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DEPARTMENT OF COMMERCE

500 Metro Square Building
St. Paul, Minnesota 55101

September 25, 1981

To : Citizens interested in the Workers' Compensation Project

From: Michael D. Markman, Commissioner of Insurance MM

Re : Progress of the Workers' Compensation Project

Enclosed are preliminary drafts of the first three sections of the analysis of Minnesota Workers' Compensation being conducted by the Minnesota Department of Commerce, Insurance Division. Included are: 1) General Overview, 2) Problem Definition, and 3) A Process Description.

The overview provides a review and brief discussion of the basics of workers' compensation insurance. This section includes a discussion of the historical perspective and the theoretical approaches to workers' compensation. These are important both for evaluating the current system and for the consideration of policy alternatives.

The second section discusses and defines why workers' compensation is a problem in Minnesota. The section presents data on costs and other factors which are symptomatic of the Minnesota workers' compensation issue. Minnesota is also compared with other states, so that Minnesota's concerns about workers' compensation may be seen in the context of a country-wide problem.

The third section describes the process for handling claims in Minnesota from injury to final disposition. The discussion only includes activities directly related to claims management and does not include other aspects of the system, such as rate-making. The process is discussed from the perspective of each major participant in the process. Then critical points in the claims process are identified and analyzed for their impact on both participants' behavior and system cost.

These preliminary drafts are not meant to be final policy recommendations or decisions by the Insurance Division. Your comments, criticisms and suggestions are invited so that they may be considered for subsequent drafts of the report. We would like written comments within two weeks. Thank you for your interest and assistance in the Workers' Compensation Project.

AN EQUAL OPPORTUNITY EMPLOYER

CHAPTER 1
OVERVIEW

I. INTRODUCTION

Workers' compensation laws define the rights of employees and the responsibilities of employers when an employee is affected by a work-related injury. These laws establish the structure and level of compensation benefits to be paid to the injured worker and require employers to provide workers' compensation benefits for their employees. Employers must either pay insurance premiums or pay benefits directly, if given approval by the state to self-insure. Workers' compensation laws are in effect in all 50 states and the District of Columbia. In addition, there are two federal laws, the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act which establish coverage for certain classes of workers. Provisions vary from state to state, however, for the coverage of employees and work-related injuries, the amount of benefits paid, insurance requirements, and administrative procedures.

In 1979, there were approximately 120,700 cases of work-related injury or illness reported in the state of Minnesota[1]. Work-related injury and illness can result in

significant economic loss for both workers and their employers. The workers suffer bodily injury, possibly permanent disability and loss of income. If an injury results in death, the worker is often survived by a spouse and dependent children who face the permanent loss of all wages earned by the employee, in addition to expenses such as burial costs, probate and lawyers' fees. Of the work-related injuries which occurred in 1979, 57,873 were reported to the Minnesota Department of Labor and Industry as claims for coverage under the state workers' compensation statute[1]. A total of $317,197,000 in workers' compensation benefits were incurred in 1979 to cover medical expenses and alleviate the economic loss due to these work-related injuries. This figure was almost $350 million in 1980.[2]

II. HISTORICAL PERSPECTIVE

Prior to the passage of workers' compensation laws in the early to mid-1900's, employees assumed the risk of injury and disability almost exclusively. Before 1910, almost all states had laws determining employer responsibility which dated back to the pre-industrial period in England and the United States. The only recourse for injured employees was through the courts under common law rules of liability. Under common law, the court attempts to determine who is at fault. If the employer practiced reasonable safety and provided a "safe environment", the

employer could not be held liabile.

Employers were provided additional protections under three common law defenses:

1. Contributory negligence-if the employee's own negligence in any way contributed to the injury, the employee cound not file damages.

2. Common employment or fellow servant doctrine-if the injury occurred due to the negligence of another employee, the employee could not collect damages.

3. Assumption of risk doctrine-when an employee takes a job, he/she enters into an implied contract in which the employee assumes certain risks, which are reflected in the pay for that job. If the injury was due to the ordinary hazards of this job, the employee could not collect damages.[3]

The burden of proof under the common law was placed almost exclusively on the employee, who often experienced long delays and incurred high costs in order to receive compensation, which was often inadequate.

With the unprecedented economic and industrial activity of the late 1800's and early 1900's came increased incidence

of job-related disability and death. There was increasing pressure to remove some of the limitations on the employee's right to recover damages. Employer liability statutes were passed in the early 1900's which modified the common law defenses. The burden remained with the worker, however, to prove liability. Liability could only be proven through litigation. Thus, the application of the law and the amount of recovery were still uncertain. Employers also had to pay high legal fees in addition to paying claims.

Continuing dissatisfaction with this system of employers' liability led to alternative concepts of compensating workers for job-related injuries. More and more responsiblity was delegated to the employer, for whom benefit payments for occupational injury and disease were seen as a cost of doing business. Modern workers' compensation represented a fundamental compromise or trade-off between employers and employees. Each gained and lost something with the replacement of employers' liability laws with workers' compensation. Injured employees were to receive prompt and certain benefits, assisted in maintaining their standard of living, and provided an incentive to return to work. Employers were made responsible for all occupational injuries regardless of fault, but their liability would be limited to medical care and loss of wages. In exchange for these certain benefits, workers' compensation became the exclusive remedy for employees and

injured employees lost the right to seek higher liability awards than the compensation benefits provided.

III. THE BASICS OF WORKERS' COMPENSATION

The characteristics defining the scope of workers' compensation are:

1. Benefits to injured workers.
2. Covered employment.
3. Covered injuries and diseases.

These general characteristics are summarized below. Specific discussion of the characteristics of the Minnesota system will occur in later sections of this report.

A. BENEFITS

Generally, workers' compensation insurance provides three types of benefits: income replacement, medical benefits, and rehabilitation benefits. Income replacement benefits are usually based upon a percentage of the injured employee's weekly wage. Although the percentage varies from state to state, it is most commonly set at 66 2/3 percent of gross earnings. In addition, states often set maximum benefit amounts both for the time period that will be covered and dollars.

Virtually all workers' compensation laws establish four types of income replacement benefits, including three types of disability benefits plus death benefits. Most workers' compensation cases involve workers who are unable to work while recovering from an injury, but are expected to fully recover. These workers receive temporary total disability benefits. While most states provide benefits for the duration of the disability, a few states limit the number of weeks or total dollar amount of payment.

Benefits for permanent total disability are paid when the injury is determined to be permanent and total and the employee is not expected to return to regular employment in any segment of the job market. The wage replacement benefit is usually similar to temporary total disability and most jurisdictions allow permanent disability benefits for life.

Payment for a permanent injury which is less than totally disabling, a permanent partial disability, is somewhat more complex. Permanent partial injuries are usually divided into two further types: scheduled and non-scheduled.

Scheduled injuries generally refer to the loss or loss of use of an extremity, eyesight, or hearing. The compensation schedule gives the number of weeks of compensation payable for each specific injury. There is great variation between state laws in the number of weeks of compensation provided for any particular injury.

The purpose of death benefits is to provide income replacement for families and other dependents. The amount of benefits and length of time they will be paid vary considerably from state to state. Some states provide benefits for life or until remarriage for a spouse, and for dependent children until they are 18, while others limit the time period during which benefits are payable and/or the total amount of benefits.

Every state law requires the employer to provide medical and hospitalization benefits to the injured worker, usually without any limits. Virtually all workers' compensation cases receive medical benefits. In recent years there has been increasing emphasis on the complete restoration of injured workers so they may return to productive employment. Prompt and quality medical care and medical and vocational rehabilitation are particularly important to the accomplishment of the

goals of the workers' compensation system.

Rehabilitation benefits are included in 47 jurisdictions and the two federal acts. These benefits include training, education, and testing to assist the employee in returning to work. Rehabilitaion is also available through the provisions of the Federal Vocational Rehabilitation Act, which requires rehabilitation programs in every state and Washington D.C.[4]

All states require private sector employers and most public employers to demonstrate they are able to pay benefits under the workers' compensation laws. Employers may meet their requirement to provide workers' compensation payments through insurance carriers, or they may self-insure. Self-insurers must demonstrate a sound financial position and may be required to make deposits with a state agency to assure that claims can be paid. State insurance may be either competitive or monopolistic, depending upon whether insurance may be purchased from sources other than the state.

B. Covered Employment

Most state workers' compensation laws cover private and public employment, but none cover all employees. Coverage under the laws may be compulsory or elective for the employer. However, if coverage is elective and an employer chooses not to cover, the common law liability remains with that employer in the case of a claim. Fifty-one of the 54 workers' compensation laws in the United States are compulsory for most employers; only three are still elective.[5]

There continue to be gaps in workers' compensation coverage for certain employees. Five states still only cover "hazardous" employment and one quarter of the states exempt employers having fewer than a specified number of employees.[6] The most commonly exempted employees are agricultural, domestic and casual employments. Others exempted include employees of charitable or religious institutions. Because of differences in state law, the percentage of employees covered by workers' compensation varies from state to state, but current state and federal programs presently cover about 88% of workers in the United States.[7] Expanded coverage of employment has occurred in

recent years. More laws have been made compulsory, numerical limitations have been eliminated, and protection has been granted to previously exempted groups.

C. Covered Injuries and Diseases

To be eligible for workers' compensation benefits in most jurisdictions, an employee must have suffered a personal injury as a result of an accident "arising out of and in the course of employment". This key phrase is the standard by which most laws determine compensability for illnesses and injuries. This requirement is open to interpretation, however, and there has been continuing broadening of the "arising out of and in the course of" requirements. There are no hard and fast rules and the requirement tends to be liberally construed in favor of the claimant.

Generally, injury refers to any physical bodily injury and includes disease as well as mental illnes. The accidental requirement suggests that the event must be unanticipated, sudden and refer to some definite moment in time. But there has been increasing sentiment that usual exertion or gradual strain leading to a problem should also

qualify for compensation. Thus a back injury or heart attack may be covered when it is the result of excessive strain in performing the work. Minnesota has completely removed the reference to accident from the statutory definition of personal injury.

Early statutes did not cover work-related disease but only work-related accidental personal injury. Although all states now extend coverage to work-related disease, there are often more restrictions than with other covered injuries. Occupational diseases were first included in workers' compensation laws only for specifically listed diseases. The number of diseases covered gradually was extended until any or all work-related diseases were covered. Usually, however, there are exposure rules and restrictive definitions which are not applied to other kinds of injuries. Some states have lower indemnity coverage for disability from disease and in a few states there is no indemnity coverage at all.

Recent changes in interpretation of workers' compensation laws affirm the coverage of psychological injuries.[8] Employees may be compensated for mental and emotional conditions

resulting from a physical injury arising out of and in the course of employment. Nor is it necessary to show physical cause for an injury to be compensated. Although the strain should be greater than one experiences in everyday life, the courts have affirmed awards for the physical results (such as heart attacks) of occupational stress. Compensation has also been recently awarded for mental disability resulting from mental or emotional stress related to work.[9]

In summary, workers' compensation benefits are paid for wages lost due to work-related injury; for any permanent, disabling injury; for the support of dependent spouses and children in case of death; and for all medical care, including medical and vocational rehabilitation. Although some employment groups are still exempt from coverage under workers' compensation, most employees are now covered by the statutes and there is a trend toward universal coverage. The standard for determining work-relatedness has been broadly interpreted and the scope of coverage for injury and disease has been expanded to include both the physical and mental results of work-related injuries and stress.

IV. OBJECTIVES OF WORKERS' COMPENSATION

Regardless of the approach used to design a policy for workers' compensation benefits, most workers' compensation laws are designed to accomplish certain objectives: broad coverage of employment and injuries, income replacement, medical care and rehabilitation, and improved safety incentives. It is expected that these objectives would be met in an effective and cost efficient manner.

The National Commission on State Workmen's Compensation Laws presented five objectives for a modern workers' compensation program in its 1972 report. The report listed four basic objectives and a fifth supporting objective. The four basic objectives are:

1. Broad coverage of employees and work-related injuries and diseases.

   Coverage should be extended to as many employees as possible and to all work-related injuries and disease. Although coverage has broadened over the years, there are still exempted employees, especially in farming, casual and domestic employment. Coverage of disease and injuries has been extended both in terms of type of injuries covered and more liberal interpretation of work relatedness. Requirements may still be more restrictive

for occupational disease.

2. Substantial protection against interruption of income.

Workers compensation benefits should replace a high proportion of the injured workers' lost wages. Income replacement should be high enough to prevent the worker from experiencing significant loss, but low enough to encourage the worker to return to work. A 66 2/3 replacement of gross wages is generally accepted as an adequate level of benefits, and this standard has been used by an increasing number of states.

3. Provision of sufficient medical care and rehabilitation services.

Unlimited quality medical care and medical and vocational rehabilitation should be provided to return the worker to his/her former earning capacity. Most states provide medical care without limits and increasing emphasis has been placed on early rehabilitation.

4. Encouragement of Safety

Economic incentives in the workers' compensation system should reduce the number of work-related accidents and

injuries. Good safety practices should be rewarded by lower pricing, while more dangerous operations would be penalized by higher prices. Employees should be encouraged to develop safe work practices by sharing in the losses due to work-related injury and should have strong incentives for returning to work. Although increased safety was an important objective when workers' compensation laws were first written, some have questioned the effectiveness of pricing and employee incentives as means for reducing work-related accidents and injuries. Insurance companies appear to be taking a more active role in working with employers to increase safety practices and reduce accidents and injuries.

The fifth major objective of workers' compensation discussed by the National Commission was considered to be necessary for the achievement of the preceding four objectives:

5. An effective system for delivery of the benefits and services.

The agency responsible for the administration of workers' compensation should meet the four basic objectives in a comprehensive and efficient manner. The administration of workers' compensation requires substantial costs involving employers, insurance

carriers, workers, attorneys, and governmental agencies. These costs must be weighed against the benefits received by the injured worker and the other objectives of workers' compensation. Prompt, active, and objective enforcement of the law is key to the efficient operation of the system.

Most, if not all, state workers' compensation laws have been intended to meet these five fundamental objectives. There may be considerable variation, however, in the benefit structure and levels of workers compensation systems which meet these basic objectives. That is, while these objectives may define workers' compensation at a general level, there are still decisions to be made concerning the underlying purpose of workers' compensation benefits. Coverage of employment, injuries and disease, and the structure and level of benefits are especially dependent on these decisions about the purpose of workers' compensation. Workers' compensation coverage of employment and work-related injury and disease will be discussed in more detail later in this report. The following two sections discuss theories and evaluation of workers' compensation benefits.

V. THEORIES OF WORKERS' COMPENSATION

Workers' compensation laws may provide benefits for

various consequences of a work-related injury or disease. First, they may provide compensation for impairment, which is defined as "any anatomic or functional abnormality or loss after maximum medical rehabilitation has been achieved". (AMA Guide, 1971, p.iii). Loss of a limb or a broken bone are examples of an impairment. An impairment may result in a functional limitation such as limited ability to walk, stoop, or lift heavy objects. Functional limitation may, in turn, cause a person to have a disability, an inability or limitation in performing social rolls or activities in relation to work, family, or other social roles. Only those disabilities which result in loss of earning capacity or actual loss of earnings are defined as work disabilities.

An injured worker who suffers an impairment may not experience functional limitations. An injured worker with functional limitations will not necessarily have a disability. And an injured worker with a disability does not necessarily experience a work disability. The possible consequences of a work related injury, therefore, include impairments, functional limitations and work and nonwork disabilities. Policy makers must decide, based on the underlying purpose of workers' compensation, which of these consequences of work-related injury should be compensable.

There are two generally accepted approaches to the payment of workers' compensation benefits. Under the economic or wage-loss theory, an injured worker is compensated for medical expenses, rehabilitation, and either lost earning capacity or for actual lost wages. Compensation payments are based on lost wages or earning capacity regardless of the actual degree of physical impairment or functional limitation. Under this approach, an injured worker is compensated only to the degree that the injury results in a work disability.

A second school of thought holds that an injured worker should be paid for both economic and non-economic loss. Under the so-called "whole-man" theory, an injured worker should be paid not only for loss of earning capacity but also for any impairment, functional limitation, or disability resulting from a work-related injury. Compensation is paid for the degree to which the employee is less than a whole person. A complicating factor in this approach is the fact that impairments may be used as a proxy for the functional limitations and disability which result from the impairment. The degree of impairment may be used as a convenient estimate of the actual work disability. It may be unclear whether the impairment per se is deemed to be compensable.

The theoretical approach or underlying purpose used to explain obligations of a workers' compensation system to the injured worker is important for two reasons. First, the approach gives direction to the development of the system itself, particularly concerning definitions of compensability, type and size of benefits. Without an explicit approach or purpose, implicit decisions are reflected in the statute, regulations and practices of the system. The result is usually conflicting and confusing. Almost all state workers' compensation systems, although based on a wage-loss approach, also provide compensation for impairment and nonwork disabilities.

Second, the underlying purpose provides the basis for defining criteria against which compensation benefits are evaluated. A workers' compensation system designed from a wage-loss approach might be judged totally inadequate from the perspective of those who support payment for impairment. Conversely, those who support payment for work disability only may believe that a compensation system which pays for impairment makes adequate and equitable payments more difficult for those who suffer actual loss of earnings.

VI. EVALUATION OF WORKERS' COMPENSATION BENEFITS

Previous sections have discussed the overall objectives of workers' compensation and the basis on which judgments

are made about which consequence of work-related injury and disease should be covered. Next, judgments must be made about the extent and structure of benefits. The workers' compensation laws of the early 1900's stressed that benefits should be adequate, equitable, prompt, and certain. These still are appropriate criteria for evaluating workers' compensation benefits.

A. Adequacy

Adequacy is concerned with the average replacement of wages for injured workers. The National Commission was clear in its report that workers' compensation should replace a substantial portion of lost income. The report indicated that workers' compensation is a social insurance program, not a welfare program, and benefits should be based on lost income, not economic need. The Commission also reasoned that a substantial portion of income should be replaced because of the basic compromise in workers' compensation, in which workers gave up the right to sue for additional damages. The entire lost wage should not be replaced, however, so that workers will be encouraged to return to their jobs as soon as possible.

The two-thirds replacement ratio which is used in most states is generally considered to be acceptable. In a system which includes payment for impairment regardless of actual wage loss, the adequacy criterion may be more lenient in order to maintain reasonable cost in the system. In such a system it may be more appropriate to establish a lower percent of wage replacement as a test of adequacy.

Measures of adequacy may also take into account other factors, such as personal characteristics of the worker, certain aspects of the benefit structure, and other benefits. These factors might include the effects of waiting periods; retroactive periods; minimum and maximum benefits; the age, education, and earning potential of the worker; the tax structure; and social security payments.

B. Equity

The second criterion for the evaluation of workers' compensation benefits is equity. The National Commission defined equity in its report as "delivering benefits and services fairly as judged by the program's consistency in providing equal

benefits or services to workers in identical circumstances and its rationality in providing benefits and services in proportion to the impairment or disability with different degrees of loss" (p. 137).

The application of this criterion may differ depending on which consequences of work-related injury are covered by the workers' compensation system. The Commission's definition of equity incorporates two dimenisions of equity. First, workers in similar circumstances with equal losses should receive equal benefits (horizontal equity). Second, workers with different losses should receive benefits which are proportional to their losses (vertical equity). In a system which pays only for work disability, equitable treatment requires that workers with equal wage loss receive equal benefits and those with different wage loss should receive benefits proportional to the lost wages. Workers with the same injury may not receive the same proportion of their wages if the injury does not result in an equal work disability.

When compensation is paid for impairment or functional limitations, equity requires equal benefits for the same injury regardless of the resulting work disability or wage loss. Workers with different losses in earning capacity may not

recieve proportional benefits. Thus, equity defined by a compensation system which pays for impairment or functional limitations is inequitable in a system which compensates work disability.

A strict definition of vertical equity requires that workers with different losses should receive strictly proportional benefits. A more general definition, however, only requires that benefits are consistent across different groups of workers. A workers' compensation system may, for example, be structured to pay a higher proportion of losses for injured workers with low wages. This general definition is also consistent with minumum and maximum benefits, since it does not require the relationship between benefits and losses to be linear. The benefits should, nevertheless, consistently increase or decrease as losses increase and the proportion of losses compensated should not be subject to abrupt change.

C. Certainty

Workers' compensation was supported as an approach which would bring certainty to the calculation and payment of benefits to injured workers, in comparison to the common law. Under workers' compensation laws the outcome of a work-related

injury is undeniably more certain than under negligence laws. Uncertainty remains, however, and can result in lengthy and costly litigation. There is still uncertainty about whether an injury or disease arose out of and in the course of employment. The extent of disability, functional limitation, or impairment is still a large and important grey area and a source of much workers' compensation litigation.

D. Promptness

Workers' Compensation benefits should be paid promptly following a work-related injury to minimize the impact of lost wages. The lengthy delays caused by court proceedings under negligence laws were to be eliminated by workers' compensation. Promptness of payment is dependent on waiting periods and statutory definitions of maximum time periods within which payments must begin. Litigation can cause extended delays in the payment of benefits. Administrative procedures are crucial in ensuring prompt payment of workers' compensation benefits, not only by effective and efficient administration of the law, but also through the provision of early and effective service to the injured worker.

VII. SUMMARY

The evaluation of a workers' compensation system is a complex task. Although the fundamental objectives of workers' compenstion may be easily identified, judgments must still be made about which consequences of work-related injury and disease (impairments, functional limitations, work and nonwork disabilities) should be compensated. The level of benefits and the benefit structure must also be analyzed. The criteria for evaluation of benefits and their measurement will depend to some extent on judgments about the purpose of workers' compensation. Then these criteria must be balanced with one another and assessed on the basis of empirical and operational realities. Given the achievement of the fundamental objectives, workers' compensation should be designed to achieve the most efficient system which is adequate, equitable, certain, and prompt. There will necessarily be trade-offs between these criteria.

The analysis is further complicated by historical as well as current inconsistencies. Historically, for example, workers' compensation laws were written from a wage-loss perspective. The laws were written to ensure prompt and certain benefits to injured workers to protect against loss of wages. However, in Minnesota and most other states the

laws were written to provide benefits which were so low they were, in fact, inconsistent with the stated intent to replace lost wages. Current law, which provides substantial payment for impairment in the form of permanent partial awards, is also inconsistent with a wage-loss approach. But the diversion from the original intent to replace lost wages may be explained by the historically inadequate income replacement benefits. One may reasonably conclude that an expensive system has evolved from a system in which benefits were too low. Consequently, it is important to understand both the intent or theoretical approach to workers' compensation and the approach which is reflected in its operation.

Finally, the workers' compensation system must be evaluated in light of cost constraints. Clearly, all the objectives of workers' compensation and the criteria for benefits described above could be easily achieved if cost were irrelevant. Cost restraints require consideration of the distribution of the limited money available for administration of the system and for benefits. Cost considerations stress the importance of efficient administration of the system and complicate evaluation of the benefit structure and levels. Maximum benefit levels are, for example, almost exclusively the result of cost constraints. Cost limitations also place special importance on the purpose or intent of workers' compensation, since it will provide the basis for allocating limited resources

among injured workers.

Although there is no clear statement of intent in the Minnesota Workers' Compensation Statute, it is clear that the present system pays for both wage loss and for impairment. It is clear that choices must be made as to whether Minnesota will continue under this dual approach or whether it will be modified. Through the course of this report, the Minneosta system of workers' compensation will be evaluated for adequacy, equity, promptness, and certainty from each perspective. Policy options and recommendations will be presented. Ultimately, through the political process, decisions must be made in Minnesota about what workers' compensation is, what it is supposed to do and for whom, and how it is to be done. The purpose of this report is to enrich the information context within which those decisions will be made.

CHAPTER 2
INTRODUCTION

Workers' compensation is an issue today because employers in Minnesota are publicly insisting that the costs of the system, as reflected by the premiums they must pay, are excessive and unreasonable. Five to ten years ago, workers' compensation was an issue because representatives of employees were persistent in publicly insisting that the benefits coming from the system were inadequate and unreasonable.

Obviously, workers' compensation costs and benefits are closely related. This relationship, however, is easily neglected during the policy making process when pertinent information may be incomplete, distorted, or even ignored. A consequence of this neglect is the tendency to address only one side of the relationship without fully understanding the potential impact of changes on the other side.

Workers' compensation is made even more problematic with the understanding that cost is not a consequence of benefits alone. Costs are also affected by the systems in place to process claims and deliver benefits to injured workers. The efficiency and integrity of these systems have a major impact on the cost of workers' compensation, and, therefore, must also be addressed, along with benefits and costs, as part of the workers' compensation problem.

The purpose of this section is to present information descriptive of the current state of affairs regarding various aspects of workers' compensation in Minnesota. Although the emphasis throughout this section is on costs, many other factors related to costs are also examined. In the second part of the section, the cost of workers' compensation in Minnesota is compared with other states, currently and during the recent past. Major participants in the workers' compensation policy debate are identified, and their concerns regarding the issue of costs are discussed. In the third part of this section, factors related to the costs of workers' compensation are discussed. These factors are benefits, injuries, and processing systems. The final part of this section includes a discussion of how the information presented here will define the remaining tasks of this report.

WORKERS' COMPENSATION COSTS IN MINNESOTA

Introduction

In 1980, Minnesota employers paid an average of $269 in workers' compensation premiums for every employee in the state. As table 1 shows, total premiums equaled $481 million. Total losses for 1980 were estimated to equal $346 million, with over 60 percent of this figure being paid during the 1980 calendar year.

These figures are the latest in a series that, for the past ten years, has reflected a rather alarming trend. The cost of workers' compensation insurance for Minnesota employers has increased substantially during the last few years. This increase in costs, however, is not unique to Minnesota. As table 2 shows, premiums paid by Minnesota employers increased by an inflation-adjusted 40 percent between 1976 and 1980. (Premiums are defined here as direct premiums written less any dividends paid to policyholders.) Premiums paid by employers throughout the United States increased by a similar proportion. In fact, premiums paid by Minnesota employers, as a percentage of total U.S. premiums, did not change significantly over the four year period. These observations support the assertion that what is happening in Minnesota, with respect to changing workers' compensation costs, is not significantly different from what is happening throughout the country.

Differences do arise, however, when the perspective is moved from a national level to a state-by-state level. Table 2 also shows the experiences of those states neighboring Minnesota. Premiums paid by employers in Wisconsin and Iowa increased by rates that were higher, but not substantially higher than the rate of increase in Minnesota. South Dakota and North Dakota, however, experienced moderate and negative increases in premiums respectively, between 1976 and 1980.

There is little evidence to suggest that the trend described above will not continue at least into the near future. Some recent changes in the laws governing workers' compensation have been aimed at reducing costs. No well-founded predictions have been offered, however, suggestive of a significant dollar impact of any of these changes. In addition, none of the recent changes have been aimed at redirecting the fundamental course of workers' compensation in terms of its purpose and role.

These observations support the assertion that significant cost reductions are not likely to result from the recent changes. They also underline the importance of two necessary ingredients to any effective cost-reducing reform of workers' compensation. First, any effective changes must be founded on a comprehensive understanding of how the workers' compensation system works and why it produces the costs that it does. Without such an understanding, great efforts will fall far short of producing desired results. The next few sections of this report are intended to contribute to this understanding.

A second necessary ingredient to substantial and effective reform is the willingness to confront the difficult issues related to the purpose of workers' compensation. As was described in the first section of this report, workers' compensation systems can be based on several different theoretical perspectives. These theoretical perspectives define the purpose of workers'

compensation, whether it be to replace lost wages or to compensate for pain and suffering, and so on. Minnesota's workers' compensation system, as will be more fully discussed later, contains elements of several different theoretical approaches. As a result, there is much overlap, conflict, and inconsistency inherent to our system. In addition, and perhaps more importantly, it is very expensive to maintain a system that is trying to achieve several different goals at one time.

The late sixties and early seventies were expansionary years for workers' compensation. The apparent feeling then was that more needed to be done to compensate the injured worker. Because cost was less of a constraint to action, there was little discussion or debate regarding the desirable and appropriate theoretical approach to workers' compensation. Benefit increases were made along all fronts because the money was there to do it. Recently, however, cost has become a very important concern.

If one intends to contain costs, there are limits to what workers' compensation can do. The realization that workers' compensation cannot do everything demands that some attention be directed toward establishing priorities for workers' compensation. Efforts to reduce or control costs, therefore, must include the establishment or restructuring of current priorities regarding the purpose of workers' compensation. Not only will this approach provide a basis for immediate cost-reducing changes, but it will also

provide a framework for contemplating further changes in the years to come. The final sections of this report will deal with this issue.

Recent changes in the laws governing workers' compensation have lacked both of the above ingredients. The changes have not been based on a comprehensive understanding of the system and have, therefore, produced unintended and undesirable effects. In addition, recent efforts to reduce costs have failed to include any examination or review of the system's fundamental purpose.

Major Participants in the Policy Debate

Five groups of individuals and organizations are identified here as having major interests in the substance of Minnesota's policies regarding workers' compensation. These are employers, workers, insurers, the governmental and legal bureaucracy, and the general public. In the following pages, these groups are briefly described and information is presented to establish the context within which workers' compensation issues are considered.

Employers

Virtually all employers in Minnesota must either purchase workers' compensation insurance or self-insure their businesses for workers' compensation liability. The cost of workers' compensation to employers, therefore, is reflected by the premiums paid to insurers and the number of dollars paid out in benefits by self-insurers. The concern of employers is, understandably, to keep their costs to an

optimally minimal level. That is, employers must seek the lowest cost system that is consistent with the provision of fair and adequate workers' compensation benefits. In recent years, employers have sought to reduce or at least slow the growth of the cost of workers' compensation. Their efforts have been initiated independently as well as collectively through many organizations including trade associations, political action groups, and ad hoc committees formed because of their common concern with workers' compensation costs.

Two measures will be used here to describe the cost dimensions of workers' compensation for Minnesota employers: premiums as a percentage of total payroll and premiums as a percentage of net corporate income. As table 3 shows, premiums as a percentage of total payroll increased from 1.43 percent in 1974 to approximately 2.28 percent in 1979. Premiums have also increased in relation to total net corporate income. In 1973, premiums paid by employers equaled about one-third of one percent of total net corporate income. By 1979, this proportion had increased to over half of one percent. These data suggest that the burden of workers' compensation premiums on Minnesota employers has indeed grown during the past few years.

A final dimension of workers' compensation for employers is its differential cost impact. The impact of rising costs is not the same for all employers. Several hundred occupational classifications exist for the purpose

of determining workers' compensation manual rates. Manual rates are individually calculated for each classification, and these rates vary significantly. For example, in 1980 employers paid 23 cents per $100 payroll to insure clerical office employees but $14.31 per $100 payroll to insure carpenters. Some employers, therefore, are much more seriously affected by rising workers' compensation costs than are others.

Insurers

Insurers collect premiums from employers and pay out benefits to injured workers. The concern of an insurer is not so much with the absolute level of either premiums or benefits but with the disparity between the two. This disparity represents the carrier's potential for profits. Over 200 carriers seek to maintain the disparity between benefits and premiums through the representation of a collectively supported organization, the Workers' Compensation Insurers Rating Association of Minnesota. Traditionally, the collective effort of insurers has been to seek higher rates rather than lower benefits. This is not to say, however, that individual insurers are not concerned about what may be happening with benefit levels and the benefit structure. When benefit levels and structure are constantly changing, insurers must attempt to anticipate the consequences of such changes and incorporate their predictions into requests for changes in rates. This is a difficult and speculative task. An insurer, therefore,

must adapt to a fluid and constantly shifting body of claims. In addition it must also deal with a total benefit level that is growing, often times faster than are premiums. While the collective efforts of insurers are aimed at obtaining rate increases, the individual efforts of insurers are to seek stability and predictability in benefits and to get an edge on the overall trend of increasing benefits by adopting more selective underwriting policies and by challenging the compensability of more marginal claims.

A commonly used measure of the disparity between premiums and losses is the loss ratio (the percentage of losses in relation to premiums). As table 4 shows, the loss ratio for Minnesota insurers increased steadily from 1975, until 1979, when the ratio actually decreased from .91 to .80. Table 4 also shows how annual changes in premiums failed to match changes in losses as a percentage of total payroll. The annual percentage change for losses exceeded the percentage change for premiums for every year through 1978. In other words, relative to total payroll, losses increased at a greater rate than did premiums. The increasing loss ratio reflects this fact.

The loss ratio is commonly used in the insurance industry to indicate the profitability from underwriting a particular line of insurance. All other things being equal (and they rarely are), the lower the ratio the greater the potential for profit. The data in table 4 suggest that workers' compensation has become a less profitable line of

insurance since 1974. This fact has important implications in that the availability of insurance will largely depend on the incentives (potential for profit) present to encourage insurers to write workers' compensation policies. As workers' compensation becomes a relatively less profitable line of insurance, insurers will become more conservative in their underwriting behavior and more likely to stop writing workers' compensation policies altogether. The result is that many employers will find it more and more difficult to obtain insurance in the voluntary market.

Another aspect of workers' compensation has important implications for insurers: the difficulty in estimating outstanding losses. (Almost 40 percent of total Minnesota workers' compensation losses incurred by insurers in 1980 are to be paid in subsequent years.) These outstanding losses must be estimated for rate-making purposes. Such estimates are very difficult to make and, traditionally, have been lower than total ultimate losses. The unpredictability associated with outstanding losses poses a serious problem for insurers. It increases the uncertainty in a major area of business. As a result, the availability of workers' compensation insurance suffers.

Workers

A very high percentage of all employees in Minnesota is covered under workers' compensation law. Workers are concerned primarily that compensation benefits be adequate, certain, and timely. As was described in the

previous section, no clear adequacy standard exists. At a minimum, however, adequate benefits would prevent major financial disruption from occurring as a result of an injury. Workers want to be certain that, if injured, they will continue to receive income. Benefits are timely if there is little or no interruption of income to the injured worker. In other words, benefit payments are as timely as possible when the transition from wage income to benefit income is immediate. The collective interests of workers in Minnesota have been represented for the most part by organized labor, most visibly the AFL-CIO.

Process-Oriented Groups

While some groups have an outcome-oriented interest in workers' compensation policies, other groups have interests that are more process-oriented. For example, injured workers are interested in benefits and employers are interested in costs. Costs and benefits are results or outcomes of the entire workers' compensation system. Attorneys, on the other hand, are more interested in the processes that deliver benefits and result in costs. In short, attorneys are interested in preserving their role in the workers' compensation system. By preserving their role, attorneys can continue promoting the rights of the injured workers and receiving fees for services. Although attorneys may certainly be concerned with the overall outcomes of the workers' compensation system, their legitimate area of interest and influence is in representing the injured worker

during the process for determining benefits. Similarly, the governmental bureaucracy is primarily interested in anything that would affect its ability to administer workers' compensation policy. The bureaucracy will be concerned about any possible changes that might make its task more difficult. In addition, the bureaucracy will seek to preserve the scope of its activities and its control over its own workload. The point to be made here is that the interests of process-oriented groups are important, separate from, and potentially inconsistent with the interests of outcome-oriented groups.

General Public

The state as a whole shares many of the interests described above. Because most of the costs of workers' compensation are ultimately paid by consumers, it is in the public interest that costs be kept under control. It is also important to the general public that injured workers be protected from economic ruin due to an injury. In theory, adequate compensation prevents injured workers from becoming a permanent burden on society and promotes the efficient allocation of resources by more accurately assigning the full costs of production to employers. The public also is concerned about a more practical issue related to cost: maintaining or improving the attractiveness of Minnesota, relative to other states, as a place to do business and employ workers.

Minnesota's attractiveness as a place for doing business is a function of many factors. The cost of workers' compensation is only one of those factors. Comparing the cost of workers' compensation with other publicly determined business costs, however, can provide some additional perspective. In table 5, workers' compensation premiums are compared with corporate income tax collections and commercial property tax receipts. Since 1976, Minnesota employers have paid more in premiums for workers' compensation insurance than they have in corporate income taxes. Although commercial property tax receipts continue to exceed workers' compensation premiums, the gap between the two has narrowed substantially since 1974. If current trends continue, compensation premiums can be expected to overtake property tax receipts within the next few years.

In assessing how workers' compensation costs impact upon Minnesota's business climate, it is necessary to compare Minnesota with other states. Comparing workers' compensation costs is a difficult task. To any given potential employer, and with all other factors being equal, the desirablility of locating in one state as opposed to locating in Minnesota will depend on rates for relevant classifications and not the average manual rate. In a study sponsored by the National Science Foundation, John Burton devised a way for making meaningful rate comparisons across states. Burton developed a sample of 45 hypothetical

employers. These employers were selected and then weighted in such a way that, together, they were a representative cross-section of the nation's industrial mix. Burton then compared all of the states in terms of the average premium rates for this representative group of employers. The results of this approach can be seen in table 6. In 1978, Minnesota had the eighth highest rate with approximately $1.82 in premiums for every $100 in payroll. In 1972, Minnesota ranked thirteenth with about 85 cents in premium for every $100 in payroll.

As stated earlier, workers' compensation costs are only one of many factors that an employer will consider when deciding where to locate. Table 7 compares workers' compensation costs, and other public policy related costs, in Minnesota and in other states. (It should be noted that some costs, such as property taxes, can also be viewed as indirect indicators of a state's economic infrastructure, providing transportation, communication, and educational support to business. Potential employers, therefore, may also perceive higher costs, such as property taxes, as benefits when making a decision regarding location.) As table 7 shows, Minnesota ranks high on two factors: corporate income taxes and workers' compensation costs. On the other hand, this state appears to be competitive with other states with regard to property taxes and sales taxes. In fact, Minnesota's rank is lower than three of four neighboring states for each of the two factors.

These observations suggest that workers' compensation rates are of limited importance to an employer deciding whether to locate in this state. Only in a very few situations would workers' compensation rates be the deciding factor. For employers already located in Minnesota, the likelihood that a move to some other state would be justified on the basis of workers' compensation rates alone is even more unlikely because the cost of physically relocating a business must also be considered.

Summary

The following major points have been made thus far:

(1) Relative to many other states, the cost of workers' compensation in Minnesota is high.

(2) The cost of workers' compensation in Minnesota has risen substantially during the last few years.

(3) There are no strong indications that the trend will end in the near future.

(4) Minnesota's rising costs are part of a national trend.

(5) Relative to neighboring states, Minnesota's workers' compensation premium rates are higher.

(6) The loss ratios for insurers have grown over the past several years.

(7) Several groups have a direct or indirect interest in how the problem of rising costs is resolved.

(8) "Business climate" is a function of many different factors, including workers' compensation costs. Minnesota's attractiveness to potential employers, therefore, cannot be judged on the basis of workers' compensation costs alone.

(9) Rising workers' compensation costs affect some business sectors much more significantly than others. The impact is greatest in sectors where costs are already high.

COSTS AS AN OUTCOME OF THE WORKERS' COMPENSATION SYSTEM

Introduction

High workers' compensation rates result from the interaction of many different factors and forces. These elements, and the circumstances in which they interact, are what constitute the workers' compensation system. Costs are a product, or outcome, of the system. Another outcome of the system are benefits received by injured workers. Many other types of outcomes exist. Benefits received by injured workers and costs, however, are of greatest concern.

Benefits received by workers and costs are clearly related. The relationship between the two phenomena, however, is not so much a causal relationship as it is a relationship based on a common origin. A causal relationship is based on the premise that one phenomenon

predetermines, and occurs prior to, another phenomenon. Benefits and costs, however, occur simultaneously. One does not cause the other. Both phenomena are outcomes of the same workers' compensation system and can be considered to be caused by the system.

The remainder of this section will be devoted to: (1) identifying the elements that constitute the workers' compensation system; (2) discussing recent changes in some of those elements and (3) discussing how this information relates to the remainder of this report.

Figure 1 is a conceptual representation of the workers' compensation system as it relates to outcomes. Four elements are shown to be interacting to produce benefits for injured workers and costs. These categories are claims, benefit levels, the benefit structure, and the processing and delivery sub-systems (hereinafter referred to simply as the processing system).

Claims Resulting From Injuries

Two aspects of injuries are important: frequency and severity. Table 8 shows the number of first injury reports received by the Minnesota Department of Labor and Industry and the accident and illness rate for Minnesota and seven other states, for the years 1975 through 1979. This state has experienced a steady increase in the number of work-related injuries since 1975. Similarly, the number of incidents per 100 full time workers per year has increased since 1977. Minnesota is not unusual in this respect.

Almost all of the other states examined have also experienced increases in their accident and illness rates. More importantly, however, is the fact that Minnesota's injury frequency rates are not significantly different from other states' rates.

Table 9 shows Minnesota's employment mix in 1979 compared with the employment mix throughout the U.S. This information is a good indicator, not only of how Minnesota's accident rate compares with the entire nation, but also of whether the types (severity) of injuries occurring in the state are likely to be different from the types of injuries occurring throughout the nation. The assumption is that employees engaged in similar occupations are exposed to similar injury and illness risks. As table 9 shows, Minnesota's employment mix is very similar to the nation's as a whole. It is unlikely, therefore, that workers in this state experience injuries of a substantially different nature than do workers throughout the U.S.

Benefit Levels

Benefit levels and benefit structure are two distinct and separate aspects of the workers' compensation system. Benefit level refers to the monetary compensation associated with particular benefit types. Although the purpose in this section is not to undertake a comprehensive review of benefit levels, it will be helpful to describe some recent changes in various benefit levels. Table 10 shows the maximum weekly compensation for total disability,

both temporary and permanent. The maximum benefit amount is also compared with the statewide average weekly wage. As table 10 indicates, the maximum weekly benefit for total disability, relative to the average wage, was very low in the early seventies. Throughout the decade, however, adjustments were made to bring the maximum benefit closer to the statewide average weekly wage.

Benefit Structure

Benefit structure refers to the assortment of laws, rules, and judicial standards used in determining who gets what benefits, for how long, and under what circumstances. These rules, laws, and standards are discussed more fully in later parts of this report. It should be noted, however, that benefit structure will vary considerably from state to state. For example, two states could conceivably have identical benefit levels but have very different benefit structures. Any comparisons among states should reflect this fact.

The Processing System

A fourth category of phenomena affecting the outcomes of the workers' compensation system includes the various administrative and legal systems in place to process and evaluate claims and deliver benefits to injured workers. Together, these systems have two primary functions. The first function in dealing with a compensable claim is to determine what the appropriate benefits are for that claim. The second function is to provide those benefits to the

injured worker. The individuals and organizations involved in the processing system are provided with, or create, laws and rules to guide them in the performance of these functions. These laws and rules represent the framework for the system. Among other things, this framework: (1) describes the decisions that must be made; (2) determines who will make the decisions; (3) controls the information available to decision makers; (4) provides maximum allowable time for making certain decisions or performing certain tasks; (5) describes the specific tasks that must be performed; and (6) determines who will perform these tasks.

The function of deciding what benefits are to be awarded for a particular claim requires the evaluation of the claim in light of benefit levels and the benefit structure and the injury itself. Benefit levels are generally clear, unambiguous, and seldom difficult to apply. The laws, rules, and judicial standards relating to benefit structure, however, are often very difficult to apply. This difficulty arises out of the fact that the benefit structure does not and cannot effectively differentiate among every conceivable type of claim. Thousands of claims are handled every year. Many of these include some unique aspect that the existing benefit structure is unable to recognize. The organizations and individuals participating in the processing system, therefore, devote great amounts of time and effort interpreting these laws, rules, and standards. In fact, a substantial portion of the framework of the

system establishes the process for resolving disputes involving conflicting interpretations of the benefit structure. The processing system helps define the benefit structure by reconciling actual claims with ambiguous and unclear laws and rules. The relationship between the processing system and the benefit structure, therefore, is a two-way street. In other words, the system awards benefits according to the benefit structure but it also assists in the definition of the benefit structure through the resolution of disputed claims.

The point in discussing the processing system is to establish that the operation of the system is a major factor in the production of the outcomes of the entire workers' compensation system, particularly with respect to benefits received by injured workers and costs. The system does not simply process claims and churn out benefits and costs according to some neat formula. If it did, then the relationship between costs and benefits (levels and structure) would be pure and complete. Changes in costs could be predicted with a fair degree of accuracy given any changes in benefit levels and structure. The actual situation, however, is one where costs and benefits awarded to injured workers change even with claims, benefits levels, and the benefit structure held constant.

SUMMARY

This section has two primary objectives: (1) to illustrate how the cost of workers' compensation in Minnesota has increased substantially over the last few years; and (2) to underline the importance of taking a comprehensive approach to the problem. In the second part of the section, four groups of factors and forces were described as being major determinants of the outcomes of the workers compensation system. These are claims, benefit levels, the benefit structure, and the processing system. The next section of this report is a description and discussion of the processing system. Following that, the benefit levels and benefit structure are analyzed. The final sections of the report explore the interrelationships of outcomes and the factors discussed earlier, and offers policy alternatives with costs and objectives in mind.

TABLE 1: Minnesota Workers' Compensation Experience: 1976 -1980
*(000's omitted)

Calendar Year	Standard Earned Premium *	Losses Paid *	Losses Outstanding *	Total Losses *	Cost Per Worker	Number of Covered Workers
1976	$217,835	$ 90,791	$ 61,650	$152,441	$139	1,571,000
1977	277,082	113,924	102,120	216,044	169	1,637,000
1978	385,826	146,286	175,035	321,321	223	1,730,000
1979	456,976	179,283	103,938	317,197	257	1,780,000
1980	481,641	221,000	125,000	346,000	269	1,793,000

Source: Minnesota Insurance Division

TABLE 2: Workers' Compensation Insurance Premiums for Five States and the United States: 1976 - 1980 (000's omitted)

Calendar Year	Minnesota	Wisconsin	Iowa	N. Dak.	S. Dak.	U.S.	MN as a percentage of U.S.
1976	$ 198,636	$ 123,136	$ 85,307	$ 297	$ 13,735	$ 7,461,351	2.7%
1977	251,664	156,431	108,202	456	14,316	10,050,229	2.5
1978	363,217	195,572	127,178	215	18,537	12,218,536	3.0
1979	404,506	229,927	166,952	322	22,635	14,300,721	2.8
1980	402,314	261,669	187,640	256	21,366	15,475,605	2.6
1976-1980 percent change							
absolute dollars	103%	113%	120%	-14%	56%	107%	
constant dollars	40%	47%	52%	-40%	7%	43%	

Source: National Association of Insurance Commissioners. Premiums are defined as direct written premiums less dividends.

TABLE 3: Premiums Compared with Payroll and Corporate Income: 1973 - 1980
*(000's omitted)

	Net Premium[1] *	Covered Payroll[2] *	Premium as a Percent of Payroll	Total Net Corporate Income[3] *	Premiums as a Percent of Income
1973	$ 110,869	(5)	(5)	$ 33,862,357	.33%
1974	138,092	$ 9,688,673	1.43%	(5)	(5)
1975	162,616	10,630,736	1.53	(5)	(5)
1976	204,064	11,877,442	1.72	43,512,988	.47
1977	254,316	13,257,061	1.92	(5)	(5)
1978	352,454	14,893,413	2.37	(5)	(5)
1979	400,696	17,600,000[4]	2.28	76,294,426	.53
1980	420,684	19,000,000[4]	2.21	(5)	(5)

[1]Source: Minnesota Insurance Division
Premium defined as premiums paid net of dividends, discounts, experience ratings, and retrospective ratings.

[2]Source: Workers' Compensation Insurers Rating Association of Minnesota. Data are for policy years.

[3]Source: The Minnesota State Corporation Income Tax, Minnesota Department of Revenue, as published in Fiscal Facts For Minnesotans 1981 (St. Paul: Minnesota Taxpayers Association, 1981).

[4]Estimated.

[5]Data not available.

TABLE 4: Workers' Compensation Premiums and Incurred Losses: 1974 - 1980

Calendar Year	PREMIUMS: As a Percentage of Total Payroll	PREMIUMS: Annual Percentage Increase	PREMIUMS: Cumulative Percentage Increase	INCURRED LOSSES: As a Percentage of Total Payroll	INCURRED LOSSES: Annual Percentage Increase	INCURRED LOSSES: Cumulative percentage increase	Loss Ratio
1974	1.43%			.87%			.61
1975	1.53	6.9%	6.9%	.94	8.0%	8.0%	.61
1976	1.72	12.4	20.3	1.28	36.2	47.1	.74
1977	1.92	11.6	34.3	1.63	27.3	87.4	.85
1978	2.37	23.4	65.7	2.16	32.5	148.0	.91
1979	2.28	-3.8	59.4	1.82	-15.7	109.2	.80
1980	2.21	-3.1	54.5	1.82	0.0	109.2	.82

Sources: Minnesota Insurance Division, Workers' Compensation Insurers Rating Association of Minnesota.

TABLE 5: Publicly Determined Business Costs: 1974 - 1979
(000's omitted)

Year[1]	Net Premiums[2]	Annual Percentage Increase	Net Corporate Income Taxes[3]	Annual Percentage Increase	Commercial Property Tax Receipts[4]	Annual Percentage Increase
1974	$138,092		$ 174,729		$ 263,000	
1975	162,616	17.8%	180,482	3.3%	281,000	6.8%
1976	204,064	25.5	176,202	-2.4	312,000	11.0
1977	254,316	24.6	237,511	34.7	334,000	7.1
1978	352,454	38.6	268,973	13.2	390,000	16.8
1979	400,696	13.6	324,126	20.5	413,000	5.9

[1]Premium and Commercial Property Tax data from calendar years. Income tax data are from fiscal years.

[2]Source: Minnesota Insurance Division

[3]Source: Minnesota Department of Revenue, as published in Fiscal Facts For Minnesotans 1981 (St. Paul: Minnesota Taxpayers Association, 1981).

[4]Commercial property tax collection estimates are based on the assumption that 31 percent of all property tax collections are associated with commercial properties.

TABLE 6:
Average Premium Rates Per $100 Payroll
for a Sample of 45 Hypothetical Employers:
15 Most Expensive Jurisdictions and States
Neighboring Minnesota

Jursidiction	1978 Rate (rank)	1975 Rate (rank)	1972 Rate (rank)	% Change 1972 - 1978
District of Columbia	3.502 (1)	1.404 (6)	.737 (19)	375.2%
Oregon	2.918 (2)	2.074 (2)	1.491 (1)	95.7%
Florida	2.641 (3)	n.a.	n.a.	n.a.
Arizona	2.505 (4)	2.178 (1)	1.385 (2)	80.9%
California	2.135 (5)	1.406 (5)	1.102 (2)	93.7%
Hawaii	2.057 (6)	1.335 (7)	.960 (6)	114.3%
Michigan	1.890 (7)	1.238 (10)	.715 (9)	117.5%
Minnesota	1.821 (8)	1.240 (9)	.854 (13)	113.2%
New York	1.770 (9)	.973 (21)	.864 (12)	104.6%
Alaska	1.762 (10)	1.721 (3)	.832 (14)	111.8%
Texas	1.753 (11)	n.a.	n.a.	n.a.
New Jersey	1.687 (12)	1.233 (11)	1.224 (3)	37.8%
Ohio	1.550 (13)	1.109 (13)	.885 (10)	75.1%
Louisiana	1.512 (14)	n.a.	n.a.	n.a.
Oklahoma	1.446 (15)	1.052 (16)	n.a.	n.a.

Jursidiction	1978 Rate (rank)	1975 Rate (rank)	1972 Rate (rank)	% Change 1972 - 1978
Iowa	1.084 (31)	.662 (34)	.451 (37)	n.a
North Dakota	n.a.	n.a.	n.a.	n.a.
South Dakota	.842 (40)	.635 (36)	.511 (32)	n.a.
Wisconsin	.752 (42)	.581 (40)	.505 (33)	n.a.

Source: John F. Burton, Jr., "Workers' Compensation Costs for Employers," Appendix 6A of The Final Report on a Research Project on Permanent Partial Disability Benefits (Ithaca, NY: Cornell University, 1980).

TABLE 7:
Public Policy Related Costs to Employers:
Twenty States

STATE	1979 Property Tax Per Capita[1]	U.S. Rank	1979 Corp. Income Tax Per Capita[2]	U.S. Rank	1979 Sales Tax Per Capita[2]	U.S. Rank	1978 Average W.C. Rate (45 Typical Employers)[3]	U.S. Rank
Arkansas	125.35	49	38.35	31	158.69	33	1.292	26
California	226.30	28	104.64	3	249.38	8	2.135	5
Colorado	326.37	21	40.51	30	185.85	17	1.210	28
Florida	246.93	31	35.49	35	219.75	12	2.641	3
Georgia	209.42	37	44.19	24	174.63	21	1.077	32
Illinois	349.54	17	43.56	27	195.52	15	1.382	20
Indiana	246.85	32	23.50	44	242.65	10	.480	47
Iowa	338.92	20	44.82	23	139.78	39	1.084	31
Kentucky	130.53	48	46.32	20	169.92	24	1.382	21
Louisiana	101.53	50	53.28	16	168.40	27	1.512	14
Michigan	375.86	11	107.70	2	184.93	18	1.890	7
Minnesota	311.10	23	87.87	4	149.75	35	1.821	8
Missouri	205.22	38	26.70	40	160.85	31	.740	43
Nebraska	388.90	10	31.76	39	160.46	32	.710	44
North Carolina	162.64	41	45.45	22	115.64	42	.532	46
North Dakota	257.09	30	43.94	25	165.89	28	n.a.	n.a.
Oregon	365.50	12	65.70	12	0.00	50	2.918	2
South Dakota	342.68	19	4.22	46	189.46	16	.842	40
Texas	273.74	27	0.00	48	163.31	29	1.753	11
Wisconsin	345.96	18	69.37	10	173.66	22	.752	42

[1]Source: Minnesota Department of Revenue, as published in Fiscal Facts For Minnesotans 1981 (St. Paul: Minnesota Taxpayers Association, 1981).

[2]Source: State Government Finances in 1979, U.S. Department of Commerce, as published in Fiscal Facts For Minnesotans 1981 (St. Paul: Minnesota Taxpayers Association, 1981).

[3]Source: John F. Burton, Jr., "Workers' Compensation Costs for Employers."

FIGURE 1: Conceptual Overview

of the Workers' Compensation System as it Relates to Outcomes

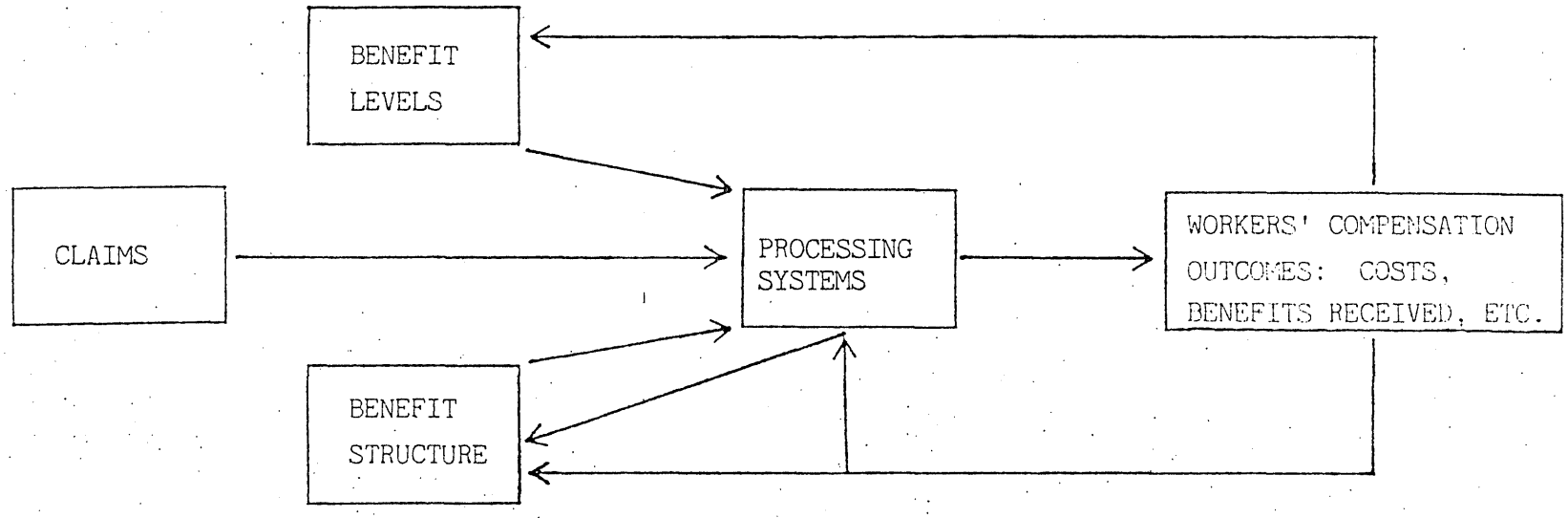


TABLE 8: Minnesota Injury Reports and Injury and Illness Rates for Eight States: 1975 - 1979

Year[1]	Minnesota First Injury Reports	Occupational Injury and Illness Incidence Rates[2] MN	WI	IA	ND	SD	MI	ID	CA
1975	40,608	8.4	11.6	10.6	8.1	7.8	9.6	9.6	9.7
1976	45,840	9.3	11.2	10.2	7.6	7,8	9.2	9.8	10.1
1977	50,009	9.1	11.4	10.0	([3])	7.8	8.8	9.9	10.3
1978	55,536	9.5	11.8	10.4	([3])	8.8	9.5	9.9	10.5
1979	60,350[4]	10.1	([3])	10.6	([3])	8.6	10.1	9.5	10.6

[1]First injury reports are for fiscal years. Injury rates are for calendar years.

[2]Number of injuries and illnesses per 100 full-time workers.
Source: Bureau of Labor Statistics.

[3]Data not available.

[4]Estimated.

TABLE 9:
1979 Employment Mix: Minnesota and the U.S.
(000's omitted)

Industrial Category	Minnesota Number Employed	%	U.S. Number Employed	%
Manufacturing Durable	234.3	12.7%	12,772	13.7%
Manufacturing Non-Durable	148.2	7.8	8,290	8.9
Mining	17.2	0.9	960	1.0
Construction	84.2	4.4	4,483	4.8
Trans. & Pub. Utilities	100.3	5.3	5,141	5.5
Trade	444.4	23.4	20,269	21.8
Finance, Insurance, Real Estate	91.8	4.8	4,974	5.3
Services	355.8	18.8	17,078	18.3
Government	294.4	15.5	15,920	17.1
Agriculture	124.5	6.7	3,297	3.5
TOTAL	1,895.1	100.0%	93,184	100.0%

Source: Bond Prospectus, Minnesota Department of Finance, as published in Fiscal Facts For Minnesotans 1981, (St. Paul: Minnesota Taxpayers Association, 1981).

TABLE 10: Maximum Weekly Compensation for Total Disability and the Statewide Average Wage: 1970 - 1979

Calendar Year	Weighted Maximum Weekly Compensation[1]	Statewide Average Weekly Wage [2]	Compensation/ Average Wage Ratio
1970	$ 70	$ 138	.51
1971	73	147	.50
1972	80	151	.53
1973	85	159	.53
1974	100	169	.59
1975	115	183	.63
1976	135	197	.69
1977	151	209	.72
1978	200	226	.88
1979	213	244	.87

[1]Maximum rates computed according to the following example. For Jan. - Sept. 1977 the maximum was $135. For Oct. - Dec. 1977 the maximum was $197. The annual maximum equals .75 (135) + .25 (197) or $150.5.

[2]Source: Minnesota Department of Economic Security.

CHAPTER 3
INTRODUCTION

In the preceeding section, it was concluded that the system for processing claims and delivering benefits is a major factor in determining the outcomes of the entire workers' compensation system. The purpose of this section is to more closely examine the current delivery system. There are two objectives in this section, the first of which is to identify specific aspects of the current system that tend to encourage departures from the normal claims management process. The second objective is to offer a variety of policy options for improving the ability of the delivery system to perform its necessary functions without contributing excessively to the total cost of workers' compensation.

THE BASIC PROCESS

In a study sponsored by The National Science Foundation, Monroe Berkowitz identified five primary functions of any claims management process. These functions are:

(1) opening,

(2) validation,

(3) payment of benefits,

(4) formal of resolution of controversy, and

(5) closing.

This framework of basic functions will be used to describe the claims management process in Minnesota.

A majority of all claims are processed through the workers' compensation system with relative ease and in a timely manner. Most claims, in fact, will not produce any controversy and, therefore, will not require the use of the fourth function listed above. The other functions, however, are relevant to the processing of all claims.

Opening

When an injury occurs, the injured worker will receive immediate medical attention. The worker, if necessary, will inform the employer that an injury has occurred. The employer will then inform the insurer and the Minnesota Department of Labor and Industry of the injury. The first function, therefore, is simply a process for informing all relevant parties that an injury has occurred.

Validation

With most claims, the next task is for the insurer to confirm the compensability of the injury. In addition, the insurer will gather the information necessary to calculate

appropriate benefits to be paid the injured worker or surviving dependents.

Payment of Benefits

The third basic function is payment of workers' compensation benefits to the injured worker or surviving dependents. If there is total disability, benefits are paid by the insurer on a periodic basis. If the injury resulted in death, payment to the surviving dependents may be in periodic amounts or as a single lump sum. Total disability benefits continue until the injured worker returns to work. The injured worker may also receive a lump sum benefit for permanent partial disability after returning to work or if the total disability is also permanent. Any medical, rehabilitation, and retraining costs are also paid by the insurer.

Closing

After an injured worker has returned to work the insurer will begin the process of closing a claim. The worker is notified that disability benefits are to be discontinued. In addition, the Department of Labor and Industry is notified that benefit payments are ending. Any remaining benefits for permanent partial disability are paid and the claim is closed. If total disability is also

permanent, then periodic payments continue indefinitely and the claim remains open. If a surviving spouse is receiving periodic benefits, the claim will be closed after ten years of benefits have been received.

CONTROVERSY AND LITIGATION IN THE WORKERS' COMPENSATION SYSTEM

The simple process described above applies to most workers' compensation claims in Minnesota. For a significant minority of claims, however, there are substantial departures from this simple process. Departures resulting in litigation are particularly important because they contribute greatly to the cost of workers' compensation. Petitions requesting hearings were filed for approximately 10 percent of all new claims in 1980. The next few paragraphs include a discussion of the current process for resolving disputes - the fourth claims management function described above. Of particular interest are the problems and events preceeding the initiation of the litigation process.

Controversy develops when an insurer (or employer) fails or refuses to meet the expectations of an injured worker. If the insurer continues to perform in a manner that is unsatisfactory to the injured worker, and if the worker's expectations are not altered to resolve the

controversy, then it is likely that the controversy will result in litigation.

Controversy is usually related to one, or both, of two issues: compensability and disability. Controveresy regarding the compensability of an injury means that the insurer refuses to pay benefits because it believes that the injury was not work-related and, therefore, not covered under Minnesota's workers' compensation laws. When the issue is disability, two different questions may be present. First, the insurer may question whether a work disability actually exists. Second, the insurer may question the degree of a permanent partial disability. Controversy, therefore, may develop because: (1) an insurer refuses to pay benefits for an injury it believes was not work-related; (2) an insurer refuses to pay benefits because it believes there is no disability; and/or (3) an insurer may disagree as to the degree of a permanent disability and pay less in benefits than is expected by an injured worker. This is not an inclusive list of all types of controversy. It does, however, include a large majority of those controversies resulting in litigation. During 1980, approximately 94 percent of all petitions for hearings received by the Department of Labor and Industry were associated with claims for benefits or the discontinuance of benefits.

Controversy Regarding Compensability

After the employer becomes aware of an injury, no more than 14 days may elapse before compensation benefit payments begin. The employer must, therefore, inform the insurer of the injury in enough time to allow the insurer to evaluate the claim and reach a decision regarding its compensability. If the insurer determines that the injury was not compensable before the 14 day time limit expires, then it files a denial of liability report with the Department of Labor and Industry, and no compensation benefits are paid. If the insurer does not deny the claim, then benefit payments begin within 14 days of the employer's notice. With some cases, however, 14 days is insufficient time in which to investigate and evaluate the claim. Although the insurer must still begin benefit payments within 14 days of the employer's notice, it is also allowed an additional 30 days during which time it may submit a denial of liability. Extensions of the additional 30 days may also be granted. During the time after benefit payments have begun, the insurer may decide either to continue benefit payments or discontinue benefits and file a denial of liability with Labor and Industry. An injured worker, therefore, may receive benefits for a short period of time, up to 74 days after the date of injury, and then have those benefits discontinued if the insurer decides to challenge the compensability of the injury.

The process just described applies only to claims for total disability benefits. With death claims, there is no maximum allowable time before benefit payments must begin. The Department of Labor and Industry, however, appears to operate under the presumption that death benefit payments must begin within 30 days of the death. Insurers may also request extensions in time for the purpose of determining compensability. Death benefits, therefore, may also be discontinued soon after they begin.

It should be noted that state law requires an employer to notify Labor and Industy within 15 days of any injury resulting in four days or more of work disability. Injuries resulting in death or that are life threatening must be reported within 48 hours. The vast majority of injuries, however, fall under the 15 day notice period. The importance of this fact is discussed later in this section.

Controversy develops when an injured worker expects to receive workers' compensation benefits but does not, or when compensation benefits are being received but are terminated soon after they begin. Controversy initiates the litigation process when the worker, or their legal representative, files a petition with the Department of Labor and Industry challenging the insurer's decision to deny liability. The petition is a statement claiming that the injury or death was, in fact, compensable, and that the injured worker is rightfully due benefits under the state's workers' compensation laws.

Within 10 days after a petition claiming benefits is filed by a worker, the Department of Labor and Industy will assign the matter to a settlement judge. The settlement judge will then schedule a conference between the insurer and the injured worker to be held within 60 days. The purpose of the settlement conference is to encourage the insurer and the worker to reach an informal agreement regarding the claim. If this does not happen, then the matter is referred to a compensation judge. The compensation judge will also bring the parties together at a pretrial hearing to encourage informal agreement. If agreement is not reached, then the compensation judge will hold a formal hearing where evidence is submitted and arguments regarding compensability are presented. After examining all of the testimony, the compensation judge will render a decision regarding the compensability of the claim. The adverse party to the decision, if it so desires, may then file for an appeal of the decision, within 30 to 60 days, before the Workers' Compensation Court of Appeals. The Court of Appeals will then review the decision and either affirm , modify, or reverse the decision or remand the petition back to a compensation judge for a rehearing. Within 30 days of receiving the decision of the Court of Appeals, the adverse party may file a writ of certiorari for a review of the decision before the Minnesota Supreme Court. The Supreme Court, if it agrees to review the matter, may reverse, sustain, or modify the decision, or remand the

petition back to the compensation judge or the Court of Appeals for a rehearing or review.

Throughout this formal process of hearings and appeals, the parties to a dispute may also be meeting informally to try to produce an agreement. The formal process, therefore, may be discontinued at any time. For example, approximately 10 percent of all requested hearings never actually occur, presumably because a large proportion are resolved informally before the scheduled hearing date. The potential for informal agreement continues until the formal litigation process produces a final resolution of its own.

Controversy Regarding Continued Disability

According to Minnesota's workers' compensation laws, a totally disabled worker will receive compensation benefits for the entire duration of the total disability. There are no limits with respect to the number of weeks of benefits or the total dollars of benefits paid. Total disability benefits for compensable injuries end under one of three conditions:

(1) the injured worker voluntarily returns to work;

(2) the worker dies; or

(3) the insurer or employer determines that total disability no longer exists and initiates administrative procedures for discontinuing benefit payments.

For most claims, return to work is the reason for termination of benefit payments. A growing proportion of claims, however, is falling under the third category. Administrative termination of total disability benefit payments has increased as a result of two factors:

(1) elimination of the automatic termination of benefits as described above; and

(2) a reduced incentive for injured workers to return to work.

Under earlier state law, payments for temporary total disability were terminated after 350 weeks of benefits had been paid. Every claim reaching that point now must either be paid until the worker's death or be administratively terminated by the insurer. (The probability that a worker will ever return to work after being disabled for 350 weeks is very slight.) Assuming that all of these claims are not paid until death, it can be concluded that the use of administrative termination has increased.

As was shown earlier in this report, the maximum weekly compensation for total disability has increased substantially since 1971. In that year, the maximum compensation equalled only 50 percent of the statewide average weekly wage. In 1979, however, the maximum compensation equalled 87 percent of the statewide wage. This suggests that a greater proportion of lost wages is being replaced by workers' compensation benefits.

Consequently, the financial incentive for an injured worker to voluntarily return to work has decreased and the necessity of administrative termination has increased.

Unfortunately, reliable data documenting the frequency of administrative termination is not available. One indication that the administrative termination of benefit payments has increased, however, is the significant increase in the number of petitions filed by workers with the Department of Labor and Industry objecting to the discontinuance of benefit payments. In 1975, 100 such petitions, or less than 3 percent of all petitions, were filed with Labor and Industry. In 1980, the number of petitions objecting to the discontinuance of payments reached 840, or 15 percent of all petitions. It is reasonable to assume that most of this increase in litigation regarding the discontinuance of benefit payments is a direct result of an increased use of administrative termination procedures.

If an insurer suspects that total disability no longer exists, it may request a current medical report from the injured worker. The insurer may also request that the worker submit to an examination by a physician of its choice. On the basis of this information, the insurer will decide either to continue payments or discontinue payments. If it decides to terminate payments, the insurer must notify the worker and Labor and Industry of its intention to

do so. It must also provide an explanation of its decision. Payments may then be terminated immediately.

Controversy will be present if the injured worker feels that total disability benefits should continue. The worker may file a petition objecting to the discontinuance of benefits with Labor and Industy, thus initiating the litigation process described earlier. The basis for filing a petition is either that total diability still exists or that the worker is unable to secure employment. The argument that disability still exists is likely to be used if that is the conclusion of the worker's physician. The litigation process must then resolve the issue of which physician is correct - the worker's or the insurer's. The argument that the worker has been unable to find employment may also be used if there is any evidence documenting the worker's efforts to do so.

Controversy Regarding the Degree of Disability

An injured worker may be eligible to receive compensation for permanent partial disability if he or she has returned to work or is classified as permanently totally disabled. (Workers may also be eligible under other less common circumstances.) When the worker meets one of these conditions, he or she must obtain a medical report from their physician describing any existing disability. The medical report is then forwarded to the insurer and the

Department of Labor and Industry. The report will include a description of all permanent consequences of the worker's injury, usually expressed in terms of the percentage disability to specific parts of the body. For example, a permanent back injury may be expressed as a "30 percent disability to the back."

Upon receiving the first medical report, the insurer has 30 days to honor the claim or request additional time from Labor and Industry to more closely evaluate the claim. The insurer may require the worker to submit to an examination by a physician of the insurer's choice. If the insurer does not question the accuracy of the first report, no examination may be necessary. For example, complete amputation of a limb is clearly a 100 percent disability to that limb. In such a case, the insurer will pay the benefit prescribed by law and the matter will be closed. If a second examination is requested and the findings are similar or identical to the findings of the first report, then the insurer will also pay the relevant benefit amount.

Controversy may develop if the results of the two medical examinations are substantially different, i.e., if the rating from the second examination is lower than the rating from the first examination. The insurer, at this point, has three options. The first is to pay permanent partial benefits based on the higher rating - the first report. This course of action is not likely to result in controversy but will cost the insurer more. The second

option is to pay benefits based on the lower rating - the second report. This course of action will initially cost the insurer less. However, because it may not satisfy the expectations of the injured worker, the potential for controversy, and thus litigation, is greater. The final cost to the insurer, therefore, may eventually equal or surpass the cost of taking the first option.

A third option is to pay benefits based on some compromise of the two conflicting ratings. For example, rather than honor the first rating of 30 percent disability or the second rating of 10 percent disability, the insurer would pay benefits somewhere inbetween, say 20 percent. This course of action, although initially more expensive to the insurer than the second option, is less expensive than the first and reduces the liklihood that the worker will seek greater benefits based on the higher rating. The Department of Labor and Industry allows this behavior on the part of insurers as a means toward reducing conflict.

When the injured worker receives the lump sum payment for permanent partial disability, he or she will compare the amount to what was expected based upon the first physician's medical report. If the amount received is less than what was expected, the worker may file a petition claiming additional benefits with Labor and Industry, thus initiating the litigation process. The task during litigation is to resolve the dispute as to the proper disability rating. Because the early stages of the process are informal (the

settlement conference and the pretrial hearing before the compensation judge), it is possible that some compromise between the conflicting ratings will be reached. If the dispute is not resolved informally, then a formal hearing will be held before a compensation judge. The compensation judge may require a third examination by an impartial physician. The apparent purpose in doing this is to substantiate one of the original two ratings. The compensation judge, after reviewing all testimony, will provide a decision regarding the disability rating. The process for appealing the decision of the compensation judge is the same as with total disability.

PARTICIPANTS IN THE CLAIMS MANAGEMENT PROCESS

The normal four-function process for managing a claim is very simple. In this normal process, there is no controversy and all participants perform as expected. The process loses it simplicity, however, when one or more of the participants engages in behavior that is unexpected or unacceptable to other participants. To understand why some claims do not follow the normal process, one must understand that the path a claim takes is largely dependent on the behavior of individual participants in the process. The behavior of individuals can be understood in terms of three

factors: (1) responsibilities, (2) interests, and (3) influence and control. In the next few pages, each major participant is reviewed with these factors in mind.

Nine individuals, groups, and organizations can be identified as important participants in the claims management process. These are: (1) the state legislature; (2) the Department of Labor and Industry; (3) the injured worker or survivor; (4) legal counsel for the injured worker or survivor; (5) the employer; (6) the private insurer; (7) members of the judiciary; (8) medical personnel; and (9) rehabilitation professionals.

Minnesota State Legislature

Responsibilities

The most important responsibility of the state legislature is to formulate and establish this state's specific policies regarding the purpose and scope of workers' compensation. In addition, the legislature must provide the Department of Labor and Industry and members of the judiciary a mandate for acting effectively and aggressively to implement state policy regarding workers' compensation.

Interest

The primary interest of the legislature is to develop a workers' compensation policy that provides acceptable outcomes in terms of benefits and costs. The legislature is interested that benefits received by injured workers are adequate and equitable, and that the systems for delivering benefits are efficiently administered.

Influence and Control

The legislature could conceivably control every detail of the workers' compensation system. As it is, the legislature has chosen to vary its approach to exercising control over the system. In some areas, the laws governing workers' compensation include great detail, e.g., differentiating between a surviving spouse with one child and a surviving spouse with two children. In other areas, the laws formally grant other parties discretion in developing the details of how state policy will be implemented. For example, Labor and Industry is responsible for the promulgation of rules regarding rehabilitation. And in still other areas, the laws regarding workers' compensation include neither detail nor grants of authority. For example, the phrase "arising out of and in the course of employment" is the standard for determining the scope of workers' compensation. However, decades of interpretation,

and a rise in the recognition that many diseases are sometimes work-related, have rendered the phrase practically useless as an effective boundary between the work-related and the non-work-related. It is in areas such as this that other parties in the system will move to fill the policy vacuum. Other parties will act because they must make decisions concerning specific claims. The point to be made here is that the influence and control of the legislature is found throughout the system, and in some very important areas the legislature has failed to exercise its control or grant authority and discretion to others.

The Department of Labor and Industry

Responsibilities

It is the general responsibility of the Department of Labor and Industry to implement state workers' compensation policies. In a more operational sense, Labor and Industry is responsible for: (1) administering the workers' compensation law so that the basic objectives of the law are met; (2) reviewing the performance of the program and keeping procedures up-to-date; (3) advising all parties in the delivery system of their obligations and rights; (4) assisting in the voluntary and informal resolution of issues; and (5) providing an adjudicative forum.

Interests

The primary interest of the Department of Labor and Industry is to effectively implement policy developed by the state legislature. Labor and Industry is also interested in efficient administration of the workers' compensation system in Minnesota. Finally, as with any bureaucracy, certain interests with respect to self preservation are inherent.

Influence and Control

Labor and Industry can influence or control various aspects of the claims process. It can influence the types and quality of information possessed by various participants in the process. The department, through its actions, will influence the speed at which a claim is settled and, therefore, the likelihood of litigation. As is, Labor and Industry can influence the substance of rehabilitation plans and, therefore, the speed at which an injured worker returns to work.

Injured Worker or Survivor

Responsibilities

It is the responsibility of the injured worker to inform the employer that an injury has occurred. The worker

must also comply with all other procedural requirements regarding the processing of their claim. Finally, it is the responsibility of the injured worker to make a reasonable effort to participate in a rehabilitation plan and return to work as soon as their physical condition so allows.

Interests

The injured worker is primarily interested in income security and, in many cases, job security. It can also be argued that the injured worker seeks to obtain the maximum dollar benefit possible from the workers' compensation system.

Influence and Control

In one sense, the injured worker can influence or control the behavior of virtually every participant in the claims management process. It is the worker who decides whether to pursue a claim or file a petition to begin the litigation process. Many of the decisions faced by other participants in the process are largely determined by the decisions made by the injured worker. The discretion of the injured worker, however, is not always so very great or meaningful. This is because the number of reasonable alternatives open to the injured worker may be limited due

to the decisions or actions of other participants in the process.

Legal Counsel for the Injured Worker

Responsibilities

The legal counsel for an injured worker is responsible for representing the interests of his or her client. This responsiblity entails at least three distinct tasks. First, the attorney must perform any procedural tasks associated with the pursuit of the worker's personal interests, such as, but not limited to, preparing and submitting a petition and arguing the worker's case before any judicial proceeding. A second task for the attorney is to keep the worker informed of the status of their claim. Third, the attorney must inform the client of all possible and reasonable options regarding pursuit of the worker's interests, including possible outcomes as well as probabilities associated with those outcomes.

Interests

The interest of the worker's attorney is to see that his or her client receives the maximum benefits possible under Minnesota's workers compensation laws. The attorney

is also interested in attracting future clients seeking representation in matters related to workers' compensation.

Influence and Control

The injured worker's attorney has great influence over the behavior of the injured worker he or she represents, although the formal relationship with the worker is only an advisory one. The attorney controls the information available to the injured worker regarding the processing of a claim and the options open to the worker in pursuing a claim. How and whether this information is presented to the worker will have great influence on the decisions the injured worker makes regarding a claim. In addition, because of the attorney's familiarity and involvement with the mechanics of the claims process, he or she can influence or control the speed at which a claim is finally resolved.

The Employer

Responsibilities

It is the responsibility of the employer to pay compensation benefits to injured workers as required by state law. It is also the employer's responsibility to inform any injured worker or surviving spouse of the availability and scope of workers' compensation. The

employer must comply with all procedural requirements concerning the processing of a claim. Another responsibility of the employer is to initiate the development of a rehabilitation plan for the injured worker. This includes, but is not limited to, providing employment for the injured worker and encouraging the worker to return to work as soon as medical conditions so allow. A final responsibility of the employer is to take all reasonable steps to improve the safety of their workplace.

Interests

The employer is interested in maximizing the productivity of labor by controlling work-related lost-time, by insuring that employees are reasonably content, and by controlling the costs of labor. Included in this third category is the desire to control or contain the cost of workers' compensation.

Influence and Control

The influence of the employer begins before the injury ever occurs with its emphasis on preventing accidents. However, once an injury occurs, the employer may exert a profound influence on the injured worker by providing or not providing the worker with important information regarding potential compensation benefits. The employer will also

influence the behavior of the insurer by providing important claim related information. These actions will partly determine the speed of settlement and the possibility of litigation. The employer will also influence the substance of rehabilitation plans and, therefore, the speed of return to work. Finally, the employer, through contact with the employee, can influence the attitude of the employee in an important way, and thereby encourage early return to work.

The Insurer

Responsibilities

The private insurance carrier enters into a contractual agreement with an employer to assume many of the responsibilities technically relegated to the employer. Among the responsibilities assumed by the insurer are (1) the payment of benefits to injured workers; (2) compliance with many of the procedural requirements associated with the processing of a claim; and (3) participation in the development of a rehabilitation plan. In addition, the insurer is responsible for evaluating the safety of the employer's work place and recommending changes designed to reduce the incidence of work-related injuries and illnesses. It should be noted that one fundamental reason why an employer obtains the service of one private insurance carrier as opposed to another is to benefit from the

carrier's superior knowledge regarding the worker's legal obligations and expertise in the area of industrial safety. It should also be noted that, while an insurer may possess superior knowledge and expertise in some areas, it may not be well suited to assure all of the responsibilities of the employer. The importance of this fact will be more thoroughly discussed later in this section.

Interests

The primary interest of an insurer is to minimize workers' compensation benefit payments and administrative costs relative to revenues - premium and investment income. The insurer is also interested in controlling its financial performance experience by improving its ability to predict future losses.

Influence and Control

Acting as agents of employers, insurers have significant influence over the course of the claims process. Insurers can affect the speed of settlement, as well as the rate of litigation, by challenging or not challenging claims. Insurers influence the rehabilitation process by providing qualified rehabilitation consultants as well as by participating in the development of rehabilitation plans. A final, and very important, manner in which the insurer

influences the claims process is by controlling the injured worker's information during the period soon after injury. It is during that time that the worker's need for information concerning income and job security is greatest. However, the most logical source for information in the worker's mind, the employer, is unable or unwilling to provide accurate information due to unfamiliarity with the law or caution in implying or promising something that later may not agree with the insurer's assessment. Only the insurer will be able to provide specific information to the injured worker regarding benefits. The information that the insurer does or does not provide soon after injury, therefore, will have a strong influence on the behavior of the worker.

The Judiciary

The judiciary, as used here, includes settlement judges, compensation judges, judges of the Workers' Compensation Court of Appeals, and members of the Minnesota Supreme Court.

Responsibilities

The responsibity of the judiciary is to objectively settle disputes between injured workers and employers. Most often, this will involve two distinct tasks: (1)

determining the facts associated with a particular dispute, and (2) interpreting the facts in light of the laws regarding workers' compensation.

Interests

The primary interest of the judiciary is to insure that the intentions of the legislature, as expressed in the laws governing workers' compensation, are carried out.

Influence and Control

Most obviously, the judiciary will control, or at least strongly influence, the outcome of individual claims brought before it and the speed of litigation. In addition, the judiciary will assume a proactive role in the formulation of workers' compensation policy when the legislature has failed to do so and when the exigencies of current disputes so require. Finally, the judiciary influences future outcomes by establishing important precedents.

Medical Personnel

Responsibilities

The primary responsiblity of all medical personnel is to provide those services necessary to return an injured

worker as nearly and as quickly as possible to their pre-injury medical condition. Additional responsibilities include prompt reporting of medical conditions and cooperation in the development of a rehabilitation plan for the injured worker.

Interests

Hospitals, clinics, and medical personnel, including physicians, chiropractors, and physical therapists, are interested in providing professional services to their patients. In addition, they are interested in collecting fees for their services and in attracting future patients.

Influence and Control

The physician can have an important influence on the speed of settlement due to the fact that the claims process cannot proceed without information provided by the physician. Decisions made by a physician will strongly influence subsequent decisions by other participants, and particularly the injured worker and the insurer.

Rehabilitation Professionals

Responsibilities

Qualified rehabilitation consultants (QRC) are responsible for planning for the injured worker's prompt return to productive employment. Several tasks are associated with this responsibility. The rehabilitation professional must become familiar with the worker's temporary and permanent medical limitations, their employable skills, and their aptitude for learning new skills. In addition, the rehabilitation professional must become familiar with current and future labor market conditions.

Interests

The primary interest of the QRC is to see that the injured worker returns to work as soon as medical conditions so allow. The QRC is also interested in attracting future referrals from insurers and employers, and in devising rehabilitation plans that satisfy the needs and expectations of injured workers.

Influence and Control

Depending on how soon a QRC begins work with an injured worker, he or she may have an important influence on the subsequent attitude and behavior of the worker. The QRC, therefore, will directly influence the speed of settlement and return to work, the litigation rate, and the substance of the rehabilitation plan.

CRITICAL AREAS IN THE CLAIMS MANAGEMENT PROCESS

There are times during the life of a claim when important decisions must be made, or important actions must be taken, that will affect the final outcome of the claim. Some of these decisions and actions may affect final outcomes by way of increasing or decreasing the potential for the use of litigation procedures. The interest here is not so much with what happens to any particular claim, but with what happens to claims in general. Understanding why one particular claim resulted in litigation is of little value in attempting to reduce the frequency of litigation. However, the identification of common circumstances surrounding claims that involve litigation may be very helpful. The purpose here is to identify particular decisions and events that are crucial in determining the final outcomes of a claim. Of particular interest are

decisions and events that seem to affect the likelihood that a claim will involve litigation.

Three periods during the processing of a claim are particularly important in determining the final outcome of the claim, and in affecting the likelihood that an injured worker will seek the services of an attorney and file a petition claiming benefits, thus initiating the litigation process. The critical periods are: (1) immediately after an injury occurs; (2) during the assessment of permanent disability; and (3) when ending benefit payments.

Immediately After an Injury Occurs

Analysis

After an injury, the insurer and the injured worker both seek information. The insurer seeks the information it needs to determine whether an injury is compensable. It also seeks information necessary to begin benefit payments. The injured worker seeks information regarding his or her physical condition, information regarding job status, and information regarding the amount and timing of possible benefit payments. The interest of the insurer is to avoid paying benefits that it does not have to pay. While the primary interest of the injured worker is to reduce the uncertainty regarding future income.

Two important decisions are being made at this point. The insurer must decide what to do with the claim. It may honor the claim, deny liability, or delay making the decision by seeking an extension in time from Labor and Industry. The injured worker will decide whether to seek the service of an attorney as a means toward reducing uncertainty. (The worker may also seek an attorney to represent him or her in actions seeking benefits. This situation is addressed later in this section.)

It is assumed here that seeking the services of an attorney as a means toward reducing uncertainty when other means are available is undesirable and should be discouraged. It is undesirable for two reasons. First, in most cases it is unnecessary. There are other, less expensive ways to reduce uncertainty. Secondly, obtaining the services of an attorney may prematurely establishes an adversarial atmosphere that increases the likelihood that controversy will develop and that formal litigation procedures will be initiated.

The intent here is not to suggest that under no circumstance should an injured worker consult with an attorney. There are times when genuine controversy does exist. At these times the interests of the injured worker are best served by obtaining legal counsel. Access to an attorney, therefore, should not be obstructed. The presumption here is that, in a large number of cases, a worker will seek the services of an attorney as a means

toward reducing uncertainty. Uncertainty, however, results from poor communications among participants in the workers' compensation system and from inconsistency in the laws governing workers' compensation. The emphasis here is in correcting these deficiencies so that the services of an attorney are necessary only when genuine controversy exists and not when the worker simply wonders what is happening to his or her claim.

Whether the injured worker decides to seek information through an attorney will depend, in part, on what the insurer decides to do with the claim. The likelihood that the worker will seek an attorney's services is less if the insurer reaches a decision soon after becoming aware of the injury and if the worker is promptly informed of the decision. Two factors, therfore, are important: prompt decision making and prompt communication with the injured worker.

There are a number of ways an injured worker may seek to reduce uncertainty. The most likely source of information is the employer. The employer, however, may be unable or unwilling to provide much useful information. The employer may be unfamiliar with the laws regarding the amount and timing of benefits and may also be hesitant to give information that might conflict with the decision of the insurer.

A second source of information is the insurer. the injured worker, however, is not familiar with the insurer.

He or she does not know whom to contact regarding their questions. In addition, the insurer will not provide the worker with substantive information if any questions remain regarding the compensability of the claim. The insurer, therefore, is not prepared to reduce the injured worker's uncertainties.

A third potential source of information is the Department of Labor and Industry. Labor and Industry is required by law to mail to every injured worker an informational brochure explaining the basic rights and obligations of the injured worker. The process for mailing this brochure, however, does not begin until Labor and Industry receives notice of the injury. Employers are not required to report injuries before 15 days have elapsed. It is not unusual, therefore, for two or more weeks to pass before an injured worker receives the brochure. In addition, the brochure will not relieve all uncertainty. In fact, it may generate more uncertainty than it relieves because of its emphasis on due process rights and litigation procedures. The impression may be that one must jump through hoops to receive lawful benefits.

The fourth and final potential source of information is the private attorney. The attorney, however, is no more equipped to tell the injured worker whether and when benefit payments will begin than is any other participant in the process. Unlike the other participants, however, the attorney is willing to speculate on such matters and

otherwise affect the expectations of the injured worker. Even though the attorney is unable to tell the worker when, or whether, benefit payments will begin, he or she is willing to talk with the injured worker and answer other questions regarding workers' compensation.

In summary, it should not be surprising that a substantial number of injured workers find it necessary to obtain the services of an attorney soon after an injury occurs. Workers are generally subject to an information "black-out" until the insurer has made a decision regarding the compensability of the claim. Neither the employer, insurer, nor the Department of Labor and Industry is willing or able to provide any assurances to the worker. Any communication with the worker, with the exception of Labor and Industry's brochure, is at the worker's own initiative. The worker may contact someone or some organization he or she is totally unfamiliar with, and find helpful information very difficult to obtain.

Until the insurer actually makes a decision regarding the compensability of a claim, there will be uncertainty. For most claims, however, there will be no question as to compensability. It is understandable that an insurer will examine questionable claims more closely and take longer in reaching a decision than with claims that are clearly compensable. For routine claims, decisions to commence benefit payments are made quickly. The worker experiencing uncertainty, however, will not know this until

he or she begins receiving benefit payments. The delivery system is inefficient if workers in this category feel compelled to turn to an attorney because of growing uncertainty when, in fact, the insurer may have already decided to begin payments.

For the twelve month period begining in July 1979, the Department of Labor and Industry received 5,792 denials of liability. This represents roughly 10 percent of all claims. An even larger proportion can be assumed to have been examined more closely by insurers than is normal for most claims. Clearly, a large number of questionable claims are entering the system. This can be attributed to several factors including: (1) the erosion of the boundary between work-related and non-work-related injuries and illnesses; (2) a lack of disability insurance for non-work-related injuries and illnesses; (3) higher benefit levels; and (4) an apparent or perceived predisposition by judicial decision makers in favor of workers. A higher number of questionable claims means that more workers will be subject to uncertainty for a longer period of time because decisions cannot be made as quickly regarding these claims. The number of workers turning to an attorney because of uncertainty will clearly be related to the number of questionable claims entering the system.

Policy Options

The policy objective here is to enhance the self-administering aspects of the workers' compensation system and, therefore, reduce the frequency with which injured workers consult an attorney because of uncertainty regarding their claim. It has been explained that injured workers will turn to an attorney because they are unable to obtain information from other participants in the process. The Department of Labor and Industry and the employer cannot provide information they do not have. The insurer does not provide the information because no decision has been made or because they simply are not prepared to communicate directly with the worker regarding the compensability of a claim. Finally, the attorney, like the employer and Labor and Industry, also cannot provide information he or she does not have. The following policy options could serve to lessen the frequency with which workers turn to attorneys for information.

1. The Department of Labor and Industry could take a more aggressive approach to reducing the injured worker's uncertainty. A necessary ingredient to this approach would be a requirement that injuries be reported by the employer to Labor and Industry much sooner after the injury occurs. (Employers in Wisconsin are required to report disabling injuries within four days of their occurrence.) Direct telephone contact could be made by Labor and Industry with

the injured worker. This should occur within two or three days of Labor and Industry receiving notice of the injury. Labor and Industry could explain to the worker what is happening to their claim and explain that there is no reason to consult with an attorney until the insurer has made a decision regarding the claim. The worker could also be encouraged to contact Labor and Industry before seeking the services of an attorney.

Given the current frequency of claims, contacting every injured worker by telephone would require a full-time staff complement of between five and ten persons. This number, however, could be reduced with little adverse effect by not contacting less seriously injured workers.

2. The insurer, or self-insuring employer, could make direct telephone contact with the injured worker. They should explain that the worker's claim is being evaluated so that a decision can be made regarding its compensability. The worker could also be contacted by the insurer as soon as the compensability of the claim is affirmed. If the decision of the insurer is to deny liability, then Labor and Industry should be immediately informed of the fact so that the information can then be relayed immediately to the worker. Contact by the insurer should not only reduce the worker's uncertainty. It should also serve to discourage the premature development of an adversarial attitude by the injured worker.

3. The state legislature could attempt to clarify the distinction between work-related and non-work-related injuries and illnesses and grant the Department of Labor and Industry the authority to develop criteria and standards for eliminating claims that clearly do not fall within the legislature's definition of work-related. Clarification should serve to decrease the number of claims where compensability is an issue and facilitate evaluation by the insurer. The current statutory and case law related to compensability is ambiguous and difficult to interpret.

How the boundary between work-related and non-work-related injuries is defined is a very important policy issue and is dealt with elsewhere in this report. The importance noted here is that the distinction be as clear as possible.

4. The Department of Labor and Industry should take an active part in implementing the legislature's intentions with respect to the scope of workers' compensation. To do otherwise is to invite claims that do not fall under the purview of workers' compensation and claims that will almost certainly be denied by insurers. Action taken by Labor and Industry would be more timely and forceful, therefore reducing the number or workers experiencing uncertainty. Due proces avenues, however, should allow for the review of any decision made by Labor and Industry.

5. Employers could be encouraged to report injuries to insurers without delay. The longer an employer takes to

inform an insurer of an injury, then the longer it will be before an insurer can reach a decision regarding the compensability of the claim. A reasonable policy would be to require an employer to reimburse the insurer for any indemnity benefits incurred while the insurer was unaware of the injury. The magnitude of the penalty should be increased for each subsequent week that the insurer is not informed of the injury. For example, if an employer were to inform the insurer of an injury three weeks after it occurred, and the weekly incurred indemnity amount equalled $200, then the emplopyer should be required to pay the insurer $200 for the first week, $400 for the second week, and $600 for the third week, or a total of $1,200. Such penalties should be in addition to normal premiums, rate adjustments or experience ratings.

6. Physicians could be encouraged to provide medical reports to insurers without delay. A major reason why an insurer must delay making a decision regarding a claim is that the initial medical report from the attending physician has not been received. A reasonable policy might be to excuse the insurer from payment of all, or a portion, of the physicians's fee if the report has not been received within one week of the initial request by the insurer.

Analysis

As was described earlier, a major opportunity for controversy is when a determination of permanent partial disability is made. The concern here is not that benefits paid for permanent partial disability are either too high or too low. This issue is related to the fundamental question of what the underlying purpose of permanent partial disability benefits is, which is addressed elsewhere in this report. Instead, the immediate concern is that the procedure for assessing permanent partial disability is inefficient because of the costly controversy and litigation it produces.

The manner in which controversy develops has been discussed earlier in this section. Basically, the worker's physician produces an assessment of disability that is higher than the assessment produced by the insurer's physician. The amount of benefits at stake in such cases can be quite large. For example, the difference between a 20 percent disability and a 40 percent disability to the back, for a worker with a wage equal to the statewide average weekly wage, is over $11,000. The great potential for controversy, therefore, is understandable.

In assessing permanent partial disability, the physician is attempting to determine the degree of permanent

bodily impairment present as a result of the work-related injury or illness. The possibility that two different physicians may reach different conclusions when evaluating the same disability can be traced to two conditions. First, physicians are not entirely immune from the effect of financial incentives. Some physicians are noted for their tendency to produce high disability ratings. In addition, these physicians may attract future referrals from workers or attorneys seeking generous ratings. Physicians selected by the insurer may be operating under similar incentives. If an insurer requests a second rating, it will send the injured worker to a physician who tends to provide more conservative ratings. A conservative rating will place the insurer in a more strategic position if there is future negotiation or litigation. The physician will also be more likely to attract future referrals from insurers. The fact that physicians tend to produce ratings that favor the participant requesting the rating is well known by those involved in the system. It is not unusual for compensation judges to request a third rating from an independent physician.

A second reason why two physicians may produce different ratings is that physicians are not required or encouraged to follow standardized procedures or methods in evaluating disabilities. It is very possible that two physicians, both immune to any financial incentives, could produce very different disability ratings. This happens

because two physicians may approach the problem from different perspectives using different techniques and criteria.

When two different disability ratings are produced, the two parties are encouraged to reach a compromise settlement. The process for reaching a compromise begins when the insurer pays benefits based on the lower rating or somewhere between the two ratings. The injured worker may then file a petition claiming additional benefits. The parties are next brought together in an informal setting where it is hoped that some compromise settlement will be reached. It is during this compromise process that it becomes clear that the initial ratings are very important in affecting the final outcome of negotiations and that a participant will be better off by starting the process with a low or high rating. For example, assuming that the correct rating is 25 percent and the rating from the insurer's physician is 20 percent, the injured worker is likely to come out of the process with a higher award if he or she begins with an initial rating of 40 percent rather than 30 percent. The same principles also apply to the insurer. It is likely to pay a lower benefit if it enters the compromise process with a low initial rating.

These observations support two conclusions. First, present incentives do not encourage both parties to produce similar ratings. This situation, not surprisingly, will encourage litigation because a compromise settlement will be

much more difficult to reach. Secondly, the scientific precision associated with disability ratings is often only illusory. The direct and indirect effect of financial incentives on physicians and the importance of compromise and negotiation in the process for resolving controversy may overshadow any association with medical science that may have been intended.

Policy Options

In summary, controversy is very likely to develop during the determination of permanent partial disability. Controversy develops because the injured worker and the insurer are encouraged and able to obtain medical evaluations that best prepare them for the process of negotiation and compromise that usually follows. As a result, compromise is difficult to reach and the controversy often develops into litigation. The following policy options are offered in the interest of improving the efficiency of the process for assessing permanent partial disability.

1. Prevent compromise and negotiation unless two ratings are very similar. Under this option, the Department of Labor and Industry would not accept as lawful any agreement that represented a compromise between two substantially different medical evaluations. Small differences, however, could be subject to compromise. (A

reasonable assumption might be that disability ratings differing by five percent or less could be resolved through negotiation.) A necessary ingredient to this option would be the understanding that any litigation involving two widely dissimiliar ratings could only result in the acceptance of one rating and the rejection of the other. Compromise and negotiation should be allowed up to the point where each party must submit its own medical report to Labor and Industry. After Labor and Industry is called upon to resolve the dispute, however, no substantive compromise should be allowed.

By preventing compromise through negotiation or litigation, much of the incentive for producing unreasonably low or high disability ratings is avoided.

The underlying assumption is that the probability that a disability rating will prevail decreases as the disparity between the rating and the true disability increases. The incentive is for both parties to produce disability ratings that are closer to the true disability. As a result, the frequency of litigation should decrease.

2. Whenever the possibility of permanant partial disability exists, a physician could be assigned, by the Department of Labor and Industry, to perform the evaluation. The agency would maintain a listing, by area, of physicians willing to cooperate with this policy. The cost of the examination would be borne by the insurer. The injured worker and the insurer would be free to obtain an independent assessment. However, the presumption would rest

with the original independent evaluation. The effectiveness of this policy would depend on the strength of the presumption favoring the original evaluation. In other words, this policy is not likely to be very successful in reducing litigation if the original evaluation is subject to frequent compromise. Deviations should be allowed only when supported by strong medical evidence.

This option is not entirely original. Evaluations by independent physicians may now be ordered by compensation judges when there is little progress in reconciling two widely disparate ratings. This policy, however, is of no help in preventing controversy or litigation from occurring. The policy proposed here should serve to reduce the frequency of both controversy and litigation.

This option is similar in concept to the pilot project now being implemented in three Minnesota counties. In this pilot project, a panel of medical professionals is established whenever the degree of disability is an important issue in a litigated claim. This alternative is different from the above option in that it becomes effective only after the formal litigation process has commenced and each party has already produced a medical report.

3. Adopt standardized methods and criteria for assessing permanent partial disabilities. As was explained earlier, a fundamental reason why controversy is possible at all is because two physicians are able to produce substantially different medical reports after evaluating the

same injured worker. The adoption of standardized methods and criteria should reduce the liklihood of this occurring. Several states have taken positive steps in this direction. In Wisconsin, for example, extensive schedules have been developed. In Florida, Guides to the Evaluation of Permanent Impairment, published by the American Medical Association, has been adopted as the appropriate standard for assessing permanent partial disabilities.

If this policy were pursued, it would be important to require all physicians to follow whatever standards are chosen. Medical reports that do not incorporate the accepted methods or criteria should be rejected as admissible evidence or testimony. This policy would require aggressive administration by the Department of Labor and Industry.

Ending Benefit Payments

Analysis

Ideally, an injured worker will return to work as soon as their medical condition so allows. It is very important, however, to ask why a worker returns to work after recovering from an injury. It may be true that the intrinsic value of productive employment is an importnat consideration. Many workers return to work because they like to work. Most would agree, however, that the primary

reason that people work at all is to earn a livelihood, i.e., to obtain income. The assumption here is that an injured worker is more likely to delay returning to work as the proportion of lost income replaced by workers' compensation benefits increases.

It was explained earlier that benefit payments for total disability may end under one of three circumstances: (1) voluntary return to work; (2) death; or (3) administrative termination. It was also explained that the frequency of voluntary return to work has probably decreased while the administrative termination of benefits has increased. The desirable situation is the voluntary return to work by the injured worker. Administrative termination is undesirable because it is much more likely to involve costly controversy and litigation.

Policy Options

Two policy objectives emerge. First, efforts should be directed at increasing the incentives present for injured workers to voluntarily return to work. Secondly, efforts should be made to decrease the probability that administrative termination will involve litigation. The following policy options are offered with these objectives in mind. The first four options are aimed to increasing the attractiveness of voluntarily returning to work.

1. Encourage the early establishment of a target date by which time the injured worker will return to work. A reasonable policy would be to encourage the establishment of such a date for all injuries involving two weeks of lost work time. The Department of Labor and Industry would be responsible for insuring that this task is performed. All relevant parites would participate in this task.

A target date could only be viewed as tentative and should always be represented as such. The purpose is not to establish a contractual agreement. Instead, the purpose in establishing a target date is to inform the worker that he or she is expected to return to work once medical conditions so allow. A target date would serve as a constant reminder of this fact.

Under current law, injured workers are referred to rehabilitation consultants within 30 days after it has been determined that the injury or disease will prevent the worker from returning to their original job. Most injured workers do not fall into this category. Returning the worker to employment, however, is a major objective for all workers and should be communicated as such.

2. Workers suffering major injuries could be screened by persons trained in physical therapy within a few days of the injury. Early screening is very important in restoring the worker to their original physical condition. Appropriate physical therapy programs should begin immediately after the injury.

The identification of workers to be screened and the development of physical therapy programs for individual workers should be the responsibility of insurers. The cost of screeneing all workers would be prohibitive. The insurer is in the best position to decide whether screening and physical therapy are appropriate.

Incentives can be provided to ensure that insurers are in fact providing physical therapy screening when necessary. A reasonable policy would be to require an employer ~~insurer~~ to make a substantial payment to the special compensation fund whenever a worker is totally disabled and no physical therapy screening was conducted during the first two or three weeks of disability.

3. Weekly benefits could be based on wages net of state and federal taxes and social security deductions. The object of concern is income and not wages. Incentives, as perceived by policy makers, are distorted when gross wages are employed. Injured workers, however, consider income as the only relevant financial incentive. Currently, more than 100 percent of after tax wages may be replaced by workers' compensation benefits. This is particularly true for those whose benefits approach the minimum amount. (This subject is discussed at length later in this report.)

5. The proportion of ~~wages~~ income replaced by benefits could be reconsidered after converting to an after tax basis. Wage-replacement policy should insure that a worker's income will be greater if he or she is working. Current policy

does not do so.

The following policy options are aimed at decreasing the liklihood that the administrative termination of benefits will involve litigation.

1. Benefit recipients could be informed 2-4 weeks prior to the discontinuance of payments. Currently, injured workers may be informed that payments are being discontinued at the same time that the discontinuance becomes effective. Such suddenness is likely to increase the likelihood of controversy and litigation. A period of 2-4 weeks would provide the worker with the opportunity to prepare for the ending of payments and, hopefully, arrange for returning to work.

2. The Department of Labor and Industry could assume an active role in the administrative termination of benefits. Responsibility for administering this state's workers' compensation policies has two complementary aspects: (1) to insure that injured workers receive rightful compensation under the law, and (2) to insure that workers do not receive benefits that are not prescribed under the law. Labor and Industry's activities have been directed almost exclusively to the first aspect. Responsibility for discontinuing benefits has been relegated to the insurer and the self-insuring employer. This situation serves to enforce the perception of workers' compensation as an adversarial process featuring the injured worker and the insurer, with the Department of Labor and

Industry simply providing the arena for conflict.

One possible step that could be taken would be to periodically review total disability cases to identify claims where continued disability appears to be in doubt. Labor and Industry could request relevant medical reports and other information regarding continued disability. If appropriate, the agency could then order the discontinuance of payments or suggest to the insurer that payments be discontinued. The due process rights of the worker to object to the discontinuance of payments would not be affected. The opinion of the agency, however, would be considered during any judicial proceedings.

A policy such as this would appear to represent a transfer of part of the normal claims management function from the insurer to the state. It is unlikely, however, that insurers will discontinue their own activities in this area. Furthermore, the approval or support of Labor and Industry should not be a prerequisite to any insurer taking action to discontinue benefits. Because of the large number of claims involved, it should be expected that Labor and Industry would have to be somewhat selective in its activities in this area.

A final area of concern is whether the Department of Labor and Industry has the expertise to perform this task. It should be noted that, as the claims management agent for the State of Minnesota, Labor and Industry has performed this task for several years.

CHAPTER 4

WORKERS' COMPENSATION BENEFITS IN MINNESOTA

As discussed in Chapter 1 of this report, workers' compensation arose out of a basic compromise. On one hand, workers were guaranteed protection against economic loss resulting from work-related injuries and illnesses. On the other hand, employers were relieved of any liability other than workers' compensation liability for basic economic loss resulting from work-related injuries and illnesses. This compromise made workers' compensation possible.

Compensation benefits may be characterized as being primary or secondary. Primary benefits are those provided to compensate for economic loss. This definition would include, at present, temporary total, temporary partial, permanent total, medical, rehabilitation, and death benefits. Secondary benefits are those provided to compensate for noneconomic loss. This would include permanent partial benefits. This distinction between types of benefits is important when considering what changing cost constraints mean in light of the fundamental compromise of workers' compensation.

The primary responsibility of any workers' compensation system is to provide protection against economic loss. Broad compensation for noneconomic loss, however, is inconsistent with the original compromise. Therefore, a

proper balance between primary and secondary benefits must be maintained in order to properly focus the system on replacement of economic loss.

In other words, it is important that the responsibility to provide primary benefits be fulfilled before any secondary benefits are provided. If the primary responsibility is fulfilled, and if additional resources are still available, then the possibility of providing secondary benefits can be considered. This also means, however, that when cost constraints increase, and when substantial secondary benefits are being provided, then any adjustment in benefits should first take place in the realm of secondary benefits.

Primary benefits, that are neither excessive nor inequitable, should not be reduced as long as substantial secondary benefits are still being provided. By taking this approach to primary and secondary benefits, policy makers can be responsive to cost constraints and, at the same time, be certain that the basic responsibility of workers' compensation is being fulfilled.

If it can be assumed that some secondary benefits will be provided, then the essential problem faced by policy makers is to seek a proper balance between primary and secondary benefits. This balance should recognize current cost constraints and, at the same time, prove consistent with the

fundamental compromise of workers' compensation.

The following sections of this chapter discuss each of the benefit provisions of Minnesota's workers' compensation system. The primary benefits (medical, rehabilitation, total and partial disability, and death) are considered first, followed by secondary benefits (permanent partial). Each benefit is discussd in terms of several important criteria: adequacy, equity, efficiency, and certainty.

MEDICAL BENEFITS

Providing necessary medical care to workers experiencing work-related injuries and illnesses is part of the primary responsibility of workers' compensation. That the employer should bear the direct cost of medical care is unquestioned.

There is, however, serious concern regarding the rising cost of medical care. In 1980, total incurred medical costs for Minnesota employers were $85,936,371 - a 99 percent increase from the 1976 cost of $43,277,348.

Medical benefits may be associated with claims for which indemnity benefits are or are not also paid. The latter are known as medical only claims and represent a very large proportion of all workers' compensation claims.

MEDICAL ONLY CLAIMS

In policy year 1978, the latest year for which data are available, there were 102,690 medical only claims reported by private providers of workers' compensation insurance. This number represents 74 percent of all claims from that policy year. The total incurred medical cost for medical only claims during that policy year was $6,950,147. The average medical cost per medical only claim was about $68.

OTHER CLAIMS

In policy year 1978, the total incurred medical cost for claims also including indemnity benefits was $45,347,837. The average cost per claim was about $1,265.

UBIQUITOUS ASPECTS

Rising medical costs is not limited to the context of workers' compensation alone. According to the U.S. Department of Labor Bureau of Labor Statistics, medical costs since 1976 have risen about 41 percent in the Iwin Cities metropolitan area.

Contributing to the overall problem of rising medical costs is an increase in the utilization of services. Although no data are readily available to document this phenomenon, the overutilization of services has been described as a major factor contributing to rising medical costs. This trend is particularly relevant to workers' compensation because of the numerous requirements and incentives present to encourage the overutilization of services. Three of these factors are discussed below.

UNIQUE ASPECTS

An injured worker is free to change physicians if he or she so desires. To some extent, this will result in the duplication of examination and diagnostic services as a second or subsequent physician becomes familiar with a new patient. The duplication of services, of course, contributes to the problem of rising medical costs.

A second important factor is the group of incentives working to encourage physicians to provide services that would not normally be provided. If a physician fears being challenged as to his or her diagnosis of a worker, then the physician will more likely perform tests or examinations, to fully substantiate his or her conclusions, that would not normally be performed. Similarly, a physician who wishes to be known as being particularly sensitive to the needs of workers or insurers will perform whatever tests or examination are needed to support his or her case.

A third factor is that some services provided to injured workers are not routinely provided to patients whose injuries are not related to workers' compensation. For example, a rating of impairment is not likely to be performed if the injury is not work-related. Similarly, the reporting requirements associated with workers' compensation injuries are probably more extensive and demanding than with other patients. Testifying during judicial proceedings may be more common with workers' compensation injuries than with other patients. All of these requirements tend to increase the charges for workers' compensation patients relative to other patients.

Finally, the workers' compensation law expressly condones the duplication of services in some cases. For example, when no agreement can be reached regarding the determination of impairment, a compensation judge is authorized to order an examination and evaluation by a third physician. Similarly, when non-emergency surgery has been proposed by a worker's physician, a second opinion from another physician must also be obtained before the employer can be held liable for the cost of the surgery. Even if the second physician does not recommend surgery, the worker may choose to have the surgery anyway - at the employer's expense.

CONCLUSIONS AND FUTURE PROSPECTS

The problem of rising medical costs is complex and widespread. With respect to workers' compensation, various incentives and requirements encourage the overutilization of medical services. Some services and tasks are unique to workers' compensation and naturally result in higher costs.

Higher medical costs are, to a great extent, closely related to concerns for the due process rights of workers and employers. Costs are also influenced by the manner in which

controversy is resolved in the workers' compensation system.

Efforts to contain medical costs may have important implications throughout the workers' compensation system. The 1981 amendments to the workers' compensation law represent an attempt to address this problem. While it is too early to evaluate the ultimate success of these amendments, further efforts in this area are almost a foregone conclusion because of the relatively narrow focus of the 1981 amendments. However, it is beyond the scope of this report to further address the ubiquitous problem of rising health care costs. Recommendations presented in other sections of this report, however, should serve to reduce medical costs. Of particular impact will be those recommendation regarding the reduction of controversy and litigation and the evaluation of impairment.

NOTES

1 Minnesota Insurance Division, I-57 reports.

2 Workers' Compensation Insurers Rating Association of Minnesota, unit statistical plan data

3 U.S. Department of Labor, Bureau of Labor Statistics, Medical Care Index.

TOTAL DISABILITY BENEFITS

I. INTRODUCTION

Workers' Compensation pays total disability benefits whenever an employee is incapable of working at any occupation as a result of a work-related injury or disease. The Minnesota workers' compensation statute provides benefits for both temporary total and permanent total disabilities. Permanent total disabilities are defined in the statute as the loss of certain body parts, such as loss of sight in both eyes, both arms at the shoulder, or both legs, complete paralysis or loss of mental faculties. The definition includes any other injury which totally incapacitates the employee and prevents him or her from earning a wage. Losses defined by statute constitute permanent total disabilities while all other total disabilities are classified as temporary total unless adjudicated as permanent.

Although benefits in the statute are defined separately for permanent and temporary total disabilities, the benefit levels and structures are identical. Temporary total disability used to be subject to a 350 week healing period after which temporary total benefits were discontinued unless the employee could show why they should be continued. This healing period was removed from the statute in 1975. As a result, almost all cases of total disability, except for

those explicitly defined by statute, are classified as temporary total; and all total disability cases are subject to the same benefit level and structure. For this reason, temporary total and permanent total benefits are analyzed together in this section of the report under the general heading of total disability.

II. BASIC PROVISIONS

When an employee suffers a work-related injury and is unable to return to work for a period of more than 3 days, workers' compensation will pay total disability benefits to the injured worker. If the disability continues for more than 10 days, compensation benefits are paid from the first day of disability.

Generally, total disability payments are equal to 66 2/3 percent of the worker's daily wage at the time of the injury. The benefit is subject to minimum and maximum payments, however, so a worker may actually receive more or less than this benefit rate under certain circumstances. Beginning on October 1, 1977, the maximum benefit payable for total disability is the statewide average weekly wage as computed annually. The minimum benefit level is somewhat more complex. Total disability benefits are subject to a minimum benefit of 50% of the statewide average weekly wage. If, however, the worker's actual weekly wage is less than 50% of the statewide average, the worker receives his or her

actual wage in benefits. But in no case can total disability payments fall below 20 percent of the statewide weekly average regardless of the worker's wage. Under these provisions, an injured worker may be eligible for more than his or her weekly wage in benefits.

Total disability payments are paid during the entire period of disability subject only to the waiting period described above. Payments will be discontinued only when the employee returns to work or refuses a job offer which is within the medical limitations of the employee. If the employee is unable to return to work at a comparable economic status due to medical limitations a portion of the income loss will be paid by temporary partial disability benefits.

Benefits must begin within 14 days of receipt of notice of injury or knowledge of the injury by the employer. The insurer or employer has 30 additional days from the date the first payment is due to determine the compensability of an injury or file a denial of the claim. The insurer or employer may reqinsurer or
employer may request an extension of this period up to an additional 30 days.

III. SPECIAL PROVISIONS

Total disability payments in Minnesota are subject to additional special provisions which affect the overall benefit

to the injured worker. These three special provisions are: the yearly adjustment of benefits; the offset of disability benefits being paid by any other government disability benefits program; and supplementary benefits.

A. Adjustment of Benefits

Since 1975, Minnesota workers' compensation law has required benefits to be adjusted to compensate for increases in living costs for those dependent on total disability payments. The current statute provides that for those injured after October 1, 1975, and beginning on October 1, 1981 and thereafter on each anniversary date of the employee's injury, the total benefits due the employee will be adjusted. The adjustment is the percent increase of the statewide average weekly wage over the two most recent years for which it is calculated, subject to a 6 percent maximum. The benefit maximum does not apply to these annual adjustments. Therefore, benefits may exceed the statewide average weekly wage effective on the date of injury. Previously, benefits were adjusted on October 1 of each year regardless of the date of injury. Starting on October 1, 1981, an injured employee's total disability benefits will be adjusted on the anniversary date of the injury. The uniform October 1 benefit adjustment drew complaints that some workers received an increase in benefits shortly after their injury while others waited close to a year for the adjustment.

B. Social Security Offset

Workers' Compensation beneficiaries who are also eligible for other government disability programs (usually social security) will have their benefits reduced, either by the government program or by workers' compensation. In Minnesota, the Social Security Administration will reduce benefits paid by whatever amount the combined total of workers' compensation and social security benefits exceed 80% of the employees average current earnings. This is generally comparable to the average weekly wage figure utilized by workers' compensation.

After $25,000 in workers' compensation indemnity benefits have been paid to the disabled worker, the Minnesota workers' compensation payments begin to be offset for any disability payments received by the claimant. The amount of weekly compensation paid to the employee is reduced by the amount of any disability payment paid under any government disability program, if these benefits are being paid for the same injury. This offset also applies to any old age and survivors insurance benefit.

C. Supplementary Benefits

An employee who suffers a compensable injury and is totally disabled for more than 104 weeks is eligible to receive supplementary benefits. A worker who is totally disabled

from a work-related injury at any time at least four years from the date of injury is also eligible for supplementary benefits regardless of whether he or she has been totally disabled for a continuous period of 104 weeks. The supplementary benefit is equal to the difference between the total disability benefit received by the employee and 65 percent of the statewide average weekly wage. Thus, all injured workers receiving total disability benefits for more than 104 weeks are raised to a benefit equal to 65 percent of the statewide average, regardless of their weekly wage at the time of the injury. A new minimum benefit is, in effect, created for this group of beneficiaries.

Employees who are receiving reduced or no workers' compensation because of credits or offsets are still eligible for supplementary benefits. If, for example, a worker's benefit has been reduced because of eligibility for social security to less than 65% of the statewide average weekly wage, supplementary benefits will be paid to raise the total benefit to 65% of the statewide average. When an employee is receiving reduced benefits due to third party liability or damages, the reduction in benefits will be computed based on the actual benefit or 65 percent of the statewide average, whichever is greater. In other words, the worker's total benefit from workers' compensation and the third party damages cannot be less than 65% of the statewide average weekly wage. In effect, any employee eligible for workers' compensation payments of less than 65 percent of the state-

wide average will have those payments raised to that level. Any claimant receiving reduced or no compensation because of prior limits on maximum total benefits paid or because of reductions due to old age or disability benefits is also eligible for supplementary benefits. An injured worker will not become eligible for supplementary benefits if he or she is receiving reduced benefits because of an agreement made as part of a settlement of a claim.

For an employee simultaneously receiving benefits from a government disability program such as social security and workers' compensation, the amount of supplementary benefits are reduced by 5%. This small offset allows the employee to continue receiving both the supplementary benefit and the full social security benefit.

Although it is the responsibility of the employer or insurer to pay the supplementary benefits described in the statute, these additional benefits are fully reimbursed from the special compensation fund.

IV. ANALYSIS

A. The Conceptual Basis for Total Disability Payments

An earlier section of this report discussed the importance of understanding the conceptual basis for determining obligations to injured employees under workers' compensation.

The underlying purpose of workers compensation benefits is important because of its impact on benefit levels and structure and on the way in which benefits will be evaluated. Two approaches to payment of benefits were discussed depending upon which consequences of work-related injury and disease are compensated: work and nonwork disabilities, functional limitations, or impairments. Total disability benefits are, both in intent and operation, designed to provide payment for work disability, that is, the loss of earning capacity or actual lost wages. "Liability on the part of an employer or his insurer for disability of a temporary total ... and permanent total nature shall be considered as a continuing product in part of the employee's inability to earn ... due to injury or occupational disease and shall be payable accordingly." (Minn. Stat. 176.021, Subd. 3). Thus it is clearly stated that the purpose of total disability payments is to compensate the injured worker for lost wages or earning capacity.

The level and the structure of total disability benefits in Minnesota raise additional issues about the purpose of workers' compensation benefits. Although the benefits are clearly dependent on the current earnings of the injured worker, at least two other factors appear to play an important role in the way total disability benefits have been structured in Minnesota.

The first factor is cost constraints. This is certainly the

main reason for setting a maximum benefit level in an effort to put a cap on the cost of individual claims. Other features of the total disability benefit (minimum benefits, supplementary benefits, the yearly adjustment, and social security offset) all suggest that, in Minnesota, total disability benefits are also determined by economic need. A system based on wage loss or loss of earning capacity, but also based on economic need and confronted with increasing pressure to reduce costs will undoubtedly create conflict.

A system designed to replace a certain portion of lost earnings should theoretically have a maximum which affects few workers and replaces approximately the same percent of wages for all. Economic need, on the other hand, dictates that a higher percent of wages should be replaced for lower income workers, since they probably require a higher percent of wages to provide for their basic needs. Higher minimums, however, are likely to require lower maximum benefits affecting more workers so that the program remains affordable. Supplementary benefits, by creating, in effect, a new minimum benefit for those disabled longer than two years, are totally based on a perceived economic need and gives the Minnesota workers' compensation system a very strong social welfare component. Although the yearly adjustment benefit may be viewed as a way of compensating workers for expected increases in wages, it is more likely based on the belief that the increase is needed to maintain the workers' economic status due to the effects of inflation. Minnesota

is one of only a few states which provide for adjustment of workers' compensation benefits.

The offset of workers' compensation when an injured worker is also eligible for social security may be justified from both a wage loss and cost constraint perspective. Offsets can reduce the cost of the system by allowing the social security program to pay as much as possible of the worker's earnings loss. Were it not for the offset, the injured worker would receive benefits for the same injury from two different sources and receive more than his or her wage loss in benefits.

The Minnesota benefit structure and benefit level for total disability are, therefore, trying to satisfy competing and conflicting objectives. There is a strong belief in the approach which pays compensation for lost earning capacity as stated in the statute itself. The benefit level (66 2/3 percent of the statewide average weekly wage) is consistent with that approach. Minimum benefit levels and supplementary benefits appear to be based, however, on the belief that the workers' compensation system should also be based on economic need and provide proportionately more benefits for those with low wages. Maximum benefit levels seem to be controlled by cost considerations. Workers' compensation offsets for social security tend to reduce costs and are consistent with a wage-loss approach, although these effects are greatly diminished by the provisions for sup-

plementary benefits. Yearly adjustment of benefits could be viewed as consistent with both the need to replace lost earnings and economic need. The evaluation of total disability benefits requires consideration of these conflicts and their impact on the adequacy, equity, promptness, and certainty of benefits. The quality of benefits as evaluated by these criteria is, in turn, an important factor in the efficient administration of workers' compensation.

B. Evaluation of Total Disability Benefits

1. Adequacy

As mentioned previously in this report, adequacy is measured by the percent of wages replaced by workers' compensation benefits. It has been stated that, generally, 66 2/3 percent is considered to be an adequate replacement level for benefits and is used by an increasing number of states. Although the Minnesota system uses the 66 2/3 percent replacement rate, many injured workers in Minnesota receive more or less than this percentage of their wage in benefits. Table 1 shows how the percent of wages which an injured worker may have replaced varies under Minnesota workers' compensation law. Using the 1981 statewide average weekly wage of $267, the table shows the actual benefit and percent of wages replaced for each of five wage categories.

Table 1

Minnesota Total Disability Benefits

Statewide Average Weekly Wage: $267.00

Weekly Wage	% SAWW	Benefit	% of Wage	% of MN Indemnity Claims[1]
greater than 400	greater than 150	267.00	less than 66 2/3%	15%
200 - 400	75 - 150	134.00-267.00	66 2/3%	54%
134 - 199	50 - 75	134.00	66 2/3 - 100%	20%
53 - 133	20 - 50	53.00-133.00	100%	10%
less than 53	less than 20	53.00	more than 100%	1%

[1] National Council on Compensation Insurance, Detailed Claim Call.

DISCUSSION DRAFT

A distribution of the weekly wages of injured workers in relation to the statewide average was taken from indemnity claims submitted to the NCCI during a one year period. This distribution was used to estimate the percent of injured Minnesota workers who would be eligible for each level of benefits. The table shows that although Minnesota workers' compensation is intended to replace 66 2/3 percent of lost wages, many workers receive more or less than that amount. In fact, according to the NCCI data, only 54 percent of Minnesota workers injured on the job would be eligible for 66 2/3 percent of their wages in total disability benefits. Fifteen percent would receive less than 66 2/3 percent, another 20 percent are eligible for more than 66 2/3 percent but less than 100 percent of their wages, 10 percent would receive their exact weekly wage in benefits, and 1 percent of Minnesota injured workers are eligible for more than their weekly wage in total disability benefits. Fewer workers (15%) are affected by the maximum than the minimum benefit (31%), which is consistent with the belief that economic need should be an important factor in determining workers' compensation benefits, while it compromises the wage-loss approach and strongly impacts upon the relative desirability of returning to work.

Adequacy of workers' compensation may take into account other factors such as age and education of the worker, number of dependents, the tax structure and availability of

other benefits, especially social security, and other aspects of the benefit structure. Three factors, the tax structure, supplementary benefits, and social security benefits are discussed in this report. A discussion of the impact of the tax structure is included because benefits are tax free and because Minnesota has one of the most progressive state income taxes in the country. The progressive nature of federal income taxes also contributes to significant changes in the relationship between gross and after tax earnings. Supplementary benefits have a signigicant impact on long-term disability benefits, especially when the worker is simultaneously eligible for social security. Social security benefits are important because of their impact on the overall size of the benefit received and their interrelationship with supplementary benefits.

a. Minnesota State and Federal Tax Structure

An individual worker judging the adequacy of his or her workers' compensation benefit is unlikely to be concerned with the percent replacement of his or her gross wage. Rather, a worker is more likely to compare the benefit with "take home pay", the amount the worker has to spend after state and federal taxes and social security are deducted. The higher and progressive state income tax in Minnesota means that the 66 2/3 replacement standard replaces more spendable earnings than it does in most other states. These spendable earnings vary

depending on marital status and number of dependents and other tax deductions. Table 2 shows the effect of taxes on the gross weekly wage of a Minnesota worker and how the workers' compensation benefits, as a percent of take home pay, vary both within and across wage levels. There is no general standard, such as the 66 2/3 percent of weekly wage, for the replacement of take home pay. Iowa, however, has recently passed legislation providing a workers' compensation benefit of 80 percent of spendable earnings, which was recommended by the National Commission on State Workmen's Compensation Laws in their 1974 report.

Table 2
Percentage of Take Home Pay
Provided by Minnesota Total Disability Benefits
Statewide Average Weekly Wage: 267.00

Single

Weekly Wage	170 (8840/yr)		267 (13,884/yr)		350 (18,200/yr)		450 (23,400/yr)	
Deductions	1	2	1	2	1	2	1	2
Federal Tax	22.80	18.80	44.20	39.20	70.30	64.30	104.40	97.70
FICA (6.65%)	11.31	11.31	17.76	17.76	23.28	23.28	29.93	29.93
State Tax	6.90	6.00	13.50	12.70	20.50	20.00	28.20	27.80
Total Deductions	41.01	36.11	75.46	69.66	114.08	107.58	162.53	155.43
Take Home Pay	128.99	133.89	191.54	197.34	235.92	242.42	287.47	294.57
Workers' Compensation Benefit	134.00[1]	134.00[1]	178.09	178.09	233.45	233.45	267.00[2]	267.00[2]
% of Take Home	104	100	93	90	99	96	93	91

Married

Weekly Wage	170 (8840/yr)		267 (13,884/yr)		350 (18,200/yr)		450 (23,400/yr)	
Deductions	2	4	2	4	2	4	2	4
Federal Tax	13.80	7.80	30.60	23.10	50.30	41.40	76.20	65.40
FICA	11.31	11.31	17.76	17.76	23.28	23.28	29.93	29.93
State Tax	6.40	4.50	13.60	11.90	21.60	21.10	30.50	29.40
Total Deductions	31.51	23.61	61.96	52.76	95.18	85.78	136.63	124.73
Take Home Pay	138.49	146.39	205.04	214.24	254.82	264.22	313.37	325.27
Workers' Compensation Benefit	134.00[1]	134.00[1]	178.09	178.09	233.45	233.45	267.00[2]	267.00[2]
% of Take Home	97	92	87	83	92	88	85	82

1 - Qualifies for 50% SAWW Minimum
2 - Reached 100% SaWW maximum

DISCUSSION DRAFT

The examples in table 2 show that workers' compensation benefits in Minnesota can replace anywhere from 82 to 104 percent of take home pay. Because married workers and workers with dependents pay fewer taxes, the benefits tend to favor single workers and workers with no dependents. Because of the progressive nature of both state and federal taxes, workers with higher salaries tend to benefit until they reach the maximum benefit level. Then the percent of take home pay covered by the benefit will begin to fall. According to the NCCI wage distribution, approximately 20 percent of injured workers have wages below those in the table and will be eligible for relatively higher benefits as a percent of both gross and take home wages. About 9 percent have higher wages than shown in the table and will be eligible for relatively less benefits due to the effect of the maximum benefit.

DISCUSSION DRAFT

In summary, most injured workers in Minnesota are eligible for well over 80 percent of their take home pay in total disability benefits. The state and federal tax structure results in the most favorable replacement ratio for single workers with few dependants. Minimum benefit levels can result in a worker being eligible for more than take home pay in benefits, while benefit maximums will cause higher paid workers to be eligible for less than the 66 2/3 percent replacement ratio de-

fined in the statute.

Workers' compensation indemnity benefits should replace a substantial portion of lost income but not so much that there is no economic incentive to return to work. Many workers in Minnesota are eligible for benefits which are very comparable to, or in some cases even more than, the income they received from working. Consequently, the financial incentive to return to productive employment is removed and a major tenet of workers' compensation is violated. A major objective of the workers' compensation system is to return the injured worker to productive employment, and benefit structure and levels should be designed to achieve that objective. But many workers under the Minnesota workers' compensation law are encouraged to make the rantional and economically sound decision to continue their disability.

b. Supplementary Benefits

The percentage of lost wage replaced by Minnesota total disability benefits is also affected by a unique provision in the Minnesota statute - supplementary benefits. Minnesota, like many other states, historically paid very low workers' compensation benefits relative to lost wages. From 1957 to 1967 the maximum weekly rate was only $45 and there was no cost of living adjustment.

Benefits were increased regularly after 1967, until, in 1977, the maximum benefit became equal to the statewide average weekly wage as computed each year. Beginning in 1976, regular workers' compensation benefits were adjusted on a yearly basis. But there were still workers whose injuries occurred during the period when benefits were low and not subject to adjustments.

Supplementary benefits were instituted in 1972, presumably to provide adequate benefits for these workers injured during the time when benefits were low. Originally, the maximum benefit was set at $60. It was raised to $70 in 1973, and beginning in 1975 was made contingent on the statewide average weekly wage. Current law provides for supplementary benefits to make up the difference between the worker's benefit and 65 percent of the statewide average weekly wage as computed annually.

Although supplementary benefits are presumed to have been written to compensate workers for historically low benefits, the original legislation did not apply only to those injuries occuring prior to a certain date. Rather, the legislation clearly has always applied to all workers who are totally disabled for more than 104 weeks. A new minimum benefit is created for this group of recipients, significantly higher than the minimum benefit for shorter term total disability. According to

the NCCI wage distribution, approximately 51% of Minnesota injured workers would be eligible for supplementary benefits if they experienced total disabilities of more than 104 weeks. The Minnesota Department of Labor and Industry estimates that between 6,250 and 7,000 workers are currently receiving supplementary benefits and the number is increasing.

Table 3 shows the impact that the supplementary benefit has on total workers' compensation benefits in terms of wage replacement. For a worker earning $170 per week, supplementary benefits raise the total workers' compensation to 102 percent of the worker's gross wage and 119 percent or more of the take home wage. For the sake of simplicity, benefits were not adjusted in this example. But both the yearly escalation adjustment and the increase in the statewide average wage would increase the actual benefit.

Table 3
SUPPLEMENTARY BENEFITS
No Social Security Eligibility

Statewide Average Weeky Wage:	267.00
65% SAWW	174.00
Eligible Wage	261.00
Range of Supplementary Benefit	0 - 120.60

Example
(without yearly adjustment)

Weekly Wage	170.00
65% SAWW	174.00
Workers' Compensation Benefit (50% SAWW)	-134.00
Supplementary Benefit	40.00
Total Benefit: Workers' Compensation	134.00
Supplementary Benefit	40.00
	174.00
Percent of Gross Wage:	102
Percent of Take Home Wage:	
single, 1 exemption:	135
married, 4 exemptions:	119

The combination of the adjustment in regular workers' compenation benefits and the yearly increase in the statewide average weekly wage has an important and possibly unexpected effect on long-term disability benefits in Minnesota. Those receiving supplementary benefits receive two types of yearly adjustment in their workers' compensation benefit. The regular workers' compensation benefit is now subject to a maximum yearly adjustment of 6 percent. The supplementary benefit is directly tied to the increase in the statewide average weekly wage and is not subject to a maximum increase. In the past few years, the statewide average weekly wage has increased faster than the 6 percent maximum increase in workers' compensation benefits. As a result, the regular workers' compensation benefits may increase by only 6 percent, but supplementary benefits automatically make up the difference between the regular benefit and 65 percent of the statewide average weekly wage. Under current law, as long as the statewide average is rising faster than 6 percent, the worker's total benefit will increase by the same percent as the statewide average weekly wage and the supplementary benefit will increase at a faster rate than the statewide proportion of the worker's total benefit over time. It also means that workers who receive long-term disability benefits but who are not eligible for supplementary benefits receive a smaller yearly adjustment in their benefits.

Example 1 illustrates this problem. The worker in this example has been totally disabled for more than 104 weeks and is currently eligible for $130 per week in regular workers' compensation benefits. The worker is also eligible for $44 per week in supplementary benefits, which raises the total benefit to $174 per week or 65% of the Statewide Average Weekly Wage.

Example 1

Year 1

Statewide Average Weekly Wage (SAWW)	267.00
Maximum Supplementary Benefit (65% SAWW)	174.00
Regular Workers' Compensation Benefit	130.00
Supplementary Benefit	44.00
Total Benefit	174.00

Year 2

Increase in Statewide Average Weekly Wage	8%
Increase in Workers' Compensation Benefit	6%
New Statewide Average Weekly Wage	288.00
Maximum Supplementary Benefit (65% SAWW)	187.00

New Workers' Compensation Benefit	138.00
New Supplementary Benefit	49.00
Total Benefit	187.00

Increase in Workers' Compensation Benefit	6%
Increase in Supplementary Benefit	11.4%
Increase in Total Benefit	8%

Supplementary Benefits increased from 25% to 26.2% of the total benefit.

The next year the Statewide Average Weekly Wage increases by 8%. Under the escalation clause in Minnesota's law, the worker is eligible for a 6% increase in the regular total disability benefit, raising this benefit to 138.00. The workers' benefit is still lower than 65% of the new Statewide Average Weekly Wage. Therefore, the worker is also eligible for supplementary benefits equal to the difference between the regular benefit ($138) and 65% of the Statewide Average Weekly Wage ($187). This new supplementary benefit is $49 per week.

A comparison of these new benefits with the benefits received in the previous year, shows that the worker's total benefit increased by 8% (the same as the SAWW), the benefit for total disability increased by 6%, while

the supplementary benefit increased by 11.4%. Supplementary benefits also increased as a proportion of the total workers' compensation benefit from 25% to 26.2%.

This differential in yearly benefit adjustment is responsible for another important phenomenon. As long as the statewide average weekly wage increases faster than the yearly adjustment in workers' compensation benefits, the worker's benefit will decrease in value relative to the statewide average. Thus, under these conditions, a worker's benefit will eventually fall below 65 percent of the statewide average weekly wage and the worker will become eligible for supplementary benefits. Again, as long as the statewide average weekly wage increases faster than the yearly adjustment in regular benefits, the number of workers eligible for supplementary benefits will increase and supplementary benefits will account for an increasing proportion of total workers' compensation benefits. Since insurers are paying a smaller portion of the total workers' compensation benefit, they have less incentive to evaluate these long-term cases.

Since supplementary benefits paid by insurers and employers are reimbursed out of the special compensation fund, it is not surprising that this fund has grown dramatically in recent years. Payments from the special compensation fund have grown from about $282,000 in 1972

to over $18,000,000 in 1980. The Department of Labor and Industry estimates that about 2/3 of the fund are for reimbursement of supplementary benefit payments. Probably an even more dramatic measure of the cost of supplementary benefits is the unfunded or outstanding liability of the special fund, the amount of which is unknown.

Although historically low benefits may have provided the impetus for supplementary benefits, the legislation has always provided supplementary benefits for any worker experiencing a long-term (more than 104 weeks) disability. The benefit creates a new minimum benefit for a large group of injured workers, generally those who make less than the statewide average weekly wage. Consequently, the total workers' compensation benefit for this group is no longer a function of the worker's wage. Only the supplementary benefit is dependent on the worker's wage, since the lower the wage, the higher the supplementary benefit must be to raise the total benefit to 65 percent of the statewide average weekly wage. Because the statewide average weekly wage has increased faster than the yearly adjustment in workers' compensation benefits, supplementary benefits have accounted for an increasing proportion of total benefits and an increasing number of workers' compensation beneficiaries are eligible for the benefit. This has resulted in unexpected, large increases in the special compensation

fund, from which these benefits must be paid.

c. Social Security Offset

The percentage of wage replaced by workers' compensation is also affected by each worker's eligibility for other governmental disability programs, especially social security. Specifically, the benefit is affected by an offset applied by Social Security during the first $25,000 in workers' compensation benefits , by an offset applied by workers' compensation after the $25,000 limit is reached, and by eligibility for supplementary benefits. The following three examples show how these factors affect benefits for different wage levels.

The examples show the impact of social security benefits on wages below, equal to, and above the current statewide average weekly wage. No yearly adjustment in workers' compensation or social security, nor changes in the statewide average weekly wage are taken into account in these examples. It should also be noted that estimates of social security benefits are very difficult to compute and depend upon many personal characteristics of the worker, including work history. These must be taken, therefore, as gross estimates of social security payments, which will in reality vary considerably between individual workers. Nonetheless, the examples do accurately reflect the relationship between workers'

compensation benefits and social security and the impact of supplementary benefits.

Example 2
Effect of Social Security Benefits
on Workers' Compensation

Weekly Wage:	170.00
Statewide Average Weekly Wage:	267.00

1. Before $25,000 limit

Workers' Compensation Benefit (50% SAWW)	134.00
Estimated Social Security	+ 90.00
	224.00
80% of Weekly Wage	-136.00
Social Security Offset	88.00
Estimated Social Security	90.00
Social Security Offset	- 88.00
Adjusted Social Security	2.00

Total Benefit:	Workers' Compensation	134.00
	Adjusted Social Security	2.00
		136.00

Percent of Gross Wage:	80
Percent of Take Home Wage	
single, 1 exemption:	105
married, 4 exemptions:	93

2. Before $25,000 limit, with Supplementary Benefits

65% of SAWW	174.00
Workers' Compensation	- 134.00
Supplementary Benefit	40.00

Total Benefit:	Workers' Compensation	134.00
	Supplementary Benefit	40.00
		174.00

Percent of Gross Wage:	102
Percent of Take Home Wage	
single, 1 exemption:	135
married, 4 exemptions:	119

Note: Workers' Compensation is paying more than 80% of the worker's weekly wage. Therefore, the entire social security benefit is offset.

3. After $25,000 limit, with Supplementary Benefits

Workers' Compensation Benefit	134.00
Estimated Social Security	- 90.00
Adjusted Workers' Compensation	44.00
65% SAWW	174.00
Adjusted Workers' Compensation	- 44.00
Supplementary Benefit	130.00
5% offset	- 7.00
Adjusted Supplementary Benefit	123.00

Total Benefit:	Adjusted Workers' Compensation	44.00
	Adjusted Supplementary Benefit	123.00
	Social Security	90.00
		257.00

Percent of Gross Wage:	151
Percent of Take Home Wage	
single, 1 exemption:	199
married, 4 exemptions:	176

Example 3
Effect of Social Security Benefits on Workers' Compensation

Weekly Wage:	267.00
Statewide Average Weekly Wage:	267.00

1. Before $25,000 limit

Workers' Compensation Benefit (66 2/3% weekly wage)	178.00
Estimated Social Security	+ 115.00
	293.00
80% of Weekly Wage	- 214.00
Social Security Offset	79.00
Estimated Social Security	115.00
Social Security Offset	- 79.00
Adjusted Social Security	36.00

Total Benefit:	Workers' Compensation	178.00
	Adjusted Social Security	36.00
		214.00

Percent of Gross Wage:	80
Percent of Take Home Wage	
single, 1 exemption:	112
married, 4 exemptions:	100

2. After $25,000 limit, with Supplementary Benefits [1]

Workers' Compensation Benefit	178.00
Estimated Social Security	-115.00
Adjusted Workers' Compensation	63.00
65% SAWW	174.00
Adjusted Workers' Compensation	-63.00
Supplementary Benefit	111.00
5% offset	- 6.00
Adjusted Supplementary Benefit	105.00

Total Benefit:	Adjusted Workers' Compensation	63.00
	Adjusted Supplementary Benefit	105.00
	Social Security	115.00
		283.00

Percent of Gross Wage:	106
Percent of Take Home Wage	
single, 1 exemption:	148
married, 4 exemptions	132

1 This worker will not be eligible for supplementary benefits until the Social Security benefit is offset.

Example 4
Effect of Social Security Benefits on Workers' Compensation

Weekly Wage:	350.00
Statewide Average Weekly Wage:	267.00

1. Before $25,000 limit

Workers' Compensation Benefit (66 2/3% weekly wage)	233.00
Estimated Social Security	150.00
	383.00
80% Weekly Wage	- 280.00
Social Security Offset	103.00
Estimated Social Security	150.00
Social Security Offset	- 103.00
Adjusted Social Security	47.00

Total Benefit:	Workers' Compensation	233.00
	Adjusted Social Security	47.00
		280.00

Percent of Gross Wage:	80
Percent of Take Home Wage	
single, 1 exemption:	119
married, 4 exemptions:	106

2. After $25,000 limit, with Supplementary Benefits [1]

Workers' Compensation Benefit	233.00
Estimated Social Security	- 150.00
Adjusted Workers' Compensation	83.00
65% SAWW	174.00
Adjusted Workers' Compensation	-83.00
Supplementary Benefit	91.00
5% offset	- 5.00
Adjusted Supplementary Benefit	86.00

Total Benefit:	Adjusted Workers' Compensation	83.00
	Adjusted Supplementary Benefit	86.00
	Social Security	150.00
		319.00

Percent of Gross Wage:	91
Percent of Take Home Wage	
single, 1 exemption:	135
married, 4 exemptions:	121

1 This worker will not be eligible for supplementary benefits until the Social Security benefit is offset.

While social security benefits are being offset by workers' compensation (before $25,000 in workers' compensation is paid) all workers in the three examples would receive the same percentage of their gross weekly wage in benefits. This is because they are equally subject to the maximum benefit set by social security, which allows the combination of workers' compensation and social security to equal 80 percent of average current earnings.

Those whose workers' compensation benefit is below 65 percent of the statewide average weekly wage will become eligible for the supplementary benefit in 104 weeks, as shown in example 2. The workers' benefit is increased to 65 percent of the Statewide Average Weekly Wage. Because this benefit is higher than 80 percent of the worker's weekly wage, social security benefits are entirely offset by workers' compensation. In this case, the worker receives over 100 percent of his or her gross wage and 119 percent or more of take home wages.

After $25,000 in workers' compensation benefits are paid (not including any supplementary benefits), workers eligible for social security will experience a dollar for dollar reduction in their workers' compensation benefits. However, workers whose benefits have been reduced because of simultaneous receipt of social

security benefits are also eligible for supplementary benefits up to 65 percent of the statewide average weekly wage. Thus, a substantial portion of the reduction in workers' compensation is replaced by supplementary benefits.

If a state workers' compensation law has a provision for reducing workers' compensation benefits to offset for social security benefits, this state provision takes precedence over the offset applied by social security. Supplementary beneits are, therefore, reduced by a token 5 percent, making the worker eligible for full social security benefits. This interaction between the workers' compensation offset and supplementary benefits has two important results.

First, it creates a progressive system of benefits for workers eligible for both workers' compensation and social security. That is, those with lower wages receive a greater percentage of their wages in benefits. This results from the fact that supplementary benefits are most beneficial to those with lower wages whose benefit would otherwise be less than 65 percent of the statewide average. It is not as important to those whose benefit would be at that level anyway, except to the extent that it replaces some of the reduction in workers' compensation. Second, the workers eligible for social security receive close to full benefits from both

disability programs. Those workers eligible for social security thus receive significantly higher benefits for their disability. Many workers are eligible for more than their gross wage, and many workers will receive significantly more than their take home wage in benefits. In example 2, the worker is eligible for 151 percent of his or her weekly wage in total benefits, while the worker in example 4, with a higher wage, is eligible for 91 percent of weekly wages.

The interaction of social security and supplementary benefits also results in a change in how total workers' compensation benefits are paid. Before the $25,000 limit is reached, only a small proportion of workers' compensation benefits are paid in the form of supplementary benefits, reimbursed through the special compensation fund. When workers' compensation is offset by social security, supplementary benefits replace most of the offset and pay a major portion of the total workers' compensation benefit. In examples 2, 3, and 4, supplementary benefits account for 74, 63, and 51 percent , respectively, of the total workers' compensation benefit after workers' compensation offsets for social security.

This proportion becomes even higher when benefits are escalated each year. The effect of benefit escalation on the proportion of workers' compensation benefits paid by supplementary benefits is shown for example 4. The

Effect of Benefit Escalation
on the Percent of Workers' Compensation
Benefits Paid by Supplementary Benefits

From Example 4:

Total Benefit:	Adjusted Workers Compensation	83.00
	Adjusted Supplementary Benefit	86.00
	Social Security	150.00
		319.00

Supplementary Benefit of $86.00 is 51 percent of the total workers compensation benefit.

If the following escalation factors applied:

1) Workers' compensation is adjusted 6%;
2) Social security increases with the cost of living by 12%; and
3) The statewide average weekly wage increases by 9%.

Total benefits would change as follows:

Workers compensation benefit	247.00
Estimated Social Security	168.00
Adjusted Workers' Compensation	79.00
65% SAWW (new SAWW = 291)	189.00
Adjusted Workers' Compensation	- 79.00
Supplementary Benefit	110.00
5% offset	- 6.00
Adjusted Supplementary Benefit	104.00

New Total Benefit

Adjusted Workers' Compensation	79.00
Adjusted Supplementary Benefit	104.00
Social Security	168.00
	351.00

Supplementary Benefit of $104.00 is now 57 percent of the total workers' compensation benefit. Supplementary benefits are raised from $86 to $104, a 20.9% increase.

workers' compensation benefit is increased by 6 percent. The social security cost of living increase is 12 percent, and the statewide average weekly wage increases by 9 percent. Due to the higher increase in social security, regular workers' compensation benefits are reduced more than they were in the previous year, and supplementary benefits must pay a higher amount to keep total workers' compensation benefits equal to 65 percent of the statewide average weekly wage. In this case the proportion of workers' compensation benefits paid by supplementary benefits increased from 51 to 57 percent.

Unfortunately, information is not available on the number of workers' compensation claimants receiving social security nor on the size of their benefits. The Department of Labor and Industry estimates that 6250 to 7000 claimants currently receive supplementary benefits and that 25% of these also receive social security benefits. If 1,562 claiments (25% of 6,250) were to receive, on the average, the same benefit as in example 2 for one year, supplementary benefits would total 8.5 million dollars. This would account for a substantial portion of the current yearly special compensation fund costs.

Since social security disability benefits and workers' compensation can provide payment for the same disability, both the federal government and some states have written offset provisions in their laws to prevent dual benefits for the same disability. Under the federal provisions, total benefits are prevented from exceeding 80 percent of average current earnings. Although a claimant may receive somewhat higher benefits because of eligiblity for social security, all are subject to the same maximum replacement of gross wages.

In Minnesota, the offset of workers' compensation by social security combines with supplementary benefits to produce a very different effect. It further strengthens the role of economic circumstances in determining benefits by creating a progressive system of benefits in which low wage earners receive a relatively higher benefit. The potential savings due to the offset for social security is effectively eliminated by supplementary benefits for lower wage earners and greatly diminished for those with higher wages. The system allows significant dual benefits which can amount to well over 100 percent of gross wages and more than 150 percent of take home wages. These benefits are also subject to yearly increases: the workers' compensation benefits will increase at the same rate as the statewide average weekly wage (because of supplementary benefits); and social security will rise yearly with the cost of

living index. After workers' compensation is offset by social security , a large proportion of workers' compensation will be paid by supplementary benefits and the proportion will increase over time as social security benefits increase and the size of the offset also increases.

2. Equity

The second criterion for evaluating workers' compensation benefits is equity. There are two tests of equity: horizontal equity requires that those workers with equal losses receive equal benefits; vertical equity requires that workers with different losses receive benefits proportional to their losses. Generally, total disability benefits in the Minnesota workers' compensation system meet the test of horizontal equity. Those with equal loss of wages have the same percent of wages replaced. Total disability benefits do not, however, meet the strict definition of vertical equity. Workers with different losses do not receive strictly proportional benefits. Minnesota workers' compensation policy clearly provides a larger portion of lost wages to low wage earners and a smaller portion to high wage earners. Minimum and maximum benefits in Minnesota are consistent with this policy. Benefits do consistently increase in proportion to wages as the amount of wage loss decreases and there are no drastic

changes in the proportion of wages replaced. Therefore, the general test of vertical equity may be judged to have been meet.

Equity, like adequacy, may be judged differently if one takes into account effects of the tax structure, supplementary benefits, and eligiblity for social security.

a. State and Federal Tax Structure

Evaluation of the equity of the Minnesota workers' compensation system is definitely altered by consideration of the Minnesota state and federal tax structure. Neither the test for horizontal nor for vertical equity are satisfied when the tax structure is considered.

Taxes for any given wage level are primarily determined by marital status and number of dependents. Thus, by providing equal wage replacement for a certain level of gross wages, there is unequal replacement of the injured worker's actual spendable earnings. Table 2 in this report shows that replacement of spendable earnings varies considerably for any given level of gross wage. Alternately, one may assume those with equal spendable earnings would not receive equal wage replacement (except when marital status and number of dependents are also

equal).

The test of vertical equity is also violated when tax structure is considered. It has already been mentioned that for any single gross wage, the compensation system favors single workers and workers with fewer dependents. That is, they receive a higher proportion of spendable earnings in benefits. Although this may be argued to be equitable in the sense that the benefit is consistent (the higher the take home pay the higher the replacement rate), it is doubtful that this was the intention of workers' compensation policy makers.

In addition, vertical equity is certainly violated across wage levels. Vertical equity is violated under both the strict and general interpretations. Totally disabled workers with different levels of spendable earnings do not receive the same proportion of their earnings in benefits. Nor does the benefit consistently increase or decrease as earnings increase or decrease. The proportion of gross wages replaced by total disability benefits increases as wages decrease. The progressive state and federal tax structures dramatically alter this pattern. Replacement ratios for spendable earnings are inconsistent, and the highest benefits go to those with above average wages. Workers with the

highest wages and average or slightly below average wages receive relatively lower benefits, while those at the lowest wage level receive relatively higher benefits due to the effect of benefit minimums.

b. Supplementary Benefits

Supplementary benefits provide a substantial minimum benefit for any worker totally disabled for more than 2 years. The benefit has no effect on the test for horizontal equity but may have some effect on the vertical equity test. It could be argued that, for at least half the injured workers, benefits are no longer in proportion to wage loss but are equal for all, in violation of both the strict and general tests of vertical equity.

c. Social Security Offsets

In combination with social security, supplementary benefits more clearly violate the horizontal test of equity. Those workers eligible for social security initially receive higher benefits than others with the same wage level because of the more liberal maximum benefit (80% of earnings). The combination of eligibility for both social security and supplementary benefits further increases this discrepancy. A low wage earner eligible for both programs may

receive almost twice the benefit of a worker earning the same wage but who is not eligible for social security.

In summary,the equity criterion is violated by the Minnesota workers' compensation system under both the vertical and horizontal tests. Although generally the horizontal test is met, it is violated when supplementary and social security benefits are considered since workers with equal wages may receive significantly different total benefits. Workers with equal spendable earnings may also receive different benefits because of the effects of the state and federal tax structure. The strict definition of vertical equity is clearly violated by total disability benefits, since workers with different wages receive differing proportions of their wages in benefits. In Minnesota, low wage earners receive a higher proportion of their lost earnings than high wage earners. Even the more general definition of vertical equity is violated if benefits are evaluated in relationship to spendable earnings. Benefits are neither proportional nor consistent from this perspective.

3. Certainty

The third criterion for evaluation of workers' compensation

benefits is certainty. The fundamental compromise of workers' compensation law was the guarantee of certain benefits in exchange for the abrogation of the right to sue the employer for additional awards. Workers should know clearly when they are entitled to benefits and how much the benefits will be. Lack of information about eligiblity and amount of benefits is likely to result in uncertainty and increased likelihood of legal involvement, possibly delayed benefits, and increased administrative costs. For the vast majority of cases, total disability eligiblity does not appear to be a problem. Most workers will be out of work for a relatively short period of time and will return to full employment. Although the minimum and maximum benefits complicate the calculation of benefits somewhat, the determination of benefits is fairly straightforward. For long-term disability, the calculation of benefits becomes much more complex, especially for those also eligible for social security. The worker may receive reduced social security benefits, then supplementary benefits may change the size of the workers' compensation benefit after 104 weeks, then workers' compensation may be reduced to offset for social security. The result is confusing at best. But since these benefit changes generally result in increased benefits for the worker they may be less likely to question these changes.

4. Promptness

Prompt payment of total disability benefits is important so that the injured worker experiences minimal delay between income loss and the commencement of benefits. As with certainty, prompt payments reduce the anxiety of the injured worker and the likelihood that the worker will believe it is necessary to contact an attorney in order to receive benefits. Current law requires that payment of benefits must begin within 14 days of notice or knowledge on the part of the employer that a work-related injury has occurred. This payment may be delayed only if the insurer files a denial of liability. Since the time for commencement of payment has recently been reduced from 30 to 14 days it is assumed that the transition between wages and benefits will improve, but it is too early to evaluate the impact on litigation rates in Minnesota.

C. Efficient Administration

Efficiency has to do with the cost of administration of the workers' compensation system, including costs incurred by employers, insurance carriers, attorneys, workers, and government administrative agencies. Efficient administration of the system does not simply mean the cheapest possible delivery system. Costs of administration must be considered relative to the quality of benefits provided by that system. Evaluation of efficiency must also consider the degree to which the system operates to support the achievement of the basic

goals of workers' compensation.

For most cases of short-term total disability, administration appears fairly straightforward and therefore efficient. Efficiency relative to the quality of benefits provided may result in a different conclusion, however. Total disability benefits are certainly adequate, but are so high that they pay more than many beneficiaries were able to earn from full time work. The benefit thus encourages behavior which is in direct contradiction to the goals of workers' compensation and contributes to inefficiency in the system. The high level of benefits also increases overall cost to the system and causes further inefficiency. Previous analysis also showed that benefit levels for total disability are inequitable. Although administration of total disability benefits may appear efficient on the surface, the quality of benefits delivered for a certain level of cost, must lead to the conclusion that current total disability benefits are not efficiently delivered. It is very likely that total disability benefits which are adequate, equitable and achieve the basic objectives of workers' compensation could be delivered at comparable or even less cost than the current system.

Cases of long-term total disability are delivered in an even more inefficient manner. The calculation of offsets, supplementary benefits and escalations are so

complex that they must increase the administrative costs of delivering these benefits. The benefits provided in these cases are even more contradictary to the goals of workers' compensation, since benefits are extremely generous and sorely inequitable. Provisions designed to reduce costs (the reductions in workers' compensation benefits for receipt of social security benefits) are rendered useless by other provisions (supplementary benefits). The costs of administration are thus increased to provide lesser quality benefits which conflict with the goals of workers' compensation.

TEMPORARY PARTIAL DISABILITY BENEFITS

Most workers suffering work-related injuries will receive medical attention and experience no loss or minimal loss of work time. Of those who lose more than three days of work and qualify for temporary total disability benefits, most will fully recover and return to their jobs at the same wage. Because of physical limitations, a few workers will only have the capability, at least temporarily, to return to their old job on a part time basis, or will be limited to full time employment at work which pays a lower wage than the pre-injury job. These workers are eligible for temporary partial disability benefits.

I. BASIC PROVISIONS

When an injured worker is partially disabled and able to earn only a portion of his or her pre-injury wage, temporary partial disability benefits will pay for 66 2/3 percent of the difference between the daily wage at the time of the injury and the wage the worker is able to earn. The benefit is subject only to a maximum payment equal to the statewide average weekly wage. There is no minimum benefit for temporary partial disability. Thus workers may never receive more than their gross pre-injury wages in combined wages and benefits. The benefits are subject to the same annual adjustment discussed under total disability benefits.

Temporary partial disability benefits are paid during the entire period of partial disability. If the former employer does not provide a job which the worker can do in his or her partially disabled condition and the worker cannot find work after a reasonably diligent effort, the employer is required to pay full compensation to the worker at the rate for temporary total disability.

Temporary partial disability benefits are subject to the same three day waiting period as total disability benefits, and if the disability continues for more than 10 days, compensation will be paid from the first day of disability. Benefits will be discontinued when the worker's current wage equals or exceeds the pre-injury wage or when the worker refuses to accept a job which is within his or her medical limitations.

II. ANALYSIS

A. Conceptual Approach

Other sections of this report have discussed the importance of the conceptual approach or fundamental purpose of workers' compensation benefits. This fundamental purpose determines the way benefits are structured and benefit levels calculated. It affects how benefits are evaluated, and is especially important to the evaluation of the adequacy and equity of benefits. Temporary partial disability benefits, perhaps more than any other workers' compensation benefits, are based on an almost pure wage-loss approach. There is no minimum benefit and the maximum benefit affects very few injured workers. (A worker with 50% wage loss would need a yearly wage of $41,600 to reach the current maximum benefit.) There is no modification of the benefit based on economic need and only a minimal cost constraint factor (the benefit maximum).

Although this wage-loss approach seems clear, there appears to be some confusion about temporary partial wage loss because of its relationship to the conceptually confusing permanent partial disability benefits. Until 1974, permanent partial disability benefits were paid to a disabled worker for presumed permanent loss of wages due to a permanent

partial disability. The benefit schedule was constructed with this purpose in mind. In 1974, however, the legislature changed the workers' compensation statute so that permanent partial disability was payment for loss of use of body parts or functional impairment and was to be considered separate and distinct from other benefits which pay for lost wages.

This change in the statute has left a curious gap in the Minnesota workers' compensation system. Although there is payment for partial loss of wages which is temporary in nature, permanent partial wage loss is no longer compensated. According to a literal interpretation of the law, a worker who suffers temporary partial wage loss receives 2/3 of lost wages in benefits, while an injured worker with a permanent equal loss of wages will receive none. It could be (and is) argued that the worker with permanent loss should be considered to be compensated by the permanent partial disability payment even though the statute says it is not a wage loss benefit.

Although the Supreme Court has set forth criteria for the determination of temporary partial disability which include the requirement that the disability must be permanent in nature (Dorn vs. A.J. Chromy Construction Co., 245 N.W. (2d) 451, 29 W.C.D. 86) the Workers' Compensation Court of Appeals has approved payment for ongoing partial wage loss along with payment for permanent partial disability (Eugene Larson vs. Century Mercury Freight, file no. 477-42-2120). A dissenting opinion cites the Dorn case and states that Minnesota law does not provide for compensation of permanent partial wage loss.

A strict reading of the statute, then, leaves an apparant gap in coverage which the courts seem to have filled but not without confusion and disagreement about the appropriate

provision of temporary partial disability benefits.

B. Evaluation of Benefits

1. Adequacy

Adequacy is measured by the percent of lost wages replaced by the benefit. Temporary partial disability benefits replace 66 2/3 percent of lost wages for almost all workers except those few workers at the high end of the wage scale who suffer rather large loss of wages. In this respect, the benefit seems to be adequate. It is not known how many of all workers experiencing actual partial wage loss receive temporary partial benefits. The confusion over its application and the very small number of recipients of temporary partial benefits suggest that many do not.

The adequacy of temporary partial benefits, like total disability benefits, are strongly affected by the state and federal tax structure. If after tax wages are considered, workers receiving temporary partial disability get much more than 66 2/3 percent of their actual wage loss (in terms of spendable earnings). Example 1 compares the take home pay, total disability benefit, and partial disability benefit for a married worker with 2 dependents and with a 50% partial disability benefit. In each case, the worker is eligible for benefits which are almost equal to or greater than his or her after tax earnings from full time work. In all cases, the partial disability benefit results in higher total income than from total disability benefits. The partial disability benefit pays a higher percent of pre-injury take home wages for those with larger wages.

The temporary partial disability benefit is clearly adequate and, in fact, can be very generous, providing more income than the worker received from full time work. Usually, the

Example 1

Temporary Partial Disability

Average Weekly Wage: $267.00

Weekly Wage	170.00
Take Home Pay (Married 2 dependents)	138.49
Total Disability Benefit *	133.50
Temporary Partial at 50% Wage Loss	
Temporary Partial Benefit	56.69
Take Home Pay	78.85
TOTAL INCOME	135.54

Weekly Wage:	250.00
Take Home Pay (Married with 2 dependents)	192.07
Total Disability Benefit	166.75
Temporary Partial at 50% Wage Loss	
Temporary Partial Benefit	83.38
Take Home Pay	107.29
TOTAL INCOME	190.67

* Minimum Benefit

Weekly Wage:	350.00
Take Home Pay (Married 2 dependents)	254.82
Total Disability Benefit	233.45
Temporary Partial at 50% Wage Loss	
Temporary Partial Benefit	116.73
Take Home Pay	143.16
TOTAL INCOME	259.89

Weekly Wage:	450.00
Take Home Pay (Married with 2 dependents)	313.37
Total Disability Benefit*	267.00
Temporary Partial at 50% Wage Loss	
Temporary Partial Benefit	150.08
Take Home Pay	176.94
TOTAL INCOME	327.02

* Maximum Benefit

temporary partial benefit combined with the worker's wages is greater than the benefit for total disability though sometimes the difference is very small. There is some incentive, therefore, for the worker to return to his or her job, at least on a part time basis, or to another job. Once the worker receives temporary partial benefits there is no incentive, for the short term anyway, for the worker to go back to work full time or to a better paying job, since the worker is getting as much or more income than from his or her pre-injury wage. If temporary partial benefits continue for more than a year, this disincentive begins to disappear because of the way temporary partial benefits are computed and escalated.

Temporary partial disability benefits are always based on the worker's wage at the time of injury. If a worker receives a pay increase six months after the injury the benefit will be based on the difference between the new wage and the wage at the time of injury. The benefit is always computed in this way and no account is made of the fact that the value of the original wage has decreased in the intervening years.

Example 2 shows how the benefits are adjusted for a worker with a pre-injury wage of $320/week and a 25% wage loss. Number 1 shows the initial benefit is $53.36 which equals 66 2/3 percent of the difference between the pre-injury wage and the new wage. A year later this benefit is subject to the 6 pecent benefit adjustment, increasing the temporary partial benefit to $56.52. This calculation assumes no change in the worker's current salary. If, six months later, the worker receives a salary increase of 10 percent, the wage differential between the new wage and the pre-injury wage must be recalculated. This new benefit level is then increased by the 6 percent adjustment factor. The new benefit is $39.59. With every wage increase the benefit is

TEMPORARY PARTIAL DISABILITY BENEFITS

ADJUSTMENT OF BENEFITS

Weekly Wage at time of injury	$ 320.00
Temporary Total Disability	213.44
1) Weekly Wage at New Job	240.00
Temporary Partial Disability	53.36
TOTAL GROSS INCOME	293.36

2) 6% Adjustment one year from injury, assuming no increase in salary

Weekly Wage:	240.00
Adjusted Benefit:	56.52
TOTAL GROSS INCOME	296.52

3) Worker receives 10% pay increase 6 months later

New weekly wage:	264.00
New Temporary Partial Benefit:	39.59
TOTAL GROSS INCOME	303.59

Benefit ends when weekly wage reaches $ 320.00.

recalculated and the benefit adjustment(s) applied. This continues until the worker's wage is equal to or greater than the pre-injury wage at which time the temporary partial benefit is discontinued. This example does not show the effect of state and federal taxes. However, with each increase in the worker's wage, the size of the workers' compensation benefit decreases and the worker's wage provides a greater share of the worker's income. Thus the untaxed portion becomes smaller while the taxed portion is larger. The net result is that the worker is likely to experience no real increase in spendable earnings and may even have an overall loss.

Example 3 shows the effect of a 10 percent wage increase on the total income of a worker with an original wage of $350 per week and a 50 percent partial disability. In this case, the worker's total income does not increase even though the worker's wage increases by 10 percent. If the worker were eligible for the 6 percent benefit adjustment, his or her total income would increase by only $6.

This analysis suggests why temporary partial benefits are rarely used in Minnesota (less than .2 percent of cases in the NCCI claims call study). The initial benefit is very generous relative to the pre-injury wage, providing as much or more spendable earnings as before the injury. This is likely to make the benefit unpopular with insurers who would rather get the worker back to work at the same job or a job with comparable pay. Although the temporary partial benefit may look appealing to the injured worker initially, it will soon become apparant that the benefit for any ongoing wage loss results in either stable or loss of total income. As the wage loss continues, benefits become more inadequate.

2. Equity

Example 3

Effect of Wage Increase on Temporary Partial Benefits

Preinjury Wage	350.00
Preinjury Take Home Pay (married, 2 dependents)	254.82

a) Temporary Partial at 50% Wage Loss:

New Wage	175.00
Temporary Partial Benefit	116.73
Take Home Pay	143.16
TOTAL INCOME	259.89

b) Temporary Partial After 10% Wage Increase:

New Wage	192.50
New Temporary Partial Benefit	105.05
New Take Home Pay	154.40
TOTAL INCOME	259.45

Temporary partial disability benefits generally meet both the horizontal and vertical tests of equity. Workers with equal loss of gross wages will receive equal benefits and workers with different wage loss receive benefits which are strictly proportional to their wage (except for those few workers who qualify for maximum benefits). Thus the benefit even meets the strict definition of vertical equity, that is, all workers receive exactly the same proportion of lost gross wages in benefits.

As with total disability benefits, judgments about the equity of temporary partial benefits may be altered if equity is judged relative to after tax earnings. Since taxes vary by marital status and number of dependents, workers with equal loss of spendable earnings will not have the same level of earnings replaced unless they are of equal marital status and have the same number of dependents. The test of horizontal equity is therefore violated.

Temporary partial disability benefits will favor single workers and workers with no dependents whose spendable earnings are lower relative to gross earnings. These workers receive a higher proportion of their spendable earnings in benefits. As was the case with total disability, higher wage earners receive a higher proportion of their spendable earnings in benefits because of the progressive tax structure. This violates the strict definition of vertical equity, and it is doubtful that the legislature intended higher wage earners to receive a higher proportion of their wages than lower wage earners.

The confusion over the application of temporary partial benefits when the partial wage loss is expected to go on for an indeterminate length of time has great potential for equity problems. If the courts were to hold to the strict interpretation of the current statute and to the criterion

established in the Dorn case, no temporary partial benefits could be paid to an injured worker with permanent wage loss. Thus, of two workers with the same wage loss, one whose wage loss is expected to be permanent may receive no benefits while the worker whose loss is expected to be temporary would be eligible for benefits. Such an interpretation would result in serious inequities. Currently the courts apparantly do not make this distinction (see Eugene Larson vs. Century Mercury Freight, Workers' Compensaton Court of Appeals, file no. 477-42-2120).

3. Certainty

Workers should know when they are eligible for benefits and how much they will be. The calculation of temporary partial benefits is fairly simple and straightforward. The application of the benefit adjustment may cause some uncertainty and ongoing payment of temporary partial benefits is bound to cause uncertainty if benefit adjustments result in actual loss of income. There seems to be confusion about when an injured worker is eligible for temporary partial benefits. The change in the statute in 1974 defining the purpose of permanent partial benefits seems to have contributed to uncertainty about the purpose of and eligibility for temporary partial benefits, which continues to be debated by the court.

4. Promptness

Unlike most other indemnity benefits in the workers' compensation system, temporary partial disability benefits usually begin many weeks after the initial injury and after the worker has already received temporary total disability benefits. It is unusual for an injured worker to initially receive temporary partial benefits after an injury. Although temporary partial benefits are subject to the same

waiting period as total disability benefits, the waiting period is rarely applicable since the worker has already been receiving total disability benefits and temporary partial benefits would not then be subject to any waiting period. There should be a smooth transition, therefore, between total disability and temporary partial disability benefits with no interruption of income. Benefits may be postponed, however, while the insurer tries to establish the worker's new wage and thus the actual size of the wage loss. The determination of actual wage loss is particularly difficult for jobs in which the wage is subject to large fluctuations (sales people who work on commission, for example).

REHABILITATION

I. INTRODUCTION

Prompt and quality medical care and physical and vocational rehabilitation are particularly important to the accomplishment of the goals of the workers' compensation system. Rehabilitation may ease the discomfort of an injury and help restore lost income by hastening return to work and by improving the worker's productivity. Perhaps most important, quality medical care and specialized rehabilitation services can play an important role in limiting the disabling effects of work-related injuries and disease.

A. Definition

Although there is increasing agreement that rehabilitation is important to the achievement of workers' compensation goals, there is still not agreement on what the term means. A worker injured on the job may receive a variety of services or benefits through workers' compensation. Part of the worker's lost income will be replaced, and all medical expenses are paid. There may also be a need for physical rehabilitation, including the use of a prosthesis, physical therapy, and training in order to return to his or her prior job. The worker may also require retraining and preparation for a new line of work. All of these activities could be considered to be rehabilitation of the injured worker. On the other hand, some define rehabilitation to mean only vocational rehabilitation or the retraining of a permanently disabled worker for a new occupation.

Sometimes distinctions are made between medical care and physical and vocational rehabilitation. Medical care usually refers to the treatment of a short-term, acute in-

jury, while physical rehabilitation is used for long-term or chronic injuries or disease. This distinction can be an artificial one, however, and one could successfully argue that rehabilitation, in fact, begins with the first medical treatment of the injury. When medical treatment and physical rehabilitation fail to restore an injured worker so that the worker can perform his or her former job, vocational rehabilitation may be needed to prepare the worker for a new occupation or a modification of the old one. Although these services undoubtedly overlap, workers' compensation agencies may record them separately, especially vocational rehabilitation.

In 1972, the report of the National Commission on State Workmens' Compensation Laws contained 12 recommendations concerning medical care and rehabilitation objectives of workers' compensation. Medical care and rehabiliation included:

1. Comprehensive medical care
2. Vocational counseling
3. Job retraining
4. Return of the injured worker to gainful employment, to the same job if possible

Generally, in this report, rehabilitation refers to physical and vocational rehabilitation, excluding only the short-term, acute medical care given to a worker immediately following an injury. The definition does include medical evaluation, physical therapy, work evaluation and counseling, job modification, job placement, on the job training, and retraining.

B. Basic Provisions

In 1979, Minnesota's workers' compensation law was substantially altered in its approach to rehabilitation of

injured workers. Prior to 1979, rehabilitation, according to the statute, was synonymous with retraining. An injured worker was eligible for retraining if a permanent disability prevented the employee from performing his or her usual work activities or if the disability was expected to continue for more than 26 weeks. If an evaluation by a "properly accredited agency" determined that retraining would reduce or remove the lack of employability, the worker could be certified for retraining by the Division of Vocational Rehabilitation. The commissioner of Labor and Industry, a compensation judge, or a court of appeals could then order workers' compensation to pay up to 156 weeks of benefits equivalent to temporary total disability benefits and any other reasonable expenses.

Apparently, five main issues were behind the desire to revise the pre-1979 rehabilitation portion of the workers' compensation statute. First, was a desire to provide for earlier intervention by the employer and insurer. Under the prior retraining law, injured workers were rarely referred to rehabilitation until at least 6 months from the date of injury. The worker was eligible for retraining if a permanent injury prevented employment, but final determination of permanent injuries may take many months or even years. In addition, litigation may cause even further delays. Delayed rehabilitation also meant delayed return to work. Automatic referral for retraining services with no other intermediate options also tended to result in extended rehabilitation and longer periods between injury and return to work. A second major issue then was to facilitate earlier return to work for the injured worker.

The synonymous use of retraining and rehabilitation also contributed to high litigation rates. Retraining is the most costly and lengthy form of rehabilitation service, and insurance companies and employers were reluctant to pay for

these services. At the same time, no other options were provided. Therefore, retraining as the sole option tended to lead to controversy and resistance by insurers and high litigation rates. A third issue behind the revisions of the rehabilitation section of the law was therefore the desire to reduce the high rate of litigation.

Delayed rehabilitation, the lack of a broader range of services, and insurance companies' reluctance to pay for retraining meant the need for other types of rehabilitation services was ignored. A fourth reason to revise the statute was to extend benefits to those injured workers who needed rehabilitation benefits other than retraining.

Finally, there was the issue of cost. As previously mentioned, retraining is the most costly type of rehabilitation service. In addition, the retraining section of the statute indicated that "additional" benefits were to be paid to the injured worker during rehabilitation according to the schedule for total disability. This was interpreted to mean that workers were eligible for both their regular temporary total benefits plus retraining benefits, resulting in so-called "double dipping". Retraining was, therefore, a costly option, both in terms of the cost of the retraining itself and the indemnity benefit. An important reason for revision of the retraining section was to reduce these costs.

Effective October 1, 1979, the retraining section of the Minnesota workers' compensation statute was repealed and a new section on rehabilitation benefits was added. The intent of the new section is to provide services to return the employee to a job related to his or her former employment or to another job which provides a similar economic status. The worker may be trained for a position which produces a higher economic status if it can be shown that

this is necessary to improve the possibility of reemployment.

Under current law, rehabilitation is mandatory for both employers/insurers and injured workers when certain conditions are met. The employer is required to provide rehabilitation consultation within 30 days of receiving medical information that an employee will be unable to return to his or her previous job. Although insurance companies typically provide their own rehabilitation consultants, the injured worker is given the final decision on which rehabilitation agency will be used.

If the rehabilitation consultant determines that rehabilitation would increase employability, a rehabilitation plan must be submitted to the commissioner of Labor and Industry. If the insurer does not provide rehabilitation consultation within the specified time, the commissioner notifies the employer that the Division of Vocational Rehabilitation will provide the consultation if the employer does not comply within 15 days. An employee who refuses to submit to a reasonable examination or evaluation of the need for rehabilitation may have his or her compensation payment reduced or suspended by order of the workers' compensation division or appeals court.

Rehabilitation plans must be approved by the Department of Labor and Industry. A decision may be appealed to a rehabilitation review panel within 30 days of the decision. This panel may formulate its own rehabilitation plan if it rejects the decision of the department. Review panel decisions may be appealed to the workers' compensation court of appeals.

Rehabilitation plans may be modified by request of the employer, insurer or employee to the Department of Labor and

Industry. The Department's decision may be appealed to the rehabilitation review panel within 15 days.

Injured workers participating in a rehabilitation plan are eligible for up to 156 weeks of compensation equal to 125% of the rate for temporary total disability, which is in lieu of payment for temporary total, temporary partial, or permanent total disability benefits. This compensation is considered the equivalent of temporary total benefits for purposes of supplementary benefits. Currently this benefit is paid only while a worker is participating in an approved retraining program. While participating in other aspects of a rehabilitation plan the worker receives compensation according to the regular schedule for temporary total disability. An appeal of this interpretation is now before the Minnesota Supreme Court.

Workers participating in on the job training programs receive different benefits from those in other types of rehabilitation plans. While participating in on the job training, the employee receives the same after-tax wages as at the time of the injury. This benefit is paid in whole or part by the insurer. The difference between the amount paid by the insurer and the after-tax wage is to be paid by the on the job employer, but in no case shall the on the job employer be required to pay more than the prevailing wage for the job. The statute directs the rehabilitation plan to contain incentives for the employer to provide on the job training. It suggests reducing the wages paid by the employer to below the prevailing wage for the job. Total compensation must not, however, fall below the after-tax wage of the employee at the time of injury. Payments for on the job training are in lieu of payments for temporary total and rehabilitation compensation benefits. The weeks during which on the job training benefits are paid are counted as part of the 156 weeks of rehabilitation benefits.

Employers or insurers are also responsible for all other reasonable rehabilitation expenses, including rehabilitation diagnosis and development of the plan, the cost of rehabilitation services and supplies, and the cost of tuition and books in the case of retraining. Where the rehabilitation plan requires residence away from the usual residence of the worker, the cost of travel, board and lodging will also be paid.

The new section on rehabilitation also creates more direct state involvement in the development and monitoring of rehabilitation plans. The statute creates the position of Director of Rehabilitation within the Department of Labor and Industry and creates a Rehabilitation Review Panel. Members of the review panel are appointed by the governor for four year terms. The review panel reviews and makes determinations on appeals of rehabilitation plans and holds hearings on the revocation of certification of rehabilitation consultants. The panel is also directed to study rehabilitation and recommend rehabilitation rules to the commissioner. The review panel includes two representatives each from labor, employers, insurers, rehabilitation specialists, physicians, and one chiropractor.
The statute also provides for state approval of rehabilitation consultants. Rehabilitation consultants must satisfy rules promulgated by the commissioner for the qualification of rehabilitation consultants. Then they may propose and implement rehabilitation plans. The commissioner is also given authority to promulgate rules necessary to implement the rehabilitaation section of the statute.

II. ANALYSIS

With the increasing emphasis and value placed on rehabilitation in the workers' compensation system, new questions

have been raised about its place in the entire workers' compensation process. Concerns are expressed about (1) Its purpose: What services does rehabilitation include and what are its goals?; (2) About roles: Who has responsibility for rehabilitation? What should be the role of employers, insurers, employees and the workers' compensation administrative agency?; (3) About incentives: What incentives operate in the current system? How do they affect participation in rehabilitation? How could these incentives be improved? These questions must be addressed in addition to the criterion of adequacy, equity, promptness and certainity. All of these questions are discussed and considered in this section of the report.

A. The Purpose of Rehabilitation

Rehabilitation was defined in this paper by the services it includes. But much discussion still centers around the purpose of rehabilitation: When is it appropriate, when should it begin, what services should be provided and what are its goals? The answers to these questions appear to be changing.

Traditionally, rehabilitation tended to be equated with vocational rehabilitation or even more narrowly, retraining a disabled worker for a new vocation or occupation. A construction worker who loses the use of his legs in an industrial accident may, for example, be trained to do drafting work. Usually, this training occured after the worker recovered fully from the injury and was diagnosed as permanently disabled. Formal schooling is usually necessary for this type of rehabilitation and costs tend to be high. As mentioned earlier, the Minnesota workers' compensation statute equated rehabilitation with retraining until 1979.

Recently, rehabilitation of injured workers has developed a

new and broader perspective. Claims representatives and rehabilitation specialists apparently have long held that the shortest and least expensive forms of rehabilitation are the most effective for work-related injuries. There are five important differences in this broader approach: (1) time of intervention; (2) types of services included; (3) range of options for returning to work; (4) length of services provided; (5) cost of services. Outcomes are, of course, also important in terms of time between the injury and return to work, wage after return to work, and whether the worker returns to the former employer.

Perhaps the most crucial factor in the broader perspective of rehabilitation is when services should begin. Under the more narrow perspective, rehabilitation was viewed as a service to be provided after the worker had attained maximum medical recovery and the inability to return to former employment because of a permanent disability was conclusively diagnosed. This resulted in delayed treatment and lengthy loss of work time. The injured worker who has been away from work for an extended period of time and is receiving weekly disability may not be easily persuaded to learn a new skill and return to a new job.

More and more emphasis is now being placed on the need for early intervention and the belief that appropriate rehabilitation services must begin as soon as an injured worker experiences substantial loss of work time. Rather than wait until a permanent disability is definitely established, there is a belief that rehabilitation can and should begin early so that the disabling effects of the injury may be reduced, if not eliminated. Prompt and appropriate rehabilitation services may return an injured worker to his or her same job at the same salary, while delayed services could result in a diagnosis of permanent disability and a need for retraining or continued benefits. To encourage

early intervention, Minnesota law requires employers to refer an injured worker for a rehabilitation evaluation within 30 days of receiving medical information that an employee may not be able to return to his or her former job.

Obviously, the number and type of services provided under this broader definition of rehabilitation have increased. They would include at least the services mentioned earlier in this paper; medical evaluation, physical rehabilitation, work evaluation and counseling, job modification, job placement, on the job training, and retraining. These services are designed to restore the worker as fully as possible in a physical sense and also to restore to the highest degree the skills used on the previous job or skills applicable to a modified or new job. Formal training for new work is only one of many possible options. Although the reference to retrainig has been removed in the current law, rehabilitation sevices are not specifically defined. They are defined, however, in the rules promulgated by the Department of Labor and Industry.

The broader perspective of the role of rehabilitation also provides injured workers with a greater range of options when they cannot return to their old jobs. In addition to formal training, the worker may return to a modified job with the same employer, to a different job with the same employer, to a modified or different job with a new employer, the worker may participate in an on the job training program, or the worker may be trained for a new occupation. Providing options with the same employer are particularly important for those workers who are concerned about maintaining seniority,pension, sick leave and vacation benefits.

Except for on the job training, the statute does not define options for returning to work. Department of Labor and

Industry rules to implement the rehabilitation section do present these options. Priority is given to plans which return the employee to a job with the former employer, either by job modification or utilization of the employee's existing skills. If this is not possible, the worker may be placed with a new employer in a similar field which utilizes existing skills. Training for work in a new field should be considered when the above options are not feasible.

Since services begin early and options other than formal training are provided, the duration of services and time between injury and return to work should also be reduced. A reduction of the duration of services and less use of formal schooling, which is the most expensive form of rehabilitation, would also be expected to reduce costs.

Rehabilitation professionals have argued that the most effective rehabilitation services as measured by rate of completion of plans and return to work are the least expensive ones. A recent study conducted by the California Workers' Compensation Institute appears to confirm this view. Although formal schooling is still the most popular and expensive type of rehabilitation in California, the use of formal schooling is declining. More emphasis is being placed on job modifications or finding new jobs which utilize existing skills of the worker. The study showed that the most expensive and most lengthy plans had the lowest completion rates. The costs of modified or alternative work plans averaged about one-third of the cost of other plans, and these plans were completed 85% of the time and in an average of 14 weeks. Formal schooling plans not only cost about three times as much, but were completed only 38% of the time and took an average of 226 weeks to complete.

The revision of Minnesota's workers' compensation law was an

attempt to incorporate this changing perspective on the rehabilitation of injured workers. The intention was to provide earlier and more successful interventions at less cost while providing more rehabilitation options for the injured worker.

B. Responsibilities for Rehabilitation

Rehabilitation services are now mandatory in Minnesota for both employees and employers. The increased emphasis on the provision of rehabilitation services for injured workers has raised new controversy about the responsibilities for rehabilitation. Who decides when rehabilitation is appropriate? What services should be provided? By whom? Who approves rehabilitation plans and monitors them? There are at least 6 major actors involved in the provision of rehabilitation services. These are: (1) injured employees; (2) insurers; (3) employers; (4) Department of Labor and Industry; (5) rehabilitation consultants; (6) medical personnel. Each of these actors has certain responsibilities and control over the rehabilitation services and process as defined in the current statute.

1. Employees

The responsibility of an employee is participation in necessary medical examinations or evaluations to determine need for rehabilitation, participation in an approved rehabilitation plan, and acceptance of a reasonable offer of employment following completion of the plan.

Although the original offer of a rehabilitation agency or consultant is likely to be made by the insurer, workers do have the final decision as to who shall provide the rehabilitation services. Employees may request a change in the plan if they feel it is ill-suited to their interest or

abilities. Decisions of the commissioner or rehabilitation review panel may be appealed to the workers' compensation court of appeals or to the supreme court if the worker disagrees with the decision. Workers risk loss of workers' compensation benefits if they refuse to participate in rehabilitation consultation and evaluation.

There is still controversy over the responsibilities of employees with regard to cooperation with rehabilitation plans and acceptance of a job offer. There is no penalty in the current statute for nonparticipation in a rehabilitation plan, although the employee may lose benefits for refusal to be evaluated for possible rehabilitation services. Therefore, the responsibilities for participation in and completion of a rehabilitation plan are not enforced by the current statute.

Another issue is the type of job the employee is required to accept after completion of a rehabilitation plan. May the employee refuse an offer of a lower paying position without losing benefits? Can the employee be required to accept such an offer as long as the employment is related to the former job, is consistent with the worker's skills and abilities, and the wage loss is made up by partial disability benefits? The statute states that rehabilitation should train an employee for work which produces an economic status as close as possible to that he or she would have enjoyed without the disability. Responsibility for acceptance of a job are, however, not clarified.

2. Insurers

The new rehabilitation law in Minnesota requires employers to provide rehabilitation consultation services for the injured worker as soon as information is received that a worker will be unable to return to his or her former job due

to a work-related injury. Rehabilitation services must be provided if it is determined that such services would increase employability. Within 90 days of the date of the injury, a report must be filed if the employee has not returned to work and likelihood of return to work is undetermined. This report must indicate what is being done to determine the employee's qualification for rehabilitation services. A similar report is to be submitted every 60 days until the employee's status is ascertained.

In practice, the insurer is in the strongest position to influence the choice of rehabilitation consultation services. Many insurance companies have rehabilitation specialists on their staff to provide services to the injured worker. If not part of the company's staff, the insurer is still likely to control selection of the rehabilitation services by directing the worker to a private rehabilitation specialist. Although insurers generally provide or choose the provider of rehabilitation services to an injured worker, plans must be approved and monitored by the Department of Labor and Industry. Some insurance companies may perceive this as loss of control and might be more reluctant to participate as a result. Some argue, on the other hand, that insurance companies who employ rehabilitation consultants have more control over the rehabilitation process than is in the interest of the injured worker. These people suggest that the insurer and worker may have different interests in rehabilitation and the provision of rehabilitation services by the insurer involves an inherent conflict of interest.

3. Employers

The responsibility of the employer, other than those which are self-insured, is less well defined, at least by statute. On the job training is encouraged but no particular incen-

tive is created for the former employer to provide this training. Employers are required by statute to provide rehabilitation services. If not self-insured, this responsiblity is passed on to the insurance company and the employer may or may not become involved in the process. In many ways the former employer has great potential control over the outcome of rehabilitation by virtue of their level of involvement and willingness to reemploy the injured worker either in a modified or new position. Yet these responsibilities are neither mandated nor encouraged by law.

4. Department of Labor and Industry

Administrative agencies may be totally unaware and uninvolved with rehabilitation activities with responsibility and control left to the employer or insurer. Or the agency may only notify the worker and insurer when rehabilitation is worth considering. Others may be closely involved in rehabilitation and the monitoring and evaluation of services. Workers' compensation administrative agencies have not traditionally been very involved in rehabilitation in the past.The immediate objectives of the administrative agency are income maintainence and settlement of claims while rehabilitation and return to work are longer range objectives. A separate state and federal vocational rehabilitation system has been in operation since World War II. This system tended to operate independently of compensation laws and programs.The provision of rehabilitation services for injured workers was dependent on interagency communication. Contracts would have to be negotiated between the two agencies and the relationship between agency administrators was an important factor in the degree of cooperation exhibited between the agencies.

The Minnesota Department of Labor and Industry now has considerable control and responsibility for rehabilitation

services under the 1979 revision of the law. The department has a Director of Rehabilitation Services who is responsible for monitoring and evaluating all rehabilitation services. Rehabilitation specialists provide consultation and can make decisions on disputed plans. The rehabilitation review panel hears appeals of disputed plans, can approve or change plans and is charged with studying rehabilitation. All rehabilitation plans must be approved by the department. The department also has the authority to approve rehabilitation consultants. Only those consultants approved by the department are considered qualified to deliver rehabilitation services in the workers' compensation system. The responsibility and control exercised by the Department of Labor and Industry is therefore related to the type and quality of services provided and the settlement of disputes. Other actors in the system decide when the worker will not be able to return to work and is in need of rehabilitation consultation.

The Department of Labor and Industry has been given a greatly increased role in the rehabilitation process by the new statute. Continuing evaluation of this more active role is necessary to ensure the most effective provision of rehabilitation services. Does the state approval of Qualified Rehabilitation Consultants, for example, improve the quality of services provided by these professionals? Is approval of every rehabilitation plan by the Department necessary? Should more resources in the Department be directed to public education with insurers and employers? Should the department have more authority with respect to the initiation of services?

5. Rehabilitation Consultants

Rehabilitation consultants may be insurance company employees, other individuals or agencies in the private

sector, or public agencies. Under current law, rehabilitation consultants must be approved by the Department of Labor and Industry to provide rehabilitation services.

The state and federal Division of Vocational Rehabilitation has had major responsibility in the past for the provision of rehabilitation for workers' compensation cases. This program was initiated in 1920 and its primary purpose was and continues to be the rehabilitation and gainful employment of the severely disabled. To be eligibile for rehabilitation services with the Division of Vocational Rehabilitation, a worker must provide proof of disability. The emphasis is on job training for those unable to return to their previous line of work. Under the old Minnesota retraining law, the Division of Vocational Rehabilitation was the only agency which could certify for retraining and, therefore, maintained considerable control over rehabilitation.

The current rehabilitation section of Minnesota's workers' compensation law has deemphasized retraining and given more emphasis to the use of other rehabilitation services. By the licensing of rehabilitation consultants, the role of private rehabilitation professionals was increased. All rehabilitation consultants are responsible for determining whether rehabilitation will increase the employability of the injured worker and, if so, the development of a rehabilitation plan and its implementation, including job placement. The plan must be approved by the Department of Labor and Industry and progress reports must be submitted to the rehabilitation director every 30 days. Thus, although the rehabilitation consultant has considerable control over the content, quality, and implementation of rehabilitation services, the consultant has no final approval of rehabilitation plans.

6. Medical Personnel

According to current law, medical personnel are a crucial link between the injured worker and the provision of rehabilitation services. Rehabilitation consultation is mandatory only when the insurer or employer receives medical information that the injured worker will not be able to return to his or her former job. Medical personnel, therefore, may have significant control over whether rehabilitation is ever initiated. A worker or insurer may, of course, request rehabilitation services whenever they feel it is warranted and a medical referral is not required to receive services. The law, nonetheless, places considerable control with the medical professionals, who may or may not have the information about the worker and his or her former job with which to make this judgment.

C. Incentives

In Minnesota, insurers are required under certain circumstances to refer injured workers for rehabilitation consultation. Injured workers are required to submit to an evaluation and participate in a rehabilitation plan when it is determined that such rehabilitation would improve the employability of the injured worker. Failure to participate in rehabilitation consultation can result in the reduction or loss of all workers' compensation benefits. Although these statutory requirements are important to the provision of timely and effective rehabilitation services, other incentives operative in the workers' compensation system may work against or in concert with these requirements and, as a result, may either reduce or inhance the amount and effectiveness of rehabilitation services provided. These incentives may have important impacts on insurers, employees, employers ,and the Department of Labor and Industry and their willingness to initiate, provide, or participate in or

encourage rehabilitation services.

1. Employees

Many provisions of the Minnesota workers' compensation law encourage disability. Generous cash benefits reduce the incentive for rehabilitation on the part of the injured worker. Earlier analysis of total disability benefits in this paper show that under the Minnesota workers' compensation system, many workers receive a very substantial portion of their spendable earnings in compensation benefits, certainly a disincentive to participation in rehabilitation and return to work. This is especially true for workers with poor work histories and/or low wages who probably receive more money from workers' compensation benefits than they did by working.

Until last year, the payment of large, lump sum benefits in the form of permanent partial awards was also a significant disincentive to return to work and discouraged participation in rehabilitation plans. These benefits must now be paid after return to work. This delay in payment of permanent partial awards and the withholding of workers' compensation benefits if a worker refuses to participate in rehabilitation consultation will undoubtedly increase incentives to participate. On the other hand, the payment of large, lump sums for permanent disability still encourages disability and the lack of a statutory penalty for refusal to participate in and complete a plan are continuing disincentives.

Minnesota's law also seeks to provide incentive to the injured worker by increasing indemnity benefits while participating in an approved rehabilitation plan. The statute provides for a weekly benefit of 125% of the benefits for temporary total disability during rehabili-

tation. This increased benefit has been interpreted by the Workers' Compensation Court of Appeals to apply only during participation in formal retraining. Therefore, the worker is given incentive to participate in the most expensive and lengthy form of rehabilitation while no such incentive is provided for participation in medical evaluation, counseling, physical therapy, job modification, job placement or any of the other possible rehabilitation services.

Rehabilitation plans are encouraged by the workers' compensation statute to include plans for on the job training. As an incentive to participate in on the job training programs, workers' will be paid the same as their after-tax wages at the time of injury while participating in such a program. Presumbly this benefit was written to encourage training with the former or new employer rather than formal classroom training away from the work site. If one looks at the effect of the tax structure on spendable earnings as was done in the analysis of total disability, however, it must be concluded that the purely economic incentive is not to participate in on the job training at all, but to participate in formal retraining. Table 1 shows why this is the case. The table compares the 125% benefit with spendable earnings and shows that this benefit is higher than spendable earnings in every case. Although there is incentive to participate in on the job training rather than not participate at all, the strongest incentive is still to participate in retraining programs.

The insurer also plays a significant role in the degree to which workers are provided incentives to participate in rehabilitation programs. An insurance company may emphasize cash settlement and downplay rehabilitation. On the other hand, the insurer may inform the injured worker of the potential benefits of participation in a rehabilitation program and provide incentives for the worker to partici-

Table

Comparison of Three Possbile Rehabilitation Benefits
Under Minnesota's Workers' Compensation Law

Statewide Average Weekly Wage: 267.00

Single

Weekly Wage	170 (8,840/yr)		267 (13,884/yr)		450 (23,400/yr)	
Exemptions	1	2	1	2	1	2
Rehabilitation Benefit						
1) Temporary Total	133.50	133.50	178.09	178.09	267.00	267.00
2) 125% Temporary Total	166.88	166.88	222.61	222.61	333.75	333.75
3) Spendable Earnings (on-the-job training)	128.99	133.89	191.55	197.35	287.47	294.57

Married

Weekly Wage	170 (8,840/yr)		267 (13,884/yr)		450 (23,400/yr)	
Exemptions	2	4	2	4	2	4
Rehabilitation Benefit						
1) Temporary Total	133.50	133.50	178.09	178.09	267.00	267.00
2) 125% Temporary Total	166.88	166.88	222.61	222.61	333.75	333.75
3) Spendable Earnings (on-the-job training)	138.49	146.39	205.95	214.95	313.37	325.27

pate.

The willingness of an injured worker to participate in a rehabilitation plan is strongly affected by litigation. While a case is being litigated a worker is not motivated to reduce or eliminate a disability or to return to work. A claimant is going to be interested in maximizing the final settlement in a litigated case. One way to do this is to ignore rehabilitation which might reduce the disability at the time of settlement. Minnesota's high rates of litigation are a major disincentive for early and effective rehabilitation.

2. Insurers

Insurers play a crucial role in the rehabilitation services provided to injured workers. Their level of motivation and belief in the effectiveness of rehabilitation is probably the single most important factor in whether rehabilitation is provided at all. Rehabilitation is required when medical information is received indicating that the worker cannot return to his or her former employement. By the time such a medical diagnosis is provided, however, the disabling process of the system may already have begun, the worker may be comfortable with the disability and receipt of a weekly check, or litigation may already be in process. Therefore, the motivation and interest of the insurer may determine when and if rehabilitation services are provided.

Insurers are influenced by two major considerations. First is their obligation to relieve the immediate physical stress and lost wages due to the work injury. Second, is the fact that rehabilitation may save the insurer more than the actual expense of the rehabilitation if it reduces the need to replace lost income or to provide medical care. Whether an insurer believes rehabilitation can ultimately reduce

costs depends upon a number of other factors.

Litigation and lump sum payments such as permanent partial awards both discourage insurance companies from providing rehabilitation services. If insurers know they will be liable to pay large, lump sum awards regardless of the outcome of rehabilitation, there will be little incentive to pay for these services. If insurers believe that litigation will result in large cash settlements which they cannot reduce there will be less incentive to provide rehabilitation.

Other incentives in the workers' compensation system still emphasize and encourage workers to participate in retraining programs which are the most costly and may be the least effective in returning the worker to productive employment. Insurers are reluctant to pay for such expensive plans and may resist payment. Insurers may also lack awareness of the potential benefits of rehabilitation services. The economic interest of the insurer is to reduce expenditures. Therefore, insurers will be motivated on strictly economic grounds to provide rehabilitation only when they believe expenditures for rehabilitation in the short run can reduce indemnity payments in the long run. Increased knowledge and evidence of the potential benefits of rehabilitation or successful experience with the provision of rehabilitation services will increase insurers incentive to provide rehabilitation services.

3. Employers

The motivation of employers and incentives for participating in the rehabilitation of injured workers is also important to the effective provision of rehabilitation services. Employers can influence the insurer by their level of interest in the employee and their willingness to make

efforts to find work for their injured employees.

Few incentives exist in the current law to motivate employers to take an active role and interest in the rehabilitation of their injured workers. Again, the incentive which does exist is primarily a financial one, since the employer believes expensive cases will affect the employer's experience rating and increase the cost of workers' compensation premiums. If employers believe that rehabilitation can reduce the ultimate cost of indemnity benefits, they will be more likely to encourage rehabilitation.

The developement of second injury funds was intended to provide incentives for employers to hire workers with impairments or disabilities from work-related injuries and illnesses. To be eligible for reimbursement from the second injury fund, however, the employee with the physical impairment must be registered with the Department of Labor and Industry. But a rehabilitation plan may include return to work before a permanent rating of impairment or disability occurs and thus before the employee can be registered. Therefore, some of the incentive for the employer to re-employ the injured worker is removed. Former employers may be somewhat less affected by this problem because they are already paying benefits to the injured worker. New employers may be less willing to hire injured workers who are not registered and may not be covered by the second injury fund.

Employers are also eligible for federal tax credits for employing persons with physical impairments or disabilities. This could be an important incentive for employers to hire workers involved in rehabilitation programs. Only the Division of Vocational Rehabilitation can certify that an employer has hired a worker who would qualify the employer

for this tax credit. This restriction probably deters the use of this incentive since most insurance companies refer injured workers to their own rehabilitation staff or private consultants for rehabilitation services.

The on the job training portion of the workers' compensation statute also encourages employers to provide jobs for workers participating in a rehabilitation plan. The statute encourages, but does not require, the payment of indemnity benefits such that the on the job employer pays less than the prevailing wage for the job being performed by the worker. The employer cannot be required to pay more than the prevailing wage for the job. Thus the employer may be given an incentive to provide on the job training depending on the amount of compensation being paid by the insurer.

4. Department of Labor and Industry

The Department of Labor and Industry is responsible for the efficient administration and implementation of workers' compensation policy. The immediate objective of income mainteinance and the settlement of claims may tend to defer emphasis on longer range objectives of rehabilitation and return to work. As an interpreter of legislatively mandated policy, Labor and Industry is primarily motivated by what the state legislature says the department must do. Because of legislative mandate , the Department is actively involved with the development and monitoring of rehabilitation plans. Labor and Industry involvement is also certainly motivated by increasing evidence that expenditures for rehabilitation in the short run can reduce indemnity payments in the long run. Rehabilitation, therefore, has the potential to improve the efficiency of the workers' compensation system by reducing overall costs to the system and increasing the self-sufficency of the worker.

D. Evaluation of Rehabilitation Benefits

The rehabilitation services provided under workers' compensation have been dramatically altered in the past 18 months. Rehabilitation consultation must be provided under certain conditions . The Department of Labor and Industry is actively involved in the development and monitoring of rehabilitation plans, and emphasis has been placed on early intervention and the broadening of rehabilitation plans to include options other than retraining. These changes are too recent to allow a thorough evaluation of their impact on the effectiveness of rehabilitation in Minnesota's workers' compensation system. There are some preliminary figures which give an indication of what is happening to rehabilitation services, and analysis of the provisions of the law allow some evaluation of the adequacy, equity, promptness, and certainty of rehabilitation benefits in Minnesota.

1. Adequacy

Adequacy of rehabilitation benefits may be measured in several ways. First, rehabilitation benefits may be evaluated in the same way as other benefits in this report. Indemnity benefits paid during rehabilitation can be evaluated relative to the percent of pre-injury wages replaced by the benefit. Second, the adequacy of rehabilitation benefits can be measured by the percent of injured workers needing rehabilitation who receive services. A third way of measuring the adequacy of rehabilitation is to measure the effectiveness of services. Are workers who receive rehabilitation services returning to work? How quickly do they return to work, and at what cost? How do wages compare to pre-injury wages? How many cases require administrative involvement or litigation?

Evaluation of the correspondence between injured workers

needing rehabilitation services and the number who receive them is nearly impossible because of poor data. It is difficult to estimate the need and to quantify the services provided. The severity of injuries is not recorded nor the distribution of lost work time. The broad classifications of temporary or permanent total and temporary or permanent partial do not aid in determining the need for rehabilitation. As the monitoring of rehabilitation by the Department of Labor and Industry continues, better information should be available to evaluate the adequacy of services.

The adequacy of indemnity benefits paid during rehabilitation can be evaluated relative to the percent of wages replaced. Workers can receive one of three benefit levels while participating in a rehabilitation plan. During most phases of a rehabilitation plan, including evaluation, counseling, physical therapy, job modification or placement, the worker receives indemnity benefits equal to the benefit for temporary total disability. While attending a formal retraining program the worker receives a benefit equal to 125% of the rate for temporary total disability. During on the job training, workers receive benefits equal to the after-tax wages received on their pre-injury job.

The adequacy of total disability benefits was discussed elsewhere in this report. Analysis of the effects of the state and federal tax structure on benefit levels showed that total disability benefits in Minnesota are very generous, in many cases providing workers with more spendable income than they received while working. Workers may be eligible for two other benefits while participating in a rehabiliation plan which provide even higher benefits than total disability rates. It was already noted that the incentive to participate in on the job training is not as great as it might be because of the effects of state and federal taxes. Table 1 shows the relationship between the

three types of rehabilitation benefits. For most workers, benefits for on the job training are higher than benefits for total disability. For low wage earners it is possible for on the job training to provide lower benefits. This happens for workers who qualify for minimum benefits and are eligible for more than their spendable earnings in total disability benefits. Except for the highest paid workers, the benefit paid during retraining is by far the most generous, paying more than spendable income from the pre-injury wage. Rehabilitation benefits are structured then to encourage the most lengthy and costly form of rehabilitation services. Ironically, the system pays these high benefits to encourage participation in rehabilitation, but the benefits are so high that there is no incentive to return to work since workers are receiving more income than they did from their pre-injury job.

Rehabilitation indemnity benefits, then, suffer from the same disincentives found in total disability benefits, while encouraging retraining over on the job training, apparently just the opposite of what the legislature intended.

Definitive answers to the questions of effectiveness require continued monitoring and data from the new rehabilitation program. A comparison of data collected by the Wausau Insurance Companies on rehabilitation services provided both before and after the changes in the rehabilitation law show significant improvement in services. The length of time from injury to completion of rehabilitation services improved from 23.95 months to only 7.74 months under the new statute. The percent of workers participating in rehabilitation programs who returned to work also increased from 43% to 86%; and 89% returned to a job with their original employer. Almost 90% returned to jobs at equal or greater wages than their previous employment. Litigation appears to be significantly decreased from 48% requiring administrative

involvement under the previous rehabilitation system, while only 7% required administrative involvement under the new system.

Data from the Department of Labor and Industry also suggest the change in the rehabilitation law has been effective. Of workers completing rehabilitation plans in the past year, 85% returned to work; and 75% of these workers returned to their former employers. Of six thousand cases referred in the past year, about 400 required administrative conferences and most of these (83%) agreed to a plan during this conference. Eighteen decisions were appealed to the rehabilitation review panel, three to the workers' compensation court of appeals, and one case was appealed to the supreme court. This data suggests that rehabilitation plans have been effective both in terms of returning injured workers to the job and reducing lost work time, often with the same employer and with little need for litigation.

2. Equity

Except for indemnity benefits, the equity of rehabilitation benefits is nearly impossible to evaluate. There is currently no way to determine whether rehabilitation differs for similiar cases or whether workers with different needs receive services in proportion to their needs. The provision of rehabilitation services is dependent on the motivation and interest of the employer or insurer and on the rehabilitation consultants who develop rehabilitation plans.

Those rehabilitation indemnity benefits which are equal to or a percentage of total disability benefits will be subject to the same equity problems discussed elsewhere in this report. The on the job training benefit alleviates these inequity problems because it is based on the worker's take

home pay, eliminating the inequities created by the state and federal tax structure. Since on the job training benefits are not subject to minimum or maximum benefits, they also are strictly proportional (everyone receives 100% of their after tax wage) and therefore satisfy even the strict definition of vertical equity.

3. Certainty

Under the current statute, there is no certainty that an injured worker in need of rehabilitation will receive services. It is uncertain under what conditions medical personnel would send information to the employer or insurer that an injured worker will not be able to return to his or her pre-injury job. Therefore, it is probably the particular policy of the insurance company or the assertiveness of the employer or possibly the injured worker which determines whether needed rehabilitation services are provided.

Certainty of rehabilitation is significantly affected by litigation. While there is controversy about the compensablity of a case, or about a rehabilitation plan, or the extent of a disability, no rehabilitation will be provided. The worker has no interest in rehabilitation since he or she is probably trying to prove the existence or extent of a work-related illness or injury, and the insurance company will not pay any additional benefits for rehabilitation as long as of the outcome of the case is in doubt. High litigation rates in Minnesota probably contribute to the uncertainity of rehabilitation benefits.

4. Promptness

The prompt delivery of rehabilitation services is also very affected by litigation. The process of conferences and

hearings can go on for months during which rehabilitation will be ignored and valuable time lost as the disabling effects of the workers' compensation system begin to operate.

How soon rehabilitation referral and service begin is primarily dependent on the insurance company and employer and how aware they are of the potential benefits of the rehabilitation services. Those workers in need of rehabilitation services who are not covered by such companies may be missed for referral, and services may be delayed or never received at all. There are no formal incentives or penalties for providing the necessary medical information requiring referral for rehabilitation.

DEATH BENEFIT POLICY IN MINNESOTA

BASIC PROVISIONS

Persons wholly or partially dependent on the financial support provided by a deceased worker at the time of death are eligible to receive workers' compensation benefits. The surviving spouse and any children of the deceased worker under 18 years of age are presumed to be wholly dependent on the income of the worker. Other relatives may also be judged wholly or partially dependent and be eligible to receive benefits.

While the law provides that payment of benefits for total disability must begin within 14 days of gaining knowledge of the injury, no deadline for the commencement of payment of death benefits is statutorily defined. Prior to 1981, a 30 day time limit was defined.

Benefits received by surviving dependents are based on four factors: (1) the weekly wage of the deceased worker; (2) the number of dependents; (3) the eligibility of the family, as a result of the death, for social security benefits; and (4) the future marital status of the spouse.

Benefits are calculated as a percentage of the weekly wage of the worker at the time of death. In no case can the weekly benefit rate exceed the statewide average weekly wage. For a surviving spouse without children, the weekly

benefit rate is 50 percent of the workers's weekly wage at the time of death. For a spouse with one dependent child, the rate is 60 percent of the weekly wage, and for a spouse with two or more children, the rate is 66 2/3 percent of the weekly wage.

A surviving spouse without children has the option of receiving either periodic benefits at the 50 percent rate for 10 years with annual escalations based on changes in the statewide average weekly wage (subject to a 6 percent maximum), or receiving a lump sum payment equal to ten years' worth of benefits calculated without escalation. If the spouse elects to receive periodic beneifts, but remarries before ten years have elapsed, then the spouse will receive either a lump sum amount equal to 50 percent of the weekly wage for two years or the remaining periodic benefits, whichever is less.

A surviving spouse with one or more children is eligible to receive 60 percent (with one dependent child) or 66 2/3 percent (with two or more children) of the weekly wage until the youngest child is no longer dependent. When all children are no longer dependent, then the spouse must choose to receive either a lump sum payment equal to ten years of compensation at a rate that is 1/6 less (with one child) or 25 percent less (with two or more children) than the rate last received and before any offsetting adjustments are made, or periodic benefits for ten years at the same rate, but with annual adjustments for inflation. If the

surviving spouse remarries with one or more children still dependent, then the spouse will receive periodic benefits for the support of the dependent children until they are no longer dependent. The amount of these support benefits is determined in a judicial hearing. In addition, the spouse will receive a lump sum amount equal to two years of benefits at a rate that equals the original weekly rate less the allocations made for the support of any dependent children.

It should be noted that, although a surviving spouse with no dependent children is allowed to choose between periodic payments and a lump sum payment, there is no common reason why any spouse would choose periodic payments. This is true even though the lump sum amount is not based on annual adjustments. The ultimate value of a lump sum amount is substantially higher than periodic payments if the sum is prudently invested and spent at the same rate as periodic payments would be received. There is little reason to expect, therefore, that any surviving spouse would choose periodic payments over a lump sum amount.

Rehabilitation services are also available to a surviving spouse. Such services include consultation, retraining, and job placement. No additional monetary compensation, however, is included with rehabilitation services.

The death benefits described above may be reduced if the surviving spouse is eligible to receive benefits from

"any government survivor program". This phrase has been interpreted as meaning the federal survivor's insurance program administered by the Social Security Administration. If applicable, workers' compensation benefits are reduced by an amount such that the combined total of weekly benefits (workers' compensation and social security) does not exceed 100 percent of the deceased worker's weekly wage. If total benefits do not exceed 100 percent of the weekly wage, then workers' compensation benefits are not reduced. If total benefits exceed 100 percent of the weekly wage by only $1, then workers' compensation benefits are reduced by $1. If total benefits would exceed the weekly wage by an amount equal to or greater than the workers' compensation benefit, then no workers' compensation benefit is paid.

The offset described above differs significantly from the social security offset for permanent total disability. For total disability, workers' compensation benefits are reduced by one dollar for every dollar received under social security. The social security offset for death benefits does not affect survivors of high wage earners. This is due to the progressive nature of social security benefits whereby the proportion of lost wages replaced by social security decreases as the former wage of the deceased worker increases, and because of the maximum workers' compensation benefits (the statewide average weekly wage). For survivors of high wage earners, the maximum workers' compensation benefit plus the normal social security benefit will be less

than the deceased worker's weekly wage, and there will be no offset. Survivors of lower wage earners are much more likely to be affected by the offset because the social security benefit is proportionately larger and the workers' compensation benefit is less than the statewide average weekly wage. It is more likely, therefore, that combined benefits will exceed the former wage of the deceased worker.

Not all death claims involve a surviving spouse and dependent children. In some cases there are surviving dependent children but no spouse. Under current law, one orphaned child is eligible to receive 55 percent of the worker's wage until he or she reaches age 18 or age 25 as a full time student. Payments may only be paid periodically.

The parents of the deceased worker may also be eligible for compensation benefits if they can demonstrate that they were wholly or partially dependent on the income of the worker and if there is no surviving spouse or child eligible to receive benefits. Two dependent parents may receive up to 45 percent of the worker's weekly wage. One parent may receive up to 35 percent. In no case can the weekly benefit amount exceed the actual support provided by the worker to the parents before death.

Other relatives, including grandparents, grandchildren, siblings, father-in-law, and mother-in-law, may also receive benefits if they can demonstrate total or partial dependency and if there is no spouse, child, or parent eligible to receive benefits. Benefits may equal as much as 30 percent

of the worker's weekly wage for one such dependent and 35 percent for two or more. Again, in no case can the weekly benefit amount exceed the actual support provided by the worker to the dependents before death.

It is important to note that recent changes in Minnesota's law designed to limit periodic benefits to ten years after all children are no longer dependent, do not affect benefits paid to orphaned children or remote dependents. For example, whereas a dependent spouse without children cannot receive benefits for more than ten years, a surviving dependent parent may receive periodic benefits indefinitely. It should also be noted that the current law is unclear as to the form of benefit payments provided to remote dependents, that is, whether they are to be periodic or lump sum. Unlike the more common situation involving a surviving spouse, the remote dependent is not offered the opportunity to choose between periodic or lump-sum benefits. However, the law also does not indicate whether benefits are to be paid periodically or in a lump-sum amount.

A final aspect of death benefit policy, is the requirement that employers must contribute to the special compensation fund in amounts dependent on the special circumstances associated with each death claim. In every case of death where no dependents are entitled to receive compensation, the insurer must pay $5,000 to the special compensation fund. Whenever the benefits payable to surviving dependents total less than $5,000, then the

insurer must pay to the special compensation fund an amount equal to the difference between $5,000 and the amount payable to surviving dependents. In no case can this amount be less than $1,000. For example, if all dependents are eligible for $4,500 in aggregate death benefits, then the insurer must pay $1,000 to the special compensation fund. If dependents are eligible to receive $3,500, then $1,500 must be paid to the special compensation fund.

UNIQUE ASPECTS

Minnesota's death benefit policy differs significantly from that of most other states. Minnesota's policy is unusual with respect to five major provisions. First, the percentage of the deceased worker's weekly wage used to determine the weekly benefit amount is much lower in Minnesota than in most states. Second, Minnesota is one of the few states that provides additional benefits for dependent children. Third, Minnesota is one of the few states that reduces workers' compensation benefits when the recipient is also eligbile to receive social security benefits. Fourth, most other states do not provide for the adjustment of benefits to reflect inflation. And finally, Minnesota is one of the few states to allow the surviving spouse to choose freely between a lump sum benefit or periodic benefits. Table 1 compares Minnesota's policy with the policy in several selected states.

TABLE I

State	Benefit Rate[1] (percentage of weekly wage)	Maximum Weeks of Compensation[1]	Maximum Weekly Dollar Amount[1]	Additional Benefits for Children	Social Security Offset	Inflationary Adjustment	Lump Sum Option
Michigan[7]	80%[2]	500	SAWW[4]	none	no	yes	no
Iowa	80%[2]	none	200% SAWW	none	no	no	no
South Dakota	66 2/3%	none	SAWW	$50 each child	no	no	yes[5]
Florida	50%	none[3]	SAWW	16 2/3%	no	no	yes[5]
New York	66 2/3%	none	$215	30%	yes	no	no
Wisconsin	70%	1,000	SAWW	none	no	no	no
Minnesota	50%	520	SAWW	10% first child 6 2/3% second child	yes	yes	yes[6]

1 For a spouse with no dependent children.
2 Based on spendable earnings.
3 Florida does, however, provide for maximum total benefits of $50,000.
4 Approximate. (SAWW = Statewide Average Weekly Wage)
5 Provided to all recepients but only with special approval.
6 Limited only to the spouse with no dependent children.
7 Effective January 1, 1982.

chart (Table 1)

CONCEPTUAL FOUNDATIONS

The effective purpose of benefit policy may be difficult to determine. In addition, once identified, the effective purpose may vary considerably from the stated or perceived purpose. Nowhere is this more true than in the case of death benefit policy. The perceived, and sometimes stated, purpose of benefit policy is to replace lost wages. This is true in every state workers' compensation system. With death benefit policy, however, the effective purpose includes many elements that are entirely unrelated to any wage-replacement principles.

The elements unrelated to wage replacement and that are present in most death benefit policies, can be traced to an effort to provide benefits consistent with the <u>needs</u> of individual recipients. A fundamentally different and competing purpose of death benefit policy thus emerges; that is, to provide benefits based on need. Providing benefits consistent with the needs of recipients has not generally been the stated or even the perceived purpose of benefit policy. That factors related to need are so important in the actual allocation of benefits, however, suggests that the effective purpose of benefit policy is at best, multi-directional. In other words, the effective purpose of

death benefit policy may be to replace lost wages and to provide benefits consistent with the needs of recipients. In the following paragraphs, the alternative policies of providing death benefits based on wage replacement and providing benefits consistent with the recipient's needs are discussed. Particular attention is devoted to three criteria described earlier in this report: adequacy, equity, and efficiency. A closer examination of Minnesota's death benefit policy is then made in light of this discussion.

Benefits Provided to Replace Lost Wages

Adequacy

If the purpose in providing death benefits is to compensate surviving dependents for lost wages, then it is unclear what would be adequate benefits. For example, there is no reason, other than containing costs, why 100 percent of all lost wages should not be replaced. In addition, benefits could be paid for the entire period of time that the worker would have worked had there been no injury resulting in death. Practical concerns for containing costs, however, could be expected to limit benefits in terms of the proportion of lost wages replaced and/or the period of time during which benefits are paid. Cost containment concerns might also require limiting benefits to some

maximum period or total amount. Most state workers' compensation laws do include one or more of the above cost containment measures. For example, in Minnesota only 50 percent of the deceased worker's pre-injury wage is provided to the surviving spouse, and then for no more than 10 years, if there are no dependent children.

Most states replace two-thirds or more of the pre-injury wage. However, most states do not recognize that an individual's wage usually increases over time. Assuming that a two-thirds replacement rate is adequate, therefore, most states provide adequate benefits for only a short period of time if benefits are not periodically adjusted to reflect the wage inflation that the deceased worker would have otherwise.

Equity

A wage-replacement benefit policy is highly equitable if benefits are defined as a proportion of lost wages. Benefits would vary directly with wage loss. Cost containment measures such as maximum benefit amounts or maximum benefit periods, however, inevitably cause some inequities to result. This is unavoidable in any approach where cost constraints are recognized.

Efficiency

Death benefit policy providing benefits based on wage loss does include an unavoidable efficiency-related problem. In addition, efforts to address this efficiency-related problem will adversely affect the equity of benefits. Essentially, the problem is in determining what the actual wage loss is for any individual claim. Most states, including Minnesota, estimate wage loss simply on the basis of the pre-injury wage of the deceased worker. Pre-injury wage, by itself, is an unreliable measure of future wage loss. Pre-injury wage is universally used because of the ease in application and because of its ready availability. The result, however, is the likelihood that major inequities will occur. Some benefit recipients will receive much less in benefits than actual wage loss would merit. Others will receive much more. There is little assurance that those experiencing the same wage loss will receive the same benefits.

More accurately estimating actual wage loss would demand that other factors, in addition to pre-injury wage, be considered. Other factors that might be important include the age, occupation, and educational level of the deceased worker. Considering these other factors, however, would demand that greater attention be devoted to assessing each individual claim. In addition, considering other factors would probably increase the likelihood that

controversy and costly litigation would occur. This is especially important as the relevant factors to consider are of a more ill defined and subjective nature. In short, expanding the relevant factors to consider in estimating wage loss so that benefits are more equitable would have an adverse effect on the efficiency of the processing and delivery system. The more restrictive a system is in terms of the factors considered in estimating wage loss, the more efficient and less equitable will be that system.

Benefits Provided on the Basis of Need

The above discussion considered benefits designed solely to replace lost wages. Factors unrelated to wage-replacement principles, such as number of dependents or marital status, were excluded from the discussion. In the following few paragraphs, the focus is on death benefits designed solely on the basis of the needs of the recipient. Factors unrelated to the concept of need are excluded from the discussion.

Adequacy

If death benefits are to be provided on the basis of need, then choosing an adequate benefit level is a very important task. The first step in doing this is to define what is and is not adequate. For example, are benefits

adequate if they satisfy only the minimum needs of the recipient, or must benefits allow the recipient to maintain his or her current standard of living? Because no state system currently provides benefits solely on the basis of need, no adequacy standard exists. Nevertheless, concern that a surviving dependent should not experience economic disaster attests to the fact that adequacy is an important, if ill-defined, issue.

Equity

Equitable benefit policy requires that surviving dependents experiencing the same needs, arising out of the death of a wage earner, are compensated equally. Similarly, benefits should vary only as the need of the recipient varies. For example, with all other things being equal, a surviving spouse with two dependent children should receive more in benefits that a surviving spouse with no children. This would also be true even if the wage of the deceased worker in the second case were several times the wage of the deceased worker in the first case. Factors relevant to the needs of any particular surviving dependent might include other income, physical and financial assets, marketable skills of household members, the number of dependents, and marital status.

Efficiency

The efficiency of a death benefit policy providing benefits based on need is likely to be much lower than if benefits were based on wage loss. Accurately assessing the needs of an individual dependent requires that considerable time and effort be allocated to evaluating each case. Routine procedures are not likely to be available or very helpful. In addition, given the variety of possible factors to consider and the subjective nature of the entire process, the potential for controversy and litigation is quite high. Efforts to enhance efficiency, however, are likely to adversely affect equity. For example, limiting consideration to the number of dependent children and the marital status of the surviving spouse may substantially improve the efficiency of the system but may also result in significant inequities.

AN ASSESSMENT OF DEATH BENEFIT POLICY IN MINNESOTA

Wage Replacement or Need?

Two very different approaches to death benefit policy have been discussed. Each approach was discussed from an ideal perspective. In other words, it was assumed that when death benefits are based on wage loss the issues related to the needs of recipients are not to be considered. This

method was used to simplify the discussion and to underline a very important point. The point is that the concepts of adequacy, equity, and efficiency have very different meanings depending on the assumed purpose of benefit policy. In discussing issues related to the adequacy and equity of death benefits, or any other workers' compensation benefits, there should be no confusion as to the assumed purpose of benefit policy. Similarly, because of the unavoidable interrelationship between efficiency in providing benefits and the equity of those benefits, the same understanding is necessary when discussing efficiency-related issues.

The above discussion of ideal types does not accurately reflect any current workers' compensation system. In other words, in no state is the effective purpose of death benefit policy to provide benefits based exclusively on wage loss or to provide benefits consistent only with the needs of the recipient. Instead, a close examination of death benefit policy will reveal a dual purpose. Certain elements of benefit policy are clearly related to wage-replacement principles and other elements are clearly related to the needs of recipients.

Minnesota, and every other state, provides a surviving spouse with a base benefit defined as a proportion of the pre-injury wage of the deceased worker. This association with the pre-injury wage of the deceased worker clearly represents a strong attachment to wage-replacement principles. Several other elements of Minnesota's death

benefit policy, however, indicate a strong attachment to the idea of providing benefits consistent with needs of recipients. First, a surviving spouse will receive higher benefits if he or she also has any dependent children. Second, benefits are ended earlier if the surviving spouse remarries. A third element related to the recipient's needs is the reduction of benefits to account for benefits received under programs administered by the Social Security Administration. Finally, that weekly benefits cannot exceed the statewide average weekly wage indicates a concern that only the reasonable needs of a recipient should be satisfied through workers' compensation.

In every state, death benefit policy provides a balance between wage-replacement principles and concerns related to compensation consistent with needs. This balance, however, is not the same in every state. In some states, compensation based on need is given very little weight while in other states, such as Minnesota, need is given substantial weight. To reiterate, <u>in no state is death benefit policy based entirely on wage-replacement principles or entirely on the concept of compensating for needs</u>.

Adequacy, Equity, and Efficiency

Because of the dual purpose nature of Minnesota's death benefit policy, issues of adequacy, equity, and efficiency are difficult to address. What is adequate from a needs

perspective may be inadequate from a wage-replacement perspective. Similarly, what appears to be equitable from a wage-replacement perspective may be very inequitable from a needs perspective. In addition, measures to enhance the efficiency of processing and delivery systems may adversely affect the equity of benefits from a wage-replacement perspective.

From a wage-replacement perspective, benefits in Minnesota appear to be adequate, or at least comparable with benefits in other states, and somewhat inequitable due to the effect of need-related factors. From a needs perspective, benefits are inadequate for some and more than adequate for others, and somewhat inequitable due to the considerable weight given to the pre-injury wage of the deceased worker and because so few need-related factors are considered.

Current death benefit policy is relatively efficient in that all of the factors used to determine appropriate benefits are objectively examined and all relevant information is readily available. Every claim is assessed in the same manner using the same procedures. Current policy is inefficient, however, in that benefits are not necessarily prompt or certain. Benefits may not be prompt in that, under current state law, payments are not required to begin before 30 days after the death. Benefits are no more certain than are any other type of benefit. Surviving dependents must deal with very poor and very sparse

information immediately after the death.

POLICY OPTIONS

Five broad policy options emerge from this discussion: (1) establish wage-replacement as the sole effective purpose of death benefit policy; (2) establish compensation based on need as the sole effective purpose of death benefit policy; (3) retain both elements but change the balance between them; (4) retain both elements and preserve the present balance but enhance the differentiating ability of the delivery system; and (5) do nothing.

To establish wage replacement as the sole purpose of death benefit policy, all need-related elements would be abandoned. A surviving spouse would receive benefits based on a set proportion of lost wages. No adjustments would be made for children, other income, marital status, or benefits received under any other program. The proportion of lost wages replaced by benefits would be limited only in the interest of containing costs. Similarly, whether other relatives could receive benefits and the amounts they could receive, and whether benefits should be limited in terms of weeks or total amount, would also be considered in the interest of containing costs. There would be no reason for including any minimum benefit provision. Finally, whether benefits are paid periodically or in a lump sum amount is

not as important as is the need to provide all benefit recipients with the same options.

This policy option is desirable for at least two reasons. First, it would make the effective purpose of death benefit policy at least superficially consistent with the commonly perceived and stated purpose. Second, with this option there is a potential for benefits to be provided with equitable results. This assumes, however, that reasonable limits on benefit periods or total benefit amounts will be established. It also assumes that attempts to control administrative costs will not be so great as to prevent the accurate determination of actual wage loss.

There are also significant reasons why this policy option is not desirable. First, it rejects completely an important and effective, but largely unspoken, sentiment that the needs of benefit recipients should be considered in providing benefits. Second, it is doubtful that the administrative cost and resulting inefficiency inherent in an equitable wage-replacement policy would be acceptable. The consequence would be that measures designed to enhance efficiency would be taken at the expense of providing inequitable benefits. One likely example is that benefits would be determined on the basis of pre-injury wage alone.

To establish compensation based on need as the sole effective purpose of death benefit policy, the pre-injury wage of the deceased worker would have no bearing in determining benefits. No person would be presumed dependent

or not dependent on the income provided by the deceased worker. Dependency, its presence and degree, would be demonstrated by the potential benefit recipient.

It is difficult to imagine why this policy option would be desirable. On the other hand, there are several undesirable aspects. First, it is not entirely clear what the insurable risk would be under such a policy. The life of the worker? The worker's wage? The income of the worker's family? A certain standard of living? The lack of a definite insurable risk could seriously reduce the willingness of private carriers to engage in the business of providing workers' compensation insurance to employers without higher expected returns.

A second undesirable aspect of this policy option is its inherent inefficiency. Determining the needs of individual recipients would require an in-depth examination of the circumstances surrounding each case.

A third undesirable aspect is the likelihood that the benefits actually provided would not be equitable from a need-related perspective. Practical concerns with efficiency and administrative costs would most likely result in severe limits being placed on the range of relevant factors and circumstances that could be considered in determining the actual needs of benefit recipients.

Under the third broad option, it may be decided that both wage loss and need are important and legitimate concerns, but that one should have greater relative weight

than it does under current death benefit policy. The number of ways in which this could be accomplished is virtually unlimited, regardless of the direction of the change. The advantages and disadvantages of this option would depend on the nature of any specific changes being considered.

One important point should be made here regarding the desirability of shifting the balance between wage replacement and need. Despite popular misperceptions, there is little reason to believe that placing greater weight in a wage-replacement approach would necessarily result in less being paid out in total benefits. Neither a wage-replacement policy nor a need-based policy is inherently less or more expensive. For example, a benefit policy designed to meet 50 percent of a survivor's minimum financial needs may be much less expensive than a wage-replacement policy designed to replace 100 percent of a deceased worker's lost wages.

To enhance the differentiating ability of the delivery system, the fourth policy option, several things are possible. Rather than calculate benefits on the basis of the deceased worker's wage, benefits should be based on the deceased worker's spendable earnings (wages less federal and state income taxes and any social security deductions). In adjusting benefits to reflect the needs of benefit recipients, other need-related factors could be considered. Examples include: (1) the earned income of the surviving dependent (benefits might be adjusted to reflect the

deceased worker's pre-injury contribution to total household income); (2) unearned income from sources such as pensions or financial holdings; (3) financial assets of significant value; and (4) medical needs (benefit recipients above a certain age might receive higher benefits in recognition of greater medical needs).

The primary advantage to this policy option is that it would provide more equitable benefits from all perspectives without forcing controversial debate regarding the appropriate purpose in providing death benefits. Two disadvantages are apparent. First, considerable inequity will remain from the perspective of any person of the opinion that benefits should be based solely on wage replacement or solely on need. A second problem is that efficiency will suffer, but only marginally. Considering more factors when determining appropriate benefits would entail greater administrative costs, primarily to be borne by the employer and the public. The extent of this increase in administrative costs, however, would depend on the number of factors being considered and the objective nature of those factors. In any case, the inefficiency occurring would be far less than if a policy based entirely on need were adopted.

To do nothing, the fifth option, the present balance between wage replacement and need would remain the same, and the factors related to each would also remain unchanged. The advantage here would be in avoiding the controversy and

debate associated with any of the substantive changes described above. The primary disadvantages would be in preserving any present inequities that might exist and in leaving the cost of death benefits unchanged.

Pursuing any one of the policy options presented above will not necessarily result in minimal total benefits being paid. None of the above options is, by definition, more or less expensive, in terms of total costs, than any other option. Within the context of any benefit policy, there exists a range of measures that can be taken to control or contain costs without seriously violating the basic purpose in providing benefits.

PERMANENT PARTIAL BENEFIT POLICY IN MINNESOTA

INTRODUCTION

Every state workers' compensation system in this country provides for compensation during periods of disability. Although each state may be somewhat unique in terms of benefit level or benefit structure, the fundamental purpose is the same - to replace the wages lost by the injured worker during the period of disability. No such common purpose can be found with respect to compensation for permanent partial disability.

Most original workers' compensation laws, including Minnesota's, strictly adhered to the notion that the purpose of providing benefits was to replace lost wages. This presumption was equally relevant to permanent partial and total disabilities. Under the early laws, it was presumed that the permanent consequences of some injuries were so severe as to result in an actual and continuing loss of earnings even after the worker had recovered to the maximum extent possible and had returned to work. This presumption, however, was reserved only for highly visible and traumatic injuries such as the amputation of limbs or the total loss of sight.

Several developments through the years have served to alter the early and close association of permanent partial benefits to the concept of replacing lost wages. Among these developments are: (1) the inclusion of many permanent injuries and illnesses in the schedule of compensable injuries; (2) the equal standing granted to the "loss of the use of" a part of the body as with "the loss of" the part; and (3) the subsequent use of ratings - the percentage loss of the use of a part of the body.

The expansion of permanent partial benefit policy beyond the replacement of lost wages has very important implications for the final outcomes of the workers' compensation system.

PERMANENT PARTIAL BENEFIT POLICY IN MINNESOTA

Workers providing medical evidence documenting the existence of permanent, but not total, impairments resulting from a work-related injury or illness are eligible to receive permanent partial benefits. Benefits may be provided: (1) upon return to work; (2) after temporary total benefits have ended; or (3) after completing a rehabilitation plan. Payments are made by lump sum unless the worker has not returned to work, did not complete a rehabilitation plan, and has not retired from the work force. In these

cases, benefits are paid in periodic amounts.

The amount of benefits paid depends on three factors: (1) the part of the body permanently impaired; (2) the extent of the impairment; and (3) the wage of the worker at the time of the injury.

Minnesota's workers' compensation law includes an extensive list, or schedule, of parts of the body for which permanent partial benefits are payable. Associated with each body part is a fixed number of weeks during which benefits are paid or which provide the basis for calculating lump sum benefit amounts. Eligible workers' weekly benefits equal 66 2/3 percent of their weekly wage, subject to a maximum of the statewide average weekly wage. There is no minimum weekly benefit amount.

If the worker has experienced total loss or total loss of the use of a body part, then he or she will receive a permanent partial benefit equal to 66 2/3% of the worker's wage multiplied by the number of weeks given for the body part in the permanent partial schedule contained in the workers' compensation law. In most cases the worker receives a lump sum benefit although the award can come in the form of weekly benefit payments. For example, a worker who has permanently lost the entire use of an arm, and whose weekly

wage was $200, would receive a weekly benefit of $133 for 270 weeks or a lump sum benefit of $36,000.

Most permanent partial claims, however, do not involve total loss or even total loss of the use of a part of the body. More often than not, a permanent partial claim will be for the partial loss of the use of a part of the body. In such cases, weekly benefit amounts are paid for only a fraction of the same number of weeks. The fraction of the number of weeks represents the proportion of total use of the body part permanently lost as a result of the injury or illness. For example, if a worker with a weekly wage of $200 has permanently lost 50 percent of the use of an arm, then he or she would receive $133 for 135 weeks or a lump sum benefit of $18,000.

For some injuries, permanent partial benefits are based not on the loss or the loss of the use of the relevant body part but, instead, are tied to the proportional impairment to the entire body. Benefits resulting from injuries to the head or to internal organs are calculated on this basis. The maximum number of weeks of benefits for these injuries is 500. Again, most benefits will be based on a proportion of the maximum number of weeks.

Permanent partial benefits are not limited to the schedule of specific body parts found in Minnesota's

workers' compensation law. A provision in the law also provides for payment of benefits for "all cases of permanent partial disability not enumerated in this schedule." These claims are commonly referred to as "non-scheduled" permanent partials. As with many other "scheduled" permanent partial injuries, benefits are based on a proportion of a specific benefit period. Unlike scheduled permanent partials, however, benefits for non-scheduled injuries are based on the effect of the impairment on the injured worker's wage earning abilities. Benefits equal 66 2/3 percent of the difference between the worker's pre-injury wage and the wage he or she is able to earn upon returning to work. The significance of this unique aspect of non-scheduled permanent partial benefits is discussed later in this section.

Another significant aspect of permanent partial benefit policy is the ability to receive compensation for more than one permanent partial impairment resulting from the same injury, commonly referred to as the stacking of benefits.

This applies to the total or partial loss of or the total or partial loss of the use of any body part. For example, a worker with a 50 percent impairment to the back and a 30 percent impairment to a leg, and with a weekly wage of $300, would receive the following benefits: $35,000 for the back (.6667 x 300 x 350 x .50); and $11,700 for the leg (.6667 x 300 x 195 x .30) Another provision in the law

requires that all multiple permanent partial benefits be increased by 15 percent. Total benefits for the above example would then be $53,705. The significance of stacking benefits is more fully discussed later in this section.

Finally, permanent partial disability benefits are paid independently of and in addition to compensation for total disabilities. Although concurrent payment may not be allowed in some instances, the amount of benefits an injured worker is eligible to receive for impairment is not affected in any way by benefits received on any other basis.

The process for evaluating impairment and resolving disputes regarding benefits has been discussed in an earlier section of this report.

CONCEPTUAL FOUNDATIONS

Analysis of Minnesota's permanent partial benefit policy requires a conceptual understanding of the objective in the payment of benefits. Benefit policy may have more than one objective and, therefore, may be based on several different concepts. It will be shown later that Minnesota's policy does, in fact, embrace at least two distinct objectives and at least as many underlying concepts. In the next few paragraphs, the possible objectives of permanent partial benefit policy, and the concepts underlying each,

are discussed. It should be noted that much of this discussion is based on the work of John F. Burton, Jr., a leading scholar in the workers' compensation field.[1]

Permanent Consequences of Work Injuries and Illnesses

Burton has identified three levels of permanent consequences resulting from work-related injuries and illnesses. These are: (1) impairments; (2) functional limitations; and (3) work and non-work disabilities. Impairment is defined by the American Medical Association as "any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved."[2] Examples of impairments are amputated limbs and scarring resulting from burns.

Functional limitations may be of a disaggregated or aggregated nature. Disaggregated functional limitations are specific limitations associated with an impairment. For example, limited motion in the back is a disaggregated functional limitation associated with compressed vertebra, an impairment. An aggregated functional limitation is a more general consequence of impairment. For example, the inability to lift heavy weight is an aggregated functional limitation resulting from the compressed vertebra.

Permanent impairment may also result in work or nonwork disabilities. Nonwork disabilities result when functional limitations prevent the injured worker from performing tasks or fulfilling roles not associated with employment.[3] Not being able to ride a bicycle, for example, is a nonwork disability. A work disability, on the other hand, results when functional limitations prevent or inhibit the injured worker from performing work-related tasks, and the limitation results in an actual loss of earnings or a reduction in the earning capacity of the worker.[4]

Whether a functional limitation gives rise to a work disability will depend on several factors including: (1) the occupation of the worker; (2) the worker's education and experience; (3) the age of the worker; and (4) general economic and labor conditions.[5] For example, loss of the ability to run probably would not be a work disability to a college professor but would be for a professional athlete. Similarly, loss of the ability to lift heavy objects may result in a work disability for a worker in an area where there is a surplus of available manual labor but not in an area where there is a severe shortage of manual labor.

It should be noted that there is a progression from impairment, to functional limitation, and then to disability. In addition, all injuries do not necessarily involve each, if any, type of permanent consequence. That

is, not all impairments result in functional limitations, and not all functional limitations result in work or nonwork disabilities.

As was stated at the beginning of this section, the original purpose of workers' compensation was to replace lost wages. Through the years, however, a variety of other objectives have competed with the wage-replacement concept for the role as the dominant purpose of workers' compensation. This commingling of objectives is most apparent in the area of permanent partial disability.

The objectives of permanent partial benefits can be related to the typology of permanent consequences described above. That is, benefits can be based on impairment, functional limitation, and/or disability. The purpose of permanent partial benefit policy may then be to compensate for impairment, functional limitation, and/or disability. Each of these possible objectives is discussed below in terms of three important evaluative criteria: (1) adequacy, (2) equity, and (3) efficiency.

Compensation for Impairment

Permanent partial benefit policy based on compensation for impairment is potentially very efficient. Identification of anatomical abnormality can be a relatively straight-

forward task. Examples include documentation of lost vision, an enervated muscle, or scarred tissue. Standardized procedures and criteria are available to facilitate the evaluation of impairment. The amount of benefits due is determined by referring to a schedule associating dollar amounts with each level of impairment. The ultimate efficiency of a policy based on impairment would depend on whether standardized procedures for evaluating impairments are adopted, on the inclusiveness of the schedule, and on the degree of adherence to the schedule.

Interest in efficiency is related to the cost of administering benefit policy. Efficiency, according to Burton, can be of a panoramic or myopic nature.[6] Panoramic efficiency is related to the administrative cost of the benefit policy given a certain quality of benefits. In other words, an increase in panoramic efficiency would provide the same benefits to the same recipients at the same time but with lower administrative costs. The administrative cost per case is reduced and the total cost of administration is reduced. An example of a move toward increased panoramic efficiency would be the adoption of standardized procedures for evaluating impairments thereby reducing the frequency of litigation. Myopic efficiency is related solely to total administrative costs. The quality of benefits is not given and may be manipulated to reduce administrative costs. The administrative cost per case may remain

the same or may even increase. Total administrative costs are reduced by reducing the quality of benefits. An example of a move toward increased myopic efficiency would be to restrict compensation to actual loss of a body part rather than to loss of use of the body part. It will be shown that concerns for equity will restrict the acceptable range of options for promoting efficiency.

Equity requires that injured workers with the same impairment receive the same benefits. (This concept is often referred to as horizontal equity.) Any impairment-based benefit policy incorporating standardized procedures for evaluating impairments and limiting benefits to scheduled disabilities should fare well under this aspect of equity. Equity, however, also requires proportionality in benefits relative to differences in degrees of impairment. (This concept is referred to as vertical equity.) It is in this area that impairment-based policies may suffer. In particular, the difficulty lies in explaining the differences in benefits for different impairments. For example, to what degree should total loss of an arm be distinguished from total loss of a leg or total loss of vision? Standards and procedures, such as the American Medical Association's Guides to the Evaluation of Permanent Impairments, are available to deal with this problem.[7] These standards and guides allow all impairments to be expressed as proportional impairments to the entire body, thus providing a means to

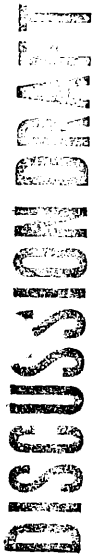
relate all types of impairments to each other. As a result, different benefits provided for different impairments can be understood.

Equity becomes a greater problem when compensation is limited to a few specific circumstances of impairment. For example, compensation may be limited to impairment of specified parts of the body or only to instances of total impairment. Such choices clearly represent a sacrifice of equity in the interest of reducing administrative costs. The result is to deny compensation to certain individuals where impairment exists.

What is adequate compensation for permanent impairment is not definable accoridng to any absolute standard. However, if impairment, in itself, is being compensated, then benefits should be the same for workers experiencing the same impairment. Reference cannot be made to the worker's wage, or any other unique characteristics, to determine what is adequate. Compensation is essentially for the disruption to the everyday lives of those suffering the impairment. That compensation for impairment is unrelated to the financial or economic consequences of injury is very important in determining what is adequate compensation for impairment.

As described earlier in this report, the primary

responsibility of a workers' compensation system is to protect against the substantial interruption of income experienced by workers as a result of injury or illness. Impairment benefits have no role in the fulfillment of this responsibility. However, insofar as the money available for all of workers' compensation is limited and because benefits provided to replace lost income take precedence over any other compensation, then the money available to compensate for impairment will be limited and constrained by the need to fulfill the primary responsibility of workers'compensation through the provision of benefits for medical care, total and partial disability, and death. In other words, defining what is adequate impairment benefits requires the consideration of how much it will cost to first provide adequate medical, disability, and death benefits.



Compensation for Functional Limitation

Permanent partial benefit policy based on functional limitation is not significantly different from policy based on impairment. Consideration is still limited to anatomical abnormality, but at a more generalized level.

Efficiency becomes somewhat more problematic for policies based on functional limitations. Standardized procedures and criteria are available for evaluating disaggregated functional limitations. Evaluating aggregated

functional limitations, however, is a much more speculative and difficult task. For example, limitation in motion in a leg, a disaggregated functional limitation, can be objectively determined using established standards. Limitation in the ability to walk up stairs, an aggregated functional limitation, is not as open to objective measurement because factors unrelated to the original injury may also be involved. Separating the influence of injury-related factors from the influence of non-injury factors is largely a subjective task. Efficiency is likely to suffer because of the increased opportunity for controversy and litigation. One area where this problem is most apparent is when trying to assess aggregated functional limitations associated with occupational diseases. Isolating the effect of employment from other contributing factors is exceedingly difficult. For example, how does one determine the functional limitation resulting from asbestosis to a worker who has also smoked heavily for decades?

The problem described in the preceeding paragraph is commonly referred to as apportionment. Another context in which apportionment is an important issue is when more than one employer is involved. For example, how does one apportion a functional limitation between two employers both of which contributed to the same occupational disease. The apportionment problem is dealt with elsewhere in this re-

port. It is sufficient to say here that the problem is particularly relevant when benefits are based on aggregated functional limitations, but it is also relevant to compensation provided for impairment and disability.

Compensation for Work Disability

It was explained earlier that disabilities can be of a work or non-work nature. It is assumed here that a benefit policy based on disability will include only work-related types of disabilities. Non-work disablities, therefore, are not considered.

Work-related disabilities reduce the earning capacity of injured workers or the actual earnings of those workers. By definition, injured workers with work disabilities experience real or potential wage loss. The distinction between potential and actual wage loss is very important. Most permanent partial benefit policies based on work disability actually compensate for potential rather than actual wage loss.

Compensation for work disability poses severe efficiency problems. This is particularly true when actual wage loss is considered. Compensating for actual wage loss requires that claims be actively monitored well after the medical condition of the injured worker has stabilized. The

wage of the worker must be compared with what the worker's wage would have been had no injury occurred. The worker is then compensated for all or a portion of the difference.

Two efficiency-related factors are important: maintaining and monitoring open cases for extended periods of time and determining what the worker's wage would have been had there been no injury. Monitoring open cases can be a costly enterprise. In this situation, the wages of the worker must be monitored and compensation payments provided on a periodic basis. Because wage loss may not occur immediately after returning to work, because wage loss may be sporadic, and because wage loss may continue indefinitely, the administrative cost per claim is likely to be relatively high. In addition, determining what wages the worker would have earned had there been no injury can be a very difficult task. Factors unrelated to the injury, such as the worker's age, education, and occupation, must be considered. Unless standardized procedures and criteria are employed, the process of estimating wages had there been no injury entails a high probability that controversy and litigation will occur.

There are few options that can be taken to enhance efficiency when compensation is based on actual wage loss. Those options that are available are limited to improving myopic efficiency. One option is to limit wage-replacement benefits to specific classes of injuries. Examples would

include paying wage-replacement benefits only in cases involving major amputations or only when lost wages exceed some arbitrary dollar threshold. Another myopic option would be to limit wage-replacement benefits to an arbitrary period of time after the injury occurs. A final option would be to limit the factors that could be considered in estimating the worker's wage had there been no injury. For example, only a very few objectively determined factors might be considered. Other factors might have no standing in the matter.

As with benefits based on impairment, efforts to improve the efficiency of a policy based on actual wage loss will be constrained by equity concerns. All of the myopic options described above will have the effect of limiting or denying benefits to workers experiencing actual wage loss.

The issue of adequacy regarding compensation for actual wage loss is limited to the proportion of lost wages replaced by permanent partial benefits. Ideally, one would expect that all lost wages should be replaced. Total replacement, however, poses a practical problem in that all financial incentive for the worker to earn wages as close to what he or she would earn had there been no injury is absent. Total replacement of lost wages is also likely to result in exaggerated estimates of lost wages and, as a

result, inflated total benefits. Adequate benefits, therefore, must be somewhat less than total lost wages.

As was stated earlier, permanent partial benefits based on disability are likely to be related to potential wage loss rather than actual wage loss. Compensating potential wage loss allows for the payment of benefits soon after the medical condition of the worker has stabilized, thereby avoiding some of the high administrative costs associated with actual wage replacement policies. An additional efficiency-related problem is present, however: estimating the impact of the disability on the wage-earning capacity of the injured worker. In determining the specific compensation for any disability, there are two tasks. First, the future wages of the worker, had there been no injury, must be estimated. This is no different than with compensation based on actual wage loss. A second task is to estimate what will be the worker's actual wages. In other words, the effect of the disability on the wage earning capacity of the worker must be determined and the consequences, in terms of actual wage loss, must be estimated. This task requires that a variety of factors, in addition to those affecting the wage of the worker had there been no injury, be considered. According to Burton, efforts to predict wage loss are largely unsuccessful and not very amendable to improvement.[8] Efficiency, therefore, will be an even greater problem with permanent partial benefit policies

based on potential wage loss. Determining appropriate benefits is more difficult and more likely to produce controversy and litigation.

The tendency in this situation, as with policies based on actual wage loss, will be to take measures to enhance efficiency, that is, to reduce or control administrative costs. Such measures are generally myopic in nature. Examples include limiting compensation to specific classes of disabilities and limiting the factors that can be considered when determining appropriate benefits. The consequences of such measures are to limit or deny benefits to certain workers suffering from disabilities and to over-compensate others. Equity, therefore, is likely to be a serious problem with policies based on potential wage loss.

AN ASSESSMENT OF PERMANENT PARTIAL BENEFIT POLICY IN MINNESOTA

Impairment or Wage-Replacement?

The task here is to describe Minnesota's permanent partial benefit policy in terms of impairment, functional limitation, and wage loss (work disability).

Minnesota's permanent partial benefit policy is not exclusively based on any of the concepts, although it contains elements of each. The law states that permanent partial benefits are "payable for functional loss of use or impairment of function." Elements of wage-replacement, however, are scattered throughout the law. Three of these departures from impairment and functional limitation are discussed below.

1. Benefits for scheduled injuries are tied directly to the wage of the injured worker. Specifically, a worker receives 66 2/3 percent of their preinjury wage for a determined number of weeks. When compensating for impairment, the preinjury wage of the worker should have no bearing on the benefit received by the worker.

2. Compensation for disfigurement and scarring is allowed only when the injury will affect "the employability, or advancement opportunity" of the worker. Again, this element is clearly related to the concept of wage-replacement. The implication is that only those workers experiencing these impairments and limitations, and who are likely to experience wage loss, should receive compensation benefits. Again, this is a clear departure from a policy based on impairment or functional limitation.

3. Compensation for impairment "not enumerated in this schedule," unscheduled permanent partials, is explicitly tied to resulting wage loss. Specifically, compensation equals 66 2/3 percent of the difference between the worker's actual wage and the wage he or she would have earned had there been no injury. This, of course, is in clear contradiction with the stated purpose of permanent partial benefit policy.

Minnesota is not unique among the states in that there appears to be no single direction or purpose in permanent partial benefit policy. Even states frequently referred to as having model systems, such as Wisconsin and Florida, are far from being conceptually pure in their approach to permanent partial benefits. It is very unusual to find a state where permanent partial policy development was ever framed as a choice between compensation for impairment, functional limitation, or wage-replacement. This is because, in the early development of workers' compensation, there was no question but that the purpose of all benefits was to compensate the injured worker for lost wages.

Two additional factors have contributed to the current problem. First, probably in recognition of the administrative problems associated with compensating for actual wage loss, early policy was to employ impairment as a proxy for wage loss. In other words, the intent was to compensate for

wage loss although impairment, in conjunction with the worker's pre-injury wage, was viewed as an indirect measure of wage loss. Benefits were limited to a very few highly visible and serious impairments, such as total loss of vision or amputation. The purpose in providing benefits, however, was to compensate for lost wages, and not for the impairment per se. There was a presumption that wage loss would follow such severe impairments.

A second important development was the steady growth in the types of impairments for which benefits were payable. In general, less and less severe impairments were included. As a result, the presumption that wage loss followed impairment became more and more tenuous. Eventually, the presumption was abandoned altogether, and what was once a benefit policy based on wage loss became an impairment-based policy. Minnesota is an excellent example of this phenomenon. The 1974 amendment to Minnesota's law asserting that permanent partial benefits were "payable for functional loss of use or impairment of function" seems to have completed the policy transformation from wage-replacement to impairment. As has been shown, however, artifacts of wage-replacement remain.

Adequacy, Efficiency, and Equity in Minnesota

The present questions are whether permanent partial disability benefits provided in Minnesota are adequate and equitable, and whether benefits are provided efficiently, that is with minimal adminstrative costs.

Along an adequacy continuum, benefits may be inadequate, adequate, or excessive. It is clear that permanent partial benefits in Minnesota are excessive. This conclusion is made in consideration of the fact that, in a system where the replacement of lost income is the primary responsibility, a very large proportion of all benefit dollars are associated with permanent partial claims.[9] Although aggregate data describing this situation are not available, there are numerous examples where injured workers receive more compensation for impairment than they receive in compensation for lost wages. This is excessive when the primary responsibility of a workers' compensation system is to replace lost wages.

Several factors contribute to the excessive nature of permanent partial benefits. First, benefit levels for individual impairments are high. If one compares the number of weeks worth of benefits provided for an impairment with the likely period of time during which an injured worker

would actually be disabled due to the injury causing impairment, it is apparent that impairment benefits will often times exceed disability benefits. For example, 40 weeks worth of impairment benefits are provided for the loss of a thumb; almost 4 months for the loss of a lesser toe; over 4 years for the loss of a hand; over 3 years for the loss of an eye; and over one and a half years for the loss of hearing in one ear. It is beyond reason to believe that these injuries by themselves could, but in exceptional cases, result in total disabilities for these periods of time. And yet, permanent partial benefits are paid on this basis. It is no wonder that impairment benefits often exceed total disability benefits for individual workers.

A second factor contributing to excessive permanent partial benefits is the stacking of awards for multiple impairments. An example will help illustrate the problem. In 1974, a worker was rendered quadraplegic due to a severe spinal injury suffered in an automobile accident. In addition to the compensation for wage loss that he will receive for the remainder of his life, the injured worker was awarded permanent partial benefits for impairment to his spine, each arm, and each leg. Total impairment benefits for this worker, at the current maximum rate, would exceed $450,000.[10]

Benefit stacking represents an even more extreme form of the problem described earlier. Insofar as the period of disability experienced by a worker with two or more impairments arising out of the same injury is not additive, then stacking benefits will provide even more, and more extreme, examples where impairment benefits exceed disability benefits. For example, a worker experiencing the loss of a thumb and the loss of an eye from the same injury is not likely to be disabled for 225 weeks (65 weeks for the thumb plus 160 weeks for the eye). The stacking of permanent partial benefits, therefore, contributes significantly to the problem of excessive benefits. When benefits are stacked, it is even more likely that impairment benefits will exceed compensation for disability.

A third factor contributing to excessive permanent partial benefits is the provision in the law requiring that benefits be increased by 15 percent whenever there are multiple impairments. Not only are benefits stacked; they are also increased by 15 percent. This of course, adds to the likelihood that, for individual workers, permanent partial impairment benefits will exceed any benefits received for disability. This provision is also interesting in that it, and stacking in general, is in direct conflict with the recommendations regarding the evaluation of multiple impairments published by the American Medical Association.[11] According to the AMA, two individual

impairments, when considered together, represent less than the sum of what each individual impairment would represent. For example, a 60 percent impairment to the whole body caused by the loss of an arm and a 10 percent impairment to the whole body caused by the partial loss of hearing would not together be a 70 percent impairment and certainly not an 81 percent impairment as the current law provides. According to the AMA, these multiple impairments would represent a 64 percent impairment to the whole body.

Permanent partial benefits are also highly inequitable. They are inequitable when considered alone, and they cause great inequities throughout the entire workers' compensation system.

There is neither vertical nor horizontal equity in current permanent partial benefits. Two workers with the same impairment have no assurance that they will receive the same benefit. This is true for several reasons. First, the pre-injury wage of the worker has a final role in determining the benefits received. Two workers with the same impairment rating do not receive the same benefits unless they also had the same pre-injury wage. Is this to mean that the pain and inconvenience experienced by a high wage earner is worth more than the pain and inconvenience experienced by a low wage earner? Current law makes this outlandish suggestion official public policy. Impairment

benefits represent financial compenstion for the non-financial aspects of permanent impairment. The pre-injury wage of the worker has no relationship with the non-financial aspects of an impairment and should not have any role in the determination of benefits.

A second reason why permanent partial benefits are inequitable is because injured workers cannot be certain that their physical condition will be accurately assessed. Physicians evaluating the same worker often times produce widely differing impairment ratings. There is no assurance that two workers with the same impairment will receive the same rating. Physicians are not encouraged or required to use the same methods or techniques in evaluating impairment. In addition, once an assessment is made, it may be amended or compromised as the claim becomes the subject of controversy and litigation. There should be little surprise that such a system produces inequitable results.

Permanent partial benefits also create serious inequities throughout the entire workers' compensation system. Again, this is due primarily to high benefit levels and the stacking of benefits. For example, two workers may both receive injuries that will eventually result in death. If one worker dies instantly, surviving dependents will receive the ususal death benefits. If the other worker lives for a short period of time, that worker may be awarded

permanent partial benefits along with the death benefits provided to dependents after death occurs. The permanent partial benefits, in such a situation, may easily exceed any death benefits provided. The fact that a worker did not die instantly does not justify such compensation.

The hypothetical situation just described has, in fact, occurred and can be expected to arise in the future. In 1975, permanent partial benefits were awarded to the parents of an employee in another state who lived between 17 and 24 minutes after the fatal accident occurred.[12] There is no logical reason to presume that such an outcome in Minnesota should not be expected. When carried to its logical end, there is no reason not to expect the provision of permanent partial benefits, along with death benefits, to become a routine practice in all cases of death.

Permanent partial benefits may also result in inequitable results when viewed in conjunction with total disability benefits. Greater permanent partial benfits may be provided to persons who are <u>not</u> presumed to be totally disabled than are provided to persons presumed to be totally disabled. For example, a worker experiencing total loss of vision is presumed, under the workers' compensation law, to be permanently and totally disabled. In other words, that person is not expected to be productively employed for the rest of his or her life. Total disability benefits and 350

weeks worth of permanent partial benefits would be paid to the worker. Another person may suffer the loss of an eye and a leg as well as 50 percent of the use of the back. It is not presumed that this person is totally disabled. However, he or she would receive 650 weeks worth of permanent partial benefits. At the current maximum benefit rate, the first worker, presumed to be permanently totally disabled, would receive $93,450 ($267 x 350) in permanent partial benefits. The second worker presumed to be temporarily disabled, would receive $199,583 ($267 x 650 x 1.15) in permanent partial benefits.

Finally, it is clearly evident that the process for providing permanent parital benefits is highly inefficient. The specific nature of this process has been described elsewhere in this report and will not be elaborated on here. The single most inefficient aspect of the process is the determination of impairment. However, the fundamental reason why the process is so inefficient is because the size of the awards at issue are so large. One of the objectives of a workers' compensation system is certainty. Certainty requires that routinized standards and procedures be present to determine and deliver benefits. A drawback of having routinized procedures, however, is that there will always be some amount of error. In other words, some workers may receive more benefits than they really should and some workers will receive less benefits than they really

should. Nevertheless, it is presumed that the value of having routinized procedures, that is, certainty in benefits, exceeds the cost of error. With an individual claim this means that it is better for all parties involved if routine procedures are followed rather than take the risk of challenging the benefits provided.

The situation now with permanent partial benefits is often one where the risk is preferrable to certainty. In other words, it is more rational in many cases, to abandon routine procedures and try to force the system to err in your favor. The larger the possible gain, and the greater the potential for error, the more likely, and rational, it is that routine procedures will be abandoned. Certainty becomes relatively less important.

The potential cost or gain resulting from error can be termendous with current benefit levels. For a person at the maximum benefit level, the difference between a 20 percent and a 40 percent impairment to the back is $18,690 in benefits. This problem is exacerbating when one considers that, for some workers, the total disability benefits approach the worker's pre-injury disposable income. Also, one would reasonably expect that a return to normal employment would reduce the potential claim to permanent disability. Therefore, every incentive exists to encourage extended total disability. This is not to suggest

dishonesty or malingering. Rather, it is to suggest that in a system where such things as the time when one may safely return to work and the discomfort one may wish to endure in so doing are extremely subjective in nature, the system virtually guarantees that the rational individual will act so as to maximize the cost to the system, to the economy, and to society as a whole.

A final point should be made regarding the direction of error in the current system. Probably with few exceptions, any error in determining permanent partial benefits has resulted in larger, rather than smaller, benefits. A quick review of past decisions shows that any doubt regarding impairment has usually been resolved in favor of the workers.

That the error is unidirectional has important implications. Those who benefit most from the current situation have an important and rational interest in preserving, not only high benefit levels, but also the opportunity to force error from the system. High benefit levels are important even if there is no system error. But high benefits also provide the reason for attempting to force error because the potential gain is so great. What this means is that high benefit levels are a very important reason why the system is so inefficient. If benefit levels were reduced, a likely consequence would be a reduction in

the controversy and litigation associated with permanent partial claims.

POLICY RECOMMENDATIONS

The fundamental problem facing Minnesota policy makers is establishing a basis for compensation that effectively resolves the dilemma of providing adequate and equitable benefits in a reasonably efficient manner and at an acceptable total cost to employers and the public.

It has been concluded that permanent partial benefits are excessive, inequitable, and inefficiently delivered. Permanent partial benefits are excessive in that, for many workers, benefits provided for impairment exceed benefits provided for disability. Because of high benefit levels and the stacking of benefits, very large awards are provided that bear no relationship whatsoever to the economic loss experienced by the injured worker. For these workers, the primary purpose of the workers' compensation system is not to compensate for their wage loss, but instead, it is to provide a large financial windfall. This situation should be corrected by reducing overall benefit levels and by not allowing the stacking impairment of benefits. These actions are necessary if protection against the substantial interruption of income is to remain the primary responsibility of workers' compensation.

Permanent partial benefits are inequitable in that low wage earners are unfairly compensated, relative to high wage earners. Impairment ratings are subjective, problematic and inconsistent, and workers with greater disability may receive less in total benefits than workers with less disability. Only the development and adoption of standard procedures and methods for evaluating impairment, and close adherence to those procedures, can add certainty and consistency to the evaluation of impairment. Reducing benefit levels and requiring multiple injury impairments to be rationally combined rather than added and then increased by 15% will also reduce the inequity caused by permanent partial benefits.

The inefficiency of the workers' compensation system is closely tied to large permanent partial awards. By reducing permanent partial benefit levels, the desirability of litigation will decrease and the efficiency of the system will thus improve. The adoption of, and close adherence to, standard procedures for evaluating impairment will also enhance the efficiency of the system.

The most important recommendation presented here is that compensation for impairment be substantially reduced. Although it may be desirable to retain some compensation for impairment, it should be recognized that such benefits are

secondary in relation to benefits provided to replace lost income. The size of impairment benefits provided to injured workers should reflect this fact.

Reducing impairment benefits, however, should not detract from the importance of compensating injured workers for income lost as a result of permanent partial impairment. This, in fact, is part of the primary responsibility of any workers' compensation system. Such compensation, however, should be provided as wage loss occurs--not on the basis of any prior prediction. Experience has shown that accurately predicting the future wage loss resulting from partial disability is virtually impossible.[13] The primary difficulty is in understanding how permanent impairment interacts with other factors, such as the age, occupation, and skills of the injured worker, to produce wage loss. The inequities resulting from an ex ante system probably exceed whatever advantages there might be in such a system. To prevent great inequities from occurring, and to insure that every injured worker experiencing actual wage loss receives adequate compensation, partial disability benefits should only be provided as partial wage loss occurs.

Specific recommendations regarding partial disability benefits are presented in a separate section of this report. The only recommendations presented here are that partial disability benefits be viewed as primary to, and independent

of, any compensation for impairment, and that partial disability benefits be provided only as wage loss actually occurs.

CONCLUSIONS

As has been explained earlier, workers' compensation originated through a basic compromise whereby workers were guaranteed protection against economic loss and employers were freed from the perilous and expensive tort liability system. The desirability of this compromise continues to be the primary reason for maintaining a workers' compensation system. Serious doubts have been raised in this chapter regarding the responsiveness of Minnesota's workers compensation system to this basic compromise. On one hand, benefits are sometimes inadequate, usually inequitable, and often times uncertain. On the other hand, employers must often pay benefits far in excess of the economic loss resulting from an injury or illness, and the litigation associated with workers' compensation claims can easily match or surpass tort liability in its complexity and uncertainty of outcome. To a large extent, therefore, the basic compromise which lends legitimacy to workers' compensation does not exist in that neither workers nor employers are realizing the professed advantages of a workers' compensation system. This is not true for all, or even most, claims. It is prevalent enough, however, to make workers' compensation a major public policy issue.

In this chapter, individual benefit types were examined in light of several important criteria. It was demonstrated that benefits provided to injured workers may be uncertain, inadequate, excessive, inequitable, and/or inefficiently delivered. Although the earlier analysis was presented at the level of the individual benefit type, the evaluative criteria used may also be helpful when thinking in terms of the composite benefit structure. This perspective is taken in the following discussion.

Adequacy

If one assumes that an across-the-board wage-replacement rate is desirable, then about 15% of workers and survivors receive inadequate benefits. These, however, are high wage earners and their survivors who receive maximum benefits, albeit at a lower replacement rate. More workers receive benefits that are somewhere between adequate and excessive. Whether a particular worker falls in the adequate area or at the excessive end of the scale appears, to a great extent, to be a matter of chance. For example, if death does not happen to be instantaneous, then a survivor may become a relatively wealthy person. If a worker's permanent impairment does not impact on future earning capacity, then that person may receive a substantial windfall even though there is very little wage loss as a result of the injury or illness. Once again, benefits for most workers are neither inadequate nor alarmingly excessive. The probability is much greater, however, that a person will receive relatively excessive rather than inadequate benefits. This often creates fundamental disincentives to return to work in a timely manner.

Equity

Workers' compensation benefits are often inequitable in that earnings loss is of limited importance in determining what benefits any particular injured worker or survivor will receive. As a result, workers with the same earnings loss often do not receive the same benefits, and benefits provided to workers with different wage loss vary by inordinate degrees. The most important factor contributing to the problem of inequitable benefits is the lack of proper balance between primary and secondary benefits.

Efficiency

The Minnesota workers' compensation system is reasonably efficient with respect to primary benefits. The process for providing secondary benefits, however, is inefficient due, in part, to the strong incentives encouraging workers and employers to become engaged in controversy and litigation.

General Conclusions

Adequacy, equity, and efficiency are important concepts for evaluating any public enterprise. With respect to workers compensation, these criteria are particularly useful as indicators of the continued validity of the basic compromise of workers' compensation. In other words, a system that provides excessive and inequitable benefits in an inefficient manner is, by definition, falling short of satisfying the basic terms of the compromise. First, benefits are excessive when the value of secondary benefits exceeds the value of primary benefits. Originally, employers were to be free of liability for losses unrelated to medical care or wage loss. The relative importance of secondary benefits clearly reflects a sizable responsibility for non-economic loss. Second, workers are unfairly treated when benefits are inequitable. And third, substituting the inefficiency of workers' compensation for the inefficiency of tort liability is hardly an improvement. In short, the basic compromise of workers' compensation is, to a great extent, an invalid justification for maintaining the status quo.

Recommendation

It is recommended that an entirely new benefit structure be enacted to replace the current benefit structure provided in Chapter 176 of the Minnesota Statutes. The new benefit structure should be responsive to the problems identified

within the preceding sections of this chapter.