponding decrease in nonconference decision-and-orders—at least partly reflecting changing preferences of the disputants.

Figure 5.8 Resolution of Rehabilitation Disputes: Final Venue for Disputes Filed 1997-1999 [1]



1. Data from DLI. Limited to disputes filed on *Rehabilitation Request* form. Appeals of hearing decisions are not included. The 1997-1999 period is used to allow the data to be sufficiently mature.
2. Includes hearings and settlement conferences.

[10] Administrative conferences on medical disputes are held either at DLI, if the disputed amount is $1,500 or less, or at OAH, if the disputed amount is more than $1,500.

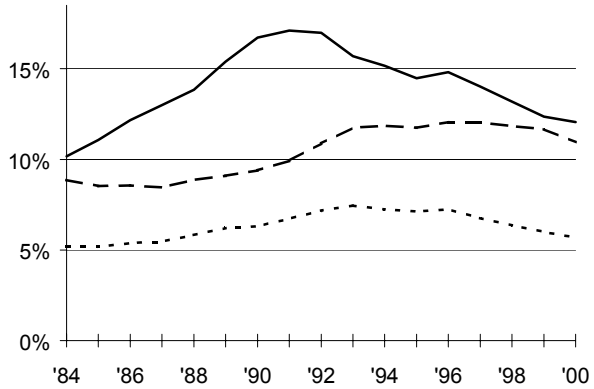
[11] In contrast with medical disputes, all administrative conferences on rehabilitation disputes take place at DLI.

Claimant Attorney Involvement

Claimant attorney involvement decreased steadily during the 1990s after a large increase in the 1980s.

- Between injury years 1991 and 2000, the percentage of paid indemnity claims with claimant attorney fees dropped from 17 percent to 12 percent.
- Among paid indemnity claims with claimant attorney fees, these fees represented about 12 percent of indemnity benefits for injury years 1993-1999, with a slight decrease in 2000.
- Among all paid indemnity claims, claimant attorney fees fell steadily from 7.5 percent of indemnity benefits in 1996 to 5.7 percent for 2000.
- Total claimant attorney fees are estimated at $21 million for injury year 2000. This is roughly 2 percent of total workers' compensation system cost.

Figure 5.9 Claimant Attorney Fees, Injury Years 1984-2000 [1]



Injury Year	Pctg. of Paid Indemnity Claims with Claimant Attorney Fees	Claimant Attorney Fees as Pctg. of Indemnity Benefits	
		Among Paid Indemnity Claims with Claimant Attorney Fees	Among All Paid Indemnity Claims
1984	10.2%	8.9%	5.2%
1991	17.1	9.9	6.7
1993	15.7	11.7	7.5
1996	14.8	12.1	7.2
1999	12.3	11.7	6.0
2000	12.1	10.9	5.7

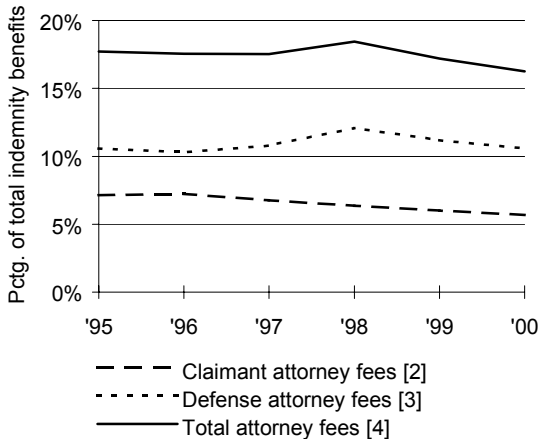
1. Developed statistics from DLI data (see Appendix C).

Claimant and Defense Attorney Costs

During the last three years, defense attorney fees exceeded claimant attorney fees by more than 80 percent. As a percentage of indemnity benefits, total attorney fees in 2000 were at their lowest level since 1995.

- Total attorney fees were about 16 percent of indemnity benefits in 2000; claimant attorney fees were about 6 percent; defense attorney fees, 11 percent.
- Relative to total indemnity benefits, claimant and defense attorney fees fell in 1999 and 2000.
- Compared to 1995, claimant attorney fees were down in 2000 while defense attorney fees were about the same.
- For 2000, total attorney fees were about $66 million, or about 6 percent of estimated total workers' compensation system cost.

Figure 5.10 Attorney Fees as Percentage of Total Indemnity Benefits, Injury Years 1995-2000 [1]



Year	Claimant Attorney Fees [2]	Defense Attorney Fees [3]	Total Attorney Fees [4]
1995	7.1%	10.6%	17.7%
1998	6.4	12.1	18.4
1999	6.0	11.2	17.2
2000	5.7	10.6	16.3

1. Data from DLI.
2. From Figure 5.10. Numerator and denominator are developed statistics on an injury-year basis.
3. Numerator and denominator are on a payment-year basis (see Appendix C).
4. Sum of first two columns.

Appendix A

Glossary

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

Administrative conference. An expedited, informal proceeding where parties present and discuss viewpoints in a dispute. If agreement is not achieved, a "decision and order" is issued which is binding unless appealed. Currently, the Customer Assistance Unit of the Department of Labor and Industry conducts administrative conferences on medical issues involving$1,500 or less and on vocational rehabilitation issues, and the Office of Administrative Hearings conducts conferences on medical issues involving more than $1,500 and on discontinuance disputes presented on a *Request for Administrative Conference.*

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

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

Cost-of-living adjustment. An annual adjustment of temporary total disability, temporary partial disability, permanent total disability, and dependents' benefits computed from the annual change in the statewide average weekly wage (SAWW). The percent adjustment is equal to the proportion by which the SAWW in effect at the time of the adjustment differs from the SAWW in effect one year earlier, not to exceed a statutory limit. The timing of the first adjustment and the annual percent limit have changed over time, as described in Appendix B.

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

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

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

Development. The change over time in the reported number or cost of claims for a particular accident year, policy year, or injury

year. Claim costs develop whether the costs are paid or incurred. The reported figures develop both because of the time necessary for claims to mature and, in the case of Department of Labor and Industry data, because of reporting lags.

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

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

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

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

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

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

Medical cost. The cost of medical services and supplies provided to the injured or ill worker, including payments to providers and certain reimbursements to the worker. All reasonable and necessary medical costs related to the injury or illness are covered, subject to a maximum-fee schedule.

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

Medical Request. A form by which a party to a medical dispute requests assistance from the Department of Labor and Industry (DLI) in resolving the dispute. The request may lead to mediation or other efforts toward informal resolution by DLI Customer Assistance (CA), or to an administrative conference. The conference is held by CA if the disputed amount is $1,500 or less; otherwise it is held by the Office of Administrative Hearings.

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

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

Minnesota Workers' Compensation Insurers Association (MWCIA). Minnesota's workers' compensation data service organization (DSO). State law specifies the duties of the DSO and the Department of Commerce designates the entity

to be the DSO. Among other activities, the MWCIA collects data on claims, premium, and losses from insurers and annually produces pure premium rates.

Nonconference decision and order. A decision issued by the Customer Assistance Unit of the Department of Labor and Industry, without an administrative conference, on a dispute for which it has administrative conference authority (see "administrative conference"), when it has sufficient information without conducting a conference. The decision is binding unless appealed or overturned by review at the Office of Administrative Hearings.

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

Objection to Discontinuance. A form by which the injured worker requests a formal hearing to contest a proposed discontinuance of temporary total or temporary partial disability benefits. The hearing is at the Office of Administrative Hearings.

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

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

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

Petition to discontinue benefits. A document by which the insurer requests a formal hearing to allow a discontinuance of temporary total or temporary partial disability benefits. The hearing is at the Office of Administrative Hearings.

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

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

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

Pure premium. A measure of expected losses, equal to the sum, over all insurance classes, of payroll times the applicable pure premium rate(s) (the rate(s) for the insurance class(es) concerned), adjusted for individual employers' prior loss experience. It is different from (and somewhat lower than) the actual premium charged to employers because actual premium includes other insurance company costs plus taxes and assessments.

Rehabilitation Request. A form by which a party to a vocational rehabilitation dispute requests assistance from the Department of Labor and Industry (DLI) in resolving the dispute. The request may lead to mediation or other efforts toward informal resolution by DLI Customer Assistance, or to an administrative conference.

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

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

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

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

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

Statewide average weekly wage (SAWW). The average wage used by insurers and the Department of Labor and Industry (DLI) to adjust certain workers' compensation benefits

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

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

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

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

Temporary total disability (TTD). A wage-replacement benefit paid if the worker is unable to work because of a work-related injury or illness. (The benefit is not payable for the first three calendar days of total or partial disability unless the disability lasts, continuously or intermittently, for at least ten days.) The benefit is equal to two thirds of the worker's gross pre-injury wage, subject to minimum and maximum weekly amounts, and is paid at the same intervals as wages were paid before the injury. Currently, TTD stops if (1) the employee returns to work, (2) the employee withdraws from the labor market, (3) the employee fails to diligently search for work within his or her physical restrictions, (4) the employee is released to work without physical restrictions from the injury, (5) the employee refuses an appropriate offer of employment, (6) 90 days have passed after the employee has reached maximum medical improvement or completed an approved retraining plan, (7) the employee fails to cooperate with an approved vocational rehabilitation plan or with certain procedures in the development of such a plan, or (8) 104 weeks of TTD have been paid (with an exception for approved retraining). Minimum and maximum weekly benefit provisions are described in Appendix B. Cost-of-living adjustments are described in this appendix and Appendix B.

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

Vocational rehabilitation plan. A plan for vocational rehabilitation services developed by a qualified rehabilitation consultant (QRC) in consultation with the employee and the

employer and/or insurer. The plan is developed after the QRC determines the injured worker to be eligible for rehabilitation services, and is filed with the Department of Labor and Industry and provided to the affected parties. The plan indicates the vocational goal, the services necessary to achieve the goal, and their expected duration and cost.

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

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

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

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

Appendix B

Workers' Compensation Law Changes of 1992, 1995, and 2000

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

1992 Law Change

Indemnity Benefits

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

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

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

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

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

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

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

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

The old schedule had assigned ratings primarily on the basis of diagnoses and surgeries performed. The new schedule relies less on these factors and more on objective findings of functional impairment and clinical test results. Thus, some cases that would have received a positive rating under the old schedule because of a diagnosis or surgery do not receive such a rating under the new schedule if the condition has completely resolved with no remaining functional impairment. The new schedule contains more zero-rated categories than the old schedule, but also some positively rated categories for impairments not in the old one.

Medical Services and Fees

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

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

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

Other Provisions

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

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

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

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

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

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

Attorney fees. Effective for fee determinations on or after July 1, 1992, all claimant attorney fees related to the same claim became cumulative (with some exceptions) and were limited to 25 percent of the first $4,000 and 20 percent of the next $60,000 of disputed benefits awarded, not to exceed $13,000 except by

petition. Previously, claimant attorney fees were limited to 25 percent of the first $4,000 and 20 percent of the next $27,500 of disputed benefits awarded, not to exceed $6,500 except by petition. The 1992 law change also introduced a limit on defense attorney costs of $13,000 per claim, with exceptions by petition.

Mandated 16 percent rate reduction. The law prohibited insurers from increasing their filed rates from April 1 through Oct. 1, 1992, mandated a 16 percent filed rate reduction effective Oct. 1, 1992, and prohibited filed rate increases from that date until April 1, 1993, at which time insurers were again free to file rate increases.

1995 Law Change

Indemnity benefits

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

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

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

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

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

Supplementary benefits and PTD minimum benefit. Supplementary benefits, available only to PTD beneficiaries after the 1992 law change, were repealed, and the PTD minimum weekly benefit was raised to 65 percent of the SAWW. In contrast with supplementary benefits, the new minimum (1) is available to all PTD beneficiaries regardless of the amount of time since the first day of total disability, and (2) is subject to the offset provision along with the remainder of the PTD benefit.[12] Under the offset provision, after $25,000 of PTD benefits have been paid, the weekly PTD benefit is reduced by the amount of any other government disability benefits for the same disability and by the amount of any social security retirement or survivor benefits.

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

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

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

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

Other Provisions

Attorney fees. The provisions allowing claimant and defense attorney costs to be paid above the statutory limits by petition were removed. In 1999, the Minnesota Supreme Court ruled that the claimant attorney fee limits were unconstitutional because with the removal of the exception provision, they were absolute and thus infringed on the authority of the judicial branch to oversee attorneys.[13] In 2000, the Workers' Compensation Court of Appeals applied this ruling to defense attorney fees.[14]

2000 Law Change

Indemnity benefits

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

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

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

PPD benefits. Benefit amounts were raised for all impairment ratings above 5 percent. In addition, the PPD award may be paid as a lump sum, computed with a discount rate not to exceed five percent. Previously, PPD benefits were only payable in installments at the same interval and amount as the employee's TTD benefits.

Other Provisions

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

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

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

Appendix C

Data Sources and Estimation Procedures

This appendix describes data sources and estimation procedures for those figures where additional detail is needed. Two general procedures are used throughout the report — (1) "development" of statistics to incorporate the effects of claim maturation beyond the most current data and (2) adjustment of benefit and cost data for wage growth to achieve comparability over time. After a description of these procedures, additional detail for individual figures is provided. See Appendix A for definitions of terms.

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

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

Research and Statistics has adapted this technique to DLI data. It tabulates statistics at regular intervals from the DLI database, computes development factors representing historical development for given injury years, and then derives developed statistics by applying the development factors to the most recent tabulated statistics. In this manner, the annual numbers in any given time series are developed to a constant maturity, e.g. a 17-year maturity for the claim and cost statistics in Chapters 2 and 3 since the DLI database extends back to injury year 1983 for claim and cost data. An example: In Figure 2.1, the developed number of indemnity claims for injury year 2000 is 34,600 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2001, 31,409, times the appropriate development factor, 1.1007.

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

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

SAWW for that year, using the SAWW reflecting wages paid during the respective year. Thus, the numbers for all years represent costs expressed in 2000 wage dollars.

Figure 2.1. The developed number of paid indemnity claims for each year is calculated from the DLI database. The annual number of medical-only claims is estimated by applying the ratio of medical-only to indemnity claims for insured employers to the total number of indemnity claims. (The ratio is unavailable for self-insured employers.) The MWCIA, through special tabulations, provides this ratio by injury year for compatibility with the injury year indemnity claims numbers. The ratio of medical-only to indemnity claims was not yet available for 2000, and so the medical-only and total paid claims numbers could not be estimated for that year.

The number of full-time-equivalent (FTE) workers covered by workers' compensation is estimated as total nonfederal Unemployment Insurance (UI) covered employment from the Department of Economic Security (DES) times average annual hours per employee (from the annual survey of occupational injuries and illnesses, conducted jointly by the U.S. Bureau of Labor Statistics and state labor departments) divided by 2,000 (annual hours per full-time worker). Nonfederal UI-covered employment is used because there are no data on workers' compensation-covered employment.

Figure 2.2. For insured employers, total cost is computed as written premium adjusted for deductible credits, minus paid policy dividends. Written premium and paid dividends for the voluntary market are obtained from the Department of Commerce. Written premium for the Assigned Risk Plan (ARP) is obtained from the Park Glen National Insurance Company, the Plan Administrator. (There are no policy dividends in the ARP.)

Written premium is adjusted upward by the amount of premium credits granted with respect to policy deductibles, in order to reflect that portion of cost for insured employers that falls below deductible limits. Premium credit data through policy year (PY) 1999 is from the MWCIA. The 2000 figure is estimated using the ratio of premium credits to written premium for 1999 (applying this to the 2000 premium figure). When the actual amount becomes available for 2000, that year's total cost figure will be revised.

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

Total workers' compensation covered payroll is computed as the sum of insured payroll, from the MWCIA (annual *Ratemaking Reports* through PY 1998, unpublished data for PY 1999), and self-insured payroll, from the WCRA. Insured payroll was not yet available for 2000, and self-insured payroll is not available for 1980-1989. These figures were estimated by extrapolating from actual figures using the trend in nonfederal UI-covered payroll (from DES) and the trend in the relative insured and self-insured shares of total pure premium (from the WCRA).

Figure 2.3. Paid indemnity claims are from the DLI database. The percentages are taken from undeveloped claim counts. Using undeveloped rather than developed claim counts has little effect on the percentages, because the number of indemnity claims develops at nearly the same rate for the different insurance arrangements.

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

Paid losses are developed to a uniform maturity of eight years (an "eighth-report basis") using

the selected development factors in the 2002 *Ratemaking Report,* and then converted to an incurred basis using the selected ratios of paid to incurred losses at eighth report, from the *Ratemaking Reports* of different years. The resulting figures thus represent incurred losses at eighth report.

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

Figure 2.7. The "insurance data" in this figure are from Figure 2.5. For the "DLI data," developed DLI indemnity cost data are combined with the same payroll data used with total system cost (Figure 2.2), described above. This payroll figure includes self-insured employers and the ARP along with the voluntary market for compatibility with the DLI indemnity cost data.

Figures 2.8 and 3.1. Figures 2.8 and 3.1 use claim and loss data from the MWCIA's *2002 Minnesota Ratemaking Report.* These data come from insurance company reports on policy experience (claims and losses) for the voluntary market and the ARP. Data are developed to a fifth-report basis using the development factors in the *Ratemaking Report,* and then adjusted for wage growth.

Figure 3.1 presents data by claim type. For permanent total disability (PTD) and death cases, the number of claims and their average cost (at any given maturity) fluctuate widely from one policy year to the next because of small numbers of cases. Therefore, in order to produce more meaningful comparisons among claim types, the data on PTD and death claims were averaged over policy years 1990-1996. 1997 and 1998 were excluded in order to avoid the relatively large variability in development for these claim types between first and third report.

Figure 4.1. The data in this figure are by injury year, and consequently develop over time. However, DLI has not yet produced developed versions of these statistics.[15] The numerator and denominator in the percentages in this figure are the number of claims with plans filed to date and the number of paid indemnity claims identified to date, respectively. For more recent injury years, both numerator and denominator are progressively less mature so that the errors tend to offset each other in the overall percentage. However, the more recent injury years must still be regarded as preliminary.

Figure 5.1. As indicated in this figure, the 2000 data are not presented because they are not yet sufficiently reliable. This determination was made by examining the stability of developed statistics for injury years prior to 2000. If a developed statistic for a given injury year changes only slightly from one tabulation (and projection) to the next, this stability indicates that developed statistics for recent injury years are sufficiently reliable to be used. There was not enough stability in the developed dispute incidence rates to deem the 2000 numbers reliable enough for publication.

Figure 5.10. Insurers submit an annual report to DLI indicating total defense attorney costs paid during the year. For the percentage in the figure, these costs are compared to total indemnity benefits paid during the year, compiled by DLI primarily from insurer reports to the SCF.

[15] Doing so may be difficult, in that recent declines in the time from injury to start of services (Figure 4.3) suggest that historical rates of development in the percentage of claims with vocational rehabilitation plans may not well predict future development for recent claims.