WORKERS' COMPENSATION

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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WORKERS' COMPENSATION

February 1988

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

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JAMES R. NOBLES, LEGISLATIVE AUDITOR

February 15, 1988

Representative Phillip J. Riveness, Chairman
Legislative Audit Commission

Dear Representative Riveness:

In May 1987 the Legislative Audit Commission directed the Program Evaluation Division to evaluate Minnesota's Workers' Compensation system. Although changes in the system have been debated for years, many fundamental questions about the system remain: How do Minnesota's costs for workers' compensation compare with those of other states? What factors in the system drive costs higher? What can the Legislature do to control costs?

The evaluation studied these questions using the best available data from state and national sources. The report concludes that Minnesota's workers' compensation costs are high mainly because benefits are high, and that costs can be most directly brought under control by limiting certain benefits and eliminating others. Obviously, this means that the Legislature must make difficult choices. We hope that this report helps to identify the choices and outline the consequences of each.

We received the full cooperation of the Department of Labor and Industry, which oversees the workers' compensation system in Minnesota, and the Department of Commerce, which administers the workers' compensation assigned risk plan.

This report was researched and written by Elliot Long (project manager), David Chein, and Dan Jacobson, with assistance from Margaret Roll.

Sincerely yours,

James R. Nobles
Legislative Auditor

Roger A. Brooks
Deputy Legislative Auditor
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WORKERS' COMPENSATION

Executive Summary

Workers' compensation has been a source of concern to the Legislature for over a decade. Although significant reforms were enacted in the early 1980s, this study was prompted by continuing and growing concern that Minnesota's system is costly, complex, and not serving well the interests of either employers or employees.

Workers' compensation is a mandatory insurance program that compensates injured workers for medical care, wage loss, and permanent impairment. In essence, it is akin to a contract between employers and employees under which both sides trade certain rights in return for certain guarantees. Workers are assured that they will be compensated for occupational injuries or illness without having to sue or prove fault. Employers give up common-law defenses and assume responsibility for injuries regardless of fault, in exchange for protection from large jury awards that might result from civil litigation. There are over 110,000 Minnesota workers' compensation claims filed annually. Case-by-case adjudication of them is a practical impossibility.

Over 110,000 workers' compensation claims are filed annually; total costs will exceed $1 billion in 1987.

Workers' compensation does not involve a large state appropriation but it has a major impact on the state's economy.

- **Minnesota's total workers' compensation premium (including self-insurance) was about $834 million in 1986. It is expected to exceed one billion dollars when total figures are in for 1987.**

Workers' compensation insurance is administered by private insurance companies. Insurance companies sell the insurance, manage claims, and pay benefits. Rates are set by competing sellers and filed with the Minnesota Department of Commerce. The Workers' Compensation Division of the Department of Labor and Industry monitors payment of benefits, keeps records, provides information, and runs several dispute resolution forums.

WORKERS' COMPENSATION BENEFITS

Workers' compensation insurance pays several kinds of benefits:

- Death benefits are paid to dependents of workers who die as a result of workplace injuries.

- Medical and rehabilitation benefits are paid to health care providers on behalf of injured workers.

- Temporary total benefits are paid to workers who are out of work for more than three days.

- Temporary partial benefits are paid if a worker can only return part-time or to a lower-paying job.

- Permanent total benefits are paid to injured workers permanently unable to work.

- Permanent partial benefits are paid, once healing is complete, if a partial disability remains.

The basic benefit for total disability is two-thirds of the employee's wage, tax-free, up to the statewide average wage.

The basic benefit for temporary total or permanent total disability is two-thirds of an employee's pre-injury gross weekly wage, tax-free, up to a maximum of the statewide average weekly wage (now $376). The minimum is half this number or the pre-injury wage, whichever is lower; an absolute minimum is 20 percent of the statewide average weekly wage.

In addition, there are supplementary benefits, escalators, offsets, and replacement of offsets. The benefit structure is complex and the statutes defining compensation are not always clear. This has led to controversial judicial interpretations.

ANALYSIS OF COST

Workers' compensation in Minnesota is expensive. The average filed rate for seven of the 50 largest occupational classifications exceeds ten percent of payroll.

- For example, on June 1, 1987, the average filed rate was $21.43 per $100 of payroll for truckers-for-hire and $17.86 for carpenters.

Workers' compensation rates in Minnesota declined during the early 1980s, but increased by more than 50 percent between 1984 and 1986. One reason for this rapid increase is the cyclical nature of insurance prices. Highly competitive periods with low prices (such as 1983-84) are followed by periods with more conservative underwriting practices and higher prices (such as today). Other reasons include the sharp increase in assessments for the special compensation fund and the assigned risk plan.

Minnesota's workers' compensation rates are among the highest in the country. In 1987, Minnesota's rates ranked fourth highest among 38 states and the District of Columbia (the jurisdictions with available data).

- **Minnesota's rates are about twice as high as rates in Wisconsin, Iowa, and South Dakota.**

Minnesota's workers' compensation rates are twice as high as rates in Wisconsin, Iowa, and South Dakota.

For several occupational classes, the difference between Minnesota and neighboring states represents a large share of the employers' payroll cost. Minnesota's rate exceeds Wisconsin's rate by more than $5 per $100 of payroll for several common occupations, including truckers, carpenters, plumbers, and sheet metal workers.

We examined several possible reasons for Minnesota's high rates, including high insurer profits, high administrative expenses, and high benefits. We found:

- **From 1978 through 1986, the ratio of benefits paid and reserved to premiums collected (the "loss ratio") was higher in Minnesota than in neighboring states and the nation as a whole.**

This indicates that insurers' administrative expenses and profits (as a fraction of premium) have been lower in Minnesota in the recent past than in other states. While loss ratios reported by insurance companies are not stable for short time periods, they are reasonable measures over time periods of several years. Furthermore, there are greater incentives to make higher loss estimates in rate-regulated states (unlike Minnesota), where insurance companies have to justify rate increase requests to regulators. As a result, we conclude:

- **Insurer administrative expenses and profits are not significant factors that serve to explain why Minnesota's workers' compensation rates are higher than rates in comparable states.**

To examine how benefits affect workers' compensation costs, we compared Minnesota's benefit cost with costs in other states. We found that:

- **Minnesota's benefit cost per $100 of payroll is significantly higher than most other states and more than twice as high as Wisconsin, Iowa, and South Dakota.**

Minnesota's higher benefit cost is not explained by its injury frequency. In fact, Minnesota's workers' compensation injury rate (as a fraction of employees) is lower than Wisconsin's rate and about the same as the national median rate.

Minnesota's higher costs are not explained by higher insurer profits or injury frequency.

To understand why Minnesota's benefit cost is higher than the costs in other states, we compared Minnesota's benefit structure with those of other states. We found that while Minnesota and most other states have similar medical benefits and basic wage replacement benefits, Minnesota's benefits are substantially more generous than benefits in other states in the following ways:

- **Minnesota is one of twelve states with a cost-of-living escalator. Excluding self-insurers, we estimate that Minnesota's escalator will cost about $45 million for accidents occurring in 1986. This accounts for about 9.4 percent of Minnesota's total benefit cost and explains about 19 percent of the difference in benefit cost between Minnesota and Wisconsin.**

Minnesota's minimum benefits and supplementary benefits are among the nation's most generous.

- **Minnesota's supplementary benefits ensure that employees who are totally disabled for more than four years receive a wage replacement benefit of at least 65 percent of the statewide average wage. While about twelve states have some form of supplementary benefits, none of these states is as generous as Minnesota. Supplementary benefit expenses for fiscal year 1987 were $48.6 million. (This includes self-insurers.) Supplementary benefits account for about 8 percent of Minnesota's benefit cost and explain about 16 percent of the cost difference between Minnesota and Wisconsin.**

- **Minnesota's minimum benefit is one of the highest in the nation. Excluding self-insurers, it cost about $11.4 million for accident year 1986. Minimum benefits account for about 2.4 percent of Minnesota's benefit costs and and explain about 5 percent of the cost difference between Minnesota and Wisconsin.**

- **In Minnesota, temporary partial benefits may last indefinitely, whereas in Wisconsin and Iowa, they must end when the healing period ends.**

The cost of allowing temporary partial benefits to last indefinitely is difficult to measure. In part, this is because the conditions under which temporary partial benefits should end still has not been settled by the Legislature or the Minnesota Supreme Court.

It is difficult to attribute the remaining difference between Minnesota and Wisconsin to specific benefit features, but we can estimate how much is explained by certain general types of benefits. Specifically,

- **Medical costs for workers' compensation are higher in Minnesota than most other states but not by as large a percentage as benefit costs as a whole. For example, Minnesota's medical costs are 53 percent higher than Wisconsin's medical costs, but its non-medical benefit costs are 166 percent higher. Medical costs explain about 20 percent of the cost difference between Minnesota and Wisconsin.**

- **The average duration of temporary total benefits was 11.4 weeks in Minnesota, compared to 6.4 weeks in Wisconsin. A difference of five weeks per indemnity case would explain about 16 percent of the difference between Minnesota's benefit cost and Wisconsin's cost.**

Since these comparisons were based on accident years 1980 through 1982, one may argue that the results would be different if the comparison were made after January 1, 1984, the date the 1983 changes to the benefit structure took effect. One objective of the 1983 law was to reduce the time it takes to get employees back to work. However, the data show little change in average temporary total disability duration between 1980 and 1985. Thus, we believe that employees in Minnesota continue to collect temporary total benefits significantly longer in Minnesota than in Wisconsin.

To understand why Minnesota's costs are high, it is also useful to examine the types of cases and types of benefits that are responsible for most of the benefit cost. In most workers' compensation cases, the employee is out of

work for less than three days and has no permanent injury. These cases, in which workers' compensation pays for only the medical costs, make up 72 percent of the cases but only 3 percent of the total benefit cost.

Claims involving more than three days of lost time or a permanent injury are called indemnity cases. Again, most of these cases are short-term and inexpensive. In approximately half of all indemnity cases, the injured employee returns to work within two weeks. In about 90 percent of the indemnity cases, the employee returns to work within one year. As one would expect, these short-term cases are common but are not responsible for most of the cost. Instead:

- **Major indemnity cases (essentially long-term disabilities) account for 3 percent of the cases, but 73 percent of the total benefit cost. (These cases include deaths, permanent total disabilities, total disabilities lasting longer than one year, and permanent partial disabilities costing more than $18,000 in indemnity benefits.)**

Most of Minnesota's benefit cost is due to wage-replacement benefits, including permanent total, temporary total, temporary partial, and supplementary benefits. Wage-replacement benefits account for about 52 percent of Minnesota's total benefit cost. Medical benefits account for 28 percent. Compensation for permanent injuries (impairment compensation and economic recovery compensation) accounts for about 13 percent of the total benefit cost. Vocational rehabilitation benefits and death benefits (for dependents of employees who die due to work-related injuries) each account for about 3 percent of the total benefit cost.

To examine the characteristics of Minnesota's most expensive cases, we reviewed data on cases reported to the Workers' Compensation Reinsurance Association (WCRA). Each year, between 800 and 900 injuries are reported to the WCRA by insurers because their cost could potentially exceed the retention limit of the primary insurer (currently, insurers can choose limits of either $180,000 or $380,000 per accident). For injuries occurring after January 1, 1984 and reported to the WCRA by June 30, 1987:

The median disability rating for Minnesota's most expensive cases is about 16 percent of the body.

- **The median disability rating for cases reported to the Reinsurance Association was about 16 percent. These disability ratings, based on medical criteria, express the disability as a percent of the whole body.**

Furthermore, WCRA data indicate that among the approximately 400 cases each year that are expected to exceed the retention limit, only five percent involve fatal injuries and only three percent involve other medically serious injuries (heart disease, brain damage, quadriplegia, paraplegia, serious burns, and serious occupational diseases). About 62 percent of these cases involve back injuries.

- **In other words, the great majority of expensive, long-term cases do not involve catastrophic injuries. Quite a few are medically not very serious.**

For many long-term disabilities, including many lifetime disabilities, employees collect total disability benefits even though they are physically able to work. For example, some employees are collecting full workers' compensation benefits indefinitely because there are no job opportunities where they live and they do not want to move. In addition, full benefits may be given indefinitely to employees who have minor permanent disabilities, are not offered "suitable" jobs by the employer, and look for work but refuse "light duty" jobs because they consider them undesireable.

BENEFIT STRUCTURE RECOMMENDATIONS

It follows that in order to have a major impact on costs, the Legislature will have to make significant changes to the benefit structure.

In order to have a major impact on costs, the Legislature will have to make significant changes to the benefit structure.

- **Although Minnesota's benefit structure is expensive, it does not follow that the essential purposes of the workers' compensation program are well served. For many, benefits are higher than necessary, and present a disincentive to return to work. Nor does the workers' compensation system always treat injured workers equitably.**

- **Also, as a practical matter, Minnesota has to consider whether it can afford costs that are much higher than neighboring states.**

Assuming that there is considerable legislative interest in cutting costs or improving the equity of benefits we offer a strategy for proceding in Chapter 8. This chapter is non-technical and should be read by those interested in a fuller presentation of our policy recommendations.

Very briefly, we suggest that an adequate and fair benefit program can be achieved, while substantial cost reductions are also realized if:

- **Wage replacement benefits are tied to a percentage (say 80 percent) of take-home pay rather than a percentage of gross pre-injury wages.**

- **Benefits should not exceed pre-injury take-home pay except in a small number of long-term cases where there is no practical likelihood of a return to work.**

- **The present cap on wage replacement benefits should be retained (this is the statewide average weekly wage, currently $376).**

In 1983, the Legislature tied payment of temporary *total* benefits to the end of the healing period (maximum medical improvement). We suggest that the Legislature look at the fact that temporary *partial* benefits (payable at the

temporary total rate) can still be paid indefinitely and clarify the meaning of the statute.

Temporary benefits should end no later than 90 days after the healing period.

- **Our suggestion is that temporary benefits should end no later than 90 days after maximum medical improvement.**

As we showed in a review of expensive cases, many people who receive wage replacement benefits for life or large settlements in lieu of lifetime benefits are not physically unable to work. Many injured workers are physically able to work but cannot get work without relocation.

- **The Legislature needs to consider if it wants workers' compensation to function in this situation like an unemployment compensation program with no time limit.**

The Legislature needs to consider placing restrictions on eligibility for permanent total disability, for instance, by requiring that those receiving permanent total benefits have a minimum disability rate such as 25 percent of the body. Also, language could be added to make clear that non-medical factors such as economic conditions are not a sufficient basis for receiving permanent total benefits.

The two-tiered permanent partial benefit structure enacted in 1983 is hotly debated. Higher-tier benefits are paid to workers who are not offered a suitable job within 90 days of medical recovery. Because tentative data show that the incentives may be working, we suggest:

- **The Legislature should not change the two-tiered system of permanent partial benefits at this time.**

Minnesota has the nation's most generous supplementary benefits. In Minnesota, workers totally disabled for more than four years (two years prior to October 1983) are guaranteed 65 percent of the statewide weekly wage. Supplementary benefits make sense for workers injured prior to October 1975 when the cost-of-living escalator became effective. However, workers injured more recently already get annual adjustments. Guaranteeing 65 percent of the statewide average wage means that some get benefits well above the pre-injury wage.

Supplementary benefits also restore most of the state reduction of workers compensation benefits for social security (disability or old age) benefits, allowing workers to receive both. In addition, many workers also receive employer-provided pension benefits. The offset provision is expensive, amounting to 38.5 percent of 1986 supplementary benefit expenses. We recommend:

- **Social security and (if administratively feasible) employer-provided pension benefits should be added to workers' compensation benefits in determining eligibility for supplementary benefits.**

SPECIAL COMPENSATION FUND

The department administers a Special Compensation Fund that reimburses insurers for supplementary benefits and for claims paid to employees whose injuries are made substantially greater because of a pre-existing physical impairment. The fund also pays benefits to injured workers whose employer is uninsured or is self-insured but unable to pay, and it pays for the administration of the workers' compensation system.

Special fund assessments have risen to 31 cents for each dollar of indemnity benefits paid to workers.

Most of the special compensation fund's revenues come from assessments against insurers. Assessments have risen dramatically in recent years. Currently, insurers and self-insurers must pay 31 cents to the special fund for each dollar of indemnity benefits paid to workers. Despite the increase in the assessment rate, the special fund has been paying out more than it brings in. As a result, the fund had a $64 million operating deficit at the end of FY 1987. More important, perhaps, is the fact that the fund reimburses insurers on a pay-as-you-go basis and does not reserve for claims that will be paid in future years. The unfunded liability of the fund is about $1.5 billion.

The special fund is a method of financing benefits other than through insurance premiums. This system has some drawbacks, however. Assessing all insurers for the cost of supplementary benefits reduces the incentives for individual insurers to manage cases efficiently and make diligent efforts to get employees back to work. It also increases state administrative costs since the state must reimburse insurers for supplementary benefit claims and then turn around and assess insurers to generate revenue to make the reimbursements. And, finally, since insurers do not set aside reserves to pay supplementary benefits, it shifts the burden for benefits paid to workers injured today to future employers. Therefore, we recommend that:

- **The Legislature should consider removing supplementary benefits from the special fund and require that they be paid directly by insurers for future injuries.**

The special fund mechanism is appropriate for subsequent injury payments, since the purpose is to encourage hiring of disabled workers by reducing the risk to one employer or insurer. However, Minnesota's subsequent injury fund is larger and more inclusive than most states. As is the case with supplementary benefits, distributing responsibility for paying claims among all insurers reduces the incentive for individual insurers to manage their subsequent injury cases efficiently and make diligent efforts to return injured workers to work. Therefore, we recommend that:

- **The Legislature should consider raising the minimum disability rating required for registering disabilities with the special fund and increase the deductible or require a co-payment by the insurer for subsequent injury claims.**

WORKERS' COMPENSATION ADMINISTRATION

The Minnesota Department of Labor and Industry has major responsibility for overseeing the administration of Minnesota's workers' compensation system. The department provides forums for resolving disputes over a wide range of workers' compensation issues, and monitors the workers' compensation system by receiving reports and maintaining workers' compensation records.

In 1987, in response to growing backlogs in case processing and adjudication at Labor and Industry and the Office of Administrative Hearings, legislation was enacted that removed some of the complexity of the dispute resolution process it eliminated a confusing "triple track system" that was difficult to administer and delayed case processing and instituted time restrictions on the processing of cases. The Department of Labor and Industry also made administrative changes designed to improve the flow of cases, especially in the area of dispute referral. Based upon interviews with department staff, observations of conferences and a review of department summaries of disputes it handled in the second half of 1987, we conclude that:

Dispute resolution at Labor and Industry has been expedited, but there is an 18-month case backlog at the Office of Administrative Hearings.

- **The department has made significant improvements in its dispute resolution procedures.**

We found no major backlog of cases awaiting conferences. Most cases were scheduled for conferences within the time period allowed by statute. Disputes are now referred to dispute resolution forums based on their subject matter, rather than the type of form used to file the dispute as had been the practice. Department settlement judges also reduced the number of cases that they automatically referred to the Office of Administrative Hearings and have begun to issue administrative decisions in hopes of reducing the number of cases appealed to the Office of Administrative Hearings.

The major impediment to efficient case processing is the 18-month backlog of pending disputes at the Office of Administrative Hearings (OAH). The Legislature provided for ten additional compensation judges for OAH in FY 1988. This has enabled OAH to meet statutory deadlines for expedited cases and to eliminate the backlog in jurisdictions other than the Twin Cities and Duluth. However:

- **There is still an 18-month backlog of cases in the Twin Cities and Duluth, where the large majority of all cases are filed.**

Failure to significantly reduce the backlog of cases at OAH, despite the addition of resources, may be attributed to the time required for formal trials at OAH, as well as the increase in litigation during the past two years. This suggests to us that a more fruitful approach to reducing the backlog of cases will be to implement fundamental changes that reduce litigation by simplifying the system of benefits and its administration.

The department's administration of workers' compensation is hampered by an inadequate information system. The system does not adequately support

operations, provide management information, or permit policy analysis needed by the Legislature and others. Given the heavy clerical requirements of workers' compensation administration and the scope of its responsibilities, the department needs to improve its information management system. As a starting point it needs to know soon if its current system can be adapted to meet future requirements. We recommend that:

- **The department should engage an independent consultant not affiliated with any hardware or software vendor to assess its data processing support needs and discuss strategies for meeting them.**

JUDICIAL INTERPRETATION OF THE 1983 AMENDMENTS

In 1983, the Legislature enacted important changes to the workers' compensation benefit structure. Temporary total benefits were limited to a period ending 90 days after "maximum medical improvement" (MMI). At this point, a benefit is paid for any remaining permanent impairment. A two-tiered system of permanent partial awards was enacted, designed to offer employees an incentive to return to work and employers an incentive to offer or assist in finding a job.

In our view, the court has eroded a central purpose of the 1983 law and created an atmosphere of confusion.

In our view, successive decisions of the Workers' Compensation Court of Appeals have eroded what many thought was a central purpose of the 1983 law and created an atmosphere of confusion that remains unresolved. Based on our review of significant cases, we conclude:

- **The Workers' Compensation Court of Appeals has been reluctant to cut benefits to workers, even when statutory language is intended to have this result. If the Legislature wants to reduce benefits, it must make its purpose abundantly clear.**

- **Contrary to the assertion of employers and insurers, the court's decision to award temporary partial benefits to people working at lower paying jobs more than 90 days after maximum medical improvement is, in our view, supported by the statutory language, indicators of legislative intent, and the general purpose behind the 1983 amendments.**

- **The court's decision to award temporary partial benefits at the temporary total rate to non-working employees is not on such solid ground. It may be contrary to the intent of the Legislature, but can be supported by the statutory language, and pre-amendment case law.**

We believe the Legislature can and should clarify its intent regarding payment of temporary partial benefits (at the temporary total rate) to non-working employees after 90 days past medical recovery. There is a contradiction between the statutory termination of temporary total benefits and the court's

decision to allow temporary partial benefits to be paid at the total rate indefinitely.

There is a contradiction between the statutory termination of temporary total benefits and the court's allowing temporary partial benefits to be paid at the total rate indefinitely.

More generally, the court relies on case law in determining eligibility for temporary partial disability benefits under the 1983 amendments. If the Legislature wishes to alter the court's interpretation, it needs to amend the statute, since it cannot change the case law.

For example, nothing in the act effectively addresses the question of whether employees who quit or are fired for cause from either suitable or light duty jobs are eligible for temporary partial benefits if they get another job.

The Legislature also should address the question of eligibility for temporary partial benefits for:

- employees working at suitable jobs and receiving impairment compensation,
- employees working at light-duty jobs and receiving higher-tier economic recovery compensation, and
- employees who do not begin working until after 90 days after maximum medical improvement.

ASSIGNED RISK PLAN

Since workers' compensation insurance is mandatory, the state needs to assure that insurance is available to all employees, even those that present risks that are rejected by the voluntary market.

In Minnesota, the availability of workers' compensation insurance is assured by an assigned risk plan (ARP) administered by the Commerce Department.

The volume of insurance sold through the assigned risk plan has grown dramatically in the last several years. Prices have also gone up, and a substantial assessment was recently levied.

- **Assigned risk plan premium volume has grown to over $100 million from about $11 million since mid-1984.**
- **Price increases of 6.5 percent and 17.2 percent were ordered in 1987.**
- **Even so, the plan has not been self-sufficient, so in December 1986, insurers were assessed 8 percent of their 1985 written premium to cover the financial shortfall.**

Rapid ARP growth signifies a problem that must be remedied, but it is a phenomenon that occurred in recent years around the country, not just in

Minnesota. In our view, both pricing decisions by the Commerce Department and general conditions affecting the insurance industry contributed to the rapid growth of the ARP. We conclude:

- **The Commerce Department has not articulated a clear pricing policy for the ARP. Also, the law governing the plan is unnecessarily vague.**

Minn. Stat. §79.251, Subd. 3 says "premiums shall not be lower than rates generally charged by insurers for the business." The statute should say more clearly that the assigned risk plan is the insurer of last resort, and that rates should be high enough to assure that agents and employers make a diligent effort to find insurance in the private market. The state may still set ARP rates at a level that requires a subsidy. But, the size of the subsidy has to be more clearly formulated as a deliberate policy decision by the Commerce Department.

The Commerce Department should set a clear pricing policy for the assigned risk plan and turn over administration to the insurance industry.

We also conclude that the zero price increase for the ARP in 1985, coupled with 23.7 percent increase in 1986-87, and an 8 percent assessment effective in 1987-88, is clear enough evidence of a pricing error, but one that has now been rectified. Such an error is in line with pricing mistakes made by the insurance industry in the 1980s for workers' compensation and other lines.

The Commerce Department has an important regulatory role that it cannot credibly perform on itself. We suggest that the department establish a clearer pricing policy and any other appropriate standards for the ARP, then turn over operation of the plan to the industry. The department does not operate other assigned risk plans although it is typically represented on their governing boards. The department's credibility as a regulatory agency will be enhanced if it is not simutaneously running what amounts to an insurance company. If it continues to administer the assigned risk plan, however, we suggest several improvements in its aproach.

INTRODUCTION

This report presents the results of a study of Minnesota's workers' compensation system. The study was prompted by growing concerns that workers' compensation insurance rates and benefits have risen dramatically in recent years, and that Minnesota's rates are much higher than other states.

This report examines:

- **the cost of workers' compensation in Minnesota over time and compared to other states,**
- **the effect of Minnesota's workers' compensation benefits on costs,**
- **the effectiveness of the Minnesota Department of Labor and Industry's management of the workers' compensation system, and**
- **the extent to which Minnesota's workers' compensation system provides employees and employers with sufficient incentives to return injured workers to work.**

The report also examines how the Special Compensation Fund and the assigned risk plan affect workers' compensation costs and incentives to return injured workers to work.

The findings and conclusions presented in this report are based on data collected from several sources, including the Minnesota Department of Labor and Industry, the Minnesota Department of Commerce, the Office of Administrative Hearings, the Minnesota Workers' Compensation Insurers Association, the Workers' Compensation Reinsurance Association, and the National Council on Compensation Insurance. We also interviewed many staff and administrators at the Department of Labor and Industry as well as other state agencies, insurance companies, business groups, and labor organizations.

The report is presented in eight chapters. Chapter 1 presents an overview of Minnesota's workers' compensation system and summarizes recent studies of workers' compensation and attempts by the Legislature to improve the system. Chapter 2 presents an analysis of workers' compensation insurance rates in comparison with other states. Chapter 3 presents an analysis of the factors contributing to workers' compensation costs in Minnesota and other states.

Chapter 4 reviews the Department of Labor and Industry's role in administering workers' compensation. Chapter 5 reviews Minnesota's Special Compensation Fund, and Chapter 6 discusses the role of the courts in interpreting workers' compensation laws. Chapter 7 examines the assigned risk plan for workers' compensation insurance administered by the Department of Commerce. Chapter 8 reviews the findings and makes recommendations that we believe will reduce the cost of Minnesota's workers' compensation system and provide better incentives for returning injured workers to work.

MINNESOTA'S WORKERS' COMPENSATION SYSTEM

Chapter 1

Workers' compensation is a no-fault system of insurance for workers injured on the job. Workers are insured for any injury incurred in the course of employment (including occupational illness), without having to show negligence or malice on the part of the employer. Injured workers are reimbursed for medical expenses and for lost wages resulting from the injury. In addition, workers receive monetary compensation for physical impairments resulting from employment-related injuries. No compensation is paid for pain and suffering.

Workers' compensation may be viewed as a "contract" between all the workers of the state and all the employers. It is a system designed to remove uncertainty. Workers receive a guarantee that they will be compensated for their injuries without having to sue their employer and prove negligence. Workers give up the right to sue and accept compensation in the form of a set schedule of benefits defined in statute. Although employers assume responsibility for practically all injuries regardless of fault, they are protected from large jury awards that might result from civil litigation.

HOW THE SYSTEM WORKS

Since 1983, the number of worker injuries has been fairly stable, but insurance rates have increased by 50 percent.

Workers' compensation systems exist in all 50 states and the District of Columbia. However, the provisions of the laws and the benefits received by injured workers vary significantly from state to state. Minnesota's workers' compensation system was established in 1913 and became mandatory in 1937. Almost all employees are covered by workers' compensation.[1] There are currently about 37,000 injuries resulting in more than three days of lost work reported to the Department of Labor and Industry each year. This number has remained stable since 1983, the earliest date for which accurate records are available.

Almost all of Minnesota's employers are required to carry workers' compensation insurance or to self-insure. Despite the fact that the number of injuries has not increased markedly in recent years, insurance rates have increased by over 50 percent since 1983. For 1986:

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1 Independent contractors, persons employed by family farms (less than $8,000 annual wages) or small non-profit corporations (less than $1,000 annual wages), and household workers earning less than $1,000 per quarter, are excluded. Federal workers are covered under a separate system.

- **Minnesota's 1986 workers' compensation insurance premium (including self-insurers) was estimated by the Minnesota Department of Commerce to be $834 million. The department projects that final figures for 1987 workers' compensation insurance premiums will exceed $1 billion.**

In the remainder of this section, we present an overview of Minnesota's workers' compensation system. More detailed discussions are presented in the ensuing chapters of this report.

Workers' Compensation Benefits

Workers' compensation benefits are provided to compensate injured workers for medical and rehabilitation expenses and for lost wages. In addition, payments are made to compensate workers for permanent physical impairments resulting from their injuries. If a worker dies, payments are made to dependents. Compensation for lost wages and physical impairment is based on the degree of disability (total or partial) and the duration of disability (temporary or permanent).

Figure 1.1 shows the benefit system. All medical and rehabilitation costs are paid. Workers unable to work for over three days receive temporary total disability benefits which replace a portion of their lost wages until they return to work or until ninety days after they reach maximum medical improvement or complete a retraining program. If they suffer a permanent disability, they receive one of three types of benefits, depending on whether they are able to work and whether their employer offers them a job. If the injury results in death, a weekly benefit is provided to survivors. These benefits are described in greater detail in Chapter 3.

The basic compensation rate for total disability in Minnesota is two-thirds of the employee's weekly wage.

The basic compensation rate for temporary or permanent total disability in Minnesota is two-thirds of the employee's weekly wage at the time of injury. (The current statewide average weekly wage is $376.) The intent is presumably to provide injured workers with an amount sufficient to sustain them while they recuperate but less than full wage replacement so as not to provide incentives to stay out of work permanently. However, the benefit is tax-exempt and is subject to statutory maximums and minimums.[2] Thus, the incentives are different depending on the workers' pre-injury wage and marginal tax rate.

Workers' Compensation Insurance

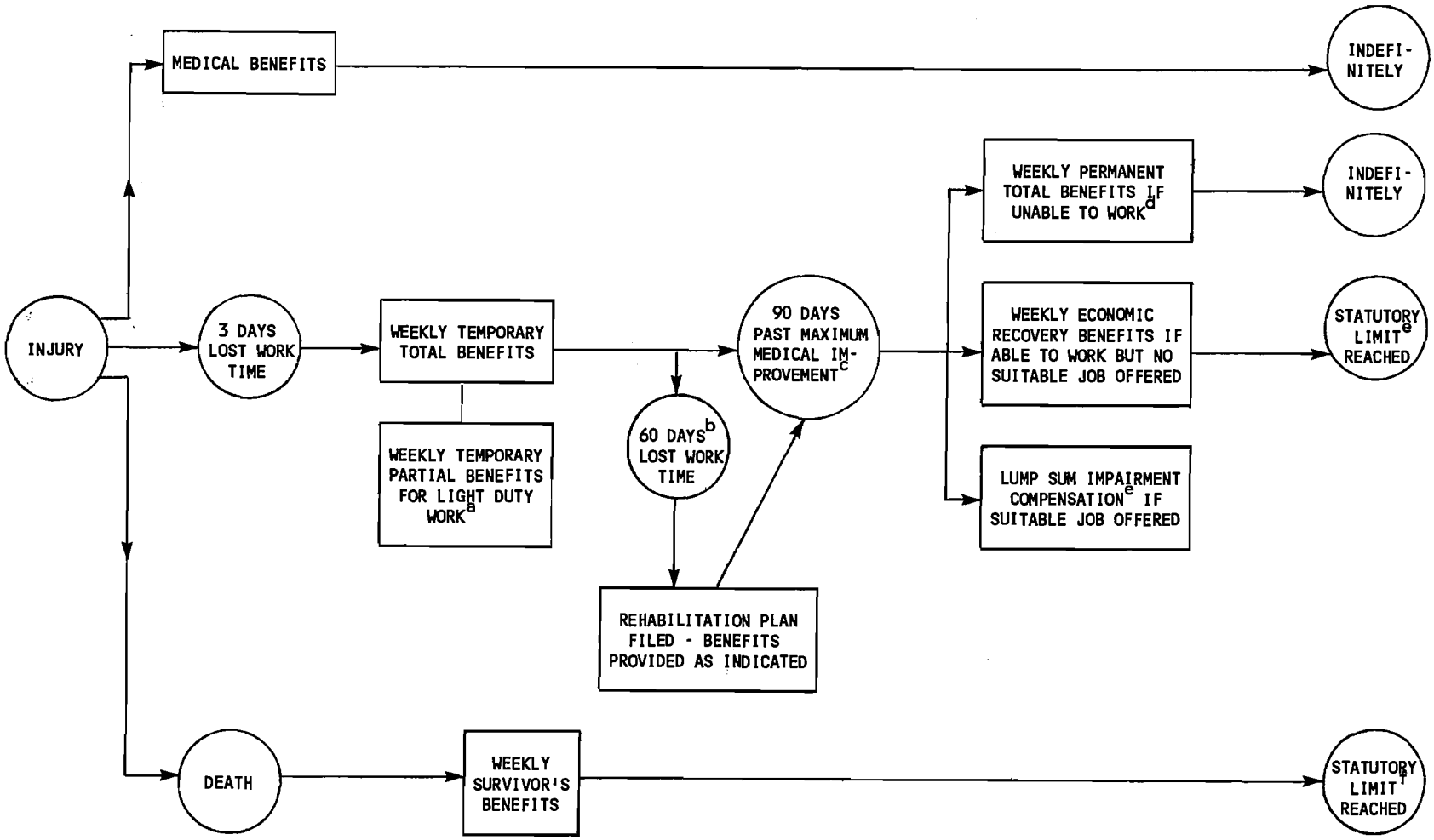
All employers liable to pay compensation are required to obtain workers' compensation insurance from a licensed carrier or obtain approval from the Department of Commerce to self-insure. Insurance rates must be filed with the Department of Commerce but do not require department approval.[3] In

2 The maximum is 100 percent of the statewide average weekly wage. The minimum is 50 percent of the statewide average weekly wage or the employee's actual wage, whichever is less. However, in no event can the benefits be below 20 percent of the statewide average weekly wage.

3 Rates were deregulated by the Legislature in 1981, effective July 1, 1983.

FIGURE 1.1

WORKERS' COMPENSATION BENEFITS FLOW CHART



[a]There is currently uncertainty and controversy as to when these benefits end.
[b]30 days for back injury.
[c]Or 90 days past completion of an approved retraining program.
[d]Impairment compensation also paid.
[e]Based on the degree of permanent disability.
[f]Based on number and ages of dependents.

1983, the Legislature created the State Fund Mutual Insurance Company, a non-profit insurance company that sells only workers' compensation insurance. It is not tax supported and it competes with other private insurance companies. Like other companies, it is free to determine its own rates and reject applications from employers that are viewed as too risky.

The Department of Commerce oversees an assigned risk plan that provides insurance for employers who are unable to obtain insurance from a private carrier because their business is viewed as too risky. The assigned risk plan's rates are set by the Commissioner of Commerce. They cannot be lower than rates generally charged by private carriers. The assigned risk plan is discussed in Chapter 7.

Most property/casualty insurers in the United States purchase reinsurance to insure themselves against very high claims. This is also the case with workers' compensation insurance. Minnesota has developed a unique system of reinsurance. In 1979, the Legislature created the Workers' Compensation Reinsurance Association and required all workers' compensation insurers in the state (including self-insurers and the assigned risk plan) to be members and to purchase reinsurance from the association.

Administration of the Workers' Compensation System

The Workers' Compensation Division of the Minnesota Department of Labor and Industry oversees Minnesota's workers' compensation system. The department:

- receives reports of injuries and benefits paid and reviews the reports to ensure that benefits are calculated correctly;
- maintains workers' compensation records;
- assists employees, employers, insurers, attorneys, and others who have questions about workers' compensation benefits and administrative procedures;
- attempts to resolve disputes over a wide range of issues;
- administers the Special Compensation Fund; and
- conducts research and public education about workers' compensation issues.

In the majority of workers' compensation cases, the employer informs its insurer of the injury, the insurer pays the benefits, and the matter is handled as any other insurance claim. The department has minimal responsibilities in these cases.

In some cases, there is a dispute. The employer or insurer may feel that the injury was not work-related. There may be a dispute about the extent of disability. There may be disputes about the appropriate medical and rehabilitation procedures, and so on. In these cases, one or more of the parties files a claim petition or request for assistance on forms provided by the department. Depending on the nature of the dispute, the statute provides for certain procedures for informally settling these disputes. These are discussed in Chapter 4.

If these informal procedures fail to settle the dispute, one or more parties may request a formal hearing before a compensation judge at the Office of Administrative Hearings. Decisions of compensation judges may be appealed to a five-member Workers' Compensation Court of Appeals. The court's decisions are appealable to the Supreme Court.

The Special Compensation Fund

The department administers a Special Compensation Fund derived from assessments against all insurers and self-insurers. The purpose of the fund is to:

- reimburse insurers for claims paid to employees whose injuries are made substantially greater because of a pre-existing physical impairment;
- pay supplementary benefits to ensure that employees totally disabled over four years (two years for injuries occuring prior to October 1, 1983) receive a minimum benefit of 65 percent of the statewide average weekly wage;
- pay benefits to injured workers whose employer is uninsured or is self-insured but unable to pay; and
- pay for the administration of workers' compensation at the department, the Office of Administrative Hearings, and the Workers' Compensation Court of Appeals.

The Special Fund is an important component of workers' compensation costs. It is discussed in Chapter 5.

RECENT STUDIES AND LEGISLATION

During the 1970s, a concern with the adequacy of workers' compensation benefits led to an increase in benefits. A national study commission established by Congress and appointed by President Nixon in 1972 concluded that state systems were not providing adequate benefits. For example, from 1957 through 1966, Minnesota's maximum weekly benefit was $45. The commission made several recommendations to states aimed at improving benefits and

extending coverage to all workers. The commission recommended that Congress mandate certain workers' compensation benefits if states fail to act themselves.

Minnesota did act. In 1971, Minnesota instituted supplementary benefits, to be paid out of a special fund, to bring the minimum weekly benefits to all workers totally disabled more than two years to $60. This was raised to 50 percent of the statewide weekly wage in 1975, 60 percent in 1979, and 65 percent in 1981. In addition, increases in benefit levels were enacted in each legislative biennium between 1967 and 1975. In 1975, the Legislature removed the 350-week limit for temporary total disability payments. In addition, annual cost-of-living increases were added for totally disabled workers and dependents of workers who died from work related injuries. In 1977, maximum and minimum benefits were tied directly to the statewide average weekly wage. Table 1.1 summarizes how Minnesota's benefits have changed since 1965.

A concern that benefits were too low in the 1970s gave way to a concern that costs were too high in the 1980s.

By the mid-1970s, concern began to develop about increases in the cost of workers compensation insurance. Comparisons were made with Wisconsin, whose rates were lower than Minnesota's rates. There was disagreement as to the cause of this difference and the reasons for Minnesota's higher costs. Some attributed it to benefit increases in Minnesota. Some believed that liberal interpretations of Minnesota's benefit structure by the courts was the problem. Others argued that it was inefficient administration of the workers compensation system, including inadequate claims management procedures, unnecessary litigation, and the ineffective use of rehabilitation. Excessive insurance company profits were also suggested.

As a result of these concerns, a legislative study commission was established in 1977 to examine the cost of workers' compensation and to recommend ways to reduce costs. The commission issued its recommendations in 1979.[4] These included some reductions in benefit levels aimed at reducing incentives for injured workers to stay out of work. For example, the commission recommended reducing minimum benefit levels so that workers could not receive a benefit that exceeded two-thirds of their wage. It also recommended that cost-of-living adjustments not begin until a worker was out of work at least two years. None of these benefit cutting recommendations were adopted by the 1979 Legislature.

The commission also recommended revamping the rehabilitation system, reducing its emphasis on retraining injured workers (which was viewed as the most costly and least effective rehabilitation method) and increasing its emphasis on returning injured workers to their pre-injury jobs. The Legislature adopted most of these recommendations in legislation passed in 1979. Responsibility for rehabilitation was removed from the Division of Vocational Rehabilitation which had emphasized retraining and replaced with a system of private rehabilitation providers. In addition, seriously injured workers were required to be evaluated for rehabilitation.

In 1981, the Legislature, hoping to promote price competition among private insurance carriers, deregulated workers' compensation insurance rates, effective July 1, 1983. Until then, uniform rates were established for all carriers, with downward deviations allowed in some instances. The 1981 Legislature

4 Minnesota Workers' Compensation Study Commission, *Report to the Minnesota Legislature and Governor* (1979).

TABLE 1.1

MINNESOTA WORKERS' COMPENSATION BENEFITS SINCE 1965[a]

	1965	1967	1969	1971	1973	1975	1977	1979	1981	1983	1985	1987
Wage Replacement Rate	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%
Weekly Maximum[b]	$45.00	$60.00	$70.00	$80.00	$100.00	$135.00	$197.00	$226.00	$267.00	$313.00	$342.00	$376.00
Weekly Minimum[c]	$17.50	$17.50	$17.50	$17.50	$17.50	$34.00	$39.40	$45.00	$53.00	$62.60	$68.40	$75.20
Temporary Total Limit	350 Weeks	350 Weeks	350 Weeks	350 Weeks	350 Weeks	None	None	None	None	90 Days Past MMI	90 Days Past MMI	90 Days Past MMI
Annual Cost-of-Living Adjustment	None	None	None	None	None	Change in SAWW	Change in SAWW up to 6%	Change in SAWW up to 6%	Change in SAWW up to 6%	Change in SAWW up to 6%	Change in SAWW up to 6%	Change in SAWW up to 6%
Supplementary Benefits Rate[d]	None	None	None	$60.00	$60.00	$85.00	$109.80	$135.85	$158.60	$188.50	$213.85	$245.00

[a]Benefits listed as of October 1.
[b]Beginning 1977, maximum benefits equal 100 percent of SAWW.
[c]Beginning in 1975, minimum benefits equal 20 percent of SAWW.
[d]Supplementary benefits bring wage replacement benefits up to $60 in 1971 and 1973, 50 percent of SAWW in 1975, 60 percent in 1979, and 65 percent since 1981.

NOTE: SAWW - Statewide Average Weekly Wage; MMI - Maximum Medical Improvement.

also appropriated money for another study of workers' compensation. This study, conducted by the Insurance Division of the Minnesota Department of Commerce, was issued in early 1982.[5] Later that year, the Citizens League issued a report on workers' compensation.[6]

Both reports reached similar conclusions. Minnesota's workers' compensation costs were higher than other states. Despite the fact that, nominally, Minnesota's benefits were similar to those of other states, the studies pointed out several areas where Minnesota's benefits were actually higher. In addition, workers injured in Minnesota tended to collect benefits for longer periods of time than workers in other states.

Studies by the Commerce Department and by the Citizens League pointed to high costs.

The Insurance Division study noted that Minnesota does not return injured workers to work as quickly as other states. It found that Minnesota had a higher proportion of large claims than other states and suggested that some individuals with relatively minor injuries were receiving benefits for long periods of time. The study noted that the structure of benefits was inequitable because benefits for low-wage earners were proportionately greater than benefits for high-wage earners and that some workers were economically better off staying out of work. It argued that Minnesota's benefit structure overemphasized compensation for permanent partial disabilities and that the laws defining many benefits were both complex and vague, thus creating opportunities for costly litigation.

The report made many recommendations, most of which related to restructuring benefits to eliminate inequities and provide greater incentives for injured workers to return to work. The report recommended that the Legislature should:

- base weekly total disability benefits, dependents' benefits and partial disability benefits on spendable earnings rather than gross wages,
- raise the maximum benefit level to 150 percent of the statewide average weekly wage,
- eliminate supplementary benefits for workers injured after October 1, 1976 when the cost-of-living escalator took effect,
- prohibit concurrent payment of partial disability and total disability benefits,
- treat compensation for physical impairments separately from compensation for economic loss, and
- allow insurers to offer deductible or co-insurance policies.

The Citizens League study, although not as comprehensive, reached similar conclusions. It noted that Minnesota had a much higher percentage of per-

5 Minnesota Department of Commerce, Insurance Division, *Workers' Compensation in Minnesota: An Analysis with Recommendations* (January 1982).

6 Citizens League, *Workers' Compensation Reform: Getting the Employees Back on the Job* (December 1982).

manently totally disabled workers than Wisconsin. It suggested that the Legislature should:

- permit insurers to offer employers the right to a deductible for the first two weeks of lost time benefits,
- eliminate supplementary benefits for workers who qualify for cost-of-living increases,
- increase maximum wage replacement benefits to 150 percent of the statewide average weekly wage,
- base the size of permanent partial awards on whether the employer offers the worker a bonafide job,
- require medical providers to use standard methods of diagnosing permanent partial disabilities, and
- require employers to continue health insurance coverage for families of workers collecting workers' compensation benefits.

The Legislature enacted major reforms in 1983.

In response to these studies, the 1983 Legislature enacted a significant revision of the workers' compensation statute aimed at controlling workers' compensation costs.[7] The following changes in workers' compensation benefits were among those enacted:

- temporary total and permanent partial benefits may not be paid concurrently;
- temporary total benefits end 90 days after the employee achieves maximum medical improvement or completes an approved retraining program, whichever is later;
- permanent partial benefits were replaced by a two-tiered system of benefits which resulted in higher payments ("economic recovery benefits") to workers' not offered a suitable job after maximum medical improvement than to those offered a suitable job ("impairment compensation"). This was intended to provide an incentive to employers to return injured workers to gainful employment;
- the Department of Labor and Industry must promulgate rules to establish disability ratings based on the percentage of loss of function of the body as a whole; and

7 *Minn. Laws* (1983), Chapter 290.

- employees injured after October 1, 1983 are eligible for supplementary benefits after four years of total disability instead of two years.

The 1983 law also stated that, "it is the intent of the legislature that workers' compensation cases shall be decided on their merits and that the common law rule of 'liberal construction'...shall not apply." This section was in response to criticism that the courts were favoring workers in interpretations of the statute. The legislation stated that questions of law are to be decided "on an even handed basis." In Chapter 6, we review some of the court decisions issued since 1983.

The 1983 law also made major changes in the administration of workers' compensation and the settlement of disputes. These are discussed in Chapter 4. Although adopting only a few of the recommendations in the Insurance Division and Citizens League reports, the 1983 law was the first major legislative attempt to control Minnesota's workers compensation costs by restructuring and reducing some benefits.

However, the changes made in 1983 have not put the issue of workers' compensation costs to rest. As we discuss in Chapter 2, insurance rates have risen dramatically since 1983. In part, this may be due to an availability crisis that has caused rates for many lines of property casualty insurance to increase dramatically since 1983.[8] In addition, it takes a long time for changes in the workers' compensation system to be reflected in insurance rates. Cases take many years to work their way through the system and the ultimate effect of the 1983 reforms is not yet fully measurable. Nevertheless, five years later, legislators remain concerned about workers compensation costs.

In this report, we update the earlier studies of workers' compensation costs. We present the most recent data available that compares Minnesota's workers compensation costs with other states. We identify the unique features of Minnesota's system that contribute to high costs. And, we assess the impact of the 1983 changes and suggest additional measures to reduce workers' compensation costs.

CRITERIA FOR EVALUATING MINNESOTA'S WORKERS' COMPENSATION SYSTEM

This section introduces and discusses the criteria against which Minnesota's workers' compensation system is examined in this report. These are criteria that can be used to evaluate any workers' compensation system; in one form or another, with minimal controversy, they have been used in previous studies in Minnesota and across the country.

The criteria we suggest are:

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8 See Office of the Legislative Auditor, *Insurance Regulation* (January 1986).

- **adequacy and appropriateness of benefits,**
- **vertical and horizontal equity,**
- **certainty and promptness in paying benefits,**
- **administrative efficiency, and**
- **incentives consistent with program goals.**

The recommendations contained in our report are designed to bring Minnesota's workers' compensation system into better alignment with these criteria. There is one important problem in doing this: the criteria are not independent of one another and trade-offs are necessary among them. For example, equity may come at the price of administrative complexity. Adequacy of benefits may come at the price of an incentive to remain out of work.

Adequacy

The concept of adequacy refers to the extent to which benefits replace current and future wage loss. Of course, what constitutes adequate benefits is the subject of much debate. As a social insurance program, workers' compensation is not designed to be based on need (like a welfare program). And, it is generally felt that adequacy does not extend to replacing 100 percent or more of lost wages since benefits should be constrained by another workers' compensation program objective which is to encourage a return to work.

The 1972 National Study Commission discussed earlier in this chapter reviewed state workers' compensation systems and reported that they were generally inadequate in terms of coverage and benefits. Benefit levels were far lower in Minnesota than they are today. As late as 1965, the weekly maximum benefit for total disability was $45. Today the total disability benefit is two-thirds of pre-injury wage, tax free, up to a maximum of the statewide average wage, which is now $376.

In Minnesota, significant reforms and extensions of benefits have been enacted since the early 1970s. Concern about adequacy and coverage has diminished. The climate in which this report is being written is far different than that which existed fifteen years ago. The question raised now is: In a well-intended effort to create adequate benefit levels, did Minnesota go too far?

Equity

Horizontal equity is achieved when workers in similar circumstances with equal losses receive equal benefits. Vertical equity is achieved when workers suffering different losses receive benefits that are appropriately different. Highly complex systems can get that way because of concerns about vertical

equity; an unintended consequence can be a loss of horizontal equity. Simple systems can achieve horizontal equity at the expense of vertical equity. As we note below, large scale social insurance programs, like workers' compensation, may not be able to achieve the same level of equity as case-by-case adjudication. But a lot of attention to individual cases is exactly what workers' compensation is designed to avoid.

Promptness and Certainty

Without workers' compensation, injured workers would have to sue for benefits, would be denied benefits if they were at fault in part for their injury, and would have trouble collecting benefits if their employer refused or was unable to pay.

While a fine level of justice may be unachievable, promptness and certainty of benefits is what workers' compensation is designed to provide. Systems that fail to achieve a satisfactory standard of promptness and certainty are achieving none of the benefits of civil litigation, but some of the costs.

Administrative Efficiency

Closely related to the foregoing is the criterion of efficiency which is an implicit or explicit standard in any evaluation study. In the current study the interest is more than academic because of concern about caseload backlogs, and the recent enactment of legislation designed to eliminate redundant and time-consuming administrative procedures. Everyone wants to save money without cutting benefits; the only way to do this is to increase the efficiency of the system.

Incentives Consistent with Program Goals

Incentives should be consistent with program goals. If the goal of workers' compensation (in most cases) is to return injured workers to work, incentives to stay out of work should be kept to a minimum. The incentives operating on various actors in the system, workers, employers, insurers, doctors, lawyers, and others need to be considered in understanding the system and designing a system that works well. It is best if the system recognizes the natural incentives operating on various actors and contains safeguards and controls where necessary as well as the opportunities that exist to employ existing incentives in advancement of program goals.

FRAMEWORK FOR RECOMMENDATIONS

The recommendations offered in this report come from a thorough review of available data. The question, for example, of whether Minnesota's workers'

compensation costs are high in comparison to neighboring states is easily settled by a disinterested review of the data.

Most issues about workers' compensation raised in this report, however, are not so easily settled. Accordingly, there will continue to be debate over the issues. Our purpose in this report is to bring the best available information to the attention of policy makers. However, neither this study nor other workers' compensation research studies can substitute for important policy decisions about the purpose and nature of workers' compensation.

Our recommendations are derived from the research evidence where it exists, the criteria discussed above, and the following additional list of practical constraints. The philosophical and political debate on workers' compensation can offer widely different alternatives, but all must pass a test of practical feasibility and common sense.

1. Minnesota needs an effective workers' compensation system. The incidence of workplace injuries is such that the judicial system would be swamped if workers' compensation claims were settled through the ordinary civil litigation process.

2. In a general way it is helpful to keep in mind other large scale social insurance programs when assessing the workers' compensation system. Such programs simply cannot achieve perfect justice in each individual case, nor match needs to resources on a case-by-case basis. Case-by-case adjudication is impossible for reasons just cited.

Workers' compensation should not substitute for social insurance or welfare programs.

3. Minnesota's workers' compensation system cannot be expected to compensate for limits built into other social insurance or welfare programs. For example, economic conditions may prevent an injured (but recovered) worker from returning to work. In Minnesota, workers' compensation pays benefits indefinitely but at some point, when the worker recovers from the injury, the problem should become one for the unemployment compensation program. When unemployment benefits run out, any injustice in the situation might best be attributed to limitations in unemployment compensation, not workers' compensation.

4. Similarly, an affordable and fair workers' compensation system has to avoid paying benefits that are due to the aging process rather than occupational injury. In the past, Minnesota courts have been generous in finding a relationship to work in illnesses that most people would say were caused by aging, diet, or lifestyle factors. A workers' compensation program that indemnifies people against the effects of age or other lifestyle decisions not related to workplace injuries will be expensive indeed.

5. Complexity and ambiguity in the workers' compensation system leads to litigation, precisely what a social insurance program is designed to avoid. Thus, even at the expense of otherwise desirable features, simplicity and clarity should be sought in a workers' compensation system.

Legal complexity and ambiguity leads to litigation and higher costs.

6. Minnesota needs to be concerned with how its benefit levels and workers' compensation costs compare with other states (especially neighboring states). Jobs will be lost if Minnesota employers and workers cannot afford workers' compensation insurance.

7. The cost of workers' compensation is directly borne by employers, but much of the cost may be shifted to employees, consumers, and even taxpayers. Minnesota employers and employees will bear more of the cost of workers' compensation in competitive industries with national markets. The money employers spend on workers' compensation insurance could otherwise go to creating new jobs, raising wages, lowering prices, or increasing profits. Therefore, business, labor, and the general public have good reasons to keep workers' compensation costs as low as possible.

WORKERS' COMPENSATION RATE COMPARISONS

Chapter 2

Most Minnesota employers must purchase workers' compensation insurance or self-insure their risks. The cost of workers'compensation insurance is a major concern among many legislators, employers, and employees. Employers frequently claim that costs are too high and that it puts them at a disadvantage with competitors in other states. Workers' compensation costs can also affect consumers or employees in several ways. Employers may pass on workers'compensation costs to consumers by raising their prices. If higher prices reduce demand for the employer's product, employees may lose job opportunities. Alternatively, employers may avoid raising prices by cutting wages. The magnitude of these effects depends on many factors, including how high are the employer's cost of workers' compensation and where the employer's competition is located. In this chapter, we examine the following questions:

- **How much does workers'compensation cost in Minnesota? How do rates vary among different occupations?**
- **What has been the trend in workers'compensation costs as a percent of payroll since 1979?**
- **How do Minnesota's rates compare to rates in other states, particularly Wisconsin and other nearby states?**

Previous studies have shown that Minnesota's rates are substantially higher than rates in most other states.

Previous studies have shown that Minnesota's rates are substantially higher than rates in most other states, particularly neighboring states.[1] In this chapter, we summarize recent evidence involving interstate rate comparisons, examine historical trends, and summarize what is known about the accuracy of the rate comparisons.

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1 Minnesota Department of Commerce, Insurance Division, *Workers' Compensation in Minnesota: An Analysis with Recommendations* (January 1982) and Citizens League, *Workers' Compensation Reform: Getting the Employees Back on the Job* (December 1982).

METHODS FOR COMPARING INSURANCE RATES

Interstate rate comparisons can be based on a variety of measures.[2] Two primary measures are:

- comparing the total premium paid in a state with the total covered payroll, called average cost comparisons, and
- comparing the official or "manual" rates filed by individual companies or state rating bureaus.

Average Cost Comparisons.

To obtain the average cost, one takes the annual premium paid by all insured employers in the state and divides by the annual payroll for these same employers. This is commonly expressed in terms of cost per $100 of payroll. While this measure is useful for examining trends for individual states, it is not generally appropriate for making interstate comparisons because it does not adjust for differences in industrial mix. That is, some states differ in the proportion of their employees engaged in high-risk industries such as manufacturing, lumber, and mining.

Differences in industrial mix are important because rates charged by insurance companies vary greatly by industrial classification. For example, the rate for carpenters is more than 30 times as high as the rate for clerical workers in Minnesota. To be useful, rate comparisons should adjust for industry mix or they should only be made among states with similar industrial mixes.

Average cost comparisons do not take into account the occupational mix of different states.

Employers are concerned about how their rate compares with rates paid by their competitors in other states. This comparison cannot be made with average cost. From the Legislature's point of view, average cost comparisons are deficient because these comparisons do not distinguish between major causes beyond its control (such as a high concentration of hazardous industries) and causes within its control (the system's benefit structure and administrative structure).

Manual Rate Comparisons

Interstate comparisons based on manual rates are better than average cost comparisons because manual rate comparisons can correct for differences in industrial mix. In most states, manual rates are set for occupational classifica-

2 The following discussion is largely based on: John F. Burton, Jr. and Alan B. Krueger, "Interstate Variations in the Empoloyers' Cost of Workers' Compensation, with Particular Reference to Connecticut, New Jersey, and New York", in James Chelius, ed. *Current Issues in Workers' Compensation*, W. E. Upjohn Institute for Employment Research, (Kalamazoo, Michigan: 1986).

Manual rate comparisons correct for differences in occupational mix.

tions established by the National Council on Compensation Insurance. Over 500 occupational classifications are commonly used by states for rate setting purposes. This uniform classification system facilitates interstate rate comparisons. Currently about 40 states use this classification system, including Minnesota, Wisconsin, and Iowa. Reasonably equivalent comparisons can be made in most of the other states by matching the classifications as closely as possible.

A potential problem with manual rate comparisons is that insurers often adjust the manual rate to determine the actual cost paid by individual employers. Insurance companies make experience-rating adjustments (e.g., discounts to employers with better than average claim experience) and offer premium discounts for employers with large payrolls. They make additional flat charges to cover the minimum cost of servicing a policy. Insurers also offer retrospective rating which adjusts the premium paid at the end of the policy period according to the employer's loss experience during the policy period. Some insurers also reduce insurance costs by providing dividends to policyholders.

During the past decade, many states with regulated rates have increased the ability of insurers to compete for workers'compensation insurance. Two types of competition allowed by many states are deviations and schedule rating. Deviations allow an insurer to deviate from the rating bureau's rates if it obtains prior approval from the insurance commissioner and applies the deviation uniformly to all of its policyholders in the state. Under schedule rating, an insurer can reduce its rates based upon its own evaluation of factors such as an employer's loss control program.

Nine states, including Minnesota, now have open competition, under which each insurer sets its own rates. Open competition gives insurers the most flexibility in setting rates.

Previous studies estimated how much these adjustments affect workers' compensation rates. John Burton, a nationally recognized researcher in workers' compensation, estimated the average effect of experience rating, premium discounts, retrospective rating, flat charges, and dividends between 1976 and 1980.[3] For the 31 states that used the National Council on Compensation Insurance as the rate-setting organization and the 10 states that used substantially equivalent procedures, Burton estimated that the above adjustments collectively reduced rates by about 15 percent.

Data that measure how competition affects the difference between the actual rates and the published rates are not as complete as they are for the other adjustments. Since Minnesota is an open competition state, we estimated the difference between the average rate filed by insurers in Minnesota and the actual average rate paid by employers. We used Minnesota's average cost computed earlier ($2.98 per $100 of payroll) to estimate the actual average rate.

- **In 1986, the average rate filed by the twenty largest insurers in Minnesota exceeds the estimated average rate actually paid by about 15 percent. This amount is similar to the average deviation found by previous studies in other states.**

3 John F. Burton, Jr. and Alan B. Krueger, "Interstate Variations in the Empoloyers' Cost of Workers' Compensation".

More refined estimates of how much these adjustments, including the effects of competition, affect manual rate comparisons will be available in February 1988, but were not available at the time this report was written. These estimates will be made on a state-by-state basis to a much greater extent than in previous studies.

While manual rates (and filed rates for states without official manual rates) tend to overstate the actual cost of insurance, we believe that the manual rates are accurate enough to make meaningful comparisons among states. This is because the amount by which manual rates overstate the actual cost is small compared to the variation in rates among states. Moreover, since most of the rate adjustments are made for large employers, manual rates should be a reasonable approximation of the cost to small employers.

WORKERS' COMPENSATION COSTS IN MINNESOTA

In 1986, workers' compensation cost Minnesota employers $834 million. This is equivalent to $2.98 per $100 of payroll.

The actuary for the Minnesota Department of Commerce estimated that in 1986, workers' compensation cost Minnesota employers $834 million, including $636 million for insured employers and $197 million for self insured employers.[4] This is equivalent to $2.98 per $100 of payroll.

Table 2.1 shows how filed rates vary among the 50 largest industrial classifications in Minnesota. The rates in Table 2.1 are the average rates filed by the twenty insurers with the largest premium volume in Minnesota. Keep in mind that the average actual rate paid by employers is about 15 percent less than the average filed rate and that there may be considerable variation around these averages.

The cost varies greatly among industrial classes. As expected, rates for office jobs are much lower than rates for jobs requiring physical labor. The filed rates as of June 1, 1987 range from a high of $21.43 per $100 of payroll for truckers-for-hire to a low of $0.49 for clerical jobs.

- **Seven of the fifty largest occupational classes in Minnesota have average filed rates that exceed 10 percent of payroll.**

These classes include carpentry-homes, sheet metal workers and drivers, road paving and drivers, lumberyards and drivers, plumbing and drivers, and truckers (both for-hire and not-for-hire).

4 The cost estimate for insured employers is based on written premium less dividends, according to data from Best's Executive Data Service. The cost for self-insured employers was estimated by assuming that since self insurers make up 24 percent of the Workers' Compensation Reinsurance Association exposure base, they also pay about 24 percent of the system's costs.

Class Title	Payroll (in Millions)	Average Rate[a]
Truckers - For Hire	$ 168	$21.43
Carpentry - Homes	78	17.86
Sheet Metal Workers & Drivers	61	12.65
Road Paving & Drivers	53	11.52
Lumberyards & Drivers	52	11.23
Plumbing & Drivers	97	10.77
Truckers - Not For Hire	147	10.68
Buildings Owner Operation	75	8.59
Creameries & Drivers	75	8.41
Policemen & Drivers	63	8.14
Plastics Manufacturing	74	7.97
Gas Stations & Drivers	98	7.58
Contractors - Supervisors	58	7.42
Auto Repair & Drivers	192	7.28
Convalescent Homes	339	7.22
Hospital - Other Employees	92	7.17
Fireproof Eqipment Manufacturing	75	6.99
Machine Shops NOC	185	6.57
Bakeries & Drivers	78	6.45
Wholesale Hardware Store	56	6.43
Wholesale Grocery & NOC	121	6.09
Electrical Wiring & Drivers	122	6.03
Paper Manufacturing	67	5.94
Carpentry Shop Only	120	5.92
Airlines - Other Employees	121	4.73
Precision Parts Manufacturing	71	4.46
Printing	209	4.35
Retail Grocers	260	4.01
Hotel Employees & Drivers	54	3.99
Restaurants	484	3.98
Retail Hardware	72	3.88
Abrasive Paper	137	3.49
Phone-Telegraph Manufacturing	154	3.36
Office Machine Installation	101	3.00
Hospital Professional Employees	447	2.61
Retail Stores NOC	266	2.61
Schools - Other Employees	285	2.49
Instrument Manufacturing NOC	77	1.92
Salesmen	1,280	1.54
Auto Salesmen	79	1.43
Airline Flight Crew	223	1.34
Retail Clothing	107	1.34
Radio TV Station & D	82	1.16
Computer Manufacturing	263	0.91
Beauty Parlors	52	0.89
School Professional Employees	762	0.77
Auditors - Traveling	93	0.70
Dentists - Doctors	371	0.61
Attorneys	166	0.50
Clerical	5,127	0.49
Total	$13,886	$ 2.77

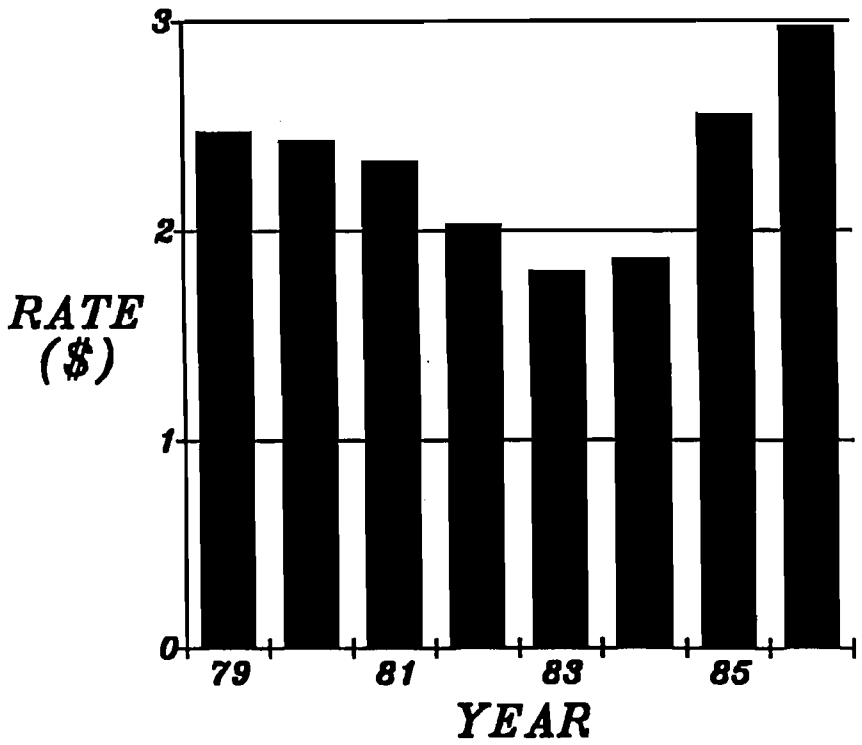
Source: Department of Commerce.

[a]Based on average rate filed by 20 largest insurers in Minnesota.

Table 2.1: Average Workers' Compensation Rates Filed in Minnesota for 50 Largest Classes June 1, 1987

TRENDS IN MINNESOTA WORKERS' COMPENSATION RATES

Figure 2.1 shows how workers' compensation rates have changed in Minnesota since 1979. Overall, rates have been rising over time, though in a cyclical pattern. During the 1970s, rates increased as Minnesota increased its benefits. After 1979, rates declined until they reached a low of $1.83 per $100 of payroll in 1983. Since 1983, rates have been rising again, particularly since 1984. Rates increased from $1.87 per $100 of payroll in 1984 to $2.98 in 1986, an increase of over 50 percent.



Sources: Written premium and dividends are from Best's Executive Data Service. Covered payroll data from 1979 through 1984 are from the Minnesota Workers' Compensation Insurers Association (based on 3rd report). Covered payroll data from 1985 and 1986 were estimated by adjusting the 1984 payroll by the change in average wage and number of employees.

[a]Rates equal $\frac{\text{written premium minus dividends}}{\text{covered payroll}}$

Figure 2.1: Average Workers' Compensation Rates in Minnesota 1979-86
Rate Per $100 of Payroll*a*

While this rapid increase followed the 1983 change in Minnesota's workers' compensation law, the increase in rates should not be interpreted as the effect of the law change.

The rapid increase in rates since 1984 has generated a lot of concern among employers and policymakers. While this rapid increase followed the 1983 change in Minnesota's workers'compensation law, the increase in rates should not be interpreted as the effect of the law change. Several other important changes that probably caused rates to increase have occurred since 1983. These include:

- **During the 1980s, workers' compensation rates in Minnesota have followed a cyclical pattern often experienced in the insurance industry. Highly competitive periods with low prices are followed by more conservative underwriting practices and higher prices. Most property casualty insurance rates declined or increased slightly during the early 1980s and have risen rapidly since 1984.[5] These cyclical changes have been partly responsible for the recent price increases in workers' compensation.**

- **Assessments made to finance the Special Compensation Fund have increased from 15 percent of paid indemnity losses in 1983 to 31 percent in 1987.**

- **Guaranty Fund assessments to cover insolvent workers'compensation insurers never reached one-half of one percent until two percent assessments were made in both 1985 and 1986.**

- **After making no assessments during the early 1980s, the Assigned Risk Plan made a five percent assessment payable in 1987 and a three percent assessment payable in 1988.**

- **According to the property/casualty actuary for the Department of Commerce, insurance companies underestimated the losses experienced under the old law. Resulting price adjustments were not made until after 1984.**

INTERSTATE RATE COMPARISONS

Interstate comparisons are useful because Minnesota companies often must compete with companies in other states, particularly nearby states. They also provide a benchmark for assessing the reasonableness of the cost of Minnesota's system. In this section we present the results of two interstate comparisons that are based on manual rates and are adjusted for industry mix.

5 *Insurance Regulation*, Office of the Legislative Auditor, (St. Paul: 1986), p. 76.

The first comparison uses the average manual rate for 44 commonly used rating classifications, weighted by the national payroll distribution.[6] The second comparison uses the manual rates for the 50 classifications with the largest payroll in Minnesota.[7] This second comparison includes Minnesota, Wisconsin, and Iowa.

Collectively, these results show:

Minnesota's workers' compensation insurance rates were about twice as high as rates in Wisconsin, Iowa, and South Dakota.

- **As of July 1, 1987, Minnesota's workers' compensation insurance rates were about twice as high as rates in Wisconsin, Iowa, and South Dakota.**
- **As of July 1, 1987, Minnesota's rates ranked fourth highest among 38 states and the District of Columbia, the jurisdictions for which data were available.**
- **Workers' compensation rates in Minnesota declined more rapidly than other states between 1978 and 1984, but grew at a faster pace than other states between 1984 and 1987. Minnesota's ranking dropped from 7th highest out of 39 jurisdictions in 1978 to 14th highest in 1984, and then rose to 4th highest in 1987.**

Interstate Comparisons

Table 2.2 presents the average manual rates by state for 1984 and 1987.[8] They are based on the average rate for 44 commonly used classifications, weighted by the national payroll distribution. The rates represent the employer's cost per $100 of payroll. Minnesota's rate was adjusted for differences in the way payroll base is calculated.

As of July 1, 1987, Minnesota's average rate was the fourth highest out of 38 states and the District of Columbia. The states with the highest three rates were Hawaii, Oregon, and Montana. Minnesota's rate was $3.17 per $100 of payroll, about 55 percent higher than the national median of $2.04. Minnesota's rate was at least twice as high as rates in 16 states, including Wisconsin, Iowa, and South Dakota.

The data show that Minnesota's rates have been increasing faster than other states since 1984, but this is partly explained by the fact that Minnesota's rates dropped faster between 1978 and 1983. Minnesota's rate declined by 23 percent between 1978 and 1983, but then it rose by 80 percent between 1984 and 1987. As a result, between 1978 and 1984, Minnesota's ranking dropped from 7th highest to 14th highest out of 39 jurisdictions, but between 1984 and 1987, its ranking climbed to 4th highest.

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6 John F. Burton, Jr., H. Allan Hunt, and Alan B. Krueger, *Interstate Variations in the Employers' Costs of Workers Compensation with Particular Reference to Michigan and Other Great Lake States*. Workers' Disability Income Systems, Inc., February 1985 and 1987 NCCI rate pages.

7 Minnesota Depatment of Commerce.

8 John F. Burton, Jr., *Op. Cit.*

Jurisdiction	1984	1987
Hawaii	4.429	4.075
Oregon[a]	2.842	3.982
Montana	2.159	3.889
MINNESOTA[a]	**1.754**	**3.166**
Washington, D.C.	2.313	3.124
New Mexico	2.288	3.116
Alaska	2.474	2.761
Connecticut	2.152	2.715
Florida	2.060	2.567
Michigan[a]	2.212	2.503
Texas	1.930	2.421
Arizona	1.461	2.312
Colorado	1.545	2.283
New Hampshire	1.761	2.259
Maryland	2.131	2.243
Idaho	1.506	2.042
Georgia	1.071	1.995
Louisiana	1.214	1.981
Maine[a]	1.954	1.973
Illinois	1.501	1.891
Alabama	1.027	1.843
Kentucky[a]	1.036	1.801
Arkansas	1.422	1.730
New York	1.351	1.579
South Carolina	1.188	1.571
Wisconsin	1.027	1.518
Mississippi	1.037	1.401
Vermont	1.019	1.395
Tennessee	.916	1.383
Kansas	.975	1.371
Iowa	1.019	1.317
Virginia	1.080	1.261
New Jersey	1.515	1.257
Utah	.937	1.242
South Dakota	.844	1.193
Missouri	.816	1.182
Nebraska	.932	1.113
North Carolina	.698	.925
Indiana	.412	.689
California	2.412	---
Delaware	1.427	---
Massachusetts	1.782	---
Ohio	1.582	---
Oklahoma	1.672	---
Pennsylvania	1.873	---
Rhode Island	1.708	---
West Virginia	1.696	---
Average	1.539 (39 states)	2.040 (39 states)

Source: John F. Burton, Jr., H. Allan Hunt, and Alan B. Krueger, Interstate Variations in the Employers' Costs of Workers' Compensation with Particular Reference to Michigan and the Other Great Lake States. Workers' Disability Income Systems, Inc., February 1985 and 1987 NCCI rate pages.

NOTE: Rates based on average manual rates for 44 classes, weighted by national payroll distribution.

[a]Assigned risk rates used for 1987.

Table 2.2: Interstate Comparison of Workers' Compensation Rates 1984 and 1987 Rate Per $100 of Payroll[a]

Individual Manual Rates in Minnesota, Wisconsin, and Iowa.

Minnesota's rate is higher than Wisconsin's rate in 46 out of 47 classes used by both states.

Table 2.3 compares Minnesota's average filed rate with manual rates in Wisconsin and Iowa for the 50 classifications with the largest payrolls in Minnesota. As a group, these 50 classifications cover 80 percent of Minnesota's insured payroll. The rates for Wisconsin and Iowa were multiplied by 1.11 to adjust for differences in the way payroll base is calculated.

Workers' Compensation Class Title	Rates Per $100 of Payroll			Percent that Minnesota Rates are Higher Than:	
	Minnesota[a]	Iowa[b]	Wisconsin[b]	Iowa	Wisconsin
Fireproof Equip. Mfg.	$ 8.33	$2.23	$4.04	274%	106%
Office Mach. Install	3.30	0.89	1.09	272	204
Auto Salesmen	1.62	0.47	0.58	247	180
Retail Grocers	4.55	1.35	2.41	236	89
Hosp. Prof. Employees	2.15	0.64	1.17	233	84
Machine Shops NOC[c]	6.42	1.99	2.78	223	131
Dentists-Doctors	0.59	0.19	0.20	210	193
Bldgs. Owner Operation	8.83	3.24	3.81	172	132
Radio TV Sta. & Driv.	1.29	0.48	0.42	170	206
Contractors - Supers	6.05	2.28	3.00	166	102
Precision Parts Mfg.	4.60	1.74	2.02	164	128
Gas Stations & Driver	7.01	2.66	3.57	163	96
Auto Repair & Drivers	7.04	2.75	3.50	156	101
Plastics Mfg.	8.08	3.19	2.53	154	219
Instrument Mfg. NOC[c]	2.03	0.81	2.45	151	-17
Carpentry - Homes	16.00	6.44	8.36	149	91
Restaurants	3.94	1.60	1.98	146	99
Retail Stores NOC[c]	2.95	1.23	1.04	139	183
Salesmen	1.43	0.60	0.67	139	115
Clerical	0.45	0.19	0.23	137	92
Beauty Parlors	0.92	0.39	0.42	137	118
School Prof. Employees	0.78	0.33	0.24	135	220
Abrasive Paper	2.86	1.25	1.47	128	95
Phone-Telegraph Mfg.	3.30	1.49	1.43	122	130
Truckers - Not For Hire	10.16	4.62	3.64	120	179
Attorneys	0.45	0.21	0.19	115	140
Printing	3.64	.70	2.12	114	71
Airline Flight Crew	1.11	--	--	--	--
Convalescent Homes	5.95	2.82	3.86	111	54
Airlines-Other Emp.	4.27	2.04	3.76	109	13
Truckers - For Hire	20.03	9.73	7.66	106	161
Policemen & Drivers	7.07	3.43	2.42	106	192
Auditors - Traveling	0.57	0.28	0.23	105	145
Bakeries & Drivers	7.00	3.49	2.89	101	143
Hotel Employees & Drivers	3.72	1.88	2.61	98	43
Lumberyards & Drivers	9.15	5.03	5.99	82	53
Hospital Other Employees	6.96	3.84	2.99	81	133
Retail Clothing	1.28	0.73	0.64	75	99
Road Paving & Drivers	10.93	6.76	--	62	--
Creameries & Drivers	7.18	4.52	3.05	59	135
Plumbing & Drivers	11.45	7.27	4.56	57	151

(Continued)

Table 2.3: Comparison of Workers' Compensation Rates In Minnesota, Wisconsin, and Iowa January 1, 1987

Workers' Compensation Class Title	Rates Per $100 of Payroll			Percent that Minnesota Rates are Higher Than:	
	Minnesota[a]	Iowa[b]	Wisconsin[b]	Iowa	Wisconsin
Whlsl Grocery & NOC[c]	6.08	4.03	3.34	51	82
Carpentry Shop-Only	5.77	3.91	3.70	48	56
Paper Manufacturing	7.07	4.78	2.34	48	202
Sheet Metal Work, Drivers	10.93	7.71	5.76	42	90
Elec. Wiring & Drivers	5.46	4.62	3.34	18	63
Computer Mfg.	1.09	1.07	0.82	3	33
Whlsl Hardware Store	6.58	--	--	--	--
Retail Hardware	4.09	--	--	--	--
Schools-other employees	2.70	4.16	2.52	-35	7
50 LARGEST CLASSES:	$2.60 MN Avg.	$1.26 IA Avg.	$1.29 WI Avg.	106% Iowa	102% Wisc.

Source: Minnesota Department of Commerce.

[a]Minnesota's rates are based on the average rate filed by the 20 largest insurance companies.
[b]Wisconsin and Iowa rates are adjusted for the difference in payroll base.
[c]Not otherwise classified.

Table 2.3: Comparison of Workers' Compensation Rates in Minnesota, Wisconsin, and Iowa January 1, 1987 (continued)

The table shows that Minnesota's rate is higher than Wisconsin's rate in 46 out of 47 classes used by both states. Similarly, Minnesota's rate is higher than Iowa's rate in 45 out of 46 classes. This data also supports the previous finding that, overall, Minnesota's rates are about twice as high as Wisconsin and Iowa.

For several classifications, the difference between Minnesota and the neighboring states represents a large share of the employers' payroll cost. Minnesota's rate for truckers-for-hire is $20.03 per $100 of payroll, more than $10 higher than either Wisconsin's ($7.66) or Iowa's rate ($9.73).

- **For eight of Minnesota's fifty largest occupational classifications, Minnesota's rate exceeds Wisconsin's rate or Iowa's rate by at least $5 per $100 of payroll.**

These classifications are carpentry-homes, truckers (both for-hire and not-for-hire), plumbing-drivers, building owner operations, fireproof equipment manufacturing, plastics manufacturing, and sheet metal workers and drivers.

CONCLUSIONS

Minnesota's workers'compensation insurance rates declined relative to other states between 1978 and 1983, but have increased since then. Minnesota's rates now average about three percent of payroll, and many occupations have rates exceeding ten percent of payroll. Minnesota's rates are now about fourth highest in the country out of 39 jurisdictions. On the whole, Minnesota's rates are about twice as high as rates in Wisconsin, Iowa, and South Dakota.

ANALYSIS OF COSTS

Chapter 3

In Chapter 2, we showed that Minnesota's workers' compensation rates are currently higher than the national average and about twice as high as Wisconsin, Iowa, and South Dakota. In this chapter, we address the following questions:

- **Why are workers' compensation rates higher in Minnesota than in other states, particularly Wisconsin? To what extent are Minnesota's higher rates due to higher profits by insurers or higher insurer expenses? To what extent are they due to high benefits?**
- **How much does each type of benefit cost in Minnesota?**
- **How do Minnesota's benefits compare with benefits in other states?**
- **How much do the cost-of-living escalator, minimum benefits, and supplementary benefits add to workers' compensation costs in Minnesota?**

POSSIBLE REASONS FOR HIGH WORKERS' COMPENSATION COSTS

Previous studies have identified the following possible reasons for Minnesota's high workers' compensation rates:[1]

- higher insurer profits and administrative expenses,
- more hazardous industrial mix,
- higher accident rates or greater accident severity within each industry,
- higher benefits or longer duration of benefits,

1 C. Arthur Williams, Jr., "Risk Management and Insurance Issues", No. 3 (School of Management, University of Minnesota, March 1984).

- more liberal eligibility standards (including continuation of benefits),
- higher medical costs for the same treatment,
- higher litigation rates,
- less effective loss control and claims management by employers, insurers, and the state workers' compensation agency, and
- less cooperative attitudes among employees, employers, and insurers.

In this chapter, we discuss the first six factors, particularly the effects of benefits on workers' compensation costs.

INSURER PROFITS AND EXPENSES

A "loss ratio" is the ratio of benefits to premium earned by an insurer.

One reason for Minnesota's high workers' compensation rates might be that Minnesota has unusually high insurer profits or expenses (including broker commissions, policy administration, and claims management). To measure the extent to which insurer profits and expenses explain Minnesota's high workers' compensation rates, we compared Minnesota's "loss ratios" with those of other states. The loss ratios we use in this report are the ratio of losses incurred (benefits paid or expected to be paid to workers injured during a given year plus any changes in the reserves for injuries during previous years) to premium earned during a given year. Thus, loss ratios represent the proportion of premium that is used for benefit payments to injured workers. High loss ratios mean that a high proportion of the premium goes toward benefits and a low proportion goes toward expenses and profits. In other words, high loss ratios imply either low profits or more efficient operations by insurers.

Data Limitations

Loss ratios have been frequently criticized for two reasons. First, since losses are based largely on the insurance industry's estimates of future payments, loss estimates are unreliable and they may be easily manipulated by the insurance industry. Second, since the loss ratio data do not adequately include investment income, the industry's profits appear to be lower than they really are.

Although these criticisms have some merit, we believe that the loss ratios are a valid measure for making inter-state comparisons. We agree that estimates of losses incurred during a given year may be unreliable because these estimates often change as claims mature. For example, if losses are initially under-estimated for "year one" and adjusted upward in "year three", the loss ratio will be too low for "year one" and too high for "year three".

But this problem can be minimized by examining several years of data. Poor initial estimates tend to be corrected in future years as claims mature and more reliable loss data becomes available.

As for the concern that the insurance industry manipulates the data for its own advantage, we note that there are greater incentives to exaggerate losses in rate-regulated states than in open-competition states such as Minnesota. In rate-regulated states, insurers must justify rate increase requests to regulators, whereas in Minnesota, insurers set their own rates.

Even though loss ratios only partially recognize the investment income that insurers can earn on workers' compensation premiums, loss ratios are still useful for making inter-state comparisons because this problem also occurs in other states. In their annual statements, insurance companies normally discount incurred losses at four percent per year, the maximum allowed by Minnesota statute. However, insurers should normally be able to earn more than four percent on their investments. This underestimate of investment income biases inter-state comparisons of loss ratios only to the extent that insurers earn more (or less) investment income per premium dollar in Minnesota than in other states.

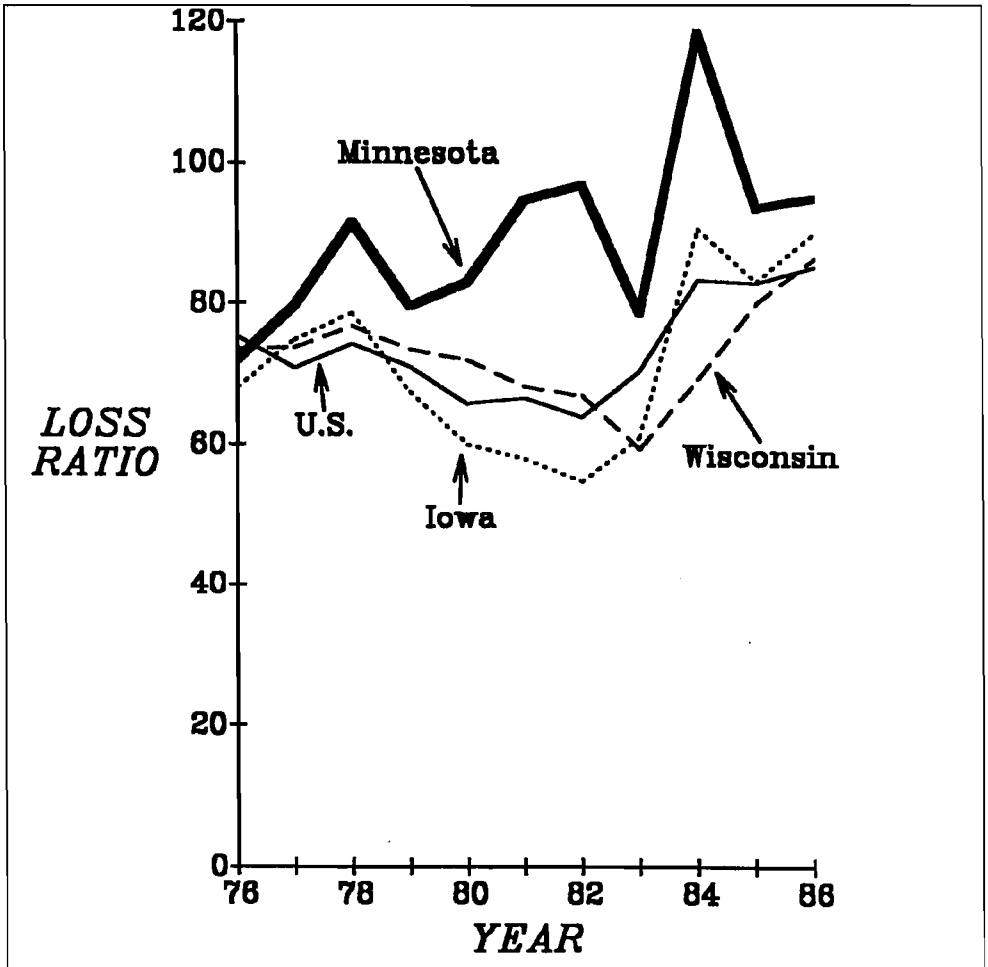
Another problem with loss ratios is that benefits financed with special assessments are often treated as expenses rather than losses. In Minnesota, this means that supplementary benefits and benefits paid through the second injury fund might be treated as expenses rather than losses. The special assessment for these benefits was about 20 percent of indemnity losses in 1986, considerably higher than other states. In 1985, special assessments averaged less than six percent among the 13 states reporting to NCCI and was about 4 percent in Wisconsin. Its not clear to what extent insurers report these assessments as losses or expenses. But to the extent that insurers report assessments as expenses, loss ratios understate Minnesota's losses to a greater degree than they do for other states. This tends to offset any bias that might occur if Minnesota's investment income was higher than average.

From 1978 through 1986, Minnesota's loss ratios were higher than the national average by at least 11 percent and by as much as 52 percent.

Results

Figure 3.1 and Table 3.1 compare Minnesota's loss ratios with ratios in neighboring states and the national average from 1976 through 1986. For each year from 1978 through 1986, Minnesota's loss ratios were higher than the national average by at least 11 percent and by as much as 52 percent. This indicates that workers' compensation was less profitable during this period in Minnesota than in the nation as a whole. During the same time period, Minnesota's loss ratios exceeded Wisconsin's ratios by at least 8 percent and by as much as 71 percent. Throughout this period, Minnesota's loss ratios were also higher than those of Iowa and South Dakota. As a result, we conclude:

- **Insurer profits and expenses are not a significant reason that Minnesota's workers' compensation rates are higher than other states.**



Source: Best's Executive Data Service.

[a]Loss ratios equal incurred losses divided by earned premium.

Figure 3.1: Workers' Compensation Loss Ratios[a] 1976-86

INDUSTRIAL MIX, ACCIDENT RATES, AND ACCIDENT SEVERITY

In Chapter 2, we discussed how a state's industrial mix may affect workers' compensation costs and showed that Minnesota's rates are high after adjusting for variation in industrial mix. For example, Minnesota's rates were substantially higher than rates in Wisconsin and Iowa over a broad range of common industrial and occupational classifications.

Another possible reason for Minnesota's high workers' compensation rates is that it might have higher accident rates or greater accident severity within

Year	Minnesota	Wisconsin	Iowa	South Dakota	U.S. Total
LOSS RATIOS[a]					
1975	60.1	61.7	--	--	72.6
1976	72.0	73.6	68.0	57.3	75.3
1977	79.6	73.7	74.8	83.6	70.8
1978	91.5	76.7	78.6	69.0	74.2
1979	79.5	73.4	67.4	59.9	71.0
1980	82.9	71.9	59.9	80.0	65.7
1981	94.6	68.1	57.9	76.2	66.5
1982	96.7	66.8	54.7	67.1	63.8
1983	78.4	59.2	60.9	71.3	70.3
1984	118.3	69.2	90.5	82.8	83.2
1985	93.5	79.9	83.0	82.8	82.8
1986	94.9	86.2	90.0	88.3	85.1
PERCENT THAT MINNESOTA'S LOSS RATIO EXCEEDS THOSE OF OTHER STATES					
1975		-2.6%	--	--	-17.2%
1976		-2.2	5.9%	25.7%	- 4.4
1977		8.0	6.4	-4.8	12.4
1978		8.3	18.0	32.7	12.0
1979		19.3	16.4	32.6	23.3
1980		15.3	38.4	3.6	26.2
1981		38.9	63.4	24.1	42.3
1982		44.8	76.8	44.1	51.6
1983		32.4	28.7	10.0	11.5
1984		71.0	30.7	42.9	42.2
1985		17.0	12.7	12.9	12.9
1986		10.1	5.4	7.5	11.5

Source: Best's Executive Data Service.

[a]Incurred losses divided by earned premium.

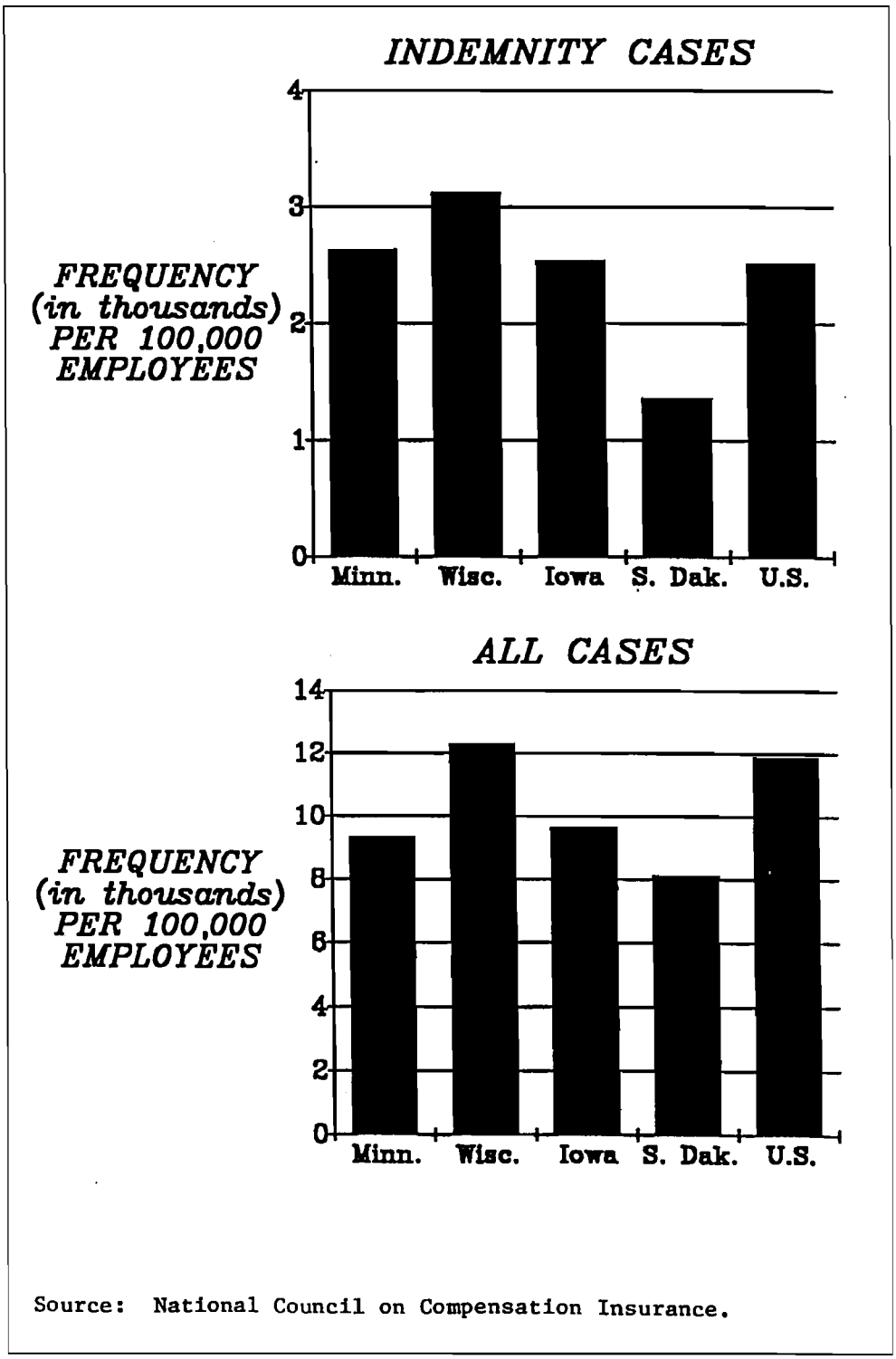
Table 3.1: Workers' Compensation Loss Ratios in Minnesota and Other States 1975-86

each industry. However, workers' compensation claim frequency data show that injury rates are not responsible for Minnesota's high rates. Figure 3.2 compares Minnesota's workers' compensation injury frequency with other states based on data from the National Council on Compensation Insurance.

Minnesota's rate of injuries and indemnity claims was lower than Wisconsin's.

- **Minnesota had 9,352 injuries per 100,000 employees for policy year 1983, lower than injury rates in Wisconsin (12,328) and Iowa (9,646). Minnesota's rate was also lower than the national median rate of 11,920.**

- **Minnesota had 2,635 indemnity claims per 100,000 employees, lower than rates in Wisconsin (3,128), and slightly higher than the national median (2,519) and Iowa's rate (2,540). It was nearly twice as high as South Dakota's rate (1,357).**



Source: National Council on Compensation Insurance.

Figure 3.2: Workers' Compensation Injury Frequency Minnesota Versus Other States

While we can compare injury frequencies among the states, there is little comparative data on accident severity.

BENEFITS

Earlier in this chapter, we showed that insurer profits and expenses were not a credible explanation for Minnesota's high workers' compensation rates. Now we examine the role of benefits paid under the workers' compensation system. Critics of Minnesota's benefit structure cite several reasons for Minnesota's high costs, including the cost-of-living escalator, supplementary benefits, indefinite wage-replacement benefits for employees who are physically able to work, minimum benefits, and the assigned risk assessment. In this section, we examine Minnesota's benefits and their effect on costs. We describe the types of benefits paid and estimate how much each contributes to Minnesota's costs. We also examine the statutory differences in benefits between Minnesota and other states and examine the differences between Minnesota's and Wisconsin's costs.

Types of Benefits

Wage-replacement benefits include temporary total, temporary partial, and permanent total.

Workers' compensation pays all medical and rehabilitation expenses, replaces lost wages, and compensates permanently injured employees for certain non-economic losses. It provides the following types of benefits to injured workers:

- Medical benefits pay for the full cost of medical care for work-related injuries.

Non-medical benefits are often called indemnity benefits. Wage-replacement benefits make up the largest indemnity benefit category. These benefits are designed to support injured workers while they are not working or working at low paying jobs. They include temporary total, temporary partial, and permanent total benefits.

- Temporary total benefits compensate injured employees for wages lost while they are recovering and unable to work.

- Temporary partial benefits are designed to compensate injured employees for wages lost while the employees are working at jobs that pay less than their pre-injury wage.

- Permanent total benefits provide income compensation to employees who cannot reasonably be expected to return to work.

Other indemnity benefits include permanency benefits, death benefits, and vocational rehabilitation benefits.

- Permanency benefits (impairment compensation and economic recovery compensation) provide benefits to employees with a permanent disability (whether total or partial) for the functional loss of use of their body.

- Death benefits replace income lost by families of employees who die as the result of work-related injuries or illnesses.

- Rehabilitation benefits pay for the cost of physical or vocational services designed to make the employee ready for employment.

In this section, we describe the above indemnity benefits and how they are adjusted through use of the cost-of-living escalator and supplementary benefits.

Temporary Total Benefits

Temporary total benefits equal two-thirds of the employee's gross pre-injury wage, subject to a minimum and a maximum.

Employees who are unable to work for more than three days while recovering from a work-related injury or illness are eligible for temporary total benefits. Compensation equals two-thirds of the employee's gross pre-injury wage, subject to minimum and maximum benefits.[2] The maximum weekly benefit is the statewide average weekly wage, currently $376. The minimum weekly benefit is 50 percent of the statewide average weekly wage or the employee's pre-injury weekly wage, whichever is less. However, in no event can the benefit be less than 20 percent of the statewide weekly wage (currently $75.20), regardless of the employee's pre-injury wage.

Temporary total benefits continue until the employee returns to work, retires, or refuses to accept a "light duty" or "suitable" job arranged by the employer.[3] However, in no case can temporary total benefits last more than 90 days after the employee reaches maximum medical improvement or 90 days after the end of an approved retraining program, whichever is later.

The rationale for ending temporary total benefits at this time is that once maximum medical improvement is reached, it ought to be possible to determine whether the employee has a permanent disability. If so, the employee is eligible for one of the permanent benefits. If not, the employee has 90 days to find a job.

Temporary Partial Benefits

Employees who go back to work at suitable or light duty jobs which pay less than their previous jobs are eligible for temporary partial disability benefits. The compensation equals two-thirds of the difference between the current wage and the pre-injury wage, subject to the same maximum as for temporary total benefits (but the minimum benefit does not apply).

There is uncertainty over when temporary partial benefits should end. The Workers' Compensation Court of Appeals ruled that employees who return

2 Employees are not compensated for the three-day waiting period unless they are unable to work for at least ten days.

3 Light duty and suitable jobs are defined in statute.

to work can receive temporary partial benefits indefinitely as long as their wage is less than their pre-injury wage. Then, in a contoversial decision, the Court of Appeals ruled that employees are also eligible for temporary partial benefits if they reach maximum medical improvement, are not offered a suitable job by the employer, and cannot find a job. Eligibility is not affected by whether or not the employee has a permanent disability. In this case, the employee receives temporary partial benefits at the temporary total rate. In effect, this makes the termination of temporary total benefits moot. We discuss this situation further in Chapter 6.

Permanent Total Benefits

Employees are eligible for permanent total benefits if they have not found and cannot be "reasonably expected to find suitable gainful employment," after considering their age, physical restrictions, transferable skills, and economic factors in their community.[4] Permanent total benefits are also paid for certain very serious injuries specified in statute, regardless of whether the employee finds a job.[5] The benefit equals two-thirds of the employee's pre-injury wage, subject to the same minimum and maximum that apply to temporary total benefits. Permanently disabled employees also receive impairment compensation as described in the next section.

Permanency Benefits

Permanency benefits compensate employees with permanent disabilities for the loss of bodily function.

Permanency benefits compensate employees with permanent disabilities for the loss of bodily function. The 1983 Legislature changed the procedure for determining permanent partial benefits effective January 1, 1984. Previously, the benefit equaled two-thirds of the employee's pre-injury wage (subject to a maximum of the statewide average wage) for a period of time determined by the severity of the disability. The injury's severity depended on the body part injured and the proportion of the body part that was disabled. Usually, the disability rating was determined at a hearing.

Under current law, the amount of the benefit is determined by the severity of the disability and whether the employer offers the employee a suitable job within 90 days after maximum medical improvement.[6] If the employer offers a suitable job within this time period, the employee receives the impairment compensation shown in Table 3.2. Otherwise, the employee receives economic recovery compensation.

Economic recovery compensation was designed to be larger than the impairment compensation to give the employer an incentive to offer the injured employee a suitable job. As shown in Table 3.2, economic recovery compensation is approximately twice as high as impairment compensation for an employee with an average wage and a disability rating of 50 percent or less (The vast majority of disabilities have ratings less than 50 percent). While

4 *Minn. Rules*, Part 5220.2520

5 These serious injuries are total and permanent loss of sight in both eyes, loss of both arms at the shoulder, complete and permanent paralysis, loss of both legs at so close to the hips that no effective artificial members can be used, and permanent loss of mental faculties.

6 Some complicating factors such as quitting a job after accepting it are discussed in Chapter 6.

Percent of Disability	Impairment Compensation	Economic Recovery Compensation	Percent Difference
2	$ 1,500	$ 3,008	101%
5	3,750	7,520	101
10	7,500	15,040	101
15	11,250	22,560	101
20	15,000	30,080	101
30	24,000	48,128	101
40	36,000	72,192	101
50	50,000	100,267	101
60	84,000	144,384	72
70	126,000	196,523	56
80	192,000	240,640	25
90	288,000	345,600	20
100	400,000	480,000	20

NOTE: The Economic Recovery award varies with the worker's wage. This table assumes the worker's wage was $376 per week. For injuries during 1988, high wage earners could receive as much as 1.5 times the amount shown for the appropriate disability rating. The minimum equals 1.2 times the impairment award amount. The impairment award does not vary with the injured worker's wage.

Table 3.2: Comparison of Impairment and Economic Recovery Compensation

economic recovery compensation varies according to the pre-injury wage, in no event can it be less than 120 percent of the impairment compensation (Impairment compensation does not vary with the employee's pre-injury wage).

Note that impairment compensation is paid in addition to the benefits that replace lost income. It is paid in a lump sum if employees accept the employer's job offer and return to work. On the other hand, economic recovery compensation may replace lost income or it may go beyond income replacement because it is paid in full regardless of whether employees later find work on their own.

Death benefits

If an employee dies as the result of a work-related injury, workers' compensation provides benefits to the employees's dependents. The benefit amount varies with the number of dependents. If the deceased employee had a spouse but no dependent children, the spouse would receive a benefit equal to 50 percent of the employee's weekly wage for ten years. If the employee and spouse had one dependent child, the spouse would receive a benefit of 60 percent of the employee's weekly wage as long as the child is under 18 or is enrolled full time in school (up to 25 years old). Thereafter, benefits are 50 percent of the weekly wage for ten years. If there are two or more dependent children, the benefit would initially be two-thirds of the weekly wage and would be reduced to 50 percent as in the previous case.

Rehabilitation Benefits

Workers' compensation pays for all rehabilitation expenses. For injuries resulting in over 60 days of lost work time (30 days for back injuries), the employee must be evaluated for rehabilitation. Rehabilitation includes physical and vocational services.

Escalation of Benefits

If benefits for a long-term disabled employee remained constant, their real purchasing power would decline because of inflation. To help offset the effects of inflation, each of the wage-replacement benefits (temporary total, temporary partial, permanent total) and death benefits are adjusted annually on the anniversary date of the injury. These adjustments apply to injuries occurring after October 1, 1975. The adjustment is based on the percentage change in the statewide average wage, subject to a maximum annual adjustment of six percent.

Supplementary Benefits

Supplementary benefits ensure that employees who are totally disabled for at least four years will receive workers' compensation benefits equal to at least 65 percent of the average statewide weekly wage (currently, this is 65 percent of $376, or $245 per week). Supplementary benefits raise long-term disability benefits in three ways. First, they help bring benefits for employees injured prior to October 1975 in line with current benefit levels. Prior to October 1975, there was no escalator clause and benefits were lower than they are today, even after adjusting for wage inflation. Without supplementary benefits, employees injured prior to 1975 would receive $100 or less per week. In contrast, an employee with an average wage who is injured today would receive $251 per week in temporary total benefits.

Second, supplementary benefits raise the benefits for employees with below average wages. The minimum total disability benefit for employees who were injured in January 1988 is $188 per week or the employee's actual wage, whichever is less.[7] For long-term disabilities, supplementary benefits raise this minimum to $245 per week, regardless of the employee's pre-injury wage.

Finally, supplementary benefits restore benefits lost due to the "social security offset." This offset reduces permanent total benefits dollar for dollar for any social security benefits received by the employee (including both old age and disability benefits). The offset applies only to workers who are permanently and totally disabled and only after a total of $25,000 in weekly compensation has been paid. Chapter 5 discusses this topic in detail.

7 But not less than $75.20 per week.

Frequency and Cost of Workers' Compensation Benefits in Minnesota

Method

To understand why Minnesota's costs are high, it is useful to examine the types of cases and benefits that are responsible for most of the benefit cost. We examined several state and national data bases on workers' compensation costs. Unfortunately, no data base contains reliable and accessible data that breaks down costs into the different types of benefits described above. For example, the Department of Labor and Industry's data base contains data on the type and amount of benefits paid in Minnesota for injuries that occurred in 1983 or after, but it lacks data on long-term disabilities. This is a significant shortcoming because long-term disabilities make up a large share of the cost of workers' compensation. One reason for this problem is that many insurers do not regularly report payments made for cases while they are still open. Furthermore, the department does not collect data on costs incurred but not yet paid by insurers. As a result, the department's data does not include most of the cost attributable to long-term disabilities, even when insurers do make interim reports.

The cost estimates in this section are based on several data sources. To estimate Minnesota's overall costs, we used the financial aggregate data prepared by the Minnesota Workers' Compensation Insurers Association and cash flow projections of the Workers' Compensation Reinsurance Association (WCRA). We projected the year-by-year payout of both indemnity benefits and medical benefits for policy year 1985.[8] We used estimates made by the actuary for the Department of Commerce for permanent total benefits and death benefits.[9] To estimate permanency benefits, we used data from the Department of Labor and Industry, the industry's statistical data, and WCRA data. We used the Department of Labor and Industry's data to estimate supplementary benefit expenses and second injury fund expenses. In addition, the industry's statistical reports have useful data on the frequency of certain types of benefits.

Combining these data bases minimizes several of the shortcomings of individual data bases, but some shortcomings remain. In particular, none of the data bases has complete data on disabilities lasting longer than three years. Furthermore, combining data from different data bases adds uncertainty to our estimates. Our estimates should not be viewed as precise measures of the cost of particular benefits, but rather as indicators of relative contribution towards Minnesota's benefit costs.

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8 The projections for the first eight years were based on the financial aggregate data presented in the rate-making report of the Minnesota Workers' Compensation Insurers Association. Since this data source does not project costs on a year-by-year basis beyond eight years, we examined the simulated cash flow projections of the Workers' Compensation Reinsurance Association. We used these projections for "years 27" and beyond (based on the assumption that almost all payments beyond "year 27" would be paid by the WCRA). We estimated payments in "years 9 through 26" by smoothing out the curve of projected payments.

9 These estimates were based on WCRA data and the supplementary benefit data of the Department of Labor and Industry.

For Minnesota's costs, we estimated the present value of benefits, based on a discount rate of seven percent per year. Discounting benefits recognizes the investment income that insurers can make on premiums used to pay future benefits. Discounting is necessary in order to compare the cost of different types of benefits. For example, the undiscounted cost of 30 years of permanent total benefits is about three times as large as the cost discounted at seven percent per year.[10] Without discounting, permanent total benefits would appear much more significant than they really are.

Workers' Compensation Cost by Type of Benefit

One way to examine workers' compensation costs is to break down the costs by type of benefit. Knowing the relative cost of each benefit type should help the Legislature identify where significant cost savings are possible.

Wage-replacement benefits account for about 52 percent of Minnesota's total benefit cost.

We estimate that Minnesota employees injured during 1986 will receive about $479 million in benefits, including $126 million in medical benefits, $327 million in indemnity benefits, and $26 million in second injury payments. These estimates do not include benefits paid by self-insured employers, who make up about 24 percent of the workers' compensation market. Table 3.3 and Figure 3.3 summarize our estimates of the frequency and cost of workers' compensation benefits in Minnesota for injuries during 1986.

- **Most of Minnesota's benefit cost is due to wage-replacement benefits, including permanent total, temporary total, temporary partial, and supplementary benefits. Wage-replacement benefits account for about 52 percent of Minnesota's total benefit cost. This cost can be divided among temporary benefits (33 percent of the total benefit cost), permanent total benefits (11 percent) and supplementary benefits (8 percent).[11] Most of the supplementary benefits goes to permanent total cases.[12]**

- **Medical benefits account for about 28 percent of the total benefit cost.**

- **Permanency benefits (impairment compensation and economic recovery compensation) account for about 13 percent of the total benefit cost.**

Death benefits and vocational rehabilitation benefits each account for about 3 percent of the total benefit cost.

These results indicate that wage-replacement benefits constitute a major part of Minnesota's workers' compensation costs. Thus, the questions of when temporary benefits should end and what should be the eligibility criteria for permanent total benefits appear to be very significant cost issues.

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10 This assumes that benefits are escalated at five or six percent per year.

11 the permanent total benefits include temporary benefits paid for the employees lifetime and settlements paid in lieu of lifetime benefits.

12 The estimate for supplementary benefits is based on expenses for fiscal year 1987. It is not an estimate of future costs incurred due to injuries in a single year.

	Frequency	Average Cost	Total Cost (in millions)
MEDICAL BENEFITS	117,100	$ 1,076	$126.0
INDEMNITY BENEFITS			
Wage-Replacement Benefits			
Temporary	30,000	5,000	150.0
Permanent Total	268	186,600	50.0
Supplementary Benefits[b]	--	--	38.4
Permanent Partial[a]	7,000	8,570	60.0
Death	89	150,000	13.4
Vocational Rehabilitation	--		15.0
Indemnity Subtotal	32,000	$ 10,212	$326.8
SECOND INJURY BENEFITS[b]	--		26.4
TOTAL	117,100	$ 4,092	$479.2

NOTE: These estimates exclude self-insurers. Benefits are expressed in current dollars based on an annual discount rate of seven percent.

Source: Program Evaluation Division estimates based on data from the Department of Labor and Industry, the Workers' Compensation Reinsurance Association, and the Minnesota Workers' Compensation Insurers Association.

[a]Includes impairment and economic recovery compensation.

[b]Supplementary benefits and second injury expenses were estimated by multiplying expenses for fiscal year 1987 by 79 percent to remove the self-insurers' share. This adjustment is based on the percent of WCRA claims made by self-insurers.

Table 3.3: Frequency and Cost of Workers' Compensation Benefits By Type of Benefit Accident Year 1986

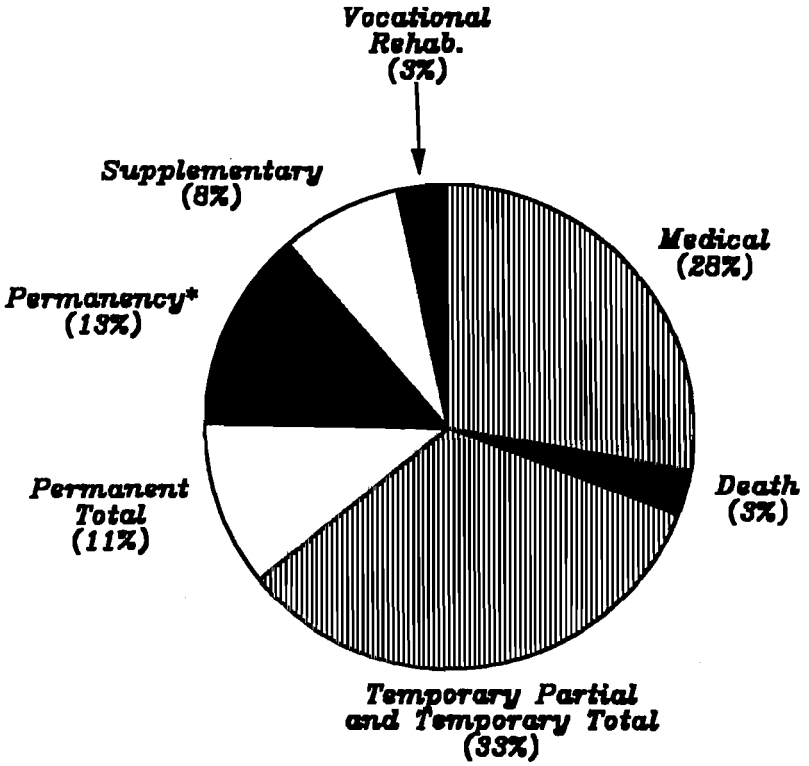
Workers' compensation costs by type of case

Another way to examine workers' compensation costs is to divide the costs according to the type of case. The types of cases we use are:

- Medical only: The employee is out of work for three days or less and receives only medical benefits.

- Minor indemnity cases: The employee receives up to one year of temporary benefits or a combination of temporary benefits and permanent partial benefits that do not exceed $18,000. These cases are essentially short-term disabilities.

- Major indemnity cases: The employee dies, is permanently totally disabled, receives temporary total benefits for more than one year, or is permanently disabled and receives more than $18,000 in indemnity benefits. These are essentially long-term disabilities.



Source: Program Evaluation Division estimates based on data from the Department of Labor and Industry, the Workers' Compensation Reinsurance Association, and the Minnesota Workers' Compensation Insurers Association.

*Includes impairment compensation and economic recovery compensation.

Figure 3.3: Cost of Workers' Compensation Benefits by Type of Benefit Accident Year 1986

Figure 3.4 and Table 3.4 summarize the frequency and cost of different types of cases. In most workers' compensation cases, the employee is out of work for less than three days and has no permanent injury. These cases, in which workers' compensation pays for only the medical costs, make up 72 percent of the cases but only 3 percent of the total benefit cost.

Claims involving more than three days of lost time or a permanent injury are called indemnity cases. Again, most of these cases are short-term and inexpensive. Minor indemnity cases account for about 25 percent of all cases (or about 90 percent of indemnity cases) and about 24 percent of the total benefit cost. In approximately half of all indemnity cases, the injured employee returns to work within two weeks. In about 90 percent of the indemnity cases, the employee returns to work within one year. As one would expect, these short-term cases are common but are not responsible for most of the cost. On the other hand:

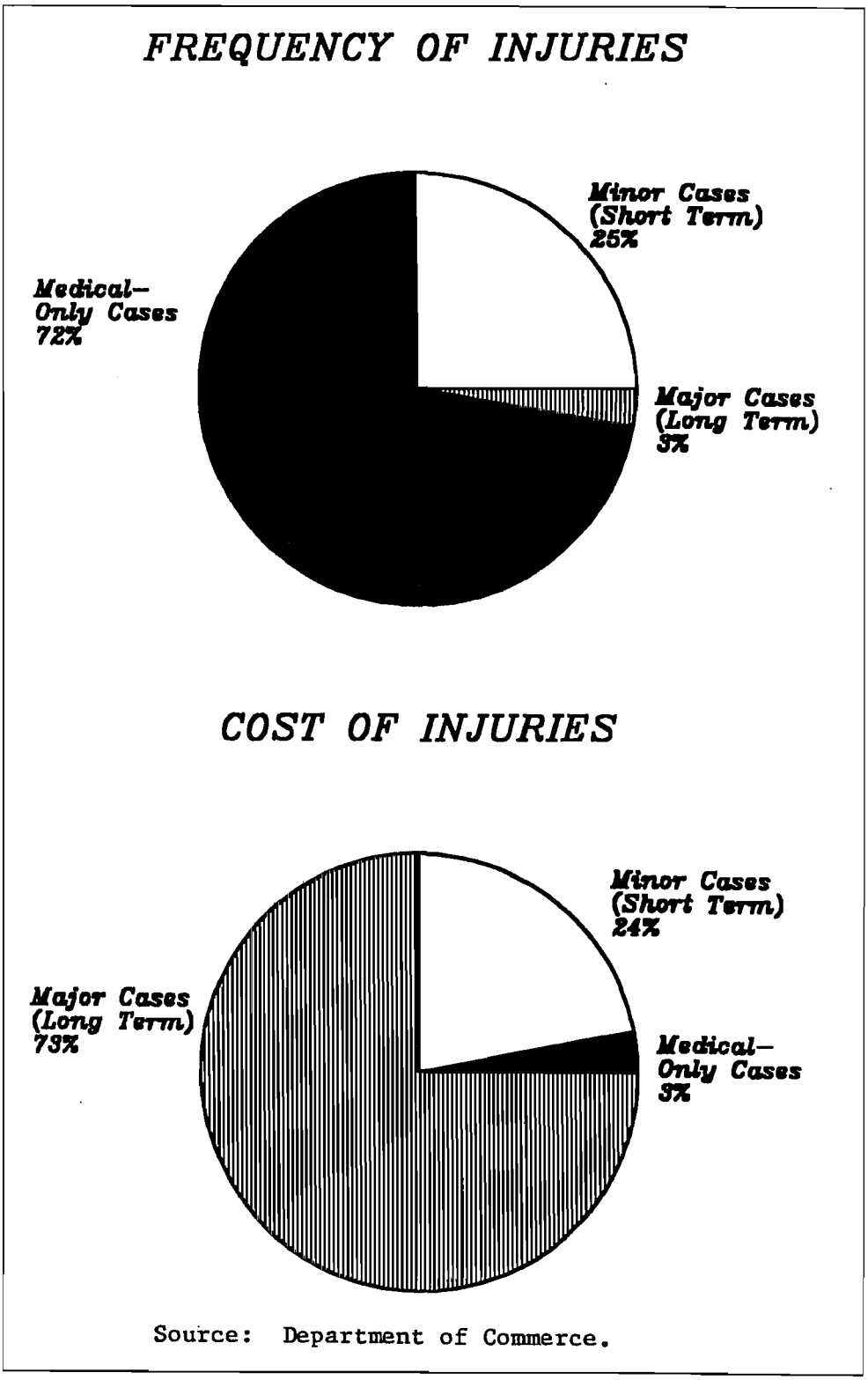


Figure 3.4: Frequency and Cost of Workers' Compensation Injuries By Type of Case

	Frequency	Average Cost	Total Cost (in millions)
Medical Only	81,852	$ 195	$ 16.0
Minor Indemnity			
Temporary Total (short term)	25,192	2,963	$ 74.6
Minor Permanent Partial	3,186	13,485	43.0
SUBTOTAL	28,378	$ 4,144	$117.6
Major Indemnity			
Death	89	$161,087	$ 14.4
Permanent Total	268	274,816	73.7
Supplementary Benefits	---	---	38.4
Major Permanent Partial (including long term temporary total)	2,637	86,851	229.0
SUBTOTAL	2,994	$118,738	$355.5
TOTAL	113,225	$ 4,320	$489.1

Source: Department of Commerce and Department of Labor and Industry.

NOTE: These estimates exclude self-insurers and second injury fund expenses. Death and Permanent Total figures are based on WCRA data and supplementary benefit data from the Department of Labor and Industry. Other data is based on the insurance industry's unit statistical plan data. Cost projections were developed to ultimate cost and discounted at seven percent per year.

Table 3.4: Frequency and Cost of Workers' Compensation Benefits By Type of Case Policy Year 1987

- **Major indemnity cases (essentially long-term disabilities) account for 3 percent of the cases, but 73 percent of the total benefit cost.**

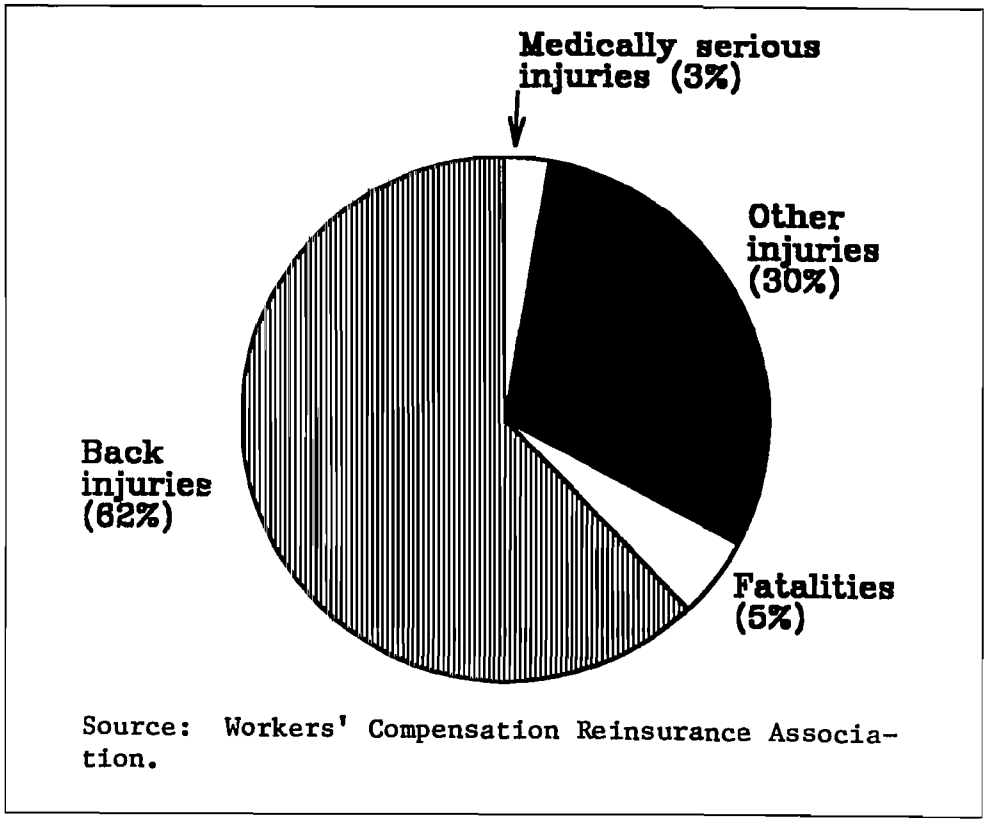
Long-term Disability Cases

If the Legislature wants to reduce the cost of the workers' compensation system, it should focus on the benefits received by long-term disability cases.

If the Legislature wants to reduce significantly the cost of the workers' compensation system, it should focus primarily on the benefits received by long-term disability cases. To help determine the appropriateness of benefits received by these cases, it is useful to know their characteristics, such as the type of injury. This may also help us understand whether the system's incentives to return injured employees to work need to be strengthened for these cases.

Data on the characteristics of all long-term disability cases are not readily available. Instead, we examined claims included in Minnesota's reinsurance system. These claims tend to be the most expensive of the long-term disability cases. The Workers' Compensation Reinsurance Association (WCRA) reimburses primary insurers for claim payments that exceed the insurer's retention limit (in 1987, insurers could choose limits of either $170,000 or $370,000 per accident). In exchange for this coverage, insurers pay premiums to the WCRA.

The WCRA estimates that between 350 and 450 injuries (including self insurers) occur each year for which it will eventually make payments. Thus, these cases represent roughly ten percent of the total long-term disability cases (3,000 cases, not including self insurers). Figure 3.5 illustrates the type of injuries for which it expects to make payments for accident years 1981 and 1982. We used data from 1981 and 1982 because it takes many years before certain injuries, particularly back injuries, are reported to the WCRA.



Source: Workers' Compensation Reinsurance Association.

Figure 3.5: Types of Injuries Reported to the Workers' Compensation Reinsurance Association 1981-82

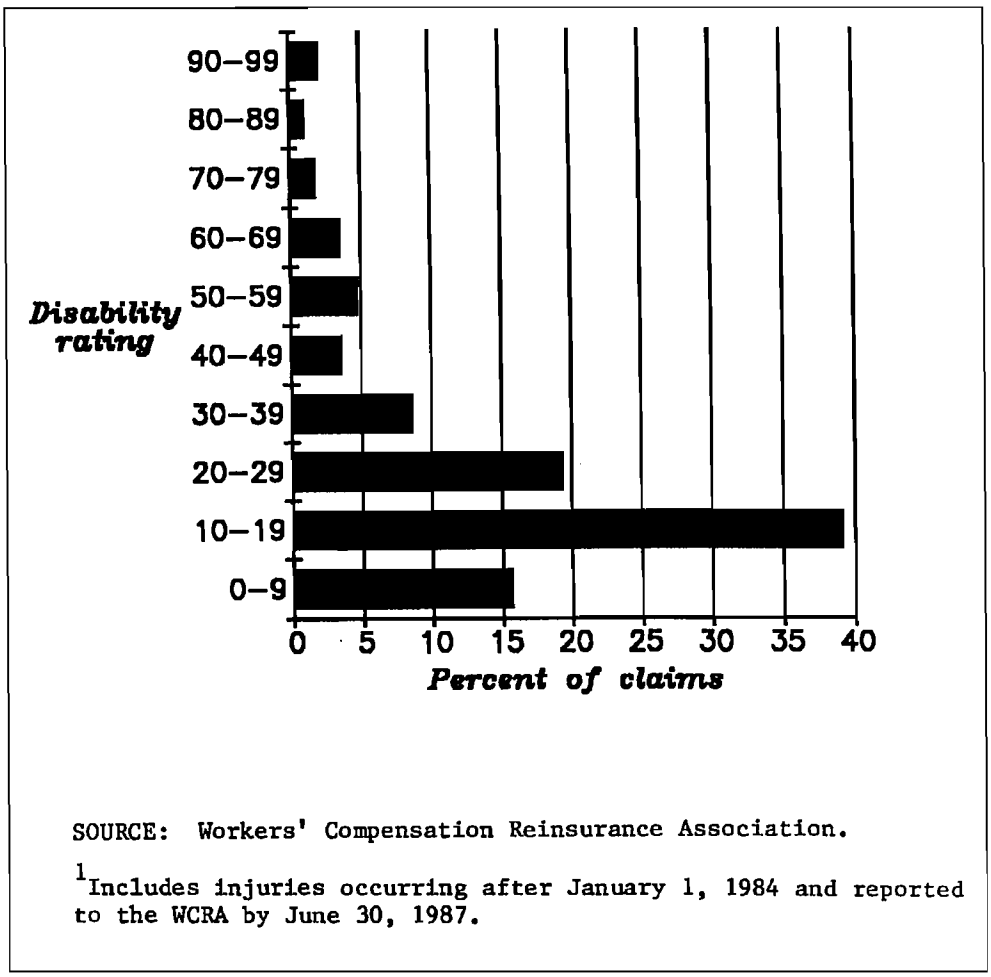
A majority of Minnesota's most expensive workers' compensation cases are back injuries.

- **About five percent of these expensive cases involved fatalities and about three percent involved medically serious injuries. These serious injuries include heart disease, brain damage, quadriplegia, paraplegia, serious burns, and serious occupational diseases.**

- **About 62 percent of the expensive cases involved back injuries.**

The prevalence of back injuries among expensive cases has important implications. Since it is difficult to objectively measure the severity of some back injuries, these are the injuries where work incentives are especially important.

Another indicator of the seriousness of injuries is the disability rating established to award impairment compensation and economic recovery compensation. These ratings, based on medical criteria, express the disability as a percent of the whole body. Figure 3.6 summarizes the disability ratings of in-



SOURCE: Workers' Compensation Reinsurance Association.

[1]Includes injuries occurring after January 1, 1984 and reported to the WCRA by June 30, 1987.

Figure 3.6: Disability Ratings for Injuries Reported to the WCRA[1]

juries that occurred after January 1, 1984 and that were reported to the reinsurance association by June 30, 1987.

- **The median disability rating of injuries reported to the reinsurance association was about 16 percent.**

The above ratings are based on 644 injuries that occurred after January 1, 1984, including about 300 injuries that occurred during 1984. For each accident year, the WCRA expects that about 800 to 900 cases will eventually be reported. The WCRA expects that almost half of these cases will exceed the insurer's retention limit.

As a result, the actual median rating may be less than 16 percent because the most serious disabilities are reported to the WCRA very soon after the injury. Many back injuries and other disabilities are not reported until it becomes apparent that the disability will be prolonged.

Department of Labor and Industry and insurance company personnel assert that people often receive wage-replacement benefits for many years (includ-

ing many who receive benefits for life) even though they are physically able to work. The prevalance of injuries with low disability ratings supports this claim. Undoubtedly, many of these employees held physically demanding jobs which they can no longer perform because of their disability. However, the issue is whether an injury that restricts but does not eliminate the employee's job opportunities entitles the employee to lifetime benefits.

In Chapter 6, we illustrate how employees can collect full workers' compensation benefits indefinitely even though they are capable of working. For example, full benefits may be given indefinitely to employees who have minor permanent disabilities, are not offered "suitable" jobs by the employer, and look for work but refuse "light duty" jobs because they consider them undesireable. In addition, some employees are collecting workers' compensation benefits indefinitely because there are no job opportunities where they live and they do not want to move.

To illustrate how expensive it is to provide lifetime benefits for employees who are capable of working, consider a typical lifetime claim. If a male employee who was injured when he was 40 lives until he is 75, he would have collected about $1.3 million in income benefits (assuming his pre-injury gross wage equaled $376 per week, the statewide average weekly wage). The present value of these benefits would be about $362,000.[13]

Cost Differences

In this section, we estimate the cost of the cost-of-living escalator clause, minimum and maximum benefits, and supplementary benefits. Except for supplementary benefits, these estimates were based on data that excluded self insurers. Self insurers represent 24 percent of the workers' compensation market in Minnesota.

Cost of the Escalator Clause

To estimate the cost of the escalator clause, we first projected the year-by-year payout of indemnity benefits for policy year 1985. We next subtracted benefit payments that are not eligible for the escalator clause, including impairment compensation, economic recovery compensation, and vocational rehabilitation benefits. The data we used already excluded medical and supplementary benefits, which are also not eligible for the escalator clause.

In order to calculate the cost of escalation for each payment year, we then estimated what the benefits would have been without escalation.[14] We discounted these costs at 7 percent per year to estimate the present value of escalation. This estimate does not include any effects that the escalator clause may have on extending time off work nor does it include the cost for self insurers.

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13 This is based on a discount rate of seven percent per year.

14 For each payment year, we divided the benefits eligible for escalation that were paid during that year by 1.055 raised to the nth power where n is the number of years between the payment year and the accident year.

- **We estimate that the cost of Minnesota's escalator clause is about $45 million for accident year 1986, or about 9.4 percent of the total benefit cost.**

Estimating the cost that would be saved by reducing escalated benefits is complicated by the fact that supplementary benefits would partially offset reductions in escalated benefits. For example, if the supplementary benefit law remains unchanged, reducing escalated benefits would have no effect on employees with below average wages who are eligible for supplementary benefits (currently, employees who have been totally disabled for more than four years are eligible for supplementary benefits). This is because supplementary benefits, in effect, escalate benefits for employees whose regular benefit is less than 65 percent of the statewide average wage.

In 1986, the escalator clause cost about $45 million and minimum benefits cost more than $11 million.

Cost of Minimum Benefits

Minimum benefits apply to temporary total and permanent total benefits. The cost of minimum benefits depends on the amount of these benefits paid and the wage distribution of the employees who receive these benefits. To estimate the cost of minimum benefits, we used our estimates of benefits for accident year 1986 and the wage distribution of injured employees who filed claims with the Department of Labor and Industry between October 1986 and September 1987. This estimate does not include any effects that the minimum may have on the time employees stay out of work nor does it include the cost for self insurers.

- **We estimate that the direct cost of minimum benefits is about $11.4 million for accident year 1986. This is about 5.7 percent of the cost of temporary and permanent total benefits, or 2.4 percent of the total benefit cost.**

Estimating the cost that would be saved by reducing the minimum benefit is more complicated. As long as supplementary benefits have a minimum benefit which equals or exceeds 50 percent of the statewide average wage, reducing the minimum for total disability benefits would not affect the employee's overall benefit once they become eligible for supplementary benefits (currently, supplementary benefits begin four years after the employee's injury). Our cost estimate above includes the cost of the total disability minimum for all years of the disability.

Cost Savings Attributable to the Maximum Benefit

We estimated the cost savings attributable to the maximum benefit for temporary and permanent total benefits. We used the same data that we used to estimate the cost of the minimum benefits. This estimate does not include the cost for self insurers.

- **We estimate that the direct cost savings due to the maximum benefit is about $13.6 million. This is about 6.8 percent of the cost of temporary total and permanent total benefits.**

Cost of Supplementary Benefits

Unlike most benefits, supplementary benefits are financed by assessments levied against insurers in proportion to each insurer's paid indemnity losses. In effect, supplementary benefits are financed on a pay-as-you-go basis. Thus, costs are normally reported in terms of losses paid during a given year for all past injuries. In fiscal year 1987, supplementary benefit expenses were $48.6 million. Assuming that self insurers account for 20.8 percent of this cost, the insured employers' share is $38.5 million.[15] A study by the Department of Labor and Industry indicates that:

- **Approximately half of supplementary benefits are paid to persons over the age of 65.**

The main reason for this is that supplementary benefits restore the social security offset. In fact, the department estimates that the restoration of the social security offset accounts for 38.5 percent of supplementary benefits(excluding cash settlements).

The department's study also estimated that the unfunded liability of supplementary benefits is over $900 million. This represents the department's projected cost for workers who have already made claims for supplementary benefits. This may be a conservative estimate because many workers who have already been injured will become eligible for supplementary benefits once they begin collecting social security benefits.

Interstate Cost Comparisons

Table 3.5 and Figure 3.7 show how Minnesota's benefit cost compares with other states and how much of the difference is due to medical benefits and

80 percent of the cost difference between Minnesota and Wisconsin is explained by indemnity costs, 20 percent by medical costs.

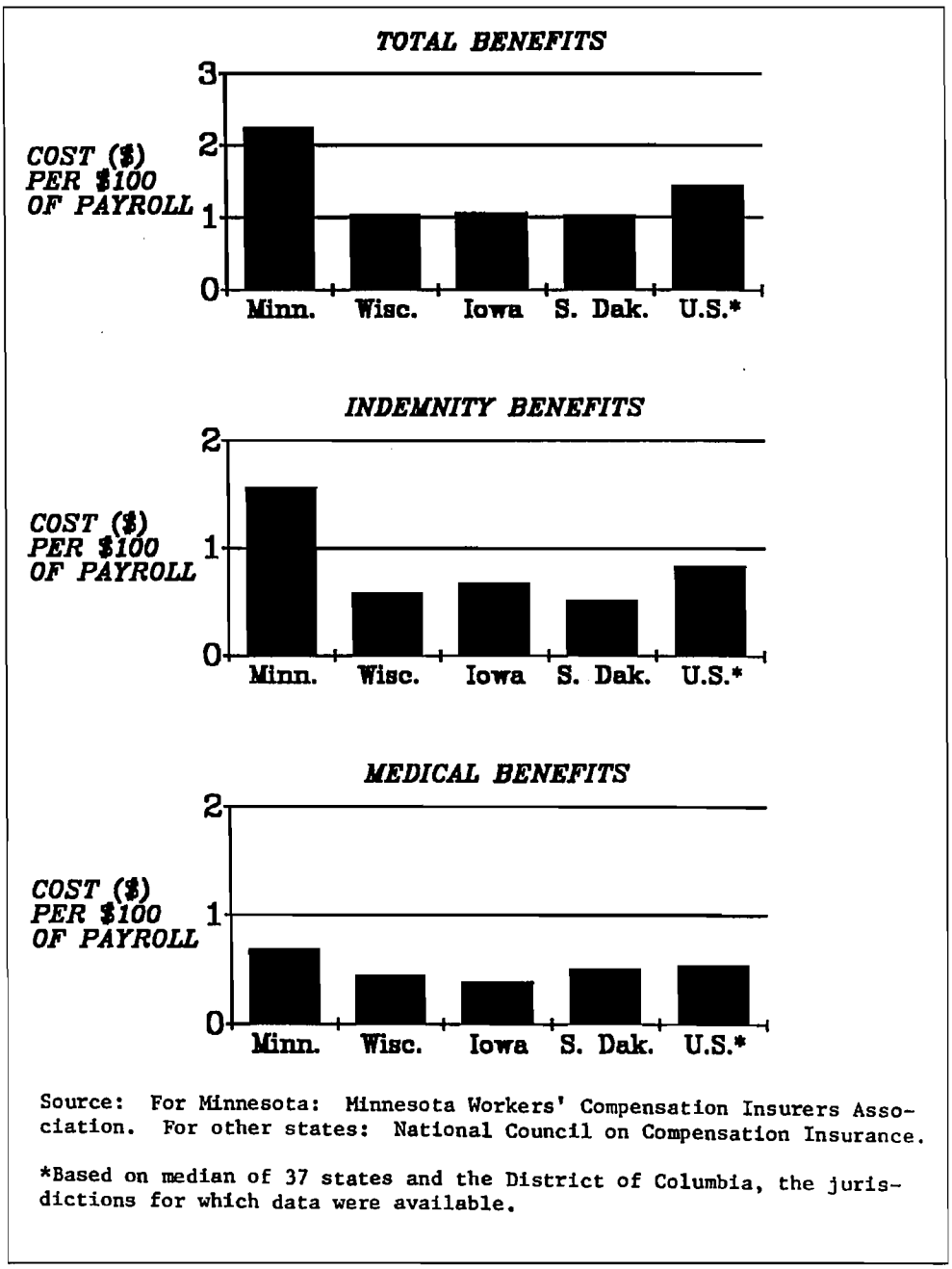
	Cost Per $100 of Payroll		
	Total Benefits	Indemnity Benefits	Medical Benefits
Minnesota	$2.25	$1.57	$.69
Wisconsin	1.05	.59	.45
Iowa	1.07	.68	.39
South Dakota	1.03	.52	.51
National Median[a]	$1.45	$ .84	$.55

Source: Cost data and payroll data were obtained from the National Council on Compensation Insurance.

[a]Based on 37 states and the District of Columbia, the jurisdictions for which data were available.

Table 3.5: Interstate Comparison of Workers' Compensation Benefit Costs Policy Year 1983

15 This assumption is based on the percentage of claims reported to the WCRA that were self insured.



Source: For Minnesota: Minnesota Workers' Compensation Insurers Association. For other states: National Council on Compensation Insurance.

*Based on median of 37 states and the District of Columbia, the jurisdictions for which data were available.

Figure 3.7: Interstate Comparison of Workers' Compensation Benefit Costs By Type of Benefit Policy Year 1983

how much is due to indemnity benefits. These comparisons are based on insurance industry data for policy year 1983, the most recent year for which national comparative data were available.

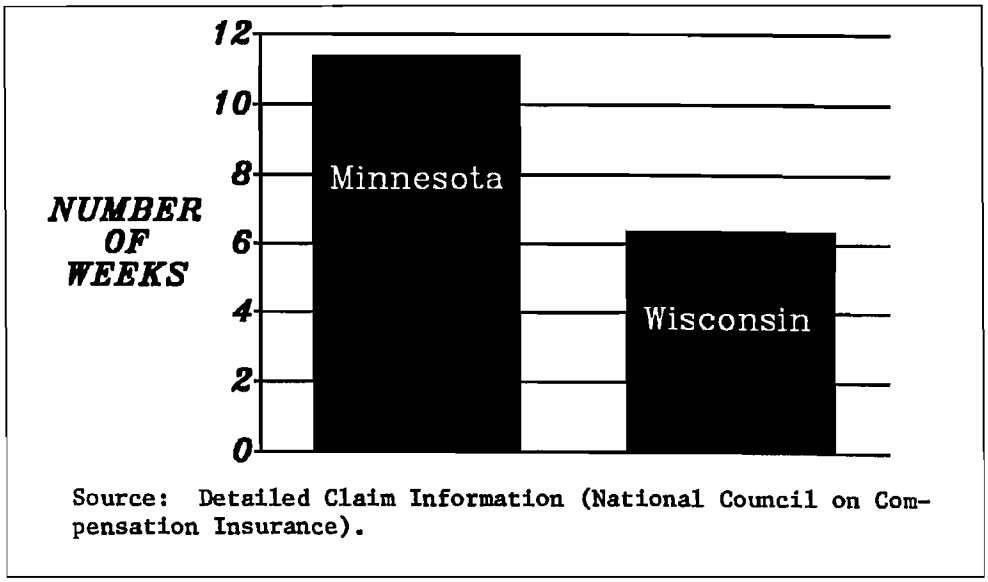
- **Minnesota's benefit cost was $2.25 per $100 of payroll, about 55 percent higher than the national median of $1.45 and more than twice as high as the cost in Wisconsin, Iowa, and South Dakota.**

- **Most of the difference in costs is explained by indemnity costs. For example, indemnity benefits explain 80 percent of the cost difference between Minnesota and Wisconsin, whereas medical benefits explain 20 percent.**

- **Medical costs for workers' compensation are higher in Minnesota than neighboring states, but not by as large a percentage as for indemnity benefits. For example, Minnesota's indemnity costs are 166 percent higher than Wisconsin's, but its medical costs are 53 percent higher.**

To help understand why Minnesota's indemnity costs are so much higher than Wisconsin's, we examined the Detailed Claim Information data from the National Coucil on Compensation Insurance. As Figure 3.8 shows, for accident years 1980 through 1982:

- **The average duration of temporary total benefits was 11.4 weeks in Minnesota, compared to 6.4 weeks in Wisconsin. A difference of five weeks per indemnity case would have cost about $33.3 million in policy year 1983, and would explain about 16 percent of the difference between Minnesota's benefit cost and Wisconsin's cost.**



Source: Detailed Claim Information (National Council on Compensation Insurance).

Figure 3.8: Average Duration of Temporary Total Benefits In Minnesota and Wisconsin Accident Years 1980-82

Employees in Minnesota collect temporary total benefits significantly longer in Minnesota than in Wisconsin.

Since these comparisons were based on accident years 1980 through 1982, one may argue that the results would be different if the comparison were made after January 1, 1984, the date the 1983 changes to the benefit structure took effect. One objective of the 1983 law was to reduce the time it takes to get employees back to work. However, the NCCI data indicate that the average temporary total duration for accident year 1984 was about one-fourth of a week longer than it was for accident years 1980 through 1982

(though the average duration for 1984 was about two-thirds of a week less than the average duration for 1983).[17] Thus, we believe that employees in Minnesota continue to collect temporary total benefits significantly longer in Minnesota than in Wisconsin.

The fluctuations in average duration between 1980 and 1984 are not large enough to conclude that any definite trend is occurring. While it is still early to judge the effects of the 1983 law, this data does indicate that it has not yet caused a major reduction in temporary total duration.

The fact that Minnesota's medical benefits are higher does not necessarily imply that Minnesota treats medical expenses differently than other states. Rather, it may simply reflect the fact that Minnesota's injured employees tend to stay out of work longer than in other states.

Interstate Comparison of Statutory Benefits

In this section, we compare Minnesota's statutory benefits with those in other states. We compare medical, temporary total, permanent total, and temporary partial benefits. We do not compare permanent partial benefits because they are difficult to compare among different states without detailed knowledge of how the system operates in each state.

We focus on total disability benefits (temporary and permanent) because they make up a large share of benefit payments, they can readily be compared on the basis of statutory formula, and these benefits vary considerably among the states. We examine the basic benefit, minimums and maximums, and various adjustments to benefit levels, including cost of living adjustments.

The information for other states is based primarily on state summaries prepared by the U.S. Chamber of Commerce and the U.S. Department of Labor.[18] We also examined state statutes for Wisconsin, Iowa, and several other states. Most of the information is as of January 1, 1987.

Medical Benefits

Medical benefits do not vary much across the nation. All states provide medical benefits to cover the full cost of treating work-related injuries. No state has limits on the amount or duration of medical benefits.

17 These figures are based on reports made 30 months after the injury for each accident year.

18 U.S. Chamber of Commerce, *1987 Analysis of Workers Compensation Laws* (Washington D.C.: 1987); U.S. Department of Labor, Division of State Workers' Compensation Programs, *State Workers' Compensation Programs: Administration Profiles*, October 1986

Total Disability Benefits

In most states, temporary total and permanent total disability benefits equal two-thirds of the worker's pre-injury wage, subject to minimum and maximum payments. Benefits are usually payable for the duration of the disability, though some states have specific time limits or amount limits.

Minnesota is one of 42 states with a basic benefit of two-thirds of the employee's pre-injury wage.[19] States with this basic benefit include Wisconsin, South Dakota, and North Dakota. This benefit is tax free from both federal and state income taxes. Three states (Iowa, Michigan, and Alaska) and the District of Columbia pay 80 percent of spendable earnings. The other five states pay various percentages of pre-injury wages, ranging from 60 percent to 75 percent. Eight states provide a small additional benefit for dependent children, ranging from $2.50 to $22 per week per child.

Most states provide temporary and permanent disability benefits for the duration of the healing period. Fifteen states have specific time or amount limits for temporary total benefits. The time limits range from 150 weeks to 600 weeks. The amount limits range from $32,550 to $179,178.

Minnesota and its neighboring states do not have specific time or amount limits for temporary total benefits. However, whereas Minnesota terminates temporary total benefits no later than 90 days after maximum medical improvement, Wisconsin and Iowa stop paying temporary total benefits immediately upon maximum medical improvement.

Seven states also have time or amount limits for permanent disability benefits, though in some of these states the limits do not apply to specified serious injuries. As with temporary total benefits, Minnesota and its neighboring states do not have specific time or amount limits for permanent total benefits.

Minimum Benefits

All states except Rhode Island have minimum benefits for temporary and permanent total disabilities. Minimum benefits vary among the states both in form and in amount.[20] Minimum benefits used by states can be divided into two forms: those that do not allow the benefit to exceed the worker's pre-injury wage and those that do.

As of January 1, 1987, twenty-one states and the District of Columbia have a minimum benefit, but do not allow the benefit to exceed the worker's pre-injury wage. Under this type of minimum, workers with low wages can receive benefits up to 100 percent of their wage instead of the normal 66 and 2/3 percent.

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19 While Wyoming's temporary total benefit equals two-thirds of the worker's wage, its permanent total benefit equals two-thirds of the state average weekly wage plus $100 per month per child.

20 C. Arthur Williams, "Minimum Weekly Benefits", in Worrall and Appel, editors, *Workers' Compensation Benefits: Adequacy, Equity, and Efficiency* (ILR Press, Cornell University: 1985).

Twenty states have minimums which apply regardless of the worker's pre-injury wage. As a result, some workers may receive more benefits per week than they earned while working.

Minnesota is one of four states that use a combination of the above two forms. Minnesota's weekly minimum benefit is 50 percent of the statewide average weekly wage (in January 1987, the minimum was $180) or the employee's pre-injury weekly wage, whichever is less. In no case can the weekly benefit be less than 20 percent of the statewide average weekly wage ($72 in January 1987), regardless of the employees pre-injury wage. These minimums are adjusted annually on October 1st based on the change in the statewide average weekly wage.

Minnesota's minimum benefit is considerably higher than the minimum in most other states.

Minnesota's minimum benefit is considerably higher than the minimum in most other states. Whereas Minnesota's minimum is $180 per week, half of the states have minimums of $75 or less. Only one state has a temporary total minimum that exceeds $180, and only three states have permanent total minimums that exceed $180. While about six states have absolute minimums greater than Minnesota's absolute minimum of $72, ranging from $75 to $139, the percent of employees affected by these absolute minimums is very small. Since these states do not also have a higher second minimum, Minnesota's minimum affects a substantially higher percentage of injured employees.

Among neighboring states, Minnesota's minimum is much higher than minimums in Wisconsin ($20), Iowa ($107), and South Dakota ($131). It is slightly higher than North Dakota's ($178). The minimums in North Dakota and South Dakota are capped by the worker's pre-injury wage and Iowa's minimum is capped by the worker's spendable earnings.

We estimated how many injured workers in Minnesota would receive higher benefits under various minimum benefits based on the wage distribution of injured workers whose claims are reported to the Department of Labor and Industry. Whereas 37 percent of Minnesota's disabled workers receive additional benefits under the current minimum, only seven percent would receive additional benefits if Minnesota adopted a minimum benefit of $75 (the national median). Similarly, Wisconsin's minimum would benefit only one percent of Minnesota's disabled workers. The comparable percentages for other border states are 14 percent for Iowa, 21 percent for South Dakota, and 36 percent for North Dakota.

Maximum benefits

All states have maximum benefits for temporary and permanent disability. Minnesota is one of 24 states that have a maximum equal to 100 percent of the state's average wage. Five states (Iowa, Illinois, Vermont, New Hampshire, and Alaska) and the District of Columbia have higher maximums than Minnesota, ranging as high as 200 percent of the state's average wage. Eleven states have maximums that are less than $240 per week, compared to Minnesota's maximum of $360 per week.

Temporary Partial Benefits

Minnesota, Wisconsin, and Iowa all pay temporary partial benefits equal to two-thirds of the difference between the employees current wage and the pre-

injury wage. However, while Wisconsin and Iowa do not let temporary partial benefits last beyond maximum medical improvement, Minnesota allows temporary partial benefits to last indefinitely.

Cost of Living Adjustments and Supplementary Benefits

Minnesota's escalator clause and supplementary benefits make its long-term disability benefit structure one of the most generous in the nation.

Some states periodically adjust benefits for long-term disabilities to keep up with inflation, to bring old benefit levels in line with current benefit levels, or to provide a higher minimum for long term disabilities. These adjustments are usually called cost-of-living adjustments, escalator clauses, or supplementary benefits. Minnesota's escalator clause and supplementary benefits make its long term disability benefit structure one of the most generous in the nation.

The District of Columbia and ten states, including Minnesota, automatically adjust benefits to protect long-term disabled employees from inflation. The other states are California, Connecticut, Idaho, Illinois, Maine, Massachusetts, New Hampshire, Vermont, and Washington. Each of these states makes adjustments annually based on the change in a wage index or a price index. In addition, Oregon adjusts benefits as funds permit.

However, states vary in the type of restrictions applied to the adjustments. Minnesota is one of three jurisdictions that limits the annual change to a fixed percentage. Minnesota has a six percent cap; Maine and the District of Columbia have five percent caps.

In other respects, however, Minnesota is less restrictive than many of the states that have automatic benefit adjustments. While Minnesota's escalator covers permanent total, temporary total, temporary partial, and death benefits, several states apply the adjustment to only some of these benefits. California covers only temporary benefits; Illinois covers only permanent total benefits; Idaho excludes death benefits; Massachusetts excludes temporary benefits. New Hampshire excludes persons who receive Social Security Disability (SSDI) benefits. Connecticut does not apply the adjustment if the workers' compensation benefit exceeds 80 percent of the weekly wage. Virginia does not apply the adjustment if the sum of workers' compensation and social security disability benefits exceeds 80 percent of the average wage. California and New Hampshire delay adjustments until two or three years after the injury.

Minnesota is one of about twelve states that use supplementary benefits to retroactively bring benefit levels for those injured in the past in line with current levels. Five of these states, including Minnesota, use supplementary benefits to establish minimum benefit levels for old injuries, regardless of the employee's wage. Washington is the only state with a supplementary benefit level that is almost as high as Minnesota's, though it only applies to injuries prior to July 1971.[21] Minnesota's supplementary benefit level (65 percent of the state's average wage) is between 50 and 100 percent higher than the levels in the other three states.

21 Washington's supplementary benefits raise weekly benefits up to 50 percent of the statewide average weekly wage, plus five percent for a spouse and two percent for each child up to a maximum of five children. Thus, for a family of five or more children, the supplementary benefit level would equal Minnesota's level.

Seven states, including Wisconsin, make retroactive adjustments based on the change in the state's wage index since the time of injury. However, several of these states restrict the adjustments to injuries occuring in certain years or fail to bring benefits up to current levels. For example, Wisconsin's supplementary benefits increase the benefits of employees with old injuries only to the 1972 benefit level. Moreover, merely escalating benefits for old injuries does not necessarily bring benefits up to current levels. Prior to 1975, benefits across the nation replaced a smaller percentage of the employees pre-injury wage than they do today. Retroactive escalators based on a wage index compensate for wage inflation but do not compensate for the low benefit levels existing a decade or longer ago.

In addition to increasing benefits for those injured in the past, Minnesota's supplementary benefits also increase the benefits for current long-term disabilities. They guarantee that effective four years after the injury, temporary and permanent total benefits will be at least 65 percent of the state's average wage. In effect, this establishes a minimum benefit level for long-term injuries. Wyoming is the only state with a minimum benefit level for long-term disabilities higher than Minnesota's.[22]

Offsets for Other Benefit Programs

As we discussed earlier, injured employees may receive benefits from other private or governmental programs, including social security disability benefits (SSDI), social security old age benefits, unemployment compensation, and private disability or retirement programs. As of January 1987, 22 states, including Minnesota and Wisconsin, had offsets for one or more of these programs. In addition, two states do not apply the cost-of-living escalator to employees who receive certain social security benefits. We did not compare how each of these offsets works, but three factors greatly limit the ability of Minnesota's offset to reduce benefits. First, it applies only to permanent total disabilities. Second, it does not take effect until $25,000 in income benefits have been paid. Finally, supplementary benefits usually restores most, if not all, of the benefits lost because of the offset after the disability lasts more than four years.

Minnesota is the only state that allows long-term disabled employees to collect a full social security disability benefit plus nearly a full workers' compensation benefit.

In one significant way, however, Minnesota's treatment of SSDI benefits and workers' compensation benefits is the most generous in the nation. For most states, the federal government limits SSDI benefits so that the sum of SSDI benefits and workers' compensation benefits does not exceed 80 percent of the pre-injury wage. The exceptions are eleven states, including Minnesota, that had their own offset prior to the time that the federal offset was enacted. However, Minnesota's supplementary benefits also apply to disabled employees whose workers' compensation benefit was reduced because of the social security offset. As a result, Minnesota is the only state that allows long-term disabled employees to collect a full social security disability benefit plus nearly a full workers' compensation benefit.

In summary, Minnesota's benefit structure is one of the most generous in the nation. While its basic benefit and its maximum benefit are close to the national average, its benefits are considerably more generous than most other states in the following ways:

22 Wyoming provides a flat benefit rate of two-thirds of the statewide average weekly wage for all permanent total cases.

- **Minnesota is one of twelve states that has automatic cost-of-living escalation of benefits.**

- **Minnesota is one of about twelve states that has supplementary benefits designed to bring benefit levels for old long-term disabilities in line with current benefit levels. Minnesota's supplementary benefits are much more generous than the supplementary benefits provided in these states.**

- **Minnesota is the only state in the nation that allows Social Security Disability Income (SSDI) recipients to collect nearly the full workers compensation benefit plus the full SSDI benefit.**

- **Minnesota's minimum benefit is one of the highest in the nation.**

- **Temporary partial benefits may last indefinitely in Minnesota, whereas they must end at maximum medical improvement in Wisconsin and Iowa.**

Cost Differences Between Minnesota and Wisconsin

In this section we summarize what we know about the reasons for the cost differences between Minnesota and Wisconsin. Earlier, we showed that Minnesota's benefit costs are roughly twice as high as Wisconsin. This implies that a feature unique to Minnesota that accounts for 10 percent of Minnesota's costs would explain 20 perecent of the difference in benefit costs.

- **The cost-of-living escalator clause explains about 19 percent of the difference between Minnesota's total benefit cost and Wisconsin's cost.**

- **The minimum benefit explains about 5 percent of the benefit cost difference.**

- **Supplementary benefits explain about 16 percent of the difference.**

- **Medical benefits explain about 20 percent of the cost difference.**

- **Differences in temporary total duration explain about 16 percent of the benefit cost difference. This estimate assumes that there is a five-week difference in temporary total duration as was indicated by**

NCCI data. This is probably a conservative estimate because the NCCI sample data appear to substantially underestimate benefit costs, particularly for Minnesota.[23]

23 One reason for this is that detailed claim information cost estimates are not developed. That is, they are not adjusted for the tendency of cost estimates to increase as claims mature. This has been especially significant in Minnesota since disabilities have frequently lasted longer than anticipated.

WORKERS' COMPENSATION ADMINISTRATION

Chapter 4

In evaluating a state's workers' compensation system, it is important to consider not only whether benefits are adequate and provide proper incentives, but also whether they are efficiently delivered. Except for the six states with exclusive state funds (where the state is the insurer), primary responsibility for administering workers' compensation claims and ensuring that benefits are delivered rests with insurance companies. Insurance companies receive reports of injuries, verify them, pay workers' compensation benefits, and monitor claims until the worker returns to work or the claim is otherwise closed.

The role of the state administrative agency is to record and summarize information on workers' compensation claims, oversee insurance companies to ensure that they are determining benefits properly and otherwise administering claims according to law, and resolve disputes that often arise about workers' compensation claims.

In this chapter, we examine the role of the Minnesota Department of Labor and Industry in overseeing Minnesota's workers' compensation system. We first present an overview of the department's organizational structure and activities and compare its budget and staff size to other states. Next, we review the processes employed by the department for resolving disputes among parties about workers' compensation issues. This section includes a review of the activities of compensation judges at the Office of Administrative Hearings. Next, we briefly review the major issues relating to medical and rehabilitation costs. Finally, we examine the record keeping and information management functions of the department.

We asked the following questions:

- **Is the Department of Labor and Industry efficiently and effectively administering workers' compensation? Are staffing levels and organizational structure appropriate?**

- **Are disputes concerning workers' compensation issues handled effectively in a timely manner?**

- **Have the Department of Labor and Industry and the Office of Administrative Hearings implemented the changes in the dispute resolution process enacted by the 1987 Legislature?**

- **Is the department's data processing support adequate, both for support of operations and policy-making.**

Our analysis is based on interviews with department managers and staff, interviews with insurance company personnel and other parties to workers' compensation disputes, observations of conferences and mediation sessions, and a review of summary data provided by the department.

The department has made substantial changes in its administrative procedures during 1987. Some of these changes are the result of legislation proposed by the department and enacted by the 1987 Legislature. Others are the result of internal reorganization and reordering of priorities.

One of the major changes in 1987 was the abolition of the "triple-track" system of settling disputes and hearing appeals from administrative decisions issued by the department. This triple-track system, established in 1983, separated medical, rehabilitation, and legal issues into three separate dispute resolution tracks. As a result of many administrative problems and delays caused by the triple-track system, the department sponsored legislation, effective July 1, 1987, that re-established a single-track system of decision review. We discuss the triple-track system in greater detail later in this chapter.

The discussion in this chapter reflects the status of the department during the Autumn of 1987, when the department was still trying to implement its new procedures and evaluate its own effectiveness.

STRUCTURE AND ORGANIZATION

The Department of Labor and Industry oversees Minnesota's workers' compensation system.

The Department of Labor and Industry has major responsibility for overseeing the administration of Minnesota's workers' compensation system. Figure 4.1 presents the department's organizational chart. In addition to its workers' compensation responsibilities, the department regulates other aspects of the workplace environment, including occupational safety and health and employment standards and wages. Our report focuses exclusively on the department's workers' compensation responsibilities.

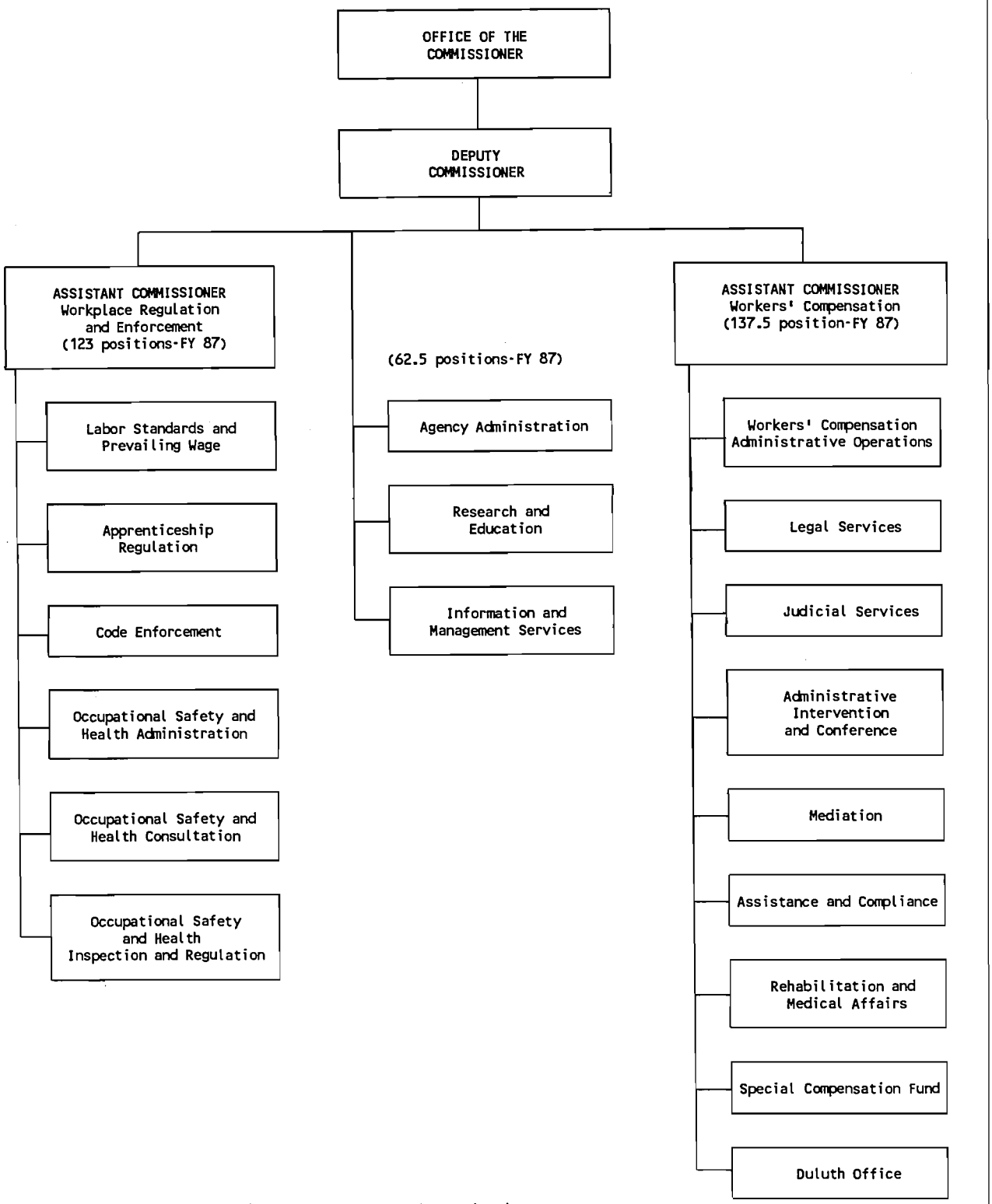
The functions of the sections in the Workers' Compensation Division are described briefly here and discussed in greater detail later in this chapter. The Legal Services section provides legal advice to the department and drafts rules and proposed legislation. The Assistance and Compliance section assists employees, insurers and others with questions about workers' compensation. This section also is responsible for auditing files to make sure that the proper forms are submitted on time and that benefits are correctly calculated.

The Workers' Compensation Administrative Operations section maintains the division's files and records pertaining to workers' compensation claims and dispute resolution. It also refers disputes that are brought to the department's attention to the proper forum for resolution.

Three department sections are responsible for resolving disputes. The Mediation section hears disputes of any nature among parties who agree to submit

FIGURE 4.1

DEPARTMENT OF LABOR AND INDUSTRY
ORGANIZATION CHART



Sources: 1987-89 Biennial Budget; Department of Labor and Industry.

the issue to a mediator. The Administrative Intervention and Conferences section attempts to resolve disputes pertaining to medical and rehabilitation issues and disputes over discontinuation of benefits. The Judicial Services section primarily attempts to resolve disputes requiring legal expertise such as eligibility for benefits, degree of disability, attorney fees, and so on. It also deals with complex medical and rehabilitation issues and cases involving multiple issues.

The Rehabilitation and Medical Affairs section is concerned with the quality and cost of medical and rehabilitation services and is responsible for conducting research, providing public education, and developing policy in these areas. The Special Compensation Fund section administers the special compensation fund (discussed in Chapter 5) including assessing insurers, paying claims, and representing the fund in the dispute resolution process. Finally, the Duluth office provides assistance to employees, insurers, and others in the Duluth area.

COMPARISON OF MINNESOTA'S WORKERS' COMPENSATION BUDGET WITH OTHER STATES

Table 4.1 compares staff sizes and agency budgets among the states. The data on state agency budgets and staff size derive from a survey of state departments conducted by the U.S. Department of Labor. Reported indemnity cases derive from the Unit Statistical Plan of the National Council on Compensation Insurance. (Reported injuries are not available for the six states with exclusive state funds. Their administrative budgets are higher because they have to administer claims as well as oversee the system.) The table allows some generalizations about the size and efficiency of Minnesota's workers compensation administrative system compared with other states.

Table 4.1 indicates that Minnesota's administrative costs per indemnity injury (those involving lost work time) is the same as the national median and its staff ratio per 1,000 injuries is only slightly higher. Thus, using comparative costs and staff size as a measure of efficiency, we conclude that:

- **Minnesota is expending about the same amount of resources as other states on workers' compensation administration.**

DISPUTE RESOLUTION

Overview

Most workers' compensation claims are uncontested. In these cases, the departments' role is to receive reports, maintain paper files and a com-

State	Annual Budget (000)	Staff Size	Administrative Cost Per Reported Indemnity Cases[a]	Administrative Staff Per 1,000 Indemnity Cases[a]
Alabama	$ 544	21.0	$ 25	1.0
Alaska	3,405	54.0	619	9.8
Arizona	8,583	211.0	436	10.7
Arkansas	2,830	89.0	283	9.0
California	37,000	816.0	174	3.8
Colorado	1,739	48.5	58	1.6
Connecticut	2,295	89.0	62	2.4
Delaware	421	18.0	138	5.9
Dist. of Col.	2,562	54.0	596	12.6
Florida	25,596	534.4	476	10.0
Georgia	5,809	146.0	211	5.3
Hawaii	2,202	89.0	171	6.9
Idaho	2,503	67.0	394	10.6
Illinois	5,700	182.0	78	2.5
Indiana	765	27.0	37	1.3
Iowa	966	30.5	50	1.6
Kansas	1,686	43.0	137	3.5
Kentucky	3,567	116.0	230	7.5
Louisiana	2,803	56.0	135	2.7
Maine	2,884	84.0	241	7.0
Maryland	4,333	120.0	160	4.4
Massachusetts	N/A	130.0	N/A	2.3
Michigan	8,846	198.0	227	5.1
MINNESOTA	**4,733**	**137.5**	**160**	**4.6**
Mississippi	2,686	76.0	208	5.9
Missouri	4,000	123.0	115	3.5
Montana	6,800	185.0	1,747	47.5
Nebraska	892	26.0	132	3.9
Nevada	26,152	647.0	N/A	N/A
New Hampshire	582	21.0	51	1.9
New Jersey	4,777	182.0	92	3.5
New Mexico	N/A	N/A	N/A	N/A
New York	57,437	1,643.0	646	18.5
North Carolina	3,121	93.0	131	3.9
North Dakota	2,133	66.5	N/A	N/A
Ohio	N/A	1,366.0	N/A	N/A
Oklahoma	2,515	70.0	102	2.8
Oregon	25,074	567.0	791	17.9
Pennsylvania	10,959	317.0	189	5.5
Rhode Island	305	14.0	33	1.5
South Carolina	3,367	82.0	277	6.7
South Dakota	1,553	9.0	608	3.5
Tennessee	687	26.0	30	1.2
Texas	6,847	339.0	63	3.1
Utah	743	21.0	72	2.0
Vermont	331	7.5	63	1.4
Virginia	5,000	117.0	191	4.8
Washington	37,631	996.0	N/A	N/A
West Virginia	12,178	493.0	N/A	N/A
Wisconsin	3,676	88.0	81	2.0
Wyoming	18,000	50.0	N/A	N/A
Median	$ 3,244	89.0	$ 160	3.9

Sources: Annual budgets and staff sizes from U.S. Department of Labor, State Workers' Compensation: Administration Profiles, October 1986; reported indemnity cases (lost-time injuries) from the National Council on Compensation Insurance, Unit Statistical Plan.

[a]Based on 1983 reported injuries except Hawaii, Louisiana, and New York, based on 1982 injuries and California, based on 1981 injuries.

Table 4.1: State Workers' Compensation Administrative Expenditures and Staff Size

puterized information system, and check the reports to ensure that the benefits are calculated correctly. About ten percent of the claims involve disputes. The disputes can arise at the time a claim is filed or during the course of the workers' disability. The former is usually a disagreement as to whether an injury is work-related. The latter can involve many issues, including medical and rehabilitation issues, extent of disability, discontinuance of benefits, and so on.

About ten percent of workers' compensation claims involve disputes.

Table 4.2 presents a breakdown of the types of disputes filed with the department for the period July 1 through December 21, 1987. Benefit issues comprise 42 percent of disputes received. These are filed on forms called "claim petitions" and involve contentions that insurance companies have denied employees all or part of the benefits to which they are entitled. Usually, these are disputes over whether the injury is work-related or disputes over the degree of permanent disability. Medical and rehabilitation issues comprise another 42 percent of the disputes. These involve the reasonableness of medical treatments and fees, whether or not the treatment was related to the injury, disputes over the proper rehabilitation plan, disputes about rehabilitation benefits, and requests to change doctors or rehabilitation consultants. Finally, issues relating to benefit discontinuance make up 16 percent of the disputes filed.

Type of Issue	Number	Percent
Amount of Benefits	2,973	42%
Medical or Rehabilitation	2,998	42
Discontinuance of Benefits	1,177	16
Total	7,148	100%

Source: Department of Labor and Industry.

Table 4.2: Types of Workers' Compensation Disputes Filed With the Department of Labor and Industry July 1 - December 21, 1987

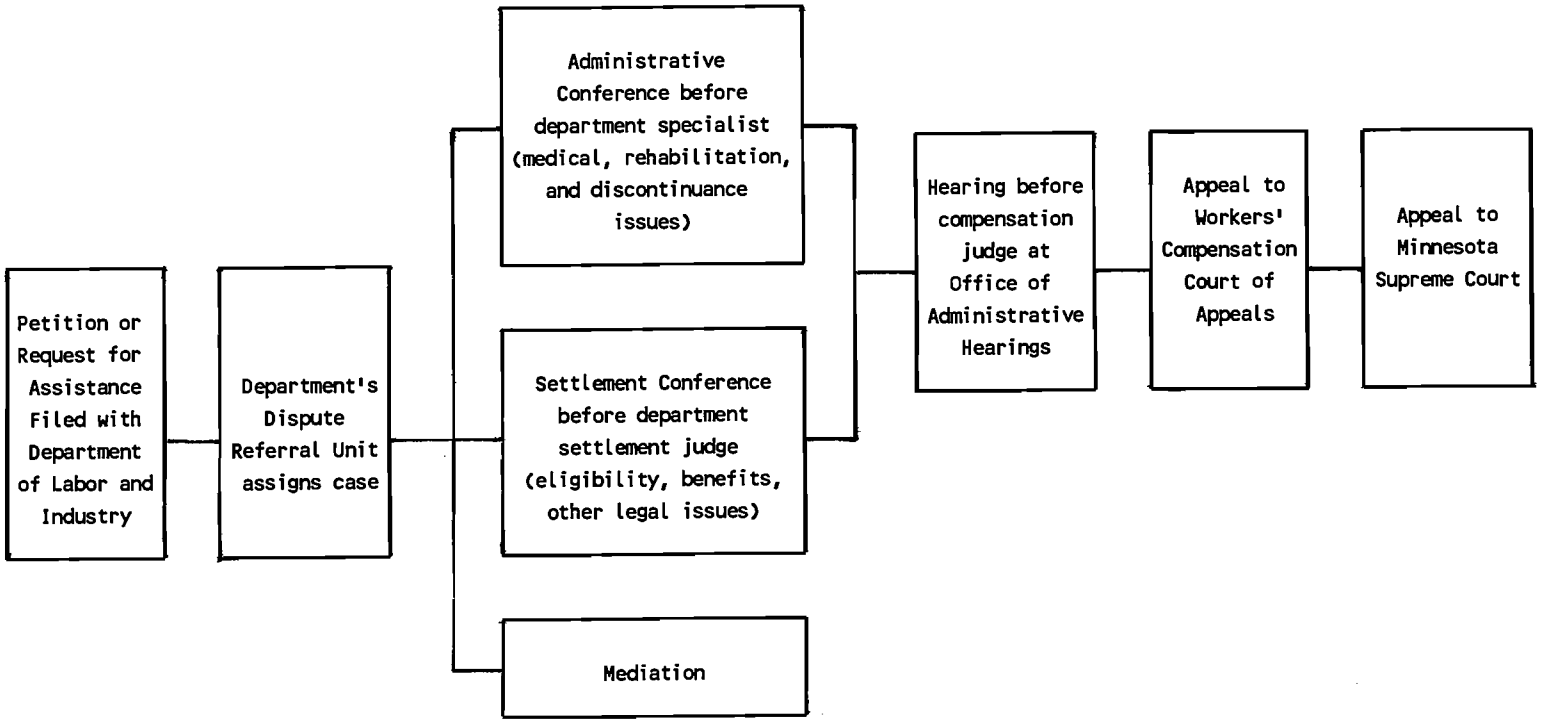
The Department of Labor and Industry provides a forum for informally resolving disputes.

Figure 4.2 depicts the current dispute resolution framework. The Legislature made major changes in the dispute resolution process in 1987. The department also made many administrative changes. The goal of these changes was to improve the efficiency of the dispute resolution process. This was done by placing time restrictions on the department to process and resolve disputes, giving the department more flexibility in processing disputes, and simplifying the system of appealing the department's administrative decisions. The 1987 Legislature also provided funding for additional compensation judges at the Office of Administrative Hearings. Our analysis focuses on the current dispute resolution process. However, relevant comparisons between the current process and the pre-1987 system are also discussed.

Figure 4.2 indicates that the Department of Labor and Industry is the first stop in the dispute resolution process. The department's role is to provide a forum for settling disputes and to approve any settlements that are reached. If a settlement is not reached, a formal hearing is held before a compensation judge at the Office of Administrative Hearings who issues a decision. That

FIGURE 4.2

DISPUTE RESOLUTION PROCESS



decision is appealable to the Workers' Compensation Court of Appeals and ultimately to the Minnesota Supreme Court.

Dispute Referral

Disputes come to the attention of the department by the filing of a petition or request for assistance form. When such a form is received, it is reviewed by the dispute referral unit of the department's Workers' Compensation Administrative Operations section. In some cases, a clerk can make a phone call or two and resolve a problem on the spot. These usually involve miscommunications or minor misunderstandings. The unit also checks to see if the parties have a dispute on a different issue pending at the department or at the Office of Administrative Hearings. If so, the new dispute is consolidated with the pending dispute for a single hearing. The remainder of the disputes are referred to a settlement conference, to an administrative conference, or to mediation.

Prior to the 1987 legislation, disputes filed as "claim petitions" were automatically referred to settlement conferences conducted by settlement judges and "requests for assistance" were referred to administrative conferences conducted by medical/rehabilitation specialists, regardless of the actual issues involved. The 1987 legislation gave the department authority to refer cases to any of the dispute resolution forums. The department now refers disputes requiring legal expertise to settlement judges for settlement conferences and those requiring medical or rehabilitation expertise to medical/rehabilitation specialists for administrative conferences. Disputes involving complex or multiple issues are referred to a settlement conference regardless of the subject matter. Mediation is provided for parties who request it as an alternative to the other dispute resolution forums.

Most disputes received by the department are referred to settlement or administrative conferences.

Table 4.3 lists the referrals made by the department for claim petitions and requests for assistance filed between July 1 and November 9, 1987. The table shows that most referrals are made to settlement conferences or administrative conferences. Over eight percent of the disputes go directly to the Office of Administrative Hearings for consolidation with ongoing disputes.[1] Less than one percent of the cases go to mediation. About two percent of the petitions are rejected as being either untimely or inappropriate subjects for dispute resolution and about three percent are resolved informally. About 18 percent of the petitions or requests had not yet been referred.

It is the department's goal to refer all disputes within 30 days of their filing. An inventory of non-referred disputes on October 6, 1987 found 394 disputes not referred within 30 days. This backlog had been reduced to 52 disputes as of December 21. The department also reports that on the average, it took 22 days to refer cases to one of the dispute resolution forums or to the Office of Administrative Hearings in October, 1987 and 21 days in November.

1 This does not include cases referred by the chief settlement judge to the Office of Administrative Hearings because one or both parties refuse to participate in a settlement conference or the issue is not viewed as likely to be settled. It also does not include cases referred to the office after a department conference fails to resolve the dispute.

Disputes Referred To	Number	Percent
Settlement Conference	1,795	34.2%
Administrative Conference	1,591	30.3
Mediation	24	0.5
Office of Administrative Hearings	453	8.6
Referral Not Yet Entered on Computer	177	3.4
Informally Resolved	145	2.8
Petition Rejected[a]	115	2.2
Not Yet Referred[b]	951	18.1
Total	5,251	100.0%

Source: Department of Labor and Industry.

[a]Includes untimely requests and issues for which conferences are not allowed.

[b]Includes requests returned to petitioner for more information and requests awaiting response from the other party to the dispute.

Table 4.3: Department of Labor and Industry Dispute Referrals July 1 - November 9, 1987

In order to keep up with the inflow of cases, the department assigned two permanent and five temporary clerical positions to the unit to help with the paperwork and with data entry. In addition, an attorney from the Legal Services section is temporarily working with the unit, reviewing the referrals of the two clerical workers as well as making the referrals on complex cases. Finally, requests for discontinuances are being sent directly to the Administrative Intervention and Conference section for referrals.

The Dispute Referral unit claims that it is undergoing a period of transition and that it does not have enough permanent staff to do its job. It has concentrated on improving procedures to keep up with the flow of cases and to meet its goal of referring all claims within 30 days. Through experience, it has been able to recognize typical dispute patterns and develop routine procedures for referring those cases. It has also developed a new form for requesting conferences on medical and rehabilitation issues that describes the nature of the dispute more clearly than the existing forms. However, until the new procedures are fully implemented, some claims may be referred to a dispute resolution forum that is not the best equipped to deal with it, necessitating a re-referral and delay in resolving the dispute.

All three of the department's dispute resolution forums have the same goal to resolve cases informally without requiring a formal hearing or trial before a compensation judge. No transcripts are kept of the proceedings and if the department issues an administrative order as a result of a proceeding, a party to the dispute may appeal and request a *de novo* hearing before a compensation judge at the Office of Administrative Hearings. We discuss the department's dispute resolution procedures in the following sections.

Settlement Conferences

Settlement conferences are administrative law hearings oriented to settling a dispute between an insurer and a claimant and their attorneys. The department has authorization for seven settlement judges, but only six positions are currently filled. In September 1987, settlement judges each conducted 50-60 settlement conferences per month. In addition, settlement judges review and approve settlements reached among parties to a dispute.

Conferences last up to an hour. Settlement conferences attempt to resolve disputes about benefits, degree of permanency, whether the injury was work related, legal fees, rehabilitation and medical issues, and other issues requiring legal expertise.

The number of claim petitions filed with the department has been increasing.

Claim petitions filed by employees involve disputes about benefits. They are typically referred to settlement conferences. Figure 4.3 shows that the number of claim petitions has gradually increased during the 1980s, with a sharp upturn beginning in 1985. Through December 21, 1987, 5,945 claim petitions were filed, a 14 percent increase over all of 1986.

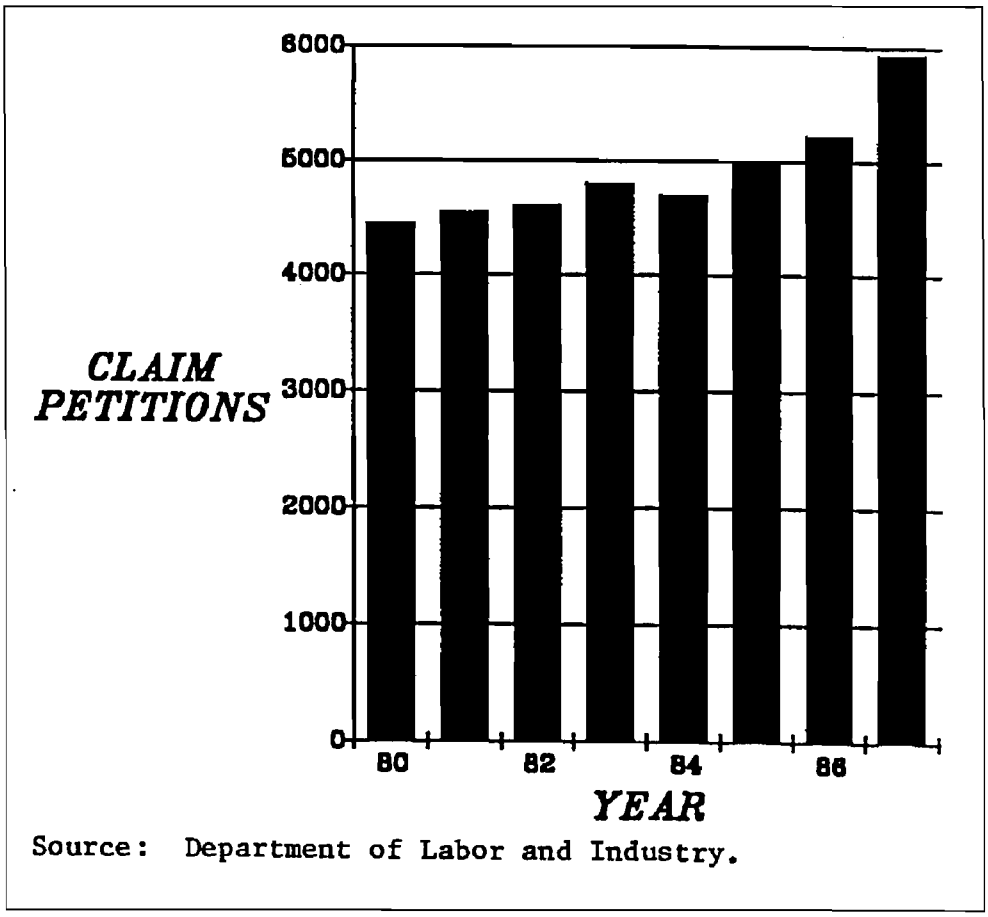


Figure 4.3: Claim Petitions Filed With the Department of Labor and Industry 1980-87

Although the reason for this increase in litigation is not known with certainty, many of the department staff and insurance company personnel we interviewed attribute this to the 1983 revision of the workers' compensation benefits and subsequent interpretations of those benefit changes by the Workers' Compensation Court of Appeals. Attorneys and others point out that any statutory change brings new uncertainties which have to be litigated in the courts before stability is returned to the system. In any event, this rapid increase in litigation is a strain on the system and may undermine efforts to improve administrative efficiency.

During July through September 1987, 590 settlement conferences were held. Of these, 281 (55 percent) were settled. As shown in Table 4.4, the most frequently contested issue in settlement conferences was legal fees. However, legal fees are not the primary cause of litigation. They become an issue when other issues are litigated. Even in cases where they are not in dispute, legal fees appear as issues because they must be included in the settlement.

Issue	Number	Percent of Cases With Each Issue n = 590
Denial of Primary Liability	39	7%
Temporary Total Benefits	202	34
Permanent Total Benefits	4	1
Temporary Partial Benefits	129	22
Permanent Partial Benefits	447	76
Rehabilitation	21	4
Medical Issues	221	37
Legal Fees	502	85
Penalties	135	23

Source: Department of Labor and Industry.

Table 4.4: Issues at Settlement Conferences July - September 1987

Excluding legal fees, permanent partial benefits, in dispute in over three-fourths of the conferences, is the most frequently disputed issue heard by settlement judges. These disputes usually center on the degree of permanency. Other common disputes involve medical issues, temporary total benefits, temporary partial benefits, and denials that an injury occurred or was work-related.

The 1987 legislation added a requirement that petitions be scheduled for a conference or referred directly to the Office of Administrative Hearings within 60 days after the department receives the petition. However, the department has adopted a new standard to schedule conferences for all disputes, rather than automatically sending the more difficult disputes directly to the Office of Administrative Hearings as was done prior to July 1987. (An exception is some cases where the employer denies primary liability. Settlement judges report that these cases are difficult to settle and will likely end up at the Office of Administrative Hearings anyway.)

A literal interpretation of the 1987 legislation is that conferences have to be scheduled (that is, put on the schedule) but not necessarily held within 60 days. However, the department's policy is to actually hold the conference within 60 days after the petition is filed. An exception is cases involving a dispute over the degree of disability, for which the insurer schedules an "independent" medical examination of the employee. The 1987 legislation gives the insurer up to 120 days to conduct the examination and submit a report to the employee and the department. The department schedules conferences for 30 days after the exam, to give the doctor time to submit a report. We checked the department's conference schedule and found that, with the exception just noted, claim petitions received on November 4, 1987, were scheduled for settlement conferences on December 16, 42 days after they were received. Thus, we conclude that:

- **the department is meeting the statutory requirement as well as its policy of holding settlement conferences within 60 days after they are filed.**

Effective July 1987, settlement judges have the power to issue an administrative decision that may be appealed to a compensation judge for a *de novo* hearing. Settlement judges have begun issuing summary decisions in cases where they feel fairly certain that their decision will be affirmed by a compensation judge if a formal hearing is requested. They have been able to do this since October 1, 1987 when the provision in the 1987 legislation requiring both sides to present relevant evidence at the settlement conference became fully effective.

Settlement judges are concerned that issuing summary decisions in all cases might raise concerns about their objectivity in future cases and undermine the primary goal of using the settlement conference forum to facilitate settlements. On the other hand, the knowledge that the settlement judge can issue a decision may induce some attorneys to settle cases rather than receive an adverse ruling that, although non-binding, will reduce their leverage in future settlement negotiations.

When decisions are issued, parties have 30 days to request a formal hearing before a compensation judge. The department must refer the request to the Office of Administrative Hearings within ten days.

As of early December, 1987, summary decisions have been issued in about 50 disputes and only one has been appealed to the Office of Administrative Hearings for a formal hearing. The department is now experimenting with two of its compensation judges issuing summary decisions in all non-settled cases to see how many are appealed and how this affects the settlement rate. We are encouraged by this new procedure. Given the backlog of cases at the Office of Administrative Hearings, discussed later in this chapter, it is important that all efforts be tried to resolve disputes informally and avoid a lengthy delay entailed by a request for a formal hearing.

Administrative Conferences

Administrative conferences deal with medical, rehabilitation, and discontinuance issues.

Most issues involving medical or rehabilitation matters and issues involving discontinuation of benefits are referred to the Administrative Intervention and Conference Unit unless there is a dispute among the parties pending before another dispute resolution forum. As we noted above, the more complex cases are referred to a settlement conference.

Medical and Rehabilitation Conferences

When employees or insurers are unhappy with the way a medical or rehabilitation issue is being handled, they may file a form that requests assistance and/or an administrative conference. Examples of medical and rehabilitation disputes are disputes about an appropriate rehabilitation plan, a dispute over the reasonableness of medical procedures or fees, whether the treatment is related to the work injury, requests to change doctors or rehabilitation consultants, and so on.

Prior to July 1987, administrative conferences had to be held on every request for assistance and the section was totally conference oriented. The 1987 legislation gave the department several additional options for settling disputes. A dispute may involve a simple misunderstanding which can be disposed of with a few phone calls. A medical/rehabilitation specialist may review the facts and issue a one-page administrative decision. This is often done in the case of an unpaid medical bill. Or, the specialist may schedule an administrative conference to try to settle the dispute. Lawyers are present in about half the conferences. The specialist is instructed to be neutral but must also protect unrepresented employees from entering into bad agreements.

In October 1987, the department received 403 requests for assistance involving medical and rehabilitation issues. Due to improper logging, the department was only able to provide information on 359 of those requests. Administrative conferences were scheduled for 232 (65 percent) of those requests. The department resolved 86 cases (24 percent) informally. In 15 cases (four percent), the specialist issued an administrative decision without a conference. The remaining 25 cases (seven percent) were re-referred because the issues were too complex or the request was consolidated with another request.

As of December 14, 1987, of the 232 cases set for an administrative conference, 81 (35 percent) were resolved informally. Sixty-eight conferences had been held and 13 decisions issued. The remainder were scheduled for conferences after December 14.

The 1987 legislation requires the department to issue a written decision, dismiss the petition for technical reasons (e.g., it was filed too late or is not an appropriate issue for a conference), refer it to another dispute resolution forum, or schedule an administrative conference within 60 days. Decisions must be issued within 30 days of the close of the conference or, if no conference is held, within 60 days of the request for conference.

Historically, the department had not kept up with the volume of requests for administrative conferences. In July 1987, the department was able to eliminate a 1,900 case backlog by consolidating cases, resolving more cases in-

formally, reducing the length of conferences and issuing summary decisions without a conference. Conferences are now limited to one hour and orders are limited to three pages. In October 1987, 59 of 403 (15 percent) requests had not been scheduled for a conference or informally resolved within 60 days. In November, only six percent of cases were not scheduled or informally resolved within 60 days. We conclude, therefore, that:

- **the department has made significant progress in implementing the administrative conference time lines embodied in the 1987 legislation.**

Discontinuance of Benefits

Discontinuance disputes arise when an employer/insurer notifies an employee that workers' compensation benefits are being discontinued and the employee disagrees. Or, the employer may request a conference for the purpose of discontinuing benefits. Examples of discontinuance disputes are allegations that the employee is not cooperating with a rehabilitation plan, the assertion that the worker has reached maximum medical improvement, and disputes about whether a job offered by the employer is suitable. Disputes may also arise after the employee has returned to work (and benefits are discontinued) and then determines that the disability makes continued employment impossible or inconsistent with rehabilitation. In FY 1987, the department received 6,439 notices of intent to discontinue benefits. Conferences were requested in 2,051 (32 percent) of these cases.

As noted earlier, most discontinuance and return to work disputes are referred to an administrative conference. As with other disputes, the department may refer the more complex cases to a settlement conference. In addition, an employer who wishes to discontinue benefits or an employee who objects to a discontinuance may bypass the department and file a petition for a hearing before a compensation judge at the Office of Administrative Hearings.

The 1987 legislation set specific time lines for resolving discontinuance cases. Discontinuance disputes take priority over other disputes. The department must schedule a conference within ten calendar days of receipt of the request. If compensation has been discontinued for a reason other than the employee's return to work, the employer must continue to pay benefits pending the outcome of the conference. If no settlement is reached at the conference, a decision must be issued within five days. If either the employer or the employee disagrees with the decision, they may request a hearing before a compensation judge. The department has ten days to refer the case to the Office of Administrative Hearings. The hearing must be held within 30 days and the decision issued within 30 days of the close of the hearing.

In October 1987, the department received 196 requests for discontinuance conferences. The department reports that as of December 14, 153 (78 percent) of these were scheduled for conferences in St. Paul. Of the remaining 43, some were scheduled for conferences in Duluth but, at the time we collected our data, the department's Duluth office had not provided statistics regarding the disposition of its cases. Other cases were settled before a conference was scheduled, were dismissed as untimely, were referred to settlement judges because of their complexity, or were continued at the request of

one of the parties. Of the 153 conferences scheduled, 90 were held and an order was issued. The rest of the cases were resolved without a conference or withdrawn.

We reviewed the department's case logs for discontinuance cases concluded in December 1987. Requests for conferences were filed by 131 parties. Of those, 107 were scheduled for conferences. (The others either were resolved without a conference, were rejected because they were filed late or improperly, or were withdrawn.) Of the 107 conferences, 100 (93 percent) were scheduled for a conference within 10 days. On average, 6.7 days passed between the time the department received the request and a conference date was entered on the calendar. Conferences were scheduled to be held, on average, 9.2 days after that (or 15.9 days after they were received). Thirty-nine of the 107 cases scheduled for conferences were resolved informally and the conference was not needed. The conference was held on the scheduled date in 56 of the remaining 68 cases (82 percent). Continuances delayed the conferences of 12 cases for an average of an additional 8.4 days.

Based upon our review, we conclude that:

- **on the whole, the department is meeting statutory requirements to schedule discontinuance cases within 10 days. There is currently no major backlog of discontinuance cases at the department.**

Mediation

Mediation must be requested by the parties and can be held at any time. Mediation sessions can be scheduled quickly and do not prejudice subsequent proceedings if the parties fail to reach an agreement. Attorneys are present in about one-fourth of the mediation sessions. Agreements must be approved by the department. In some cases, the parties have reached agreement among themselves and use mediation as a forum for approving the agreement. For example, a disabled worker and an insurer may agree to discontinue weekly benefits in return for a fixed lump sum payment (cash settlement). The director of the Mediation section will not approve a settlement unless she is assured that the settlement is not detrimental to the worker or unless the worker is represented by counsel.

Of the 782 mediation cases closed in 1986, 372 (48 percent) were successfully resolved.

Disputes are referred to the Mediation section by one of the parties to the dispute, by the Dispute Referral unit, or by one of the department's other dispute resolution sections. A description of the department's mediation services, along with a telephone number, are given to injured workers in a brochure mailed to all injury victims reported to the department. The department is also working with insurance companies to make them aware of the mediation option.

In 1986, the department disposed of 782 requests for mediation. Mediation was declined by the other party to the dispute in 325 of those requests (42 percent). In 42 of the disputes (five percent), the issue was resolved over the phone. Mediation sessions were held for 378 disputes resulting in successful resolutions of 330 (87 percent) of the disputes. Of the 782 mediation cases closed in 1986, 372 (48 percent) were successfully resolved.

Informal Resolution Over the Phone

We have already noted that the Dispute Referral unit and the Mediation section resolve some disputes over the phone. In addition, the department's Assistance and Compliance section receives over 250 telephone calls per day from injured workers, employers, insurers, doctors, lawyers, and others. Many of these calls involve requests for information but others involve requests for assistance with problems that are being encountered. The department has six professional staff handling these calls. For most problems involving potential disputes, the staff will explain the dispute resolution process and mail out appropriate forms. In some cases, however, staff members who answer the calls may be able to resolve disputes themselves by calling up other parties and clarifying misunderstandings.

Appeals of Department Decisions

The "triple-track" system, established in 1983, proved to be administratively confusing and was abolished in 1987.

Abolishing the Triple-Track System

In 1983, the Legislature established a "triple-track" system of hearing appeals from administrative decisions issued by the department. Appeals of medical issues were heard by a Medical Services Review Board and appeals of rehabilitation issues were heard by a Rehabilitation Review Panel. Formal hearings for all other issues were conducted by compensation judges at the Office of Administrative Hearings. Compensation judges had no jurisdiction over medical and rehabilitation issues.

The rationale behind the triple-track system was that experts trained in medicine and rehabilitation were more qualified to review those issues than legally trained compensation judges. However, the system became administratively confusing. Many cases involved multiple issues. For example, a back injury might involve a dispute about the extent of impairment (heard by a department settlement judge and, if no settlement was reached, referred to a compensation judge at the Office of Administrative Hearings for a formal hearing), a dispute about medical care (heard by a department medical/rehabilitation specialist whose decision could be appealed to the Medical Services Review Board), and a dispute about the appropriate rehabilitation plan (heard by a department medical/rehabilitation specialist whose decision could be appealed to the Rehabilitation Review Panel). Cases such as this were heard independently by three different review forums despite the interrelationships among the issues. This created logjams in the dispute resolution process as a review forum had to wait for the other forums to dispose of a case before it could address the issues relevant to it. Files frequently could not be located and parties experienced considerable delays in having their disputes resolved.

Recognizing these problems, the department sponsored legislation, passed in 1987, that revoked the review functions of the two boards and re-established a single-track system of decision review.[2] Now, all issues are heard by the same dispute resolution forum at the department. For multiple issue disputes, this is likely to be a settlement conference. If a settlement is not reached through one of the department's dispute resolution forums, or if a party to a dispute wishes to appeal an administrative decision, that party can request a formal hearing before a compensation judge at the Office of Administrative Hearings.

Department staff and insurance company representatives we interviewed unanimously praised the abolition of the triple-track system. All the issues pertaining to a case are now heard in one administrative proceeding. However, the additional responsibilities for the Office of Administrative Hearings may impede progress in reducing the backlog of cases there. We discuss this backlog in the next section.

The Office of Administrative Hearings

The Office of Administrative Hearings (OAH) has had responsibility for managing the adjudication of contested workers' compensation claims since July 1981. Prior to that time, the Department of Labor and Industry was responsible. If a dispute cannot be informally resolved at one of the department's dispute resolution forums, a formal contested case hearing is conducted by a compensation judge at OAH.

Formal hearings are more time-consuming than informal ones. Thus, while the department can conduct a conference in about an hour, most hearings at OAH require a half to a full day and about 25-30 percent require more time. OAH typically schedules pre-trial conferences with the opposing attorneys in hopes of settling cases without a formal hearing.

As of early 1987, there was an 18-month backlog of cases awaiting formal hearings at the Office of Administrative Hearings.

An inventory of cases on December 31, 1985 indicated that 2,730 cases were awaiting a hearing and another 136 had been heard but were awaiting a decision from a compensation judge. As of January 1, 1987, the number of cases awaiting a hearing had grown to 3,935, a 44 percent increase over December, 1985. A case backlog that was estimated to be between 14 and 15 months at the beginning of 1987 had grown to 18 months by the summer of 1987. The backlog in Duluth was 21 months.

Figure 4.4 shows the number of cases received and disposed of by OAH from 1983 through 1987. After a drop in 1984, the number of cases referred to OAH has been steadily increasing since then. Although OAH has increased the number of cases it resolved in 1986 and 1987, it was unable to keep up with the increase in new cases. For the first six months of FY 1988, however, OAH has received 2,500 cases and returned 2,600. It appears that if there is no upturn in the number of new cases received, OAH may be able to keep up with its incoming caseload.

2 Both boards continue to exist. The Medical Services Review Board reviews disciplinary actions brought by the department against doctors, recommends fee schedules for medical services, studies and recommends updates for ratings of different disabilities. and advises the department on policy issues. The Rehabilitation Review Panel reviews appeals of department decisions pertaining to the certification and disciplining of qualified rehabilitation consultants and rehabilitation vendors.

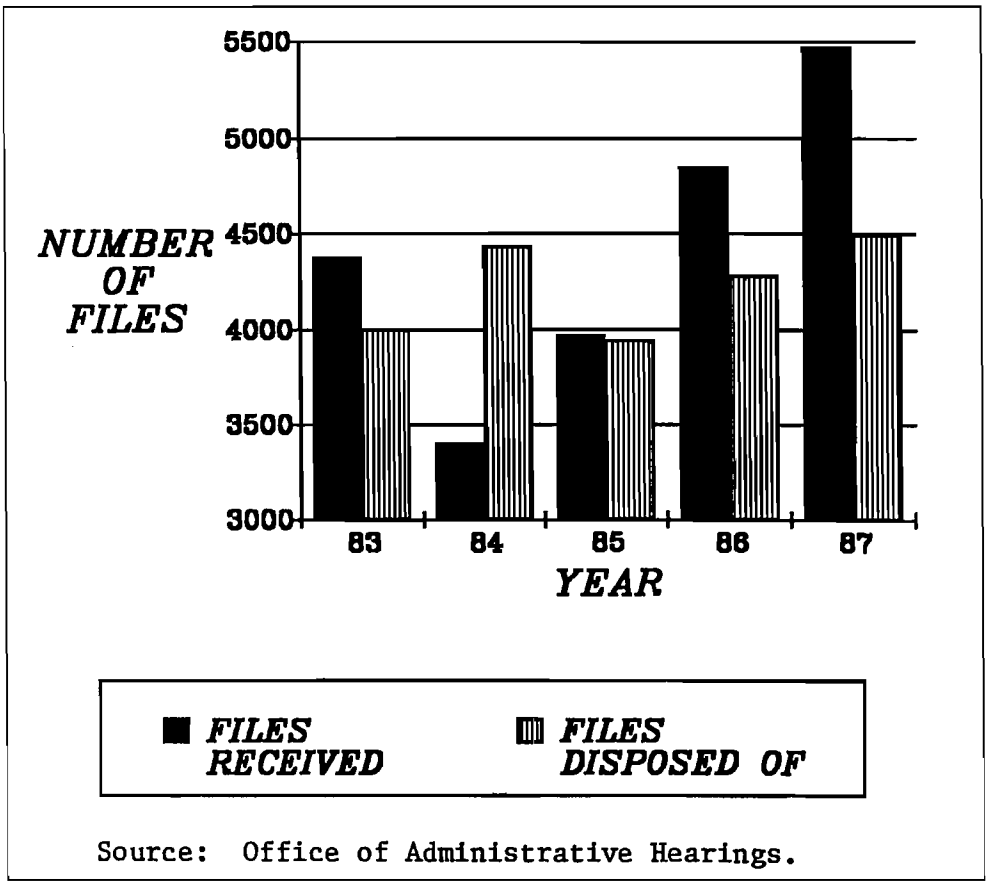


Figure 4.4: Files Received and Disposed of By the Office of Administrative Hearings

As we noted above, the 1987 legislation required that discontinuance issues be decided on an expedited basis. A hearing must be held within 30 days of the office's receipt of the request and a decision must be issued within 30 days of the close of the hearing record. OAH formerly had 75 days to hear a discontinuance case.

The 1987 Legislature provided for 10 additional compensation judges.

For other issues, the 1987 legislation provides that an employee may request an expedited hearing which must be granted upon a showing of significant financial hardship. For these cases, a prehearing conference at OAH must be scheduled within 45 days. If a settlement cannot be reached before or at the conference, the issue will be scheduled for a hearing.

The 1987 Legislature also provided for 10 additional compensation judges in the hopes that the backlog of cases can be reduced. Since July 1987, OAH has concentrated its efforts on meeting the statutory requirements for scheduling discontinuance and other expedited cases and on reducing the backlog of cases in outstate Minnesota. During the summer of 1987, OAH scheduled settlement conferences for all outstanding cases outside of a ring formed by St. Cloud, Mankato, and Rochester (excluding Duluth and Virginia). Settlement conferences were held in September and hearings were concluded by the end of January 1988. Cases between the Twin Cities Metropolitan Area and the ring formed by Rochester, Mankato and St. Cloud are now being scheduled for hearings. OAH expects to conclude those hearings by March or April.

As of now, new cases from outside the seven-county Twin Cities Metropolitan Area and the Duluth-Virginia area are being processed immediately upon receipt from the department. OAH has assigned a second judge to its Duluth office and hopes to eliminate the backlog there over the next 18 months.

Although OAH has concentrated its efforts on eliminating the backlog of cases in outstate Minnesota, the overwhelming majority of petitions are filed by Twin Cities employees. OAH reports that the backlog for those cases remains about 18 months. That is, disputes filed in August 1986 have been scheduled for hearings in January and February 1988. OAH hopes that this backlog will be reduced when the Supreme Court rules on certain important cases. Supreme Court rulings will set precedents that will result in parties settling pending disputes.

So far, the increased allotment of judges has allowed OAH to reduce the outstate backlog and keep up with the new requirements for expedited proceedings in discontinuance and financial hardship cases. However:

- **the addition of ten compensation judges has not has not solved the problem of long delays in holding hearings before compensation judges.**

Long delays can result in a denial of justice. Attorneys can file petitions and request formal hearings on frivolous cases as well as those with legitimate disputes. Delays cause unnecessary expenses for insurance companies and forces them to settle cases even when a settlement is not merited.

In FY 1987, OAH issued 916 decisions. (The remaining cases disposed of were either settled, dismissed or stricken from the calendar because of a technical deficiency.) Of those decision, 432 (47 percent) were appealed to the Workers' Compensation Court of Appeals. This is a small increase in the rates of appeal of 43 percent in FY 1986 and 42 percent in FY 1985. It means, however, that for many cases the issue is still not resolved after the compensation judge at OAH issues a decision.

MEDICAL AND REHABILITATION COSTS

We did not undertake a separate analysis of medical and rehabilitation issues. However, in the course of our interviews with department staff and insurance company personnel, several problems involving medical and rehabilitation cost control became apparent. We discuss these problems in this section.

In June 1987, the department created a new Medical and Rehabilitation Affairs section. This section currently has six full-time staff. Two staff handle certification of qualified rehabilitation consultants (QRCs). One specialist staffs the Rehabilitaion Review Panel and works on rehabilitation rules and disciplining QRCs. One specialist staffs the Medical Services Review Board and works on the medical fee schedule, permanent partial disability schedules (there are still some gaps) and other rules. There is one clerical person and the director. The section has a part-time physician consultant on call.

Medical Costs

We noted in Chapter 3 that medical expenses make up about 30 percent of workers' compensation costs. Despite this, medical cost control is only beginning to receive attention from insurance companies or from the Department of Labor and Industry. Although there has not been a systematic study of workers' compensation medical costs, insurance personnel and department staff tell us that workers' compensation patients are charged higher fees than other patients for the same medical procedures. The problem of medical cost control is not unique to Minnesota. In fact, Minnesota is one of only 19 states that have any medical fee schedules for workers' compensation. However, as presently constituted,

- **Minnesota's medical fee schedule has not effectively controlled medical costs in workers' compensation. It does not cover most medical procedures or any hospital-based procedures or hospital out-patient services.**

The Department of Labor and Industry is responsible for establishing fee schedules. Minnesota defines the data base to be used in deriving fee schedules in statute. It has to use the Minnesota Department of Human Services and Blue Cross-Blue Shield data bases of fees customarily charged. However, if the fee for a specific procedure differs by over 20 percent between the two data bases, it cannot be used for workers' compensation. In addition, there have to be data from at least three providers for a procedure for its fee to be usable. This is often difficult because the large health maintenance organizations are not part of the data base. As a result, only 19 percent of the current medical procedures listed by the American Medical Association (commonly referred to as Common Medical Procedures or "CPT codes") are included in the department's fee schedule.[3]

As with other aspects of claims management, medical cost control is primarily the responsibility of insurers. Although there is a belief among insurers and the department's staff that some doctors overutilize medical services, this contention is difficult to document. The only avenue open to insurers is to request an administrative conference regarding a particular case. There is no mechanism on a large scale to find that a particular doctor or clinic is overprescribing medical services. We note that the impact of overutilization goes beyond the actual medical costs. It can lead to longer disabilities and greater indemnity costs.

The Medical Services Review Board was given authority to review health care providers but was not appropriated additional funds. The department has not developed standards or rules to review providers for quality of care or overutilization. Current priorities are the medical fee schedule and filling in the gaps in the permanent partial disability schedule.

The department is working with the professional associations to develop a plan to refer flagrant abuse cases (poor care, overutilization) to the State Board of Medical Examiners or the Chiropractor's Board for investigation.

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3 Many of the medical procedures listed by the American Medical Association are not common to workers' compensation cases. The percentage of common workers' commpensation medical procedures covered by the fee schedules may be higher.

However, no doctors suspected of overutilizing the workers compensation system were disciplined in 1987. The department does not maintain data on a doctor-by-doctor or clinic-by-clinic basis on the number and types of procedures performed or the fees charged.

One possible way to control medical costs would be for the Legislature to empower the department to certify doctors, clinics, or health maintenance organizations to provide medical and rehabilitative services to injured workers. Workers who do not use a certified health care provider would not be reimbursed for medical or rehabilitative services. Health care providers would have to provide their fees and conform to established fee schedules in order to be licensed. Records could also be kept on average number of treatments and total medical costs per case. Providers with unusually high costs would have to justify them in order to remain eligible to handle workers' compensation cases. This would subject medical care financed by workers' compensation to the same type of pre- and post-payment controls that are typically in place for other public and private insurance programs.

Another possibility is to permit a stricter limit on choice of provider than the law currently allows so that health maintenance organizations, preferred provider organizations, and other types of organizations that promote cost-effective health care can get into the business of insuring the medical care part of workers' compensation. Now, workers' compensation recipients are not limited to the degree that most workers are in the choice of provider allowed by their health insurance carriers. In addition, workers' compensation medical fees are not reviewed in the same way that health insurers routinely review them for privately paying enrollees.

Rehabilitation

The 1979 and 1983 legislation, discussed in Chapter 1, required that a rehabilitation consultation be made for all injuries involving over 60 days lost work time (30 days for back injuries). Insurance companies can, with the department's approval, waive rehabilitation consultation if it is not viewed as beneficial. However, the department reports that few insurance companies take advantage of this option.

Insurance companies may contract with qualified rehabilitation consultants (QRCs) to develop rehabilitation plans for injured workers and make sure that workers follow through with their plans. QRCs are licensed by the department. Many injured workers distrust the QRC assigned by the insurance company and request a change. This has been a source of many disputes. To cut down on litigation, the 1987 legislation allows the employee to change QRCs twice, once before the rehabilitation plan has been adopted and once after, without approval by the insurance company or the department.

There remains considerable controversy about the usefulness of QRCs in particular and mandatory rehabilitation plans in general. Some critics contend that QRCs retained by injured workers (or their attorneys) have an incentive to provide costly rehabilitation or retraining plans, perhaps to justify higher permanency awards. Others suggest that QRCs are not necessary and that insurers would provide rehabilitation anyway to return injured workers to work and reduce indemnity costs.

We have not analyzed QRC effectiveness or other rehabilitation issues in this report. The department has recently studyied rehabilitation issues and has provided some answers to questions regarding the effectiveness of the current rehabilitation system.

RECORD KEEPING AND INFORMATION MANAGEMENT

Reporting of Injuries

All injuries resulting in more than three days lost work time must be reported to the Department of Labor and Industry.

All injuries resulting in more than three days lost work time must be reported to the Department of Labor and Industry. These "first reports of injury" contain basic data about the nature of the injury, the employee's job and wage level, and the weekly benefits to be paid. These data are then entered into the department's computer by the Information Management Services division and a paper file is created. The file is then referred to the Workers' Compensation Administrative Operations section which stores the file. The file containing the first report of injury is then referred to the Assistance and Compliance section.

The Information Management Services Division mails a brochure to the injured worker that describes workers' compensation benefits and administrative procedures. Assistance and Compliance section staff then check the first reports of injury for accuracy. Of primary concern is that the weekly benefit is calculated correctly. In cases where errors are detected, the department informs the insurer and the error is usually corrected. (If the insurer does not correct the error, the employee is notified of the innacuracy and informed of the avenues of recourse.)

For cases of prolonged disability, insurers are required to submit annual reports of benefits paid and a final report when benefits are terminated. This updated information is then entered into the computer. However,

- **insurers have not regularly submitted required updates on long-term disability cases and the department does not have complete information on the amount of benefits paid.**

For example, there are many cases listed as open by the department where a first report of injury is filed and the department never receives additional reports. The department does not know whether these cases are closed or ongoing. As a result,

- **the department cannot provide current and complete data on the duration of cases, the types of benefits paid, or the amounts of benefits paid.**

Summary data are important to measure trends, assess the impact of proposed and actual changes in benefits, and formulate workers' compensation policy.

The department recognizes this deficiency in its information system. The department has about 14 staff reviewing computer records of about 150 to 200 cases per week to check that the information is complete and to remove closed files from their manual and computerized filing systems. The department's goal is to review each of the 150,000 to 165,000 open cases at least once per year but this goal is not being met.

The 1987 legislation provided for penalties to insurers for not submitting reports on time. The department plans to issue warning letters to insurance companies that have not submitted required reports and then assess penalties if the information is not provided. However, department staff are concerned that they will not be able to keep up with the large volume of warning letters and penalties that will have to be assessed.

Information Management

In addition to incomplete information on workers' compensation claims,

- **the department is hampered it its ability to assess trends and present statistical summaries by an inadequate information system.**

The department's computer went on-line in late 1982. Department staff inform us that it took a year or more to become fully operational, so less confidence is placed on pre-1984 data. The department's computer system was designed and programmed to store information on individual cases. It is relatively simple to access a specific case file. However, it is much more cumbersome and time consuming (and sometimes impossible) to produce summary data from the individual cases on the system. Each of the components of the department's computerized system is stored separately and cross-referencing and comparison is difficult. This makes it difficult for the department to analyze trends and assess the impact of policy alternatives.

Indeed, the department has had much difficulty in producing summary reports for interested legislators and others that simply describe the number of reported injuries and their characteristics. For example, although employers must file first reports of injuries only for cases resulting in over three days of lost work, all injuries relating to state employees, including medical only cases, are included in the data base. (The department used to administer state employee claims.) Other medical only cases are also erroneously included in the data base. The department's information system is unable to remove the medical only cases to determine how many lost-time cases actually occurred each year, a seemingly simple problem for an adequate information system.

The department's data processing system is inadequate.

The inadequate information system has implications for the department's internal management as well. Department staff spend a lot of energy storing and retrieving manual files (and tracking down lost files) because the specialists do not have confidence in the computerized information. We also observed, until very recently, a complete absence of usable computerized information on case processing, information the department needs to assess its compliance with statutory time lines and otherwise assess and evaluate its efficiency. Even now, the department's computer cannot adequately track individual cases through the dispute referral process to produce reports on the percentage of injuries resulting in litigation, the percentage of disputes that

are successfully resolved by each of the dispute resolution forums, the types of issues that are more amenable to resolution by the different dispute resolution forums, and the percentage of cases resolved within a specified time frame.

The department's administrative functions involve large scale clerical processes such as record keeping, auditing files and forms for completeness and accuracy, mailing notices to workers, insurers and others, and other clerical functions. These functions could be performed more efficiently if supported by an adequate data processing system.

The department has historically neglected research and education. Some research did not always meet reasonable scientific standards and was subject to self-serving interpretations of the department. Under these circumstances, it was difficult for the department to recognize the deficiencies of its information system and the needs of policy makers for useful summary data. It was only in 1987 that a significant effort was devoted to research. This department is now struggling with the inadequacies of the information system for research applications in an effort to produce accurate reports.

CONCLUSIONS

In view of the time-consuming nature of formal trials at the Office of Administrative Hearings, the Legislature has provided less formal procedures for dispute resolution at the Department of Labor and Industry. However, the department's informal procedures have historically been characterized by delays and confusion. In addition, the triple-track system of appeals resulted in multiple files on the same case and files getting lost in the system.

The department sponsored legislation in 1987 to eliminate the confusing triple-track system and put all disputes on a single track. The department also has made improvements to the informal dispute resolution process. Although it is too early to fully evaluate the effects of these administrative changes, our review indicates that the department has significantly reduced the amount of time it takes for conferences to be held and has taken steps to improve the process by which cases get referred to a particular dispute resolution forum. Rather than making the referral on the basis of the type of form that is filed, referrals are now made on the basis of the content of the dispute. In addition, all facets of multi-issue disputes are now heard in the same dispute resolution forum. Although there are always problems implementing administrative changes, we conclude that:

- **the department has made significant improvements in its dispute resolution procedures.**

Case backlogs at the department have been reduced or eliminated and referrals, for the most part, have been made promptly.

Although progress has been achieved in implementing the 1987 administrative reforms, there are some aspects of the administration of workers' compensation that concern us. These are discussed below.

Delays

Many of the experts we interviewed told us workers and employers both benefit from the speedy resolution of workers' compensation disputes. Lengthy litigation and delays increase costs and diminish cooperation between injured workers and their employers. Rehabilitation efforts are delayed. Workers are put in a position where they must prove their disability. They may accept their dependency rather than make active efforts to return to work.

Long delays for cases awaiting formal hearings remains a problem.

Our review of the dispute resolution system indicates that the department has made improvements in resolving cases informally but that there is still a major backlog of cases at the Office of Administrative Hearings awaiting formal hearings. OAH has eliminated the backlog in outstate Minnesota but it is questionable whether OAH can clear the backlog in the Twin Cities and Duluth areas with existing resources. Since every case can be appealed *de novo* to OAH, the reduction of delays at settlement and administrative conferences at the department can be misinterpreted if delays at OAH are not simultaneously considered. Our review indicates that improvements have been made at the department and increased resources applied at OAH. However, it is far from clear that the problem of long delays and case backlogs has been resolved.

One reason for the backlog at OAH is the formal nature of the hearings there. Witnesses, including medical experts, testify in person and are subject to cross examination. The hearing is based on a judicial model, not an administrative model. Although we did not conduct an in-depth comparative analysis of other states' administrative hearings processes, many of them merely provide an administrative review before a hearing officer, similar to the settlement and administrative conferences at the department. Unlike Minnesota, where parties may appeal an administrative decision to a new formal hearing, many states have workers' compensation boards or commissions that review decisions of department administrators, based upon the evidence presented at the administrative hearing. Thus, the whole step of formal trial-like hearings is bypassed.[4]

One purpose of the workers' compensation system is to remedy workplace injuries quickly without the formalities of the civil justice system. By providing a dispute resolution system that ultimately relies upon formal litigation, Minnesota has provided a model that emphasizes the judicial process rather than administrative efficiency. Such a system can be expected to generate more delays and more costly administrative processes, with no guarantees that either the worker or employer is better served.

Failure to significantly reduce the backlog of cases at OAH despite the addition of resources may also be attributed to the increase in litigation during the past two years. This suggests to us that a more fruitful approach to reducing the backlog of cases may be in implementing fundamental changes that simplify the system of benefits and its administration. Thus:

4 However, these states do permit appeals to the courts.

- **delays in resolving disputes may be more effectively addressed by reducing benefits and complex features of the system than by adding more compensation judges and other staff.**

Coordination of Dispute Resolution Efforts

It is important that activities at the separate dispute resolution forums within the department are coordinated with each other and with the Office of Administrative Hearings. The relationship between the department and OAH is of particular concern because they are administratively separate. While this separation may be justified from the standpoint of maintaining the objectivity of compensation judges who must rule on appeals from department administrative decisions, there is a potential for conflict and poor communication between the department and OAH. Decisions of compensation judges, since they are formalized statements of policy in resolving workers' compensation disputes, should be communicated to settlement judges and department specialists and mediators and guide their approach to conferences and mediation sessions. Likewise, administrative decisions made by the department may affect OAH's activities. For example, department policy on referring cases directly to OAH affects OAH's caseload.

The department's Assistant Commissioner for Workers' Compensation and the Assistant Chief Aministrative Law Judge have begun to meet regularly to discuss administrative issues and resolve problems. We believe, however, that there should be a formal organizational tie for these two major components of the dispute resolution process that transcends the current personnel. We recommend that:

- **the Department of Labor and Industry and the Office of Administrative Hearings should establish a committee made up of department personnel and compensation judges that meets regularly to discuss mutual concerns and improve coordination and efficiency in resolving workers' compensation disputes.**

Information Management

In 1983, the department invested millions of dollars in a new computer system called MAPPER that promised to meet the department's data processing needs.[5] As of late 1987, it is not clear that current and future needs can be met with this system, even if it is modified (which the department agrees needs to be done).

Workers' compensation is now a billion dollar a year program. Surely, up-to-date data processing support is essential under the circumstances. Given the scope of the department's administrative functions, and the fact that exotic state-of-the-art technology is not required, we recommend that:

5 Between 1982 and 1986, the department spent $2.5 million in equipment and $800,000 in software and consulting services.

- **the department should engage a consultant to perform a general assessment of data processing support needs, and develop a reasonable strategy for meeting them.**

This consultant cannot be affiliated either formally or informally with any hardware or software vendor, but previous experience in an insurance industry setting or another state's workers' compensation administrative setting would be helpful.

The department needs to improve its computer capabilities.

Depending on the outcome of this study, the department may need to conduct a full scale study of data processing needs and requirements including support for operations, management of information, and research, or it might need to hire someone to provide needed systems expertise internally and supervise a data processing staff. The end result may be the installation of a new computer system, or it may be possible to re-program or otherwise change the existing system to meet the department's needs.

Fortunately, the data processing problems at the Department of Labor and Industry have been addressed before in Minnesota and around the country. The money that will be required to solve the problem will not be excessive considering the size of the workers' compensation program and the potential savings from improved efficiency.

SPECIAL COMPENSATION FUND

Chapter 5

The special compensation fund, created by the Legislature in 1919, helps spread the cost of certain workers' compensation benefits among all workers' compensation insurers. Specifically, the fund:

- reimburses insurers and self-insurers for claims paid to employees whose injuries are made substantially greater or are a result of a pre-existing physical impairment;
- pays supplementary benefits to ensure that employees totally disabled over four years (two years for injuries occuring prior to October 1, 1983) receive a minimum benefit of 65 percent of the statewide average weekly wage;
- pays benefits to injured workers whose employer is uninsured or is self-insured but unable to pay; and
- pays for the administration of workers' compensation at the department, the Office of Administrative Hearings, and the Workers' Compensation Court of Appeals.

The Department of Labor and Industry administers the fund. Revenues are derived primarily from assessments against all insurers and self-insurers.

Figure 5.1 indicates that supplementary benefits make up the largest component of the special fund expenditures in FY 1987, followed by subsequent injury benefits. Administration of the workers' compensation system and payment of benefits to workers of uninsured or insolvent self-insured employers (special claims) make up smaller percentages of special fund expenditures.

In this chapter, we ask:

- **What impact does the special compensation fund have on workers' compensation costs?**
- **How does the special fund affect incentives to return injured workers to work?**
- **How effectively is the department administering the special fund?**

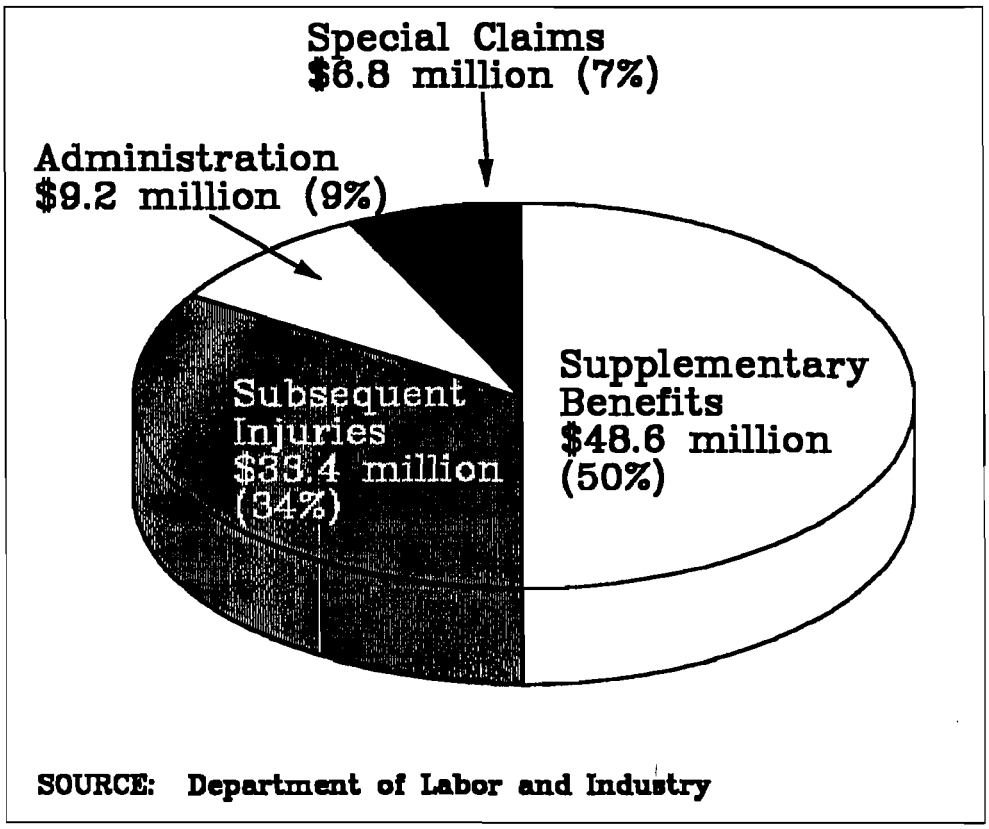


Figure 5.1: Special Compensation Fund Expenditures 1987

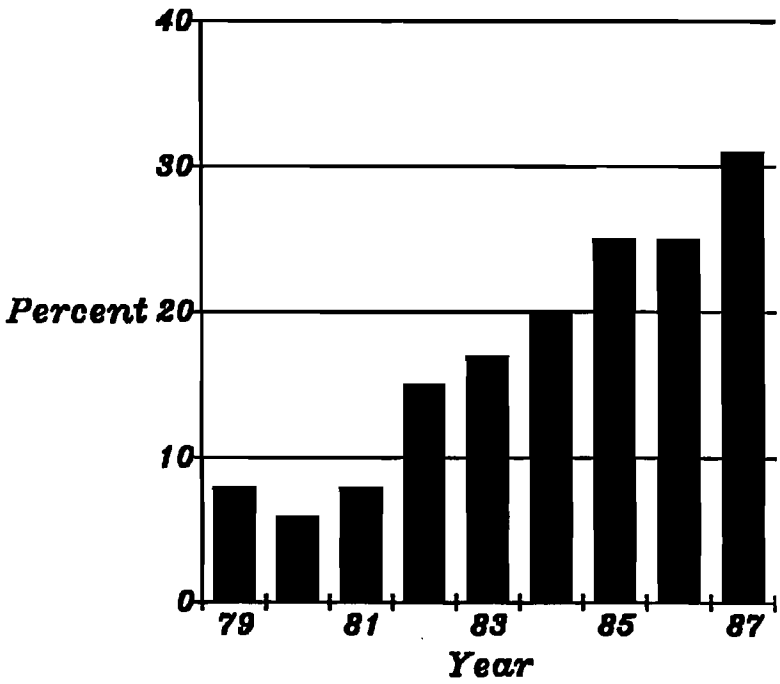
- **How does Minnesota's special fund compare with those of other states?**

Our discussion is divided into six sections. First, we discuss the fund's revenues and its cash flow problems. Next, we examine supplementary benefits and assess their impact upon costs. Third, we review the subsequent injury component of the fund. Fourth, we examine the special claims component of the fund that handles claims for employees of uninsured companies. Fifth, we briefly discuss the impact of having the fund pay for the administration of workers' compensation. And finally, we draw some conclusions on the impact of the fund on workers' compensation costs and providing incentives to return injured workers to work.

REVENUES

The special fund's FY 1987 revenues were $80,850,000. About 95 percent of the revenues were derived from assessments against insurers and self-insurers. The remainder came from fines levied against insurers for a variety of violations (for example, filing reports late), interest, recoveries from bankrupt self-insurers of benefits paid by the fund to their employees, and subrogation rights against liable third parties.

The amount of the assessment is a percentage of each insurer's disbursements for disability and death benefits for the previous fiscal year. Originally established in 1935 at one percent of an insurer's permanent partial benefits paid to employees, the rate has increased steadily over the years. In 1984, the Legislature set an assessment rate of 20 percent but instructed the department to adjust this base rate by -10 to +12 percent depending on whether the fund showed a surplus or a deficit for the previous year. Figure 5.2 presents the assessment rate since July 1979. Figure 5.2 shows that the rate has increased dramatically and is currently 31 percent.



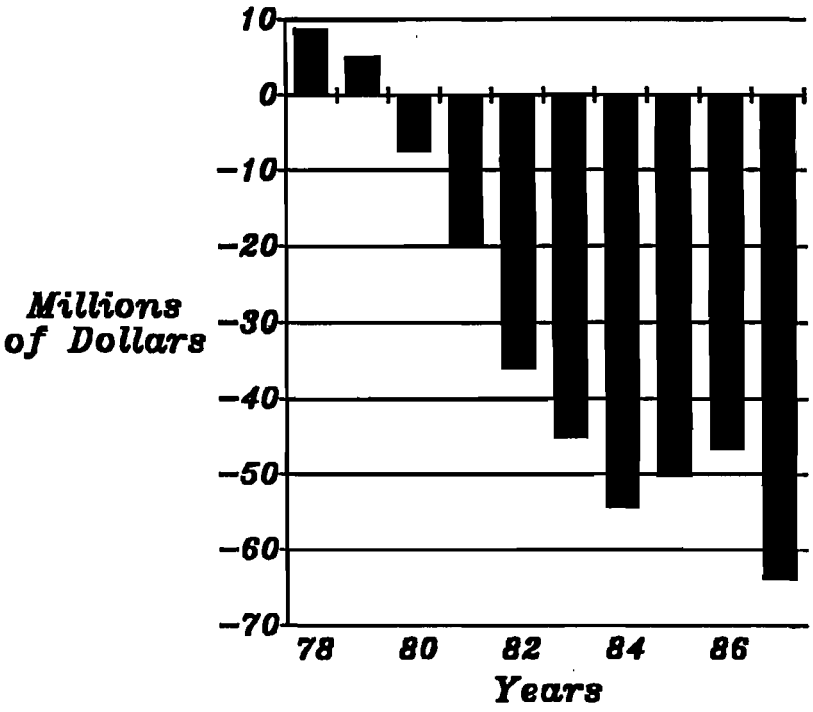
Source: Department of Labor and Industry, Special Compensation Fund Financial Forecast for Fiscal Years 1987 and 1988, March 1987.

Figure 5.2: Special Compensation Fund Assessment Rate 1979-87

Despite a rapid increase, assessments for the special compensation fund have not been sufficient to pay for claims made against the fund.

Despite the dramatic increase in the assessment rate, the assessments have not been sufficient to pay for the claims made by insurers against the fund each year. As a result, there has been an increasing deficit in the fund's balance. Figure 5.3 shows the end of year cumulative fund balance since FY 1978.

Figure 5.3 shows that, except for a small recovery in FY 1985 and 1986, the deficit has been increasing steadily and now is at its highest point. It is important, however, to keep in mind the meaning of this deficit. Insurers are required to pay certain benefits to injured workers. For policy reasons discussed later in this chapter, the special fund reimburses insurers for some of those payments. The special fund gets the money to reimburse insurers by levying assessments against them. Thus, the insurance industry is not directly losing money because of the deficit. The effect of the deficit is to delay reimburse-



Source: Department of Labor and Industry, Special Compensation Fund Financial Forecast for Fiscal Years 1987 and 1988, March 1987.

Figure 5.3: Special Compensation Fund Cash Balance 1978-87

ments to insurance companies by about one year. Depending on their percentage of losses reimbursable by the special fund, some insurance companies will benefit and some will suffer as a result of this delay.

The fund's unfunded liability is about $1.5 billion.

More important than the cash flow deficit is the unfunded liability of the fund. Because reimbursements and assessments are based on a claims paid basis, the common insurance company practice of reserving money for incurred future losses is not followed by the fund. The exact amount of the unfunded liability is unknown but the department estimates it to be about $1.5 billion. This expense will be borne by future insurers and, therefore, future employers.

The cost of the benefits that are funded through special fund assessments has been increasing and now makes up a significant portion of the insurance industry's costs. As a result, a significant portion of insurance company costs (and, therefore, insurance premiums) are beyond their direct control. This has important consequences for insurance company incentives to effectively manage cases. We discuss this in the following sections.

SUPPLEMENTARY BENEFITS

Supplementary benefits were established in 1971. They were created to raise benefit levels of workers totally disabled for over two years. Originally, benefits were raised to $60 per week, but in 1975 the Legislature significantly increased supplementary benefits to 50 percent of the statewide weekly wage. They were raised to 60 percent of the statewide average weekly wage in 1979, and 65 percent in 1981. In 1983, the Legislature enacted the first curtailment of supplementary benefits, extending from two to four years the duration of total disability required to become eligible for supplementary benefits. This change was effective for all injuries incurred on or after October 1, 1983.

Today, supplementary benefits can increase workers' benefits in three ways. First, it helps raise benefit levels for workers injured before October 1, 1975 to current benefit levels. Second, it raises the minimum benefit for long-term disabilities. This primarily benefits below average wage earners. Third, it restores benefits that were reduced for some workers who also received social security benefits. We discuss these reasons for receiving supplementary benefits in the following sections. Note, however, that these categories are not mutually exclusive and that workers may receive supplementary benefits for two or all three of these reasons.

Workers Injured Prior to October 1975

Workers injured before October 1, 1975 do not qualify for annual cost-of-living adjustments. Thus, without supplementary benefits, weekly compensation rates would not increase for the duration of their disability. Maximum benefit levels were quite low before 1975 (See Table 1.1). Supplementary benefits were enacted to bring compensation for workers injured prior to October 1975 to more appropriate levels.

Table 5.1 shows supplementary benefits paid in 1986 by the year in which the injury occurred. These figures do not represent past and future benefits relating to these injuries.

Year of Injury	Amount (000s)	Percent
1946-1950	$ 67	0.2%
1951-1955	252	0.6
1956-1960	1,622	4.0
1961-1965	3,059	7.6
1966-1970	8,556	21.3
1971-1975	16,479	41.0
1976-1980	7,948	19.8
1981-1985	2,216	5.5
Total	$40,199	100.0%

Source: Department of Labor and Industry, Special Fund Section.

Table 5.1: 1986 Supplementary Benefits Payments By Year of Injury

The table shows that few of the 1986 claims pertain to injuries that occurred after 1981 since for injuries occurring after October 1, 1983, workers must be totally disabled for four years before they can receive supplementary benefits. About 73 percent of the 1986 payments were for injuries occurring before October 1, 1975 when the cost-of-living escalator became effective. Without supplementary benefits, these workers would be receiving between $17.50 and $100 per week, depending on the year of their injury and their weekly wage at the time. (The older the injury, the lower the benefit level.) By contrast, workers injured between October 1, 1987 and September 30, 1988 would receive between $75.20 and $376 per week, the current minimum and maximum.

Most supplementary benefits go to workers whose benefits are low and who are ineligible for cost-of-living adjustments.

We conclude, therefore, that the major portion of supplementary benefits currently go to workers whose benefits are low by today's standards and who are ineligible for cost-of-living adjustments. However, many of these workers are also eligible for supplementary benefits because their wages were low or because their benefits were reduced to offset social security payments they were receiving. Furthermore, the percentage of supplementary benefits paid to workers injured too early to qualify for cost-of-living adjustments will decline and eventually become zero as those workers die or go back to work and recently injured workers become eligible for supplementary benefits.

Below Average Wage Earners

The second category of worker to benefit are those earning low wages at the time of injury. For example, workers injured on January 1, 1988 earning less than $366.60 per week (97.5 percent of the statewide average weekly wage) would receive basic weekly benefits between $75.20 and $245. Once they qualify for supplementary benefits, they would receive a total of $245 per week, which is 65 percent of the statewide average weekly wage.[1] As a result of supplementary benefits, many below average wage earners eligible for supplementary benefits receive considerably more from workers' compensation than they earned while working. Because workers' compensation benefits are tax exempt, the take home differential is even greater.

Restoration of the Social Security Offset

The third reason workers receive supplementary benefits is to restore the state reduction in benefits for workers who are also eligible for social security benefits. On the surface, both federal and state law prohibit simultaneous receipt of social security and workers' compensation benefits. However, workers collecting supplementary benefits can in fact collect most of their workers' compensation benefits as well as social security benefits.

A 1965 federal law requires that social security disability benefits be reduced so that the total of state workers' compensation benefits and social security disability benefits does not exceed 80 percent of the pre-injury wage.

1 For simplicity's sake, this illustration ignores cost-of-living increases. The basic weekly benefit and the supplementary benefits rate will both be higher when the worker injured in 1988 becomes eligible for supplementary benefits.

However, the reduction does not apply if a state reduces workers' compensation benefits by social security benefits received. In 1973, Minnesota enacted a state offset. After the first $25,000 in total disability benefits, subsequent weekly workers' compensation benefits received by permanently disabled workers are reduced by benefits received under any government disability program and by old age and survivors benefits (social security).

From a state's perspective, it makes sense to offset workers' compensation benefits by social security benefits. This saves the state's employers money at the expense of social security. Minnesota is one of eleven states with such an offset. Recognizing the potential for other states to enact an offset, a 1981 federal law required the social security administration to refuse to recognize any new state offsets. State offsets in effect prior to that law were grandfathered in.

In theory, therefore, workers cannot simultaneously receive all of their social security disability benefits and workers' compensation benefits. If a state is not one of the eleven states with pre-1981 laws reducing workers' compensation benefits, then the federal government reduces social security benefits.

Some Minnesota workers collect both social security and nearly the full workers' compensation benefit.

However, a loophole in the federal law allows Minnesota workers to receive both benefits simultaneously. The relevant federal statute states that the social security offset does not apply if there is a reduction in state benefits (for the eleven states that already have reductions), but it does not specify that there be a 100 percent reduction.[2] Thus, one of the eleven states could reduce only a portion of the workers' compensation benefits and injured workers would still be eligible for social security disability benefits.

In Minnesota, eligibility for supplementary benefits is determined on the basis of weekly workers' compensation benefits after those benefits are reduced by social security benefits. In order to comply with the federal requirement that there be a reduction in state benefits, supplementary benefits are reduced by five percent. In 1978, Minnesota received a ruling from the Social Security Administration that its five percent reduction in workers' compensation benefits is acceptable and does not result in the federal government reducing social security disability benefits. In effect, many injured workers in Minnesota are eligible for both social security and workers' compensation disability benefits.

There is no federal reduction in social security old age benefits for workers' receiving workers' compensation benefits. On the other hand, Minnesota's reduction in workers' compensation benefits does apply to social security old age benefits (for permanently totally disabled workers after the first $25,000 in benefits). Once again, this reduction in workers compensation benefits is restored for workers eligible for supplementary benefits.

Table 5.2 illustrates the calculation of social security and workers' compensation benefits for workers of different income levels.[3] We note that the actual amount of social security benefits is based on several factors, including wage

2 See U.S. Code, Title 42, §424a (d).

3 These wage levels are, respectively, 200, 150, 100, 75, 50, 20 and 10 percent of the statewide average weekly wage.

TABLE 5.2

CALCULATION OF WORKERS' COMPENSATION SUPPLEMENTAL BENEFITS AND SOCIAL SECURITY BENEFITS
As of January 1988 for Selected Weekly Wages

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
Wage	Workers' Compensation Benefit	Social Security Benefit[a]	W.C. Benefit After Social Security Offset (b - c)	Supplemental Benefits ($245 - d)	5% Reduction (.05 x e)	Net Supplemental Benefits (e - f)	Total Benefits (c + d + g)	Percent of Wage (h / a)
$752	$376	$240	$136	$109	$ 5	$104	$480	64%
564	376	203	173	72	4	68	444	79
376	251	163	88	157	8	149	400	106
282	188	133	55	190	10	180	368	130
188	188	103	85	160	8	152	340	181
75	75	67	8	237	12	225	300	400
38	75	34	41	204	10	194	269	708

[a]Ninety percent of first $319 monthly salary, 32 percent of next $1,603, 15 percent of remainder.

history and family size. The amounts in our illustration are a reasonable estimate of what social security benefits would be.

Table 5.2 shows that the total benefits (weekly compensation, supplementary benefits and social security) in "column h" exceed the workers' pre-injury wage ("column a") for all workers earning the January 1988 statewide average weekly wage of $376 and less. The lower the pre-injury wage, the greater the percentage of total benefits to wages ("column i"). For workers earning $75 per week, the total workers' compensation, social security and supplementary benefits would be over four times their pre-injury income. When taxes are considered, a much higher percentage of workers receiving supplementary benefits and social security have more take-home pay than before they were injured. For example, if workers earning $564 per week paid 25 percent of their gross pay in federal, state and social security withholding taxes (a conservative estimate), their combined benefits of $444 per week would exceed their after tax weekly wage of $423. Some workers also receive benefits from union or other private pension plans and additional social security benefits to their dependents. These benefits would be in addition to the amounts in "column h" of Table 5.2.

A recent study of insurance company requests for reimbursement of supplementary benefits in the year ending September 30, 1986 found that 38.5 percent of supplementary benefits (excluding cash settlements) were paid to reimburse workers for reductions in their basic benefits due to their receipt of social security benefits.[4] If these percentages are applied to FY 1987 expenses, approximately $18.7 million is spent restoring reductions for simultaneous receipt of social security benefits. The study also found that 63.8 percent of the workers receiving supplementary benefits for the year ending September 30, 1986 were over age 60 and 44.1 percent were over 65 years old. In other words, many were eligible for and presumably receiving social security old age benefits. Although the 1983 legislation instituted a rebuttable presumption that anyone injured after October 1, 1983 who received social security old age benefits was retired from the labor market (and, therefore, not eligible to collect workers' compensation), workers merely have to state that, but for the injury, they would have continued working in order to remain eligible for workers' compensation, even though they also collect social security retirement benefits. Thus, many injured workers eligible for supplementary benefits can effectively retire with combined social security and workers' compensation payments higher than when they worked.

Comparisons With Other States

Minnesota is one of about 12 states that pay supplementary benefits. In Chapter 3, we compared Minnesota's supplementary benefits with those of other states. We concluded that:

- **Minnesota's supplementary benefits are more encompassing and more generous than supplemental benefits of other states.**

4 Pamela Wheelock, *The Minnesota Workers' Compensation Supplementary Benefits Program*, (Minnesota Department of Labor and Industry, January 1988).

Supplementary Benefits and Incentives to Return Injured Workers to Work

Minnesota's supplementary benefits result in many workers receiving higher weekly after-tax incomes than before they were injured.

Minnesota's supplementary benefits result in many workers receiving higher weekly after tax incomes than before they were injured. The number of workers receiving combined social security and workers' compensation supplementary benefits which exceeds their pre-injury wage is considerably higher. Also, the insurance company managing a specific claim lacks a strong incentive to aggressively work to return the employee to work, since a large proportion of the costs of that claim are paid by all insurers through the special fund. We conclude, therefore, that:

- **supplementary benefits paid through the Special Compensation Fund reduce the incentives for many injured workers to return to work and reduce employers' and insurance companies' incentives to control costs and help return injured workers to work.**

Recommendations

In drawing conclusions and making recommendations about workers' compensation benefits, we are guided by certain assumptions outlined in Chapter 1. Workers' compensation benefits should provide adequate compensation while limiting incentives for workers to stay out of work. We conclude that:

- **On the whole, Minnesota's current system of supplementary benefits is more than adequate and contains important incentives for some injured workers to remain out of work.**

In our view, workers permanently totally disabled prior to October 1975 who are ineligible for annual cost-of-living adjustments should receive supplementary benefits to bring their weekly compensation up to an acceptable level. Most workers injured after that date have less need for supplementary benefits since annual cost-of-living adjustments help their benefits keep pace with inflation.

One option for the Legislature to consider is to eliminate supplementary benefits for all future injuries. However, if this were done, workers at the low end of the wage scale might not receive benefits sufficient to subsist. An argument can be made that many low wage earners would have raised themselves to a higher salary over time. For example, a part-time worker attending school at night, but for a disabling injury, might have achieved a relatively high future salary. In cases such as this, raising benefits to 65 percent of the statewide average weekly wage could be considered fair compensation for the individual's loss of future earnings capacity. This case must be weighed against a low-wage workers who has little likelihood of raising his or her income level.[5] For low-wage workers, supplementary benefits function as a min-

5 A few states allow adjustments to the pre-injury wage for long-term disability benefits of workers' who can show that their wages would have likely increased had they not been injured.

imum benefit level for long-term disabilities. Accordingly, we suggest that to the extent that the Legislature wishes to reduce costs:

- **supplementary could be reduced to provide a minimum benefit of, for example, 50 percent of the statewide average weekly wage.**

Adopting this recommendation will reduce costs and still leave Minnesota with one of the highest minimum benefit levels for long-term disabilities in the country.

Workers' compensation should not provide strong rewards for staying out of work.

Workers' compensation should not provide strong rewards for staying out of work. The workers' compensation system is designed primarily to replace lost wages that result from workplace injuries, not as an income maintenance or retirement program. Accordingly, we recommend that the Legislature consider the following additional changes in supplementary benefits to reduce workers' compensation costs, ensure that benefits go to those who need them, and retain incentives for employees and employers to return injured workers to work:

- **Future supplementary benefits could be restricted to persons found to be permanently totally disabled.**

To the extent that those designated as permanently disabled are truly unable to work, the issue of providing improper incentives is less important.

- **Social security old age and disability benefits and employer-provided pension benefits should be added to workers' compensation benefits in determining eligiblity for supplementary benefits.**

Injured workers should not collect both benefits to the extent that the total exceeds their pre-injury wage. Based on the study discussed above, we estimate that adopting this recommendation would reduce supplementary benefit payments by over 38 percent in the long run and reduce the likelihood that many workers would receive total benefits in excess of their pre-injury wages. It would still raise benefits for low-wage earners.

We see no significant advantage to the current system for financing supplementary benefits.

Finally, we think the Legislature should consider:

- **financing supplementary benefits for future injuries through the regular insurance system instead of through the Special Compensation Fund.**

In other words, insurers would pay supplementary benefits to eligible workers along with basic wage-replacement benefits and there would be no reimbursement from the special fund.

We see no significant advantage to the current system for financing supplementary benefits.[6] Under the current system, the insurance company pays

6 It made sense when supplementary benefits were first established that increased benefits for workers injured in the past be shared by all insurers. However, this reasoning does not apply to future injuries, where insurers are able to reserve for future losses.

the benefits and is reimbursed by the special fund. The special fund then assesses all insurance companies for the cost of reimbursing them.

We see two problems with this arrangement. First, as discussed above, spreading the cost burden for supplementary benefits among all insurers provides individual insurance companies with economic incentives not to manage individual claims aggressively and not to strive to return injured workers to work. Second, this three-step process of handling what is essentially a one-step payment increases the state's administrative expenses. The state must go through the expense of receiving and reviewing each reimbursement request, reimbursing each insurer, and determining and collecting the assessment from each insurer. If the supplementary benefits were handled like any other claim, these expenses would not be necessary.

We recognize that the prospective reduction of supplementary benefits and their removal from the special fund will not immediately produce significant cost savings. In fact, insurers will now have to reserve for future obligations rather than treat them as an expense when the assessment comes due. In the short run, this by itself might lead them to increase their workers' compensation insurance rates. In the long run, however, adequately reserving for future obligations is more fiscally responsible and produces a more accurate picture of the true cost of supplementary benefits.

Benefits are currently being paid to workers injured as much as 40 years ago. Thus, it may take 40 years or longer before those workers currently receiving supplementary benefits are removed from the system.[7] Indeed, the department estimates that if all supplementary benefits were prospectively terminated, it would still cost over $900 million to pay supplementary benefits over the lifetimes of the current recipients. Nevertheless, we believe that our recommendations are consistent with the goals of workers' compensation and would represent an improvement over current practices.

SUBSEQUENT INJURIES

The second largest and the oldest component of the special compensation fund is the payment of subsequent injury claims. This has commonly been called the "second injury fund" although it applies to all subsequent injuries. The special compensation fund reimburses insurers for a portion of the benefits paid to workers who suffer an injury that is made worse by or would not have occurred at all except for a prior injury or condition.

Reimbursement of employers for benefits related to second injuries was established in 1919 when the special compensation fund was created. The purpose of reimbursement is to reduce job discrimination against previously injured or otherwise disabled workers. It is thought that employers would be reluctant to hire handicapped or previously injured employees for fear that they are more susceptible to future injuries and would make the employer susceptible to more workers' compensation claims and higher insurance premiums. By

7 The oldest recipient of supplementary benefits is currently 96 years old.

reimbursing employers from the special fund, all employers must share the risk of hiring disabled or previously injured employees.

Registration of Injuries

Minnesota requires workers with an existing disability or injury to register with the special compensation fund prior to the subsequent injury. The statute allows registration of a number of conditions, such as epilepsy, hemophilia, diabetes, heart disease, and other impairments equivalent to a disability rating of ten percent of the body if evaluated according to the standards for evaluating permanent partial disability. The condition or disability does not have to be the result of a work-related injury. The department received 6,269 registrations in 1986. Of these, 2,155 were for diseases or inherited conditions including diabetes, epilepsy, vision problems, neuromuscular diseases, and others. The remainder were orthopedic conditions, mostly back injuries.

We examined a ten percent sample of registrations received in 1986. Table 5.3 presents a breakdown of registrations according to general categories of the condition or previous injury. Table 5.3 indicates that almost half of the registered conditions are back injuries. Arm and leg injuries and diabetes and kidney disorders make up the next most popular groups. Only a small percentage of these employees will have a subsequent injury and receive benefits reimbursed by the special compensation fund.

Condition/Injury	Percent of Registrations
Back Injury	46%
Arm, Leg Injuries	15
Diabetes, Kidney Disorders	13
Epilepsy, Seizures, Head Injuries	8
Hearing, Vision Disorders	5
Heart, Lung Conditions	5
Muscle, Bone Diseases	4
Other	4
	100%

Source: Department of Labor and Industry records.

Table 5.3: Percentage Breakdown of Fiscal Year 1986 Subsequent Injury Registrations

Between 1979 and 1986, Minnesota allowed injured workers to register for the fund retroactively up to six months after the injury. If an insurance company could present evidence that the second injury was exacerbated by a previous injury or condition, it could still put in a claim for reimbursement from the special fund. Effective August 1, 1986, only injuries for workers whose condition is pre-registered with the fund are eligible for reimbursement. Department staff review registrations and reject those that do not meet statutory requirements.

Reimbursement by the Special Compensation Fund

Minnesota permits two kinds of reimbursements for subsequent injuries. The first is for injuries that are made worse because of a previously registered injury or condition. For example, consider the case of a worker with a ten per-

cent disability of the back who has a second injury that would not itself have been serious but because of the prior condition, it results in a 50 percent disability. For these types of cases, the special fund reimburses the insurer for the portion of benefits attributable to the second injury (in this example, 40 percent) after a deductible of $2,000 in medical payments and 52 weeks of indemnity payments.

The second kind of reimbursement is for injuries that would not have occurred but for a previously registered condition. For example, a worker with epilepsy would qualify if he had a seizure that resulted in a fall and a serious injury. For these types of cases, the special compensation fund reimburses the insurer in full. There is no deductible.

Department staff review requests for second injury reimbursement. This includes a review of the medical reports to determine whether the second injury was, in fact, made worse because of a pre-existing registered condition. If the staff believes that there are not adequate grounds for reimbursing the insurer, the department will deny the claim and defend the fund in any ensuing litigation. In FY 1987, the special fund reimbursed insurers $33.4 million for second injuries.

Comparison With Other States

All fifty states and the District of Columbia have second or subsequent injury funds. However, they vary greatly in the extensiveness of their coverage. Most states, including Minnesota, have broad coverage for any disability made substantially greater because of a pre-existing injury or condition. Nineteen states limit coverage to subsequent injuries that result in permanent total disability. A few states, including Iowa, Illinois, and Indiana are very restrictive. In those states, the second injury fund only covers prior conditions such as the loss of one eye, arm, or leg followed by a subsequent loss of the other eye, arm, or leg.

For most states, reimbursement is limited to the difference between compensation for the combined disability and that which would have resulted had the injury occurred without any prior injury. Some states also restrict prior conditions to work-related injuries. Minnesota does not require prior conditions to be work-related and reimburses the employer for all benefits relating to the second injury less the benefits paid on the first injury and the deductible discussed above.

Minnesota's second injury reimbursements are among the highest in the nation.

Table 5.4 presents data from a U.S. Department of Labor survey of benefits reimbursed by the second injury funds of the different states. The table also indicates the percentage of second injury benefits to total workers' compensation benefits paid in those states. The data reflect the most recent information available, usually 1985 or 1986. Some of the second injury funds may include payments for other purposes, such as supplementary benefits and payments to employees of uninsured employers.

Table 5.4 indicates that Minnesota's second injury reimbursements are among the highest of the 40 states for which information is available. Minnesota is behind only West Virginia, Kentucky, and New York on a total dollar basis and behind Kentucky, West Virginia, and Connecticut as a percentage of total

State	Benefits Paid by Second Injury Fund (000s)	Percent of Total Benefits Paid[a]
Alabama	$ 83	0.0%
Alaska	2,100	2.3
Arizona	4,850	2.9
Arkansas	825	0.6
California	4,055	0.2
Colorado	N/A	N/A
Connecticut	19,418	7.3
Delaware	1,893	5.2
Dist. of Col.	150	0.2
Florida	N/A	N/A
Georgia	325	0.1
Hawaii	6,923	6.0
Idaho	N/A	N/A
Illinois	700	0.1
Indiana	477	0.4
Iowa	107	0.1
Kansas	7,434	5.8
Kentucky	54,900	28.3
Louisiana	N/A	N/A
Maine	122	0.1
Maryland	N/A	N/A
Massachusetts	N/A	N/A
Michigan	13,691	2.2
MINNESOTA	**33,900**	**9.2**
Mississippi	21	0.0
Missouri	5,991	3.1
Montana	212	0.3
Nebraska	120	0.2
Nevada	132	0.1
New Hampshire	137	0.2
New Jersey	N/A	N/A
New Mexico	938	0.8
New York	33,386	3.9
North Carolina	42	0.0
North Dakota	76	0.3
Ohio	N/A	N/A
Oklahoma	N/A	N/A
Oregon	8,204	2.4
Pennsylvania	51	0.0
Rhode Island	2,700	3.1
South Carolina	11,702	9.1
South Dakota	17	0.1
Tennessee	48	0.0
Texas	137	0.0
Utah	3,989	6.0
Vermont	0	0.0
Virginia	5	0.0
Washington	N/A	N/A
West Virginia	59,219	23.4
Wisconsin	N/A	N/A
Wyoming	0	0.0
Mean	6,955	3.2
Median	589	0.3

N/A - Not available.

Sources: U.S. Department of Labor, State Workers' Compensation Administration Profiles, October 1986; National Foundation for Unemployment Compensation and Workers' Compensation, "Fiscal Data for State Workers' Compensation Systems", February 1987; Minnesota Department of Labor and Industry.

[a]Based on 1984 benefits paid.

Table 5.4: Interstate Comparison of Second Injury Funds

benefits paid in the state. (Kentucky and West Virginia both have large coal mining industries and a high percentage of their subsequent injury benefits go to victims of black lung disease.) Benefits paid by Minnesota's second injury fund amount to about nine percent of the total workers' compensation benefits paid in the state, whereas 60 percent of the states reporting second injury fund expenditures indicate that second injury reimbursements make up less than one percent of the total benefits paid.

Based on the data in Table 5.3 and the discussion above, it is apparent that although all states have second injury funds, Minnesota's is more inclusive than most states. We discuss the policy implications of this in the next section.

Discussion

Unlike supplementary benefits, reimbursements to insurers for claims relating to second injuries do not directly effect the total amount of benefits paid. However, there is undoubtedly an indirect effect, perhaps substantial, although it cannot be quantified. It seems plausible that insurance companies will exert less effort in managing second injury claims and returning injured workers to work when they know that they will be reimbursed by the fund.

For example, a worker earning $376 per week, the current statewide average weekly wage, would receive temporary total benefits of about $251 per week. If the worker had a previously registered disability, the insurers' liability would be limited to 52 weeks of benefits plus $2,000 of medical expenses for a total of $15,035. The insurer might believe it had legal grounds to contest the claim, but the potential legal and administrative fees might exceed its liability. Similarly, there would be less economic incentive for the employer to offer the worker in this example a suitable job because the higher economic recovery benefits would be reimbursed by the special fund.

Thus, we conclude that:

- **the subsequent injury component of the special compensation fund provides some disincentives for effective claims management and the speedy return of injured workers to their jobs.**

The subsequent injury component of the special compensation fund is justified as a means of reducing job discrimination against handicapped or disabled workers. Although it is logical to assume that employers will be more willing to hire disabled workers if their workers' compensation liability is reduced, this proposition has never been empirically verified. Are employers more concerned about possible future workers' compensation costs, or are they primarily concerned whether or not the disabled employee can adequately do the job? Furthermore, many small employers are not experience rated. Their insurance premiums are not directly affected by the claims of their employees.

If insurance companies have fewer incentives to manage subsequent injury cases as aggressively as other claims, it is important that the state agency fill this void. The department, however, does not have the authority to manage these cases. The department's efforts are directed toward protecting the fund

from invalid second injury claims. The department recently received authority to audit insurance company claim files and has refused to reimburse claims that were not viewed as legitimate. On the whole, however, the department does not have the resources to aggressively oversee insurance companies' management of claims after the liability of the second injury fund has been established. Generally, the department gets involved only when a petition is filed by an employee or insurance company or a settlement is proposed that would affect the fund's future obligations. Therefore, the possible refusal of the department to reimburse the insurer is the only factor countering the built-in disincentives to effective management of second injury claims.

The second injury component of the special fund should be retained but limited.

It is likely that some disabled workers find it easier to obtain employment because of second injury reimbursements.[8] However, this must be weighed against the disincentives created for controlling workers' compensation costs and returning injured workers to work. We suggest that the second injury component of the special fund be retained but that it be limited. One way to limit reimbursements is to restrict registrations to more seriously impaired workers. We recommend that the Legislature consider:

- **raising the minimum disability rating required in Minn. Stat. §176.131, subd. 8(t) for registration with the special fund.[9]**

For example, based on data provided by the department for the first six months of 1987, raising the minimum disability rating from ten to twenty-five percent would eliminate about 62 percent of the registrations.

We also think that:

- **the deductible could be increased or a co-payment by the insurer could be required to increase incentives for employers and insurers to manage cases effectively and make greater efforts to return injured workers to work.**

For example, the Legislature could extend the deductible period from one to two years. Or, the Legislature could require that the insurer provide a 20 to 25 percent co-payment on indemnity payments beyond the first year. In addition, the current $2,000 deductible amount for medical expenses could be raised. These changes would reduce the special fund's expenses while maintaining protection for the insurer in the more serious cases.

In summary, the second injury fund decreases the likelihood of effective claims management for a significant percentage of claims and distributes these costs to all insurers (and ultimately employers). While this procedure probably helps some disabled people get jobs, it also increases the cost of the workers' compensation system. Restricting eligibility for second injury reimbursement to more seriously disabled workers strikes the proper balance be-

8 On the other hand, some disabled workers might be urged to take jobs that pose medical risks for them since insurers do not bear the full financial risks of subsequent injuries.

9 Subd. 8(t) permits registration for "any other physical impairment resulting in a disability rating of at least ten percent of the whole body if the physical impairment were evaluated according to standards used in workers' compensation proceedings."

tween encouraging hiring of the disabled and providing proper incentives to control costs and return injured workers to work.

SPECIAL CLAIMS

All states require employers to carry workers' compensation insurance, either by purchasing it on the voluntary market, by self-insuring, or, for six states, by participating in an exclusive state fund. Despite the mandatory insurance requirements, many employers fail to obtain insurance. In some cases, self-insurers go bankrupt and are unable to meet their insurance obligations. Although self-insurers are required to post a bond, the bond is often insufficient to pay all of the company's ongoing workers' compensation benefits. In these instances, workers injured on the job cannot collect benefits unless the state provides a mechanism to pay them.

In 1987, the special fund paid $6.8 million in benefits to workers of uninsured or bankrupt self-insured employers.

According to the U.S. Department of Labor survey, about half of the states without exclusive state funds have a special fund for paying benefits to employees of uninsured employers or bankrupt self-insured employers. In Minnesota, the special claims component of the special compensation fund pays these benefits. The special claims component also pays benefits on a temporary basis in cases where insurers dispute which one is liable for the injury. The fund is then reimbursed for benefits paid plus interest calculated at 12 percent per year by the insurer ultimately found to be liable.

Special claims make up only seven percent of special fund obligations. In FY 1987, special claims expenses were $6.8 million. Several major bankruptcies of self-insurers make it likely the amount will increase in FY 1988.

Table 5.5 summarizes the outstanding special claims cases as of September 30, 1987. Table 5.5 indicates that there are currently 1,185 open files, of which 903 (76 percent) involve payment of benefits. Almost three-fifths of the cases involve employees of uninsured employers and 37 percent are employees of bankrupt self-insurers. Only 45 cases are being paid by the fund temporarily until a dispute among insurers is resolved. The 1987 legislation strengthened

Type of Case	Status Not Yet Determined	Case Being Litigated	Medical Only Benefits Being Paid	Indemnity Benefits Being Paid	Total
Uninsured	58	219	282	143	702
Bankrupt Self-Insured	0	5	314	119	438
Temporary Orders	0	0	18	27	45
Total	58	224	614	289	1,185

Source: Department of Labor and Industry.

Table 5.5: Special Claims Cases Outstanding As of September 30, 1987

statutory language allowing the department or a compensation judge to require one of the disputing insurers to make payments pending a determination of which one is liable. As a result, the special fund is likely to process fewer temporary orders cases in the future.

In FY 1987, the department recovered $1 million from a bankrupt self-insurer and about $66,000 in repayments for temporary order reimbursements. The special fund also received a $2 million appropriation from the state's general fund to partially compensate it for special claims expenses. The Legislature appropriated $2.5 million for this purpose in each year of the 1988-89 biennium. Recoveries of $139,000 from unemployed insurers were credited to the general fund. It is clear that:

- **the special fund recovers only a small fraction of the special claims benefits that it pays, and the Legislature has not appropriated sufficient general fund revenues to make up the difference.**

The special fund receives about 40 new cases each month. In most of these cases, the department is contacted by the injured party who is having difficulty finding out from the employer who the insurer is (because there is none). The department will telephone the worker and check to see if the employer is insured. If it is not, the department will assist the worker in filing a first report of injury. In some cases, the employer files a first report of injury and leaves the name of the insurer blank.

Most uninsured companies are either new or very small. Some claim to not understand the insurance requirements, viewing themselves as contractors and their employees as subcontractors. Department staff report that a good proportion of uninsured employers are roofers, landscapers, and truckers who pay employees by the job, not by the hour.

In cases where the employer accepts liability, the department will pay the benefits and work out an agreement for partial reimbursement based on the employer's ability to pay. A condition of these settlements is that the employer obtain insurance so that future accidents are covered. The settlement may also involve a penalty against the employer for failure to insure. The 1987 legislation increased the penalty to $750 for companies with fewer than five employees and $1,500 for larger companies (up from $100 and $400, respectively). If the department determines that the employer willfully and deliberately failed to obtain insurance, the fine is now $2,500 for companies with fewer than five employees and $5,000 for larger companies (up from $500 and $2,000, respectively).

The department's policy is to accept partial reimbursement rather than force small companies into bankruptcy. The department would rather get some settlement than go through the expensive process of litigation involved in a bankruptcy proceeding and end up with nothing. In cases involving larger companies, the department reports that it has been able to obtain full reimbursement for claims. If the employer refuses to cooperate, the department may file a petition for reimbursement. A hearing is then held before a compensation judge. In most of these cases, the employer does not show up for the hearing and a default judgement is entered. The department can then go to district court and place a lien on any property owned by the employer. This is rarely done. For small employers, especially independent contractors, there may be no property and little to actually collect.

The Attorney General's Office represents the department in collection proceedings. Attorney General staff report that they would like to take more cases to court to enforce collections, but they do not have adequate resources. Given the expense and difficulty involved in actually collecting reimbursements from uninsured employers, we conclude that:

- **the department's emphasis on settling cases and accepting partial reimbursement from uninsured employers is reasonable.**

The department has recently hired an investigator to locate uninsured companies before there is a claim. A penalty is then imposed. More important, the employer is encouraged to obtain insurance or risk a greater fine for noncompliance.

Self-insured companies are required to post a bond with the Department of Commerce. This bond is easily collectible by the department, but it has not been adequate to cover outstanding benefits in large bankruptcy cases. The 1987 legislation significantly increased the bonding requirements for workers' compensation self-insurers. In addition to collecting the bond, the department, through the efforts of the Attorney General's Office, is usually a party to bankruptcy proceedings. The Attorney General is also concerned with other employee benefits, such as pensions, so recovering significant amounts through bankruptcy proceedings is unlikely.

Department staff report that they do not automatically pay all claims. Like other insurers, the department talks to the employer about the circumstances of the injury and reviews medical records. If the employer presents valid reasons why the claim should be denied and is willing to share the legal expenses in fighting the claim, the department may contest the claim. As is true for private insurers, most contested disputes are settled at settlement conferences. If a formal hearing is conducted by a compensation judge, the Attorney General's Office represents the special fund.

ADMINISTRATIVE EXPENSES

The 1983 legislation added 90 positions to the department and appropriated funds for FY 1984 from the special compensation fund to pay for them. In 1985, the Legislature shifted responsibility for funding the entire administration of the workers' compensation system from the general fund to the special fund.

According to the U.S. Department of Labor survey, most states support their workers' compensation administrative systems with revenues derived from the insurance industry, either through premium taxes or assessments against insurers. Only 17 states support the system through general appropriations.

In Minnesota, special fund assessments support the Workers' Compensation Division of the Department of Labor and Industry, the compensation judges at the Office of Administrative Hearings, and the Workers' Compensation Court of Appeals. In FY 1987, these expenses amounted to $9.2 million, or nine percent of special fund expenses. Thus, requiring the insurance industry

to support the administration of workers compensation contributes to the cost of workers' compensation insurance.

In 1987, special fund expenses amounted to $98 million, or about 12 percent of the total cost of workers' compensation.

SUMMARY

Assessments by the special compensation fund constitute a significant portion of costs for Minnesota insurers. Minnesota's special fund is much larger than those in other states, both in absolute terms and as a percentage of total benefits paid. In FY 1987, the special fund's expenses amounted to $98 million, or about 12 percent of the total cost to employers of workers' compensation in Minnesota. Currently, for every dollar paid out in benefits for lost time or death cases in Minnesota, an additional 31 cents is paid to the fund. Most of this money pays for benefits that would have to be paid by insurers even if there were no special fund. However, by providing this mechanism whereby all insurers share the cost of supplementary benefits and benefits for subsequent injuries, the incentives for individual insurers to control costs and effectively manage claims are reduced. While the magnitude of this indirect effect is unknown, the Legislature needs to consider the effect that it may have on increasing the overall costs of workers' compensation in Minnesota.

In this chapter, we demonstrate that supplementary benefits sometimes result in workers earning more money after an injury than before, thus reducing their incentives to return to work. We think that supplementary benefits could be reduced and that cost savings to Minnesota's employers would result. We also think that removing supplementary benefits from the special fund and financing them through insurance rates like other benefits would indirectly reduce expenses, give insurers a greater degree of control over their costs, and reduce unnecessary administrative expenses.

In the case of subsequent injury benefits and claims for employees of uninsured (or bankrupt self-insured) employers, a special fund is a reasonable method of spreading the costs around. If concerns over workers' compensation claims is indeed a factor that inhibits employment of the disabled, then a subsequent injury fund should reduce that concern. However, Minnesota's subsequent injury fund is more inclusive than most states. We suggest that restricting those eligible to register for subsequent injury benefits and reducing the deductible amount or requiring a co-payment could strike a better balance between providing incentives to employers to hire the handicapped and providing incentives to insurers to control costs.

The Department of Labor and Industry is adequately administering the special fund.

The evidence we have been able to gather suggests that the Department of Labor and Industry is adequately administering the fund. The department is actively involved in managing special fund cases and denying those requests for reimbursement that do not meet statutory requirements. If the fund is involved in a contested case or a case in which the worker accepts a lump sum settlement, department staff intervene in the case and represent the interests of the fund. The department also represents the fund in cases involving uninsured employers if it believes that the worker's claim is not valid. Thus, although we cannot objectively judge the results of the department's efforts on behalf of the fund, those efforts appear to be worthwhile.

However, the department's efforts are not an effective substitute for cost-effective claims management. That remains the responsibility of insurance companies. Because Minnesota's special compensation fund is so encompassing, it removes incentives for efficient claims management for a significant portion of workers' compensation claims. Although we cannot quantify the exact effects, this claims management void is undoubtedly refected in higher claims expenses and higher insurance premiums.

JUDICIAL INTERPRETATION OF THE 1983 AMENDMENTS

Chapter 6

One of the major goals of the 1983 amendments to the Workers Compensation Act was to reduce costs by encouraging an early return to work. The Legislature sought to accomplish this goal by: (1) involving a Qualified Rehabilitation Consultant (QRC) in the employee's recovery as early as possible, (2) providing incentives for both employers and employees to get employees back to work, and (3) termination of the open-ended temporary benefit structure. The Legislature also sought to reduce costs by reducing the uncertainty in the law and, thereby, reducing litigation.

This chapter takes a close look at what happened to the statutory changes in 1983 designed to limit temporary benefits and reduce uncertainty in the law. As will soon become clear, successive court cases have eroded what many thought was the purpose of the 1983 law, and created an atmosphere of confusion that remains unresolved.

CHANGES IN THE BENEFIT STRUCTURE

The most significant changes enacted by the 1983 Legislature affected the Compensation Schedule contained in *Minn. Stat.* §176.101. Under both the new law and the old law [1] January 1, 1984, and covers all work-related injuries after that date. injured employees can receive both wage-loss benefits and loss of function benefits. Wage-loss benefits are benefits for permanent total disability (PTD), temporary total disability (TTD), and temporary partial disability (TPD), and are based primarily on the employee's pre-injury wage. Loss of function benefits are benefits for permanent partial disability (PPD) and are based, in part, on the percentage of permanent disability the employee suffered as a result of the injury. The new law made changes in both the wage-loss and the loss of function benefits.

1 Throughout this chapter we will refer to the Workers' Compensation Act prior to the 1983 amendments as the old law and after 1983 amendments as the new law. The new law took effect on January 1, 1984, and covers all work-related injuries after that date.

Temporary Benefits

Under the old law, eligibility for temporary total disability (TTD) benefits was based on the employee's inability to find and hold a job rather than the temporary or total nature of the physical injury.[2] Since the statute did not provide an end date for TTD benefits, employees could receive TTD benefits indefinitely as long as they were unable to hold a job. Under the new law, TTD benefits cease, at the latest, 90 days after an employee reaches maximum medical improvement (MMI) or 90 days after completion of an approved retraining program.[3] MMI is defined as "the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based on reasonable medical certainty."[4] Cutting off TTD benefits 90 days after the employee reaches MMI (90 days post-MMI) is designed to encourage employees to return to work as soon as possible.

It is also based on a concept of workers' compensation that emphasizes:

- the finite duration of temporary benefits;
- linkage of termination of temporary benefits to the end of the healing period;
- the importance of a return to work, not just the adequacy of indemnity benefits; and
- the inability of an affordable workers' compensation system to totally protect workers from all consequences of work-related injuries.

The new law also provides that temporary total disability (TTD) benefits cease when the employee is offered a job which meets the requirements of either *Minn. Stat.* § 176.101, Subd. 3e (1986) (hereafter Subd. 3e), or *Minn. Stat.* §176.101, Subd. 3f (1986) (hereafter Subd. 3f). A 3e job is also referred to as a "suitable job" and a 3f job is referred to as a "light-duty job." Both 3e and 3f jobs must be offered before 90 days after MMI.[5] Thus, TTD benefits can cease before 90 days post-MMI under the new law if the employee receives a suitable (3e) or light-duty (3f) job offer. See Tables 6.1 and 6.2 for a summary of benefits under present law.

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2 See *Schulte v. C.H. Peterson Construction Co.*, 278 Minn. 79, 153 N.W. 2d 130 (1967).

3 *Minn. Stat.* §176.101, Subd. 3e(a) (1986).

4 *Minn. Stat.* §176.011, Subd. 25 (1986).

5 The basic difference between a suitable (3e) and a light-duty (3f) job is that a suitable job must be one that either returns the employee to a job related to the employee's former job or produces an economic status as close as possible to that which the employee would have enjoyed without the disability. Light-duty jobs have neither of these requirements.

Situation	TTD Benefits	TPD Benefits	PPD Benefits
Employee receives and accepts a 3e job offer at a wage loss.[a]	Cut-off when job is offered.	Eligible from time TTD benefits end until employee reaches 2/3 of pre-injury wage.	Receives IC.
Employee receives and refuses a 3e job offer.	Cut-off when job is offered.	Never eligible.	Receives IC.
Employee receives and accepts a 3f job offer at a wage loss.[a]	Cut-off when job is offered.	Eligible from time TTD benefits end until employee reaches 2/3 of pre-injury wage.	Receives IC until 90 days post-MMI, then receives ERC if no 3e job is offered.[b]
Employee receives and refuses a 3f job offer.	Cut-off when job is offered.	May be eligible at TTD rate from time TTD benefits end.[c]	Receives IC until 90 days post-MMI, then receives ERC if no 3e job is offered.[b]
Employee receives a job offer after 90 days post-MMI.	Cut-off at 90 days post-MMI.	May be eligible at TTD rate from time TTD benefits end until employee begins working.[c] Then eligible in accordance with wage.	Receives ERC.
Employee receives no job offers.	Cut-off at 90 days post-MMI.	May be eligible at TTD rate from time TTD benefits end.[c]	Receives ERC.

[a] 3e and 3f jobs are, by definition, jobs offered before 90 days post-MMI. See. Minn. Stat. 176.101 subds. 3e and 3f (1986).

[b] ERC benefits are offset by IC benefits already paid.

[c] Non-working employees who are ineligible for TTD benefits may be eligible for TPD benefits if they can prove a loss of earning capacity. If non-working employees can prove that they have no earning capacity as a result of their disability, they can receive TPD benefits at the TTD rate. See Yates v. Eitel Hospital, 39 W.C.D. 373, 380 (WCCA 1986). Employees who never get jobs can, apparently, receive TPD benefits indefinitely at the TTD rate.

TTD - Temporary total disability
TPD - Temporary partial disability
PPD - Permanent partial disability
IC - Impairment compensation
ERC - Economic recovery compensation
3e job - Suitable job
3f job - Light duty job

Table 6.1: Summary of Wage-Loss and Loss of Function Benefits For Permanently Partially Disabled Employees

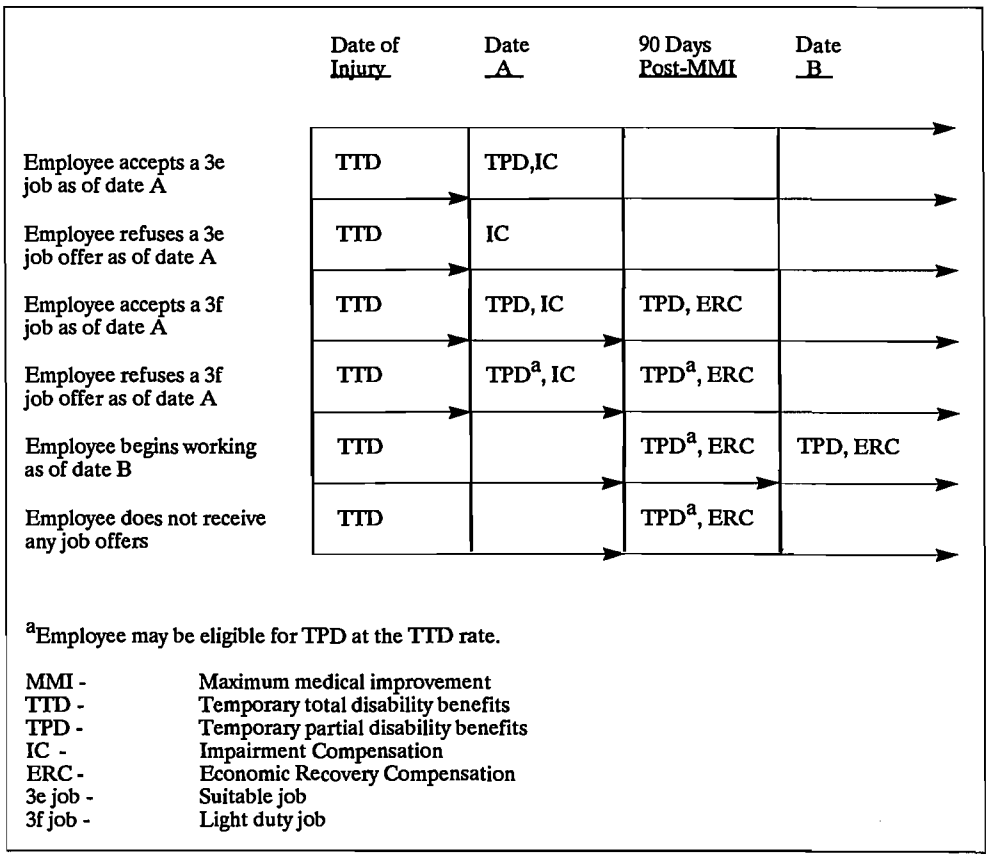

Table 6.2: Summary of Benefits

Regarding temporary partial disability (TPD) benefits, the new law deleted the last sentence of *Minn. Stat.* §176.101, Subd. 2 (hereafter Subd. 2). The last sentence of Subd. 2 provided:

> If the employer does not furnish the worker with work he can do in his temporary partially disabled condition and he is unable to procure such work with another employer, after a reasonably diligent effort, the employee shall be paid at the full compensation rate for his or her temporary total disability.

The new law discarded the old permanent partial benefit structure and created a two-tier benefit structure.

In addition, the new law added *Minn. Stat.* §176.101, Subd. 3h (hereafter Subd. 3h) and *Minn. Stat.* §176.101, Subd. 3n (hereafter Subd. 3n). Subdivision 3h provides that employees who accept and begin 3e or 3f jobs shall be eligible for TPD benefits pursuant to Subd. 2, (if otherwise appropriate). Subdivision 3n provides that employees who refuse 3e job offers shall not be eligible for TPD benefits or rehabilitation.

Permanent Partial Benefits

The new law discarded the entire permanent partial disability (PPD) benefit structure under the old law and created a two-tier benefit structure. Two

types of PPD benefits now exist, Impairment Compensation (IC) and Economic Recovery Compensation (ERC).[6] The higher-tier ERC benefits are awarded to employees who sustain a permanent disability to a part of their body and have not been offered a 3e job within 90 days post-MMI.[7] ERC benefits must be, at least, 120% of IC benefits for the same injury.[8]

The two-tier PPD benefit structure is designed to give employers an incentive to offer or find employees suitable jobs after they are injured. If an injured employee returns to work at a suitable (3e) job before 90 days post-MMI, the employer only has to pay the lower-tier IC benefits for any permanent partial disability the employee sustained. If the injured employee does not return to work at a 3e job before 90 days post-MMI, the employer is liable for the higher-tier ERC benefits. Again, see the tabular presentation of benefits presented in Tables 6.1 and 6.2.

The extent to which the changes made by the 1983 amendments will accomplish the Legislature's goals is not clear yet.

The extent to which the changes made by the 1983 amendments will accomplish the Legislature's goals is not clear yet. As was pointed out in earlier chapters, it takes several years once a provision is enacted to begin to see its impact in the normal statistical reports.

In the case of the 1983 amendments however, there is an additional problem. In the last year or so, the Workers' Compensation Court of Appeals (WCCA) has issued a number of decisions which have employers and insurers complaining about their effect on costs, and complaining that these decisions undo the reforms enacted in 1983. Temporary partial disability (TPD) benefits have been an area of particular concern to employers and insurers. In various decisions, the WCCA has:

- awarded TPD benefits to employees who are not working but are ineligible for temporary total disability (TTD) benefits;
- awarded TPD benefits to nonworking employees at the TTD rate;
- awarded TPD benefits to employees beyond 90 days post-MMI when they are not working at 3e jobs and, thus receiving ERC benefits;
- resurrected the reasonably diligent search for employment standard despite the fact that it was deleted from Subd. 2, and;
- awarded TPD benefits to employees who quit or were fired for cause from jobs.

Employers and insurers claim that the WCCA is ignoring the intent of the 1983 Legislature and essentially rewriting the statute.[9] They also claim that

6 *Minn. Stat.* §176.101, Subds. 3a and 3b (1986).

7 *Minn. Stat.* §176.101, Subd. 3p (1986).

8 *Minn. Stat.* §176.101, Subd. 3t(a) (1986).

9 Patricia Johnson, General Counsel, State Fund Mutual Insurance Company (undated memo).

these decisions have resulted in higher than expected costs and, in some cases, higher costs than under the old law.[10]

Employers and insurers claim that the court is ignoring the intent of the 1983 Legislature.

This chapter will look at the decisions of the WCCA regarding TPD benefits. It will attempt to examine how the WCCA arrived at its decisions, and whether the decisions are consistent with the language of the statute and the goals of the 1983 amendments. The purpose of this discussion is to review WCCA decisions affecting TPD benefits so that policy makers can determine what, if anything, needs to be done to achieve or promote the goals of the 1983 amendments.

WORKERS' COMPENSATION COURT OF APPEALS DECISIONS INTERPRETING ELIGIBILITY FOR TEMPORARY PARTIAL BENEFITS

The first and most important of the decisions issued recently by the Workers' Compensation Court of Appeals (WCCA) regarding temporary partial disability (TPD) benefits was *Yates v. Eitel Hospital.*[11] The *Yates* decision specifically addressed whether an employee was eligible for TPD benefits after she refused a light duty (3f) job offer. The court held that the employee was not eligible for TPD benefits because she did not conduct a reasonably diligent job search. In dicta, [12] however, the court said that employees who perform a reasonably diligent job search after refusing a 3f job offer may be eligible for TPD benefits even if they fail to find another job.[13] The court also said that these employees may be entitled to TPD benefits at the TTD rate.

The following discussion will examine the WCCA's decisions in *Yates* and subsequent cases regarding TPD benefits. The discussion is divided into five different issues. These are: (1) TPD benefits for employees who are not working, (2) TPD benefits rates, (3) eligibility for TPD benefits beyond 90 days post-MMI, (4) the reasonably diligent search for employment standard, and (5) the effect of quitting or being fired for cause on TPD benefits. Unfortunately, these issues are not all completely distinct, so the reader should not try to comprehend one issue separately.

10 Insurer's Brief to the Minnesota Supreme Court, *Gasper v. Northern Star Co.* (hereafter *Gasper* Brief).

11 39 W.C.D. 373 (November 13, 1986).

12 Dicta are those portions of the court's opinion which are not essential to the outcome of the case before the court. Conservative jurists generally consider it improper to announce important legal rules in dicta.

13 *Yates*, 39 W.C.D. at 380.

Temporary Partial Benefits for Employees Who Are Not Working

***Yates v. Eitel Hospital* first suggested that non-workers could receive temporary partial benefits.**

In order to arrive at the conclusion that non-working employees may be eligible for temporary partial disability (TPD) benefits, the WCCA interpreted *Minn. Stat.* §176.101 (1986) very literally, relying to a great extent on pre-amendment case law. Although Subd. 2 implies that only working employees are eligible for TPD benefits, neither it nor any other section of the statute states so explicitly.

Minn. Stat. §176.101, Subd. 2 (1986) states, in pertinent part:

> In all cases of temporary partial disability the compensation shall be 66-2/3 percent of the difference between the weekly wage of the employee at the time of injury and the wage the employee is able to earn in the employee's partially disabled condition. This compensation shall be paid during the period of disability except as provided in this section . . ..

The *except* language in Subd. 2 was added by the 1983 amendments. Looking at the *except* language, the WCCA in *Yates* concluded that the 1983 amendments did not overrule previous case law interpreting eligibility for TPD benefits, but simply created some exceptions to pre-amendment eligibility.[14]

Before the 1983 amendments, the case law interpreting eligibility for TPD benefits under Subd. 2 basically held that in order to collect TPD benefits employees must show that they suffered a loss of earning capacity as a result of a physical disability.[15] This test is based on the "able to earn" language in Subd. 2. Thus, under Subd. 2, as interpreted in Yates, employees are eligible for TPD benefits "during the period of disability" when they suffer a loss of earning capacity due to the disability, unless some other provision of Minn. Stat. §176.101, (1986) makes them ineligible.

The court then went on to conclude that the only exception to pre-amendment eligibility for TPD benefits created by the 1983 amendments was contained in *Minn. Stat.* §176.101 Subd. 3n (1986) (hereafter Subd. 3n):

> An employee who has been offered a job under subdivision 3e and refused that offer and who subsequently returns to work shall not receive temporary partial compensation pursuant to subdivision 2 if the job the employee returns to provides a wage less than the wage

14 Yates, 39 W.C.D. at 377.

15 See *Bliss v. Minneapolis Star andTribune Co.*, 303 N.W. 2d 460 (Minn. 1980); *Huck v. ABI Contracting, Inc.*, 34 W.C.D. 346, 348 (WCCA), summarily affirmed by the Minnesota Supreme Court on December 17, 1981.

> at the time of the injury. No rehabilitation shall be provided to this employee.

While Subd. 3n explicitly makes employees who refuse 3e job offers ineligible for TPD benefits, it says nothing about 3f (light duty) job offers. Relying on *Minn. Stat.* §645.19 (1986) which provides, in pertinent part, that: "Exceptions expressed in a law shall be construed to exclude all others," the WCCA concluded [16] that Minn. Stat. §176.101, (1986) allows employees who refuse 3f job offers to collect TPD benefits under Subd. 2, in appropriate circumstances.[17] In later decisions, the court followed this same reasoning to the conclusion that employees who receive neither 3e nor 3f job offers are eligible for TPD under Subd. 2, in appropriate circumstances.[18]

Following the *Yates* decision, employers argued that Subd. 2 only indicates how TPD benefits should be calculated, not under what circumstances they should be paid. The employers asserted that Subd. 3h sets forth the only circumstances under which an employee is eligible for TPD benefits.[19] Subdivision 3h provides:

> An employee who accepts a job under subdivisions 3e or 3f and begins that job shall receive temporary partial compensation pursuant to subdivision 2, if appropriate.

Employers argued that any other interpretation would render Subd. 3h meaningless. The WCCA rejected this argument without much discussion. The court emphasized the language in Subd. 2 which states that "This compensation *shall* be paid during the period of disability . . .." The court also relied on its decision that Subd. 3n states the only exception to this language.[20]

In reaching this conclusion, the WCCA might also have pointed out that the language in Subd. 2 was used to determine eligibility for TPD benefits before the 1983 amendments. Since the Legislature did not alter this language in 1983, the court could conclude that the Legislature did not intend to alter its use either. To provide further support for this conclusion, the court could have pointed to *Minn. Stat.* §645.17 (4) (1986) which provides that when the court of last resort has construed the language of a law, the Legislature, in subsequent laws on the same subject, intends the same construction. In addition, Subd. 3h does not say that *only* employees who accept and begin 3e or 3f jobs are eligible for TPD benefits. Therefore, it can be interpreted as merely

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16 *Yates,* 39 W.C.D. at 378.

17 Appropriate circumstances exist when the employee can prove a loss of earning capacity due to the disability.

18 See *Galba v. R.L. Hamann Roofing,* WCCA No. 474-48-2277 (December 31, 1986); *Parson v. Holman Erection Co.,* WCCA No. 425-66-5224 (May 4, 1987).

19 See e.g., *Gasper v. Northern Star Co.,* WCCA No. 476-88-1280 (April 13, 1987).

20 *Gasper* at 3 (emphasis in the original).

making explicit that employees working at 3e or 3f jobs are eligible for TPD benefits along with any other employees also eligible under Subd. 2.

The WCCA found further support for its conclusion by looking at two indicators of legislative intent, the adminstrative interpretation of the statute and contemporaneous legislative history.[21] The court found it "noteworthy" that adminstrative interpretations of Subd. 2 perpetuate the idea that an employer's liability for TPD benefits is a continuing product of the reduction in the employee's earning capacity.[22] The court also cited the fact that the 1986 Legislature considered and rejected an amendment to Subd. 2 which provided that TPD benefits would begin when an employee starts working at a 3e or 3f job and end when an employee begins receiving ERC benefits.[23]

Minn. Stat. §645.16 (1986) provides that the courts may ascertain legislative intent by considering: (a) the occasion and necessity for the law; (b) the circumstances under which it was enacted; (c) the mischief to be remedied; (d) the object to be obtained; (e) the former law, if any, including other laws upon the same or similar subjects; (f) the consequences of a particular interpretation; (g) the contemporaneous legislative history; and (h) the legislative and administrative interpretation of the statute. The factors in *Minn. Stat.* §645.16 (1986) which the WCCA did not consider in Yates are probably as significant as those it did consider. For example, if the court had chosen to focus on the circumstances under which the 1983 amendments were enacted, *Minn. Stat.* §645.16(2) (1986), or the former law, *Minn. Stat.* §645.16(5), it might have reached a different result.

The court also failed to comment on the fact that the 1983 Legislature removed what had been the last sentence of Subd. 2 That sentence stated:

The court has allowed non-working employees to receive temporary partial benefits indefinitely.

> If the employer does not furnish the worker with work which he can do in his temporary partially disabled condition and he is unable to procure such work with another employer, after a reasonably diligent effort, the employee shall be paid at the full compensation rate for his or her temporary total disability.

Although this provision blurred the distinction between TPD and TTD benefits, it explicitly allowed employees who were not working to receive ongoing benefits.

- **The fact that this sentence was removed by the 1983 amendments provides a compelling argument that the Legislature did not want non-working employees to receive TPD benefits on an ongoing basis. It also provides a compelling argument that TPD benefits should not be paid at the TTD rate. In *Yates* and subsequent decisions, the WCCA essentially wrote this sentence back into Subd. 2.**

The court's interpretation of Subd. 2, Subd. 3n, and Subd. 3h all reflect a very literal reading of the statutory language. The court basically says that nothing

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21 *Yates*, 39 W.C.D. at 379.

22 *Yates*, 39 W.C.D. at 379, citing *Enfield v. Target/Dayton-Hudson Corp.*, File No. 475-22-4865, Rehabilitation Decision, June 3, 1986.

23 H. F. 1873 §15 (1986); *Id.* at 379-380.

in the statute explicitly makes all non-working employees ineligible for TPD benefits and the court is correct. The court then concludes that non-working employees may be eligible for TPD benefits if they can satisfy the requirements of Subd. 2 as interpreted by the courts.

- **Although it can be argued that the Legislature did not intend this result, it is difficult to argue that it is contrary to the statutory language.**

In addition, the indicators of legislative intent contradict each other. On the one hand, the 1983 amendments sought to reduce workers' compensation costs, in part, by cutting off temporary benefits in certain circumstances, indicating that the Legislature did not intend to allow non-working employes who are ineligible for TTD benefits to collect TPD benefits. On the other hand, the 1986 Legislature rejected an amendment to Subd. 2 which could have explicitly codified the result urged by the employers, indicating that the Legislature might have intended non-working employees to receive TPD benefits. Therefore, the WCCA could and did essentially pick the indicator which supported the conclusion it wanted to reach.

The Legislature should clarify the statute governing temporary partial benefits.

- **If the Legislature does not intend the result reached by the WCCA, it needs to make its intention explicit through the words of the statute. In light of the fact that the WCCA is clearly not eager to cut back benefits to workers, nor to abandon pre-amendment case law, the Legislature must rely on clear statutory language to obtain the desired result.**

Temporary Partial Benefit Rates

In *Yates*, the WCCA held that the employee was not entitled to TPD benefits because she did not conduct a reasonably diligent job search. Therefore, the court was not called upon to decide at what rate TPD should be paid to non-working employees. The court, however, went beyond the task at hand and commented that non-working employees may be eligible for TPD benefits at the temporary total disability (TTD) rate.[24] This comment unleashed a flood of criticism from employers and insurers who repeatedly argued that this result circumvented the provisions of *Minn. Stat.* §176.101 (1986) which cut off TTD benefits. The WCCA, however, refused to reconsider this point and in later decisions relied on the dicta in *Yates* to award TPD benefits at the TTD rate.[25]

As it did when in conlcuded that non-working employees are eligible for TPD benefits, the WCCA relied on pre-amendment case law interpreting Subd. 2

24 *Yates*, 39 W.C.D. at 380.

25 See, e.g., *Ryan v. Jorgenson Chevrolet*, WCCA No. 468-50-9575 (July 1, 1987).

to conclude that non-working employees may be eligible for TPD benefits at the TTD rate. Under Subd. 2, TPD benefits are calculated as the difference between 66-2/3 percent of the employee's weekly wage[26] at the time of the injury and the wage the employee is "able to earn" in his partially disabled condition. The Minnesota Supreme Court interpreted Subd. 2 to mean that TPD benefits were calculated on the basis of what an employee was able to earn, not what an employee was actually earning.[27] Since the Yates court determined that the 1983 amendments did not alter this standard, it concluded that employees who could prove that they were unable to earn anything in their disabled condition could collect TPD benefits at the TTD rate.[28]

The WCCA in *Yates* also implied that an employee's ability to earn would be determined by the employee's subsequent job search rather than by reference to any job previously held by or offered to the employee.[29] In other words, if an employee refused a 3f job offer, then conducted a reasonably diligent, but unsuccessful, search for another job, the court implied that it would find the employee had an ability to earn equal to what the employee would have earned at the job the employee refused. This result is not, however, consistent with the rationale for awarding TPD benefits at the TTD rate. Since the decision to award TPD benefits at the TTD rate is based on a determination that the employee has no ability to earn, the fact that the employee is not working should not automatically mean that TPD should be awarded at the TTD rate. While actual earnings are generally presumed to be a fair measure of earning capacity,[30] this presumption can be rebutted by evidence showing that the employee's earning capacity is not zero. In a case such as Yates where the employee refused a 3f job, the employer should argue that the employee's earning capacity is equal to that which she would have earned at the job she turned down.

Not only is the court's language in *Yates* inconsistent with its rationale, the decision to allow employees to collect TPD benefits at the TTD rate is contrary to the goals of the 1983 amendments and appears to be an obvious attempt to circumvent the provisions of *Minn. Stat.* §176.101 (1986) which discontinue TTD benefits upon the happening of certain events. In defense if the WCCA, however, once it concluded that non-working employees could receive TPD benefits, it needed some way to calculate those benefits. The court's decision to award TPD benefits to non-working employees essentially necessitated the decision to award TPD benefits at the TTD rate in some circumstances. Thus:

- **By not being more specific with regards to eligibility for TPD benefits in the new law, the Legislature provided the court a way to conclude both that non-working employees are eligible for TPD**

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26 Prior to the 1983 amendments, TPD benefits were calculated on the basis of the employee's daily rather than weekly wage. For the purposes of this discussion, however, this difference is insignificant.

27 Dorn v. A.J. Chromy Const. Co., 310 Minn. 42, 245 N.W.2d 451, 453 (1976); *Kuehn v. State, Dep't of Tenth Judicial District*, 271 N.W. 2d 308, 310 (Minn. 1978).

28 Yates, 39 W.C.D. at 380. The TTD benefit rate is the same as that arrived at for TPD if the amount the employee is able to earn in the partially disabled condition is zero. See, *Minn. Stat.* §176.101, Subds. 1 and 2 (1986).

29 Yates, 39 W.C.D. at 380.

30 Kuehn, 271 N.W. 2d at 310.

benefits and that they may be eligible at the TTD rate by relying on case law interpreting Subd. 2 under the old law. In order to change both of these results, the Legislature must amend *Minn. Stat.* §176.101 (1986) so that it explicitly provides that non-working employees are ineligible for TPD benefits.

Eligibility for Temporary Partial Benefits for People With Jobs After 90 Days Post-MMI

This section will discuss three situations in which the issue of whether employees are eligible for TPD benefits after 90 days post-MMI may arise. These are: (1) when an employee has a suitable (3e) job before 90 days post-MMI and begins receiving IC benefits; (2) when an employee has a light duty (3f) job before 90 days post-MMI and begins receiving ERC benefits; and (3) when an employee has no job at 90 days post-MMI and begins receiving ERC benefits, but later gets a job which pays less than two-thirds of the employee's pre-injury wage. The third situation will be discussed separately from the first two as it involves different problems. This section will not discuss whether non-working employees should receive TPD benefits at the TTD rate after 90 days post-MMI. The preceding sections covered this situation. Again it may be helpful to refer to Tables 6.1 and 6.2.

Employees Working at 3e or 3f Jobs

Although it appears fairly certain that the 1983 Legislature did not intend to permit non-working employees to collect TPD benefits (at the TTD rate), it is by no means certain that it did not intend to allow employees working at 3e or 3f jobs to collect TPD benefits after 90 days post-MMI and concurrently with IC or ERC benefits, if their new wage is less than two-thirds of their old wage. In fact, there are several compelling arguments that the Legislature did intend to allow TPD benefits to continue beyond 90 days post-MMI. In addition, the statutory language is most easily intepreted to support this result.

Employers and insurers believe, however, that the 1983 amendments only permit employees working at 3e jobs to collect TPD benefits after 90 days post-MMI. This belief is based on the position that ERC and TPD benefits cannot be paid concurrently, while IC and TPD benefits can.[31] If this position is correct, employees working at 3f jobs become ineligible for TPD benefits at 90 days post-MMI because they begin to receive higher-tier ERC benefits. Since employees working at 3e jobs continue to receive lower-tier IC benefits when they reach 90 days post-MMI, however, they can also continue to receive TPD benefits.

The argument that ERC and TPD benefits cannot be paid concurrently is based on interpretations of *Minn. Stat.* §176.101, Subds. 3p and 3q (1986) (hereafter Subd. 3p and Subd. 3q). Subdivision 3q provides that ERC is payable at the same intervals and in the same amounts as TTD was paid. The employers and insurers argue that because ERC is payable in the same man-

31 The employers and insurers also apparently argue that Subd. 3h compels this result. See *Gasper* brief. It is not clear how they reach this conclusion, since Subd. 3h says that employees with 3e or 3f jobs shall receive TPD benefits pursuant to Subd. 2.

ner as TTD, it was intended to replace TTD. Although Subd. 3p does not expressly state that ERC and TPD benefits cannot be paid concurrently, they also argue that allowing concurrent payment would make benefits under the new law greater and more expensive than the benefits under the old law. Since the new law was designed to reduce workers' compensation costs, they argue that the Legislature could not have intended this result.[32]

In *Gasper v. Northern Star Co.*, WCCA No. 476-88-1280 (April 13, 1987), the WCCA rejected this argument. The court did not engage in much discussion, however. It simply noted that Subd. 3p does not expressly prohibit concurrent payment of ERC and TPD benefits. Absent an express prohibition, the court determined that an employee could receive ERC and TPD benefits concurrently under Subd. 3q.

Although it did not do so, the court might also have pointed out that Subd. 3p *does* expressly prohibit concurrent payment of ERC and TTD benefits and that other sections of *Minn. Stat.* §176.101 (1986) expressly prohibit the concurrent payment of other types of benefits.[33] In light of this, it can be argued that if the Legislature meant to prohibit concurrent payment of ERC and TPD benefits, it would have said so explicitly.

It can also be argued that this conclusion is supported by the legislative history the court relied on in *Yates.* In 1986, the Legislature proposed and rejected an amendment to Subd. 2 which explicitly provided that TPD benefits cease upon the commencement of ERC benefits.[34] Since the Legislature rejected this amendment, it can be argued that the Legislature did not intend the result dictated by it.

It should also be noted that Judge Leslie Altman of the WCCA has consistently disagreed with the other judges regarding payment of TPD benefits to employees who are not working and at the TTD rate. She agrees, however, that TPD and ERC benefits can be paid concurrently. In her concurring opinion in *Gasper*, Judge Altman says, "The employee should receive temporary partial disability because he suffered a loss of earning capacity. As the employee observes, the two-tier benefit system rewards employees who return to work by paying (Impairment Compensation) in a lump sum and temporary partial disability. This also serves to encourage the employer and insurer to provide suitable work."[35]

Judge Altman's comments in *Gasper* raise one final point which suggests that the employers' and insurers' interpretation of *Minn. Stat.* §176.101, Subds. 3p and 3q is incorrect. The combination of IC and ongoing TPD benefits may add up to more money than ERC benefits. This result would be contrary to the logic of the 1983 amendments in that it would discourage employers from offering or procuring 3e jobs for injured employees. In addition, the total amount of ERC benefits due to an employee with a 3f job is certain while the total amount of IC and ongoing TPD benefits due to an employee with a 3e job is not. The uncertainty of the amount due to employees with 3e jobs

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32 See *Gasper* brief.

33 See e.g., *Minn. Stat.* §176.101, Subd. 3e (1986).

34 H.R. File No. 1873 §15 (1986) (as reported out of committee on February 26, 1986).

35 *Gasper*, at 4.

makes offering 3e jobs less attractive to employers than offering 3f jobs. Even if IC and TPD benefits did not exceed ERC benefits, employers cannot be certain of this at the time they must decide whether to offer an employee a 3e or a 3f job. The certainty of the amount of ERC benefits may be worth the extra cost to employers.

- **In contrast to the WCCA's decision to allow non-working employees to collect TPD benefits, the court's decision to allow employees with 3e or 3f jobs to continue collecting TPD benefits after 90 days post-MMI appears to be supported by the statutory language, the indicators of legislative intent, and the general purpose behind the 1983 amendments. If the Legislature did not intend this result, it most certainly erred in the expression of its intention.**

The court's decision to allow working employees to collect temporary partial benefits beyond 90 days after medical recovery is supported by statutory language.

Employees Who Do Not Begin Working Until After 90 Days Post-MMI

In *Shipton v. Go. A. Hormel & Co.*, WCCA No. 471-70-4672 (July 1, 1987), the WCCA held that an employee who did not begin working until after 90 days post-MMI was eligible for TPD benefits. Citing *Yates*, *Riley*, and *Gasper*, the court awarded the employee TPD benefits at the TTD rate from 90 days post-MMI until he began working and awarded TPD benefits at a rate in accordance with his new wage after he began working. The WCCA has never, however, addressed the issue of whether employees who do not begin working until after 90 days post-MMI are eligible for TPD benefits once they begin working if they are not eligible while they are not working. Therefore, it is difficult to determine what result the court would reach if faced with this issue.

The statutory language in *Minn. Stat.* §176.101 (1986) and the legislative history cited by the WCCA in *Yates*,[36] both support the conclusion that employees who do not begin working until after 90 days post-MMI are eligible for TPD benefits once they begin working as well as they support the conclusion that employees working at 3e or 3f jobs continue to be eligible for TPD benefits after 90 days post-MMI. Neither Subd. 3p, nor any other section of the statute prohibits concurrent payment of ERC and TPD benefits in either situation. An amendment to Subd. 2 rejected by the 1986 Legislature would have expressly altered the conclusion in both situations.

- **Awarding TPD benefits to employees who do not begin work until after 90 days post-MMI does not, however, seem consistent with the goals of the 1983 amendments.**

Such a rule does not fit in well with the incentive system set up in 1983. Although it gives employees an incentive to go back to work, it does not give employers an incentive to help get employees back to work. In fact, it has the opposite result. If the employees who get jobs after 90 days post-MMI are eligible for TPD benefits, employers will not rehire employees after 90 days post-MMI, since doing so would increase their workers' compensation costs.

- **For this reason, it seems unlikely that the 1983 Legislature intended to allow employees who begin work after 90 days post-MMI to receive TPD benefits, although they may have intended to allow**

36 39 W.C.D. at 379-380

employees working at 3e or 3f jobs to receive TPD benefits after 90 days post-MMI.

- **If the Legislature intended to make both employees with 3e or 3f jobs and employees who do not begin work until after 90 days post-MMI eligible for TPD benefits after 90 days post-MMI, the statutory language in *Minn. Stat.* §176.101 (1986) appears to achieve this result. If, however, the Legislature intended to make either or both groups ineligible for TPD benefits, the statutory language does not adequately express this intention and needs to be changed.**

The Legislature needs to consider whether various court decisions reflect its intended purpose.

The Reasonably Diligent Search for Employment Standard

As was noted earlier, the 1983 amendments to *Minn. Stat.* 176.101 removed the last sentence of Subd. 2. This sentence provided:

> If the employer does not furnish the worker with work which he can do in his temporary partially disabled condition and he is unable to procure such work with another employer, after a reasonably diligent effort, the employee shall be paid at the full compensation rate for his or her temporary total disability.

Despite the fact that this sentence was removed from Subd. 2 by the 1983 amendments, the WCCA continues to use the reasonably diligent job search standard contained in it to determine whether employees are eligible for TPD benefits at the TTD rate when they are not working. In *Yates*, 39 W.C.D. at 380, the court said:

> To say that a search for alternative employment is no longer a relevant consideration in determining whether benefits are payable pursuant to *Minn. Stat.* §176.101 Subd. 2 is too broad a statement and implicitly overrules a large body of case law in a number of situations which are not specifically addressed by the otherwise very specific provisions of subdivisions 3a through 3v.

Under the old law, the reasonably diligent job search standard was a source of uncertainty and litigation.[37] The WCCA determined whether an employee had conducted a reasonably diligent job search on a case by case basis by looking at factors such as the number and quality of the job contacts. As a result, neither employers nor employees could be certain whether an employee's job search was diligent enough. This, in turn, probably resulted in more litigation.

At least one commentator believed that the 1983 amendments removed the reasonably diligent job search standard as a consideration in awarding TPD benefits and transferred it to the rehabilitation provision of the Act.[38] *Minn. Stat.* §176.102, Subd. 13 (1986) now provides that all Workers' Compensation benefits may be discontinued if an employee "does not make a good faith ef-

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37 Crochiere, *The Plight of the Displaced Employee Improves: An Analysis of the 1983 Changes to Minnesota's Workers' Compensation System*, 12 Wm. Mitchell L.Rev. 623, 640-641 (1986).

38 Crochiere, *supra* at 649.

fort to participate in a rehabilitation plan." This provision places the responsibility for a diligent job search with the employee and a Qualified Rehabilitation Consultant (QRC) rather than with the employee alone. Crochiere argues that substituting the "cooperate with rehabilitation" standard for the reasonably diligent job search standard should reduce litigation because an employee's job search will now be conducted with the expert assistance of a QRC resulting in more effective job search strategies.[39] In addition, the new standard gives employers an incentive to develop aggressive, structured rehabilitation plans for injured employees. Aggressive rehabilitation plans are more likely to get employees back to work and allows employers to "catch" employees who are not cooperating.

Although the new standard does give employers an incentive to help develop aggressive rehabilitation plans for injured employees, it may not eliminate the uncertainty which surrounds the reasonably diligent job search standard. The meaning of the phrase "good faith effort" seems no clearer than "reasonably diligent." The courts may adopt a case-by-case analysis of the new standard which is not more certain than that applied to the old standard. The new standard may not result in less litigation either. Nothing in the statute requires employers to develop aggressive rehabilitation plans in order to catch employees not cooperating. Even if employers do not insist on an aggressive plan, they can still attempt to prove that employees are not cooperating with the plans that do exist. For these reasons, the continued use of the reasonably diligent seach for work standard is probably not resulting in higher workers' compensation costs than anticipated under the new law, except to the extent that it reflects the fact that the WCCA is awarding TPD benefits to non-working employees.

Effect of Quitting or Being Fired For Cause.

Nothing in the Workers' Compensation Act clearly indicates what effect quitting or being fired for cause[40] from a 3e or 3f job has on an employee's eligibility for TPD benefits. Minn. Stat. §176.101, Subd. 3n (1986) makes employees who refuse 3e jobs ineligible for TPD benefits. It does not, however, apply to 3f jobs, or explicitly to employees who quit or are fired from 3e jobs. Minn. Stat. §176.102, Subd. 13 (1986) provides that employees forfeit their benefits if they fail to cooperate with their rehabilitation plan. This section, like Subd. 3n, does not explicitly indicate what effect it has on employees who quit or are fired from 3e or 3f jobs.

In *Riley v. Twin City Fan & Blower Co.*, 39 W.C.D. 380 (WCCA 1987), the WCCA held that an employee fired from a 3f job remained eligible for TPD benefits as long as he made a reasonably diligent job search after getting fired. In so holding, the court rejected arguments that by getting fired the employee refused to cooperate with rehabilitation and failed to conduct a reasonably diligent job search.[41]

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39 Crochiere, *supra* at 657.

40 An employee who is fired for cause is fired for a work-related reason such as tardiness, not showing up for work, or inability to do the job. Employers and insurers apparently do not argue that employees who are fired without cause should be denied benefits. In this section, fired or discharged means fired or discharged for cause.

41 Id. at 391-392.

The court also implied in *Riley* that getting fired is not the same as refusing a job.

- **Therefore, it does not appear that the court will use Subd. 3n to cut off benefits to employees who are fired from suitable (3e) jobs. If getting fired from a 3e job, like getting fired from a 3f job, does not constitute a refusal to cooperate with rehabilitation or a failure to make a diligent job search, then employees fired from 3e jobs, as well as employees fired from 3f jobs, should remain eligible for TPD benefits as long as they begin a reasonably diligent job search after getting fired.**

A series of cases suggests that the court is reluctant to limit benefits.

The WCCA has not taken any explicit position on whether employees who quit 3e or 3f jobs forfeit their TPD benefits. Its decision in *Murphy v. Control Data Corp.*, WCCA No. 495-54-7319 (July 1, 1987), however, suggests that employees who quit 3e or 3f jobs do not forever lose their right to collect TPD benefits under Subd. 2. In *Murphy*, the court held that an employee who quit a job he was unable to perform in his disabled condition[42] could receive TPD benefits once he began a diligent job search even though he should have requested a job he could perform from his employer before quitting. To reach this conclusion, the court relied on *Mayer vs. Erickson Decorators*, 372 N.W. 2d 729, 731 (Minn. 1985). In *Mayer*, the Supreme Court said that if an employee who previously refused to cooperate with rehabilitation later requests and agrees to cooperate with rehabilitation and begins a reasonably diligent job search, then that employee will become re-eligible for TPD benefits. Although the Mayer case concerned a pre-amendment injury, the use of it in Murphy suggests that the WCCA believes its holding still applies.

- **Thus, it appears that even if quitting a 3e or 3f job constitutes a refusal to cooperate with rehabilitation, quitting does not forever bar an employee from receiving TPD benfits.**

The decisions in *Riley* and *Murphy* suggest that the WCCA will not interpret either *Minn. Stat.* §176.101, subd. 3n (1986) or *Minn. Stat.* §176.102, subd. 13 (1986) to make employees who quit or are fired from 3e or 3f jobs irrevocably ineligible for TPD benefits. Allowing employees who quit 3e or 3f jobs to receive TPD benefits does not, however, seem consistant with the idea of providing incentives for employees to return to work. In some circumstances, allowing employees who are fired from 3e or 3f jobs to receive TPD benefits does not seem consistent with this idea either.

- **Since nothing in the workers' compensation statute deals effectively with this problem, it is up to the legislature to amend the statute if it wants to restrict the eligibility of employees who quit or are fired from 3e or 3f jobs for TPD benefits.**

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42 Because the employee in *Murphy* was unable to perform the job it was not a 3e or 3f job. By definition, both 3e and 3f jobs must be jobs which the employee can perform. See *Minn. Stat.*§176.101, Subds. 3e and 3f (1986).

CONCLUSIONS

The Legislature can wait for the Supreme Court to settle the issues under debate. A better alternative may be for the Legislature to act itself.

The preceeding discussion indicates that a claim that the WCCA is rewriting the Workers' Compensation Act is, for the most part, unwarranted. None of the court's decisions regarding the TPD benefits contradict the explicit language of the statute. The fact is that the statute is frequently ambiguous, which gives the WCCA a great deal of latitude in interpreting its provisions. The charge that the WCCA is ignoring the intent of the 1983 Legislature may, however, be warranted. It appears that the WCCA is reluctant to terminate open-ended temporary benefits for employees.

Although some employers and insurers also claim that the WCCA decisions discussed above have created uncertainty in the area of TPD benefits, an examination of the decisions indicates that the WCCA has been very consistent. The court steadfastly adheres to its dicta in *Yates* and its decision in *Gasper*, making it clear that unless the Legislature or the Minnesota Supreme Court speaks out, non-working employees, employees who have reached 90 days post-MMI, and employees who quit or are fired for cause from 3e or 3f jobs may be eligible for TPD benefits and may be eligible at the TTD rate.

There is, on the other hand, some uncertainty generated by the fact that the Minnesota Supreme Court has not addressed these issues. Fortunately, at least some of this uncertainty should be resolved soon. The Minnesota Supreme Court is currently considering appeals in *Gasper v. Northern Star Co.*,[43] and *Parson v. Holman Erection Co., Inc.*[44] In both *Gasper* and *Parson*, the Supreme Court has been asked to address whether employees who are not working at 3e jobs can receive TPD benefits after 90 days post-MMI. This question necessarily includes the question of whether employees can receive ERC and TPD benefits concurrently. In addition, in *Parson*, the Supreme Court has been asked to address whether employees who are not working can receive TPD benefits. Oral arguments in these cases were heard in October and November, 1987. Therefore, the court should issue opinions very soon.

Even though the Supreme Court may resolve some of the controversy surrounding TPD benefits in the near future, there is no guarantee that its interpretation of *Minn. Stat.* §176.101 (1986) will differ from that of the WCCA. At best, the language in *Minn. Stat.* §176.101 (1986) is ambiguous, especially when interpreted in light of pre-amendment case law. At worst, the language does not say what the Legislature intended it to say. Therefore, the controversy surrounding TPD benefits may not be resolved until the Legislature takes action to clarify the language of the statute and its intent.

43 WCCA No. 476-88-1280 (April 13, 1987).

44 WCCA No. 425-66-5224 (May 4, 1987).

ASSIGNED RISK PLAN

Chapter 7

The workers' compensation insurance assigned risk plan (ARP) has been a subject of contention between the insurance industry and the Department of Commerce, the state agency with primary responsibility for insurance regulation.

Employers must purchase workers' compensation insurance in order to conduct business legally. Thus, Minnesota and other states need to provide a way for all employers to obtain workers' compensation insurance coverage. In Minnesota, availability of insurance is assured by an assigned risk plan administered by the Minnesota Department of Commerce. Employers whose application for workers' compensation insurance is denied by an insurance company can apply to the plan for coverage.

Annual premium volume of the assigned risk plan has grown from about $11 million to over $100 million.

The volume of insurance sold through the assigned risk plan has grown dramatically in the last several years. Premium volume has grown to over $100 million from about $11 million since mid-1984. A large assigned risk plan is evidence that the workers' compensation system is not working as intended. In Minnesota rates are set through competitive pricing by about 200 workers' compensation insurance sellers. Competition is expected to make insurance available to nearly all buyers at a price that is reasonable in light of the structure and level of workers' compensation benefits and the need of private companies to make a profit. An assigned risk plan will always have to exist to cover employers who are, for one reason or another, uninsurable. But these should be a small percentage of all employers under ordinary circumstances.

This chapter asks:

- **What does the rapid growth in ARP premium volume between 1984 and 1987 signify?**
- **What is the state's assigned risk plan policy? Is it appropriate and effective? Are statutory changes indicated?**
- **How effectively has the Commerce Department administered the assigned risk plan? Should the Commerce Department continue to administer the plan?**

We studied the recent operation of the assigned risk plan, and interviewed industry representatives and Commerce Department officials. We looked at:

- the history of premium volume, price changes, and assessments;
- the clarity and appropriateness of Commerce Department policies affecting the assigned risk plan;
- the process by which pricing decisions have been made; and
- administration of the plan by the Commerce Department.

There will usually be two kinds of employers in the ARP. One type consists of the undesirable and hard-to-rate risks that the industry will not insure for good reasons. Since even these kinds of employers--if otherwise legal--need insurance, they get it through the ARP.

Small employers are often in the assigned risk plan because they are hard to rate and expensive to service.

The other kind consists of small employers who are in the plan because they are expensive to service, hard to rate, and easy to ignore. The presence of both types makes it difficult to establish a fair price for insurance through the ARP. If the ARP is priced so that it is totally self-sufficient, the small employers will bear the full burden of subsidizing risky employers. If the ARP is less than self-supporting, it receives a subsidy through an assessment on all insurers. If this subsidy is too large, insurance for some or all will be cheaper through the ARP than in the voluntary market.

The Commerce Department does not think it is fair to force small employers to carry the whole burden of subsidizing the purchase of insurance for high-risk companies. So it feels insurance purchasers as a whole should subsidize the ARP. On the other hand, Commerce would prefer high-risk operators to pay an actuarially sound price for insurance. Maybe, if they do, they will be moved to improve the safety of their operations.

One type of employer should not be in the ARP, specifically, the otherwise insurable employer who finds it is cheaper to purchase insurance through the ARP than elsewhere. As costly as workers' compensation insurance is in Minnesota, holding its price down by underpricing the market will not work for long.

The insurance system works best if employers pay a price for insurance that reflects the risk inherent in their business and businesses pay a price that is lower to the extent that they implement procedures to enhance workplace safety. An assigned risk plan has to exist, since the state limits the amount of insurance that companies can write through its financial solvency requirements. While the ARP is a practical necessity given the fact that workers' compensation insurance is mandatory, there are a lot of reasons why it is best that the size of the plan be maintained at as low a level as possible.

ASSIGNED RISK PLAN PREMIUM VOLUME AND MARKET SHARE

As noted, the volume of insurance sold through the assigned risk plan has grown rapidly in the last several years. Table 7.1 presents data on assigned risk plan premium volume for each 12-month period ending between August 1982 and November 1987. During the 12 months ending July 1984, premium volume hit a cyclical low point of $10.8 million. By November 1987 this number had grown to over $100 million. In round numbers premium volume grew eight fold in three years between mid-1984 and mid-1987.

	12 Month Volume Ending With Each Month					
Month	1982	1983	1984	1985	1986	1987
JAN		18,452,259	13,914,596	17,060,862	52,654,839	76,293,049
FEB		18,337,940	13,142,405	19,307,389	54,422,647	80,439,870
MAR		17,736,579	12,898,113	20,842,570	62,013,549	83,860,303
APR		16,746,552	12,564,578	22,694,721	66,062,311	96,181,308
MAY		16,310,946	11,893,204	24,966,148	71,056,614	94,723,343
JUN		15,766,258	11,189,669	26,742,954	72,217,516	97,197,249
JUL		15,094,337	10,838,578	31,198,281	70,310,596	95,866,707
AUG	20,725,684	15,161,293	11,809,649	36,506,918	70,820,095	98,063,414
SEP	20,612,300	15,008,838	13,195,397	40,392,249	75,791,231	100,294,682
OCT	20,864,170	14,644,345	14,827,150	43,546,804	77,929,295	101,484,259
NOV	20,079,943	14,757,653	16,008,181	45,877,200	77,724,864	100,712,779
DEC	19,628,405	14,069,301	16,736,294	51,562,820	77,147,545	

Source: The Department of Commerce

Table 7.1: Assigned Risk Plan Premium Volume

The average premium size of policies sold through the ARP grew from $804 in July 1984 to $2,792 in November 1987. Prices only went up about 67 percent during this period; thus, the ARP is insuring larger businesses now than it did a few years ago. This adds additional weight to the point that many employers that are usually attractive to insurers are getting their insurance through the ARP.

The market share of the assigned risk plan has also grown significantly over the same period. As table 7.2 shows, ARP written premium represented about 4.4 percent of total written premiums in 1983. In 1986 ARP written premium was nearly 18 percent of the market.

What caused the volume of ARP written premium to go up along with its share of the insurance market? Two possible explanations are:

- The Commerce Department underpriced ARP insurance relative to the voluntary market.

- Commerce ARP pricing decisions were reasonable, but the industry lacked capacity to write all the insurance that was demanded.

Year	Assigned Risk Plan Written Premium (in thousands)	Total Minnesota Net Written Premium (in thousands)	ARP as a Percent of the Total
1976	$ 9,055	$199,754	4.5%
1977	20,900	251,664	8.3
1978	44,719	363,271	12.3
1979	55,868	404,453	13.8
1980	49,500	402,087	12.3
1981	35,687	393,196	9.1
1982	19,628	327,830	6.0
1983	14,069	323,328	4.4
1984	20,589	353,996	5.8
1985	62,512	517,841	12.1
1986	113,000	636,642	17.7

Sources: Assigned risk premium volume from the Department of Commerce. Minnesota total net written premium from Bests Executive Data Service.

Table 7.2: Assigned Risk Plan Written Premium as a Percent of Total Minnesota Net Written Premium

The growth of the assigned risk plan in Minnesota is similar to the growth of plans in other states.

The growth of the assigned risk plan in Minnesota is similar to what happened in other states. The National Council of Compensation Insurance (NCCI), reinsures many states' assigned risk plans. The premium volume represented by these plans grew from 8 percent in 1982 to 16.2 percent in 1986, as Table 7.3 shows. Minnesota's experience is similar. Thus, what happened in Minnesota is typical of what happened, on average, in 32 other states plus the District of Columbia. The percentage of workers' compensation written premium sold through assigned risk plans in 32 states grew to 16.2 percent in 1986 compared to 17.7 percent in Minnesota. This does not mean Minnesota made the right pricing decisions. However, at a minimum, Minnesota was not alone in making mistakes.

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Minnesota	4.5%	8.3%	12.3%	13.8%	12.3%	9.1%	6.0%	4.4%	5.8%	12.1%	17.7%
NCCI Pool (32 states plus Wash. D.C.)	NA	NA	12.7	12.7	12.2	10.2	8.0	6.2	5.5	9.7	16.2

Source: National data: National Council on Compensation Insurance, The Workers' Compensation Reinsurance Pools, Management Survey 1986, p.15; 1985, p.23.

[a]Plus the District of Columbia.

NA = Not Ascertained.

Table 7.3: The Share of Written Premium in the Assigned Risk Plan Minnesota Compared to 32 States[a]

Two indicators, at least, raise questions about Minnesota's pricing of workers' compensation insurance through the ARP: the growth of premium volume from 10.8 to 100 million between 1984 and 1987, and the price increase of 6.5 percent ordered in December 1986 effective March 1987 and 17.2 percent ordered June 1987 effective September 1987.

The Commerce Department took over the ARP in mid-1982. It issued its first rate order in November 1983, a 9.6 percent rate increase effective January 1984.[1] Table 7.4 shows the rate increases and assessments ordered by Commerce from 1983 to the present. The Commerce Department also eliminated premium discounts and reduced agent commissions in an effort to make the ARP less attractive. Altogether, rates have been increased 67.4 percent over this period. Assessments totalling 8 percent of 1985 written premium were ordered in December 1986, since the plan was not taking in enough money.

Order Issued	Date Effective	Rate Change	Assessment Ordered	Date Assessment Effective
6/5/87	9/1/87	17.2%	--	--
12/31/86	3/15/87	6.5	5% 3	3/16/87 3/16/88
12/20/85	3/1/86	0.0	--	--
2/28/85	3/15/85[a] 6/1/85	22.4	--	--
2/16/84 11/23/83	1/1/84	9.6	--	--
1983-1987[b]		67.4	--	--

[a]New business increase effective in March, renewal increase in June.

[b]November 1983 to December 1987.

Table 7.4: Assigned Risk Plan Rate Changes and Assessments 1983-87

The insurance industry argues that Commerce should have raised rates more and sooner. The zero increase ordered in late 1985, for 1986 is a particular point of contention. The industry argues that rates in the voluntary market went up faster during the period, and that if ARP rates had been adequate, and ARP insurance were priced above the market, the large increase in ARP written premium would not have occurred.

1 Actually, the November order was for 1.6 percent plus an amount from the Special Compensation Fund that was later determined to be 8 percent. These increases sum to 9.6 percent.

Table 7.5 presents average workers' compensation rates for Minnesota by policy year for the years 1980 through 1986. Also shown is the year-to-year percentage change in rates. While a close comparison between rate changes in the voluntary market and the ARP is difficult to make due to differences in measurement and timing, it is clear from Table 7.5 that pricing changes in the voluntary market have been dramatic and erratic during the 1980s. Prices were cut by sizeable amounts or stayed about the same through 1984. (Until 1983 rate changes required state approval which was not always forthcoming. For example, a 15 percent rate decrease was mandated in 1981.)

	Voluntary Market		Assigned Risk Plan
Policy Year	Rate[a]	Annual Change	Annual Change[b]
1980	2.44	--	--
1981	2.34	-4.1%	-15.0%
1982	2.03	-13.2	0.0
1983	1.81	-10.8	4.1
1984	1.87	3.3	9.6
1985	2.56	36.9	22.4
1986	2.98	16.4	0.0

[a]Rates are estimates of those actually charged per $100 of payroll.

[b]The timing of changes in ARP rates is only approximately the same as the voluntary market.

Table 7.5: Workers' Compensation Rates in the Voluntary Market 1980-86 and Annual Percentage Change in Rates Compared to the Annual Change in Assigned Risk Plan Rates

But in 1985 and 1986 rates in the voluntary market went up about 37 and 16 percent, respectively. Rate increases in the ARP were 22 percent in early 1985 and zero in 1986. Looking at this small slice of history, the insurance industry's criticism of ARP pricing by the industry is justified. However, taking a broader view as we do in the next section, this criticism is overstated.

Having reviewed the ARP's recent rate history, what is the historic and current financial status of the plan? The plan has had to make, or has chosen to make assessments from time to time. Table 7.6 shows a long history of assessments under the management of the industry and the Commerce Department. Both the industry and the Commerce Department have had to make assessments in order to keep the plan solvent when premium dollars alone were insufficient for this purpose. Assessments are made against insurers in proportion to the direct workers' compensation premium they write in Minnesota.

In late 1986 the Commerce Department ordered a five percent assessment due and payable March 1987 and a three percent assessment due March 1988. The insurance industry estimates this assessment will total $39 million. This will be paid (indirectly) by every insurance purchaser other than those in the assigned risk plan. The industry feels the Commerce Department should have

Year Ending	ARP Direct Written Premium	Assessment	Percent
INDUSTRY ADMINISTRATION			
1949	$ 278,523	$ 75,000	26.93%
1950	N/A	0	0.00
1951	313,562	0	0.00
1952	412,001	0	0.00
1953	496,477	0	0.00
1954	625,144	162,000	25.93
1955	651,383	43,340	6.65
1956	664,972	109,662	16.49
1957	762,158	90,779	11.91
1958	751,083	142,149	18.93
1959	762,749	81,266	10.65
1960	711,143	501,024	70.45
1961	788,029	507,063	64.35
1962	911,456	411,580	45.16
1963	970,170	0	0.00
1964	1,019,791	24,295	2.38
1965	1,086,247	154,607	14.23
1966	1,326,807	352,756	26.59
1967	1,611,035	163,708	10.16
1968	2,001,274	131,506	6.57
1969	2,060,795	409,344	19.86
1970	2,151,346	0	0.00
1971	2,655,941	0	0.00
1972	3,241,426	192,669	5.94
1973	3,046,913	637,258	20.91
1974	3,211,396	0	0.00
1975	4,304,180	0	0.00
1976	9,033,013	0	0.00
1977	20,874,362	3,258,975	15.61
1978	44,586,969	4,782,035	10.73
1979	55,629,285	12,628,079	22.70
1980	53,395,415	15,186,014	28.44
1981	35,458,477	0	0.00
1982	4,487,861	0	0.00
COMMERCE DEPARTMENT ADMINISTRATION			
1982	11,002,782	0	0.00
1983	15,701,127	0	0.00
1984	20,588,582	0	0.00
1985	62,512,284	0	0.00
1986	113,000,000	0	0.00
1987	N/A	25,000,000	-
1988	N/A	14,000,000	-

Source: Minnesota Insurance Federation and the Department of Commerce.

Table 7.6: Assigned Risk Plan Assessments Under Insurance Industry Administration and Commerce Department Administration 1949-88

priced the ARP to be self-sufficient or more nearly self-sufficient. It argues the size of the assessment is due to pricing decisions calculated to force the industry to keep its rates down.

The Commerce Department denies that this is its motivation. It argues that it was difficult to anticipate the magnitude of recent changes in the workers' compensation insurance market.

The industry argues that not only did the Commerce Department have data on the assigned risk plan deficit in late 1985, it should have guessed on the basis of historical experience that loss ratios would be worse than those for the voluntary market.

WHAT CAUSED THE PROBLEM?

We have talked to the Commerce Department and the industry at some length and the following are our conclusions:

- **The growth of premium volume in the assigned risk plan is a serious problem. Every reasonable effort should be made to reduce the size of the plan consistent with state policy.**

For reasons addressed earlier, the existence of a substantial assigned risk plan premium volume is evidence that something is wrong with the insurance market. Neither the industry nor the Commerce Department that administers the plan can long accept an ARP that represents a large share of workers' compensation business. The incentives for efficient administration, smart underwriting, and competent claims management that are induced by market competition are diluted when a major part of insurance is financed through an assessment on all companies.

The premium charged by insurance vendors should mainly reflect actual loss experience and risk. In Minnesota, a significant proportion of the price of insurance is due to various assessments on all sellers regardless of their skill in claims management, underwriting, and administrative efficiency. The assigned risk plan assessments add to this burden. For a number of reasons, it is important to price the ARP appropriately, however:

Neither the Legislature nor the Commerce Department has adopted a clear pricing policy.

- **The Commerce Department has not articulated a clear pricing policy for the Assigned Risk Plan. Also, the law governing the plan is not specific, although it permits a more precise policy than the department has formulated.**

The price of insurance through the ARP should be distinctly higher than the average of all of the major sellers of insurance for the major industry and occupational classifications. The statute (*Minn. Stat.* §79.251, subd. 3) says "premiums shall not be lower than rates generally charged by insurers for the business." This language is unnecessarily vague and permissive. If the Legislature meant to permit the assigned risk plan to set rates at or even below the

average of the voluntary market, the idea should be discarded. If it meant to assure that rates would be higher, it should say so more clearly.

The Legislature should adopt a clear pricing policy.

Minn. Stat. §79.252 says that the ARP exists to provide insurance to employers who have been rejected by an insurer. This language is also more permissive and vague than it ought to be. The assigned risk plan should function as the insurer of last resort. Indeed, the Commerce Department and the industry agree in general about the purpose of the ARP, but when actual prices and assessments have to be set, judgments have to be made about the extent to which the assigned risk plan should risk competition with the voluntary market and the extent to which it should be strictly an insurer of last resort, even at the cost of hardship to employers. In Minnesota an employer only has to get one rejection from an insurer. Since insurance companies compete for various segments of the market, rejection by one company does not mean insurance is completely unavailable. While a stricter standard might not work, the requirement of a single rejection might encourage employers to stop looking for insurance. It also allows agents to stop looking.

The Commerce Department has not formally committed itself to what kind of pricing policy it wants to pursue. The only written indication of pricing policy is contained in the February 1985 Commerce Department rate order in which a paragraph suggested that a five percent surcharge was appropriate. We think that the assigned risk plan should set rates high enough so that all employers will expend a reasonable effort to find insurance in the voluntary market, and agents will be forced to help them even if it takes a little work.

This, in fact, is our understanding of the Commerce Department's current policy. We recommend, however, that the Commerce Department put its policy in writing. Indeed, it might be best to enact a pricing policy in statute as, for example, the health insurance assigned risk plan does. *Minn. Stat.* §62E.08 effectively sets the price of assigned risk health insurance at 125 percent of the price charged by the five largest insurers for standard policies.

Alternatively, the Commerce Department can decide to what extent the workers' compensation plan should be self-sufficient and price accordingly. According to the department, it is possible as a technical matter to price ARP insurance to achieve this objective as long as ARP volume is reasonably high.

According to an analysis by the Commerce Department that was based on an audit by Touche Ross and a separate actuarial study by Milwaukee Teleservices, the ARP will be solvent after 1987, and an assessment of about 1.6 percent in 1989 on expected industry premium of $500 million will cover the expected 1987 deficit.

In effect, for the long run, at current volume the plan is predicted to be self-sufficient once the rate increases already announced take effect. Does this mean that the Commerce Department will cut plan rates in the future because a self-sufficient ARP is not its objective for reasons already discussed? The answer to this question is obscure because the Commerce Department does not have a policy that is cast in terms either of average market rates or the degree to which the plan is to be self-supporting. Indeed, a wise policy would recognize that a high volume ARP can be more self-sufficient than a low volume plan. The ARP pricing policy should be formulated accordingly.

The insurance industry and the Commerce Department like to argue about whether the plan should be self-supporting. The issue involved in this decision is whether and to what extent the risks of employers rejected by the voluntary market should be spread beyond plan participants to the market as a whole. It seems to us that there is less of a fundamental difference between the industry and the department than might appear at first glance. Neither the industry or the department wants a high volume ARP. The industry recognizes the need for an assessment mechanism and used the mechanism itself when administering the plan. Of course, the industry did not always get to change the rates it wanted to when the state had prior approval authority. The industry also recognizes that it cannot ignore the problem of small employers and marginally profitable risks as a practical matter.

If the industry is willing to tolerate some subsidy for the ARP, however, it will not agree to overt competition by the ARP. But this is a point on which state policy is clear enough: Workers' compensation prices are to be set by competition.

The motivation to keep workers' compensation rates down by the one mechanism directly under the control of the Commerce Department is understandable.

- **There are a lot of small employers that the private market is not very interested in serving, especially when a capacity shortage exists in the industry.**

- **If ARP prices are self-sufficient, the small employers in the plan are bearing the whole cost of insuring the companies that are unusually risky.**

- **Workers' compensation prices are very high in Minnesota to begin with.**

However, under Minnesota's system where market competition sets the price for most insurance, the Commerce Department cannot, in the long run, help insurance purchasers by undercutting the market price. Any temporary break for ARP participants will have to be assessed against purchasers as a whole. Some assessments will be necessary because there always will be errors made in pricing insurance. Some assessments will be advisable because of a conscious plan to have insurance purchasers as a whole subsidize the ARP. But this latter assessment should not be due to pricing ARP insurance below the market for ordinary buyers. If this happens, more employers will belong to the ARP. At some point, all employers will belong to the ARP and there will be no one left to assess. Something like this actually happened recently in Maine.

The State Fund Mutual Insurance Company was established by statute, in part, to serve small employers. If the voluntary market fails to adequately serve small companies that are not unfavorable risks--and it is not really known by the Commerce Department what the dimension of the problem is--

then the Commerce Department could set up a separate rate schedule for high or low risk purchasers. Its failure to do so while maintaining that most ARP participants are suitable risks can be questioned.[2]

WHO SHOULD ADMINISTER THE WORKERS' COMPENSATION ASSIGNED RISK PLAN?

The Workers' Compensation ARP is administered by the Commerce Department unlike the organization of virtually all other insurance residual market arrangements in Minnesota.

According to the department, responsibility for the Workers' Compensation ARP was assigned to the Commerce Department because of dissatisfaction with the way the industry ran the plan. Commerce Department administration of the ARP has been a major source of contention and criticism by the industry.

This section examines the question of who should administer the plan. The questions that we feel are germane to this decision are:

- **Has Commerce done a good job administering the plan?**

- **Given the regulatory responsibilities of Commerce and the regulatory system in Minnesota, is it appropriate for Commerce to run the plan?**

The issue of how well the department has administered the assigned risk plan has, in part, been addressed by preceding sections of this chapter which examined how well the plan has worked in recent years.

There are nuts-and-bolts issues that have not been addressed however. The Commerce Department runs the plan by hiring third-party administrators to carry out the functions of an insurance company, e.g., selling insurance directly or through agents, paying claims, collecting bills, etc. The department will conclude three-year contracts with three administrators later this year and conduct another solicitation for the business.

There have been problems, none extraordinary, with the present arrangement and improvements need to be sought in the future. One problem is the inability of at least one contractor to supply data needed to accurately measure reserves and thus the financial status of the plan. We are told that this contractor, however, has installed a new computer system to remedy the problem.

Another problem concerns the contractual relationship between Commerce and the third-party administrators. The administrators were recruited

2 The department does have a five percent merit rate reduction for small employers and is planning to tie a credit to employees' experience rating.

through a competitive bidding process. Four timely responses were obtained to the Commerce Department's request for proposals, three bids were accepted. Administrators are reimbursed a percentage of written premium.

This arrangement lacks desirable incentives:

- **The administrators lack an incentive to collect bills, since their reimbursement is based on written premium rather than collected dollars.**

- **The administrators lack the incentive an insurance company has to manage claims since they get paid the same whether they are effective or ineffective in managing claims.**

There are problems, none insurmountable, in the administration of the plan by the Commerce Department.

While it is advantageous to engage several contractors in order to learn which is best for the long-run and to avoid developing a sole-source dependency, the three contractors are paid a very different price for their services ranging from 13 to 22 percent of written premium. It will perhaps come as no surprise that the cheapest contractor has caused the most problems. Using several contractors also means that it is difficult to establish uniform policies and procedures.

The Commerce Department has struggled with these problems. It has hired a collection agency to collect the bills that go unpaid for more than sixty days. It holds frequent meetings with the three administrators in order to standardize procedures and achieve the result that insurance buyers will be treated the same by any of the administrators.

Another problem that Commerce has experienced is its inability to activate the Assigned Risk Plan Review Board called for in Minn. Stat. §79.251. The Board is to consist of two insurance company representatives, three employer representatives, and the Commissioner of Commerce. The Board, by law, is to monitor the operation of the assigned risk plan and to audit the reserves set aside to pay anticipated losses.

Apparently, the distinction between the Board and the Commerce Department has been lost in recent months because the Board Chairman feels that he was denied, for a time, access to the 1986 audit done by Touche Ross and the actuarial report by Milwaukee Teleservices. In any case, the letter of transmittal accompanying these reports is not addressed to the Review Board. Thus, a desirable distinction concerning who engages an audit firm and receives the results of the audit has been overlooked.

The Board Chairman, however, is the president of the State Fund Mutual Insurance Company, a state-capitalized insurance company that was created in 1983 by statute when the state moved to the current competitive rating system and wanted something akin to a competitive state fund to help assure competition, and availability of insurance for small employers, and to provide a source of trustworthy data on workers' compensation. The State Fund is a company that, more than some others, competes for the workers' compensation insurance business of small employers. If the ARP is charging too little, the State Fund Company is directly affected.

Also, the State Fund Mutual Insurance Company might compete for the contract to administer the ARP. Thus, its president is not a disinterested critic of

the ARP. However, neither would any insurance company representative on the board be disinterested. Insurance company interest in the ARP is precisely why there are two industry positions on the Board.

In our judgment, there is no reason why the Commerce Department cannot administer the assigned risk plan. None of the problems we have noted is beyond solution. The industry is profoundly critical of the arrangement, however. Along with many other criticisms the industry notes that two of three current plan administrators are not insurance companies and lack the kind of committment to claim management that they believe only insurance companies have. If this were a problem, of course, the Commerce Department could hire insurance companies to administer the plan. The fact is that the assigned risk plan under any administration would levy assessments to cover losses that exceed premiums and investment income. It seems to us that the major contention between the industry and the department hinges not on administrative efficiency but on pricing policy.

While there is no fundamental reason why Commerce cannot administer the plan, we question whether it should. This issue is discussed next.

SHOULD COMMERCE ADMINISTER THE PLAN?

But we conclude that the plan should not be administered by Commerce, because of that department's regulatory responsibilities.

In our judgment, the regulatory responsibility of the Commerce Department is incompatible with, in effect, running an insurance company. The best idea for the long run is for Commerce to strengthen its ability to regulate the assigned risk plan, then get out of operating it. As a regulator, the Commerce Department should:

- **Establish a clear pricing policy for the ARP.**
- **Establish clear standards for administering the plan, including standards for processing paperwork, meeting reporting requirements and anything else it feels the plan must accomplish.**

The point is: Can the department regulate itself as well as it could regulate an independent entity. The first part of this chapter concludes that Commerce has to clarify its ARP policy. The fact is that credibility as a regulator and insurance company operator is at least somewhat incompatible. The essential role of the Commerce Department is to set policy and see that it is carried out by insurance companies, not to operate an insurance company itself.

There are many residual market arrangements that could be adopted in lieu of Commerce Department operation, including administration of the plan by the Minnesota Workers' Compensation Insurance Association, the industry service organization that currently still has a few statutory functions. The model chosen should be operated by the industry and regulated by the state, with appropriate consumer representation. Most workable governing boards have a majority of industry seats, along with Commerce Department and consumer representatives.

CONCLUSIONS AND RECOMMENDATIONS

Chapter 8

In this chapter, we review our major conclusions about workers' compensation costs in Minnesota and recommend several important changes in Minnesota's workers' compensation benefit structure. Recommendations about other features of Minnesota's workers' compensation system, including its administration, the special compensation fund and the assigned risk plan, are contained in Chapters 4, 5 and 7.

OVERVIEW

In evaluating the workers' compensation system and reviewing proposed changes, the Legislature must consider the purpose and goals of workers' compensation. As discussed in Chapter 1, workers' compensation was created as an alternative to the costly and time-consuming requirements of the civil justice system. Workers gave up the right to sue and employers gave up common law defenses against lawsuits in exchange for defined benefits designed to replace a portion of the injured workers' lost wages. We suggested in Chapter 1 that workers' compensation benefits should be adequate, that they should be equitably distributed, that they should be distributed promptly and efficiently, and that they should provide incentives to return injured workers to work. Clearly, Minnesota must also be concerned with the cost of its workers' compensation system. For example, the sysyem could be constructed to give all injured workers 100 percent or more of their pre-injury wages and to provide those benefits for an unlimited time period. The benefits would certainly be adequate, but the costs might be judged to be too high.

The Legislature must balance the benefits provided by the workers' compensation system against the costs.

The job of the Legislature is a difficult one: it must balance the benefits provided by the workers' compensation system against the costs. At the same time it must try to maximize equity and efficiency and ensure that the proper incentives are built into the system. If the cost of Minnesota's workers' compensation system gets too far out of line with other states, and particularly neighboring states, the state's economy may suffer as jobs may be lost and employers may go elsewhere. It is this concern with workers' compensation costs which largely motivated this study. Cost comparisons among states are imperfect. Each state has a somewhat different occupational and demographic composition. However, studies that have controlled for these factors show that:

- **Minnesota's workers' compensation insurance rates are among the highest in the country.**

Our analysis in Chapter 2 shows that as of July 1, 1987, Minnesota's workers' compensation rates ranked fourth highest among a comparison of 38 states and the District of Columbia. Our analysis also revealed that:

Minnesota's workers' compensation insurance rates are among the highest in the nation and about twice as high as rates in Wisconsin, Iowa, and South Dakota.

- **Minnesota's workers' compensation insurance rates are about twice as high as rates in Wisconsin, Iowa, and South Dakota.**

These observed differences are not the result of higher insurance company profits in Minnesota compared to other states. The available evidence presented in Chapter 3 shows that:

- **From 1978 through 1986, the ratio of benefits paid and reserved to premiums collected (the "loss ratio") was higher in Minnesota than in neighboring states. This was not due to unusual reserving practices. In fact, Minnesota under-reserved in recent years. This indicates that insurers' profitability has been lower in Minnesota in the recent past than in neighboring states.**

While insurance companies have some flexibility in the way they report losses, they cannot easily manipulate long-term trends. Furthermore, there are greater incentives to exaggerate losses in rate-regulated states (unlike Minnesota), where insurance companies have to justify rate increase requests to regulators.

Another possibility is that Minnesota's higher costs can be explained by administrative inefficiencies, either in state government or the insurance industry. Our analysis in Chapter 4 does indicate some problem areas, particularly the backlog of cases at the Office of Administrative Hearings. Also, insurers do say that claims management is somewhat more difficult in Minnesota. These inefficiencies need to be addressed, but they are relatively minor and seem unlikely to account for the major cost differences between Minnesota and other states.[1]

Rather, a review of Minnesota's laws and the best available cost data leads us to conclude that:

- **Minnesota's workers' compensation costs are high primarily because its benefits are high.**

Workers' compensation benefits are designed to replace wages without discouraging a timely return to work. On average, however, Minnesota's workers' compensation indemnity benefits replace 90 percent of pre-injury take-home pay. In many cases, benefits replace over 100 percent of pre-injury take-home pay. In addition, injured workers in essentially similar circumstances can receive very different benefits. Furthermore, many long-term cases follow injuries that are not medically serious. Therefore, we conclude that:

1 In fact, these delays may be attributed to Minnesota's complex and generous benefit system which encourages costly and time-consuming litigation.

- **workers'compensation benefits are sometimes more than adequate, are not always distributed equitably, and contain some important disincentives for returning injured workers to work.**

We believe that reforms to the workers' compensation benefit structure will contribute significantly to controlling the costs of the system and achieving its goals.

Reforming the workers' compensation benefit structure will contribute significantly to controlling costs.

In the remainder of this chapter, we review our findings on Minnesota's workers' compensation benefits and recommend changes that we believe will reduce costs, remove some of the inequities in the workers' compensation system, and strengthen the incentives to return injured workers to work. Our discussion is divided into six parts. We first discuss the weekly wage replacement formula, including minimum and maximum weekly benefits, and the effect of this formula on injured workers' take-home pay. Next, we discuss temporary benefits and the problem of defining when they should end. Third, we review permanent benefits, including the two-tiered system of permanent partial benefits enacted in 1983. Fourth, we discuss the cost-of-living escalator and its effect on costs. Fifth, we review supplementary benefits and discuss needed changes there. And finally, we discuss some miscellaneous issues that affect benefits and costs.

MINIMUM AND MAXIMUM BENEFIT LEVELS

Minnesota, like most states, has a basic wage replacement rate for temporary and permanently totally disabled workers of two-thirds of the employee's pre-injury gross weekly wage. This amount is viewed as adequate to sustain workers during their disability but not so high as to provide an economic incentive for them to remain out of work beyond the period of their disability.

Since workers' compensation benefits are not subject to income or social security withholding tax, these benefits actually replace more than two-thirds of the injured worker's take-home pay. Statutory maximums and minimums also affect wage-replacement rates. The Department of Labor and Industry estimated the after-tax income replaced by workers' compensation for different income levels. Weekly workers' compensation benefits for most workers who earn less than $200 (up to 53 percent of the statewide average weekly wage) equal 108 to 117 percent of their pre-injury after-tax income. Workers earning between $250 and $650 per week (66 to 173 percent of the statewide average weekly wage) receive benefits that equal between 75 and 82 percent of their pre-injury after-tax wage. The percentage of after-tax income replaced declines for workers with weekly incomes above $650.[2]

2 Lisa Thornquist and David Bogenschultz, *Income Replacement in the Minnesota Workers' Compensation System*, Department of Labor and Industry, January 1988, p. 33. These figures are for married workers who are the sole income provider in the family. The percentage of after-tax income replaced by workers' compensation is slightly higher for non-married workers and workers in two-wage families.

For all workers, the department concluded that because of minimum benefit provisions, the average gross income benefit (before taxes) for Minnesota workers is actually 75 percent of their pre-injury wage. On an after-tax basis, the average benefit replaced 90 percent of workers' net income.[3] Minnesota's wage replacement benefits are a percentage of the worker's gross wages. However, because workers' compensation benefits are not taxable, workers in different tax brackets do not receive the same percentages of take home pay to all workers. Therefore, we recommend that:

The average workers' compensation benefit replaced 90 percent of workers' take-home pay.

- **The Legislature should change the basic wage replacement formula to base wage replacement benefits on spendable earnings (i.e., after-tax wages) rather than gross pay.**

The 1972 National Commission discussed in Chapter 1 recommended 80 percent of net lost wages as a standard for measuring the adequacy of benefits. Four states use a percentage of spendable earnings (net wages) in their basic wage replacement formula. Three of those, including Iowa, use 80 percent of spendable earnings. Changing the basic wage replacement formula to 80 percent of take-home pay (without changing the minimum or maximum limits) will result in a small reduction in workers' compensation costs.

In Chapter 3, we estimate that the direct cost of minimum benefits, excluding self-insurers, are about $11.4 million per year or 2.4 percent of the total benefit cost. On the other hand, Minnesota saves about $13.6 million per year because of its maximum benefit level. In addition, minimum benefits result in about two percent of workers receiving benefits that exceed their gross wages and about 12 percent receiving benefits that equal their gross wage. About 27 percent receive wage replacement benefits that exceed their take-home pay.

As noted, workers' compensation benefits should be both adequate and equitable. In addition, except for a small number of long-term cases where there is no practical likelihood of a return to work, the Legislature may not want to provide benefits that result in take-home pay that exceeds workers' pre-injury take-home pay. Benefits that exceed pre-injury wages provide a disincentive to return to work. Accordingly, to remove this disincentive, we recommend that:

- **the Legislature should consider limiting workers' compensation benefits to a worker's pre-injury take-home pay (based on a reasonable employment history) except for permanent total disabilities.**

One rationale for minimum benefits is that a workers' wage at the time of injury may not reflect his or her career prospects for a higher wage. There may also be some individuals whose wage is so low that they cannot sustain themselves on their workers' compensation benefits. Eliminating minimum benefits may impose a real economic hardship for them. However, Minnesota provides a separate mechanism, supplementary benefits, for providing higher minimum benefits for long-term serious injuries. (We discuss supplementary benefits in Chapter 5 and later in this section.) For temporary injuries, the

3 *Ibid.*, p. 30.

issue is whether the workers' compensation system should take over the function of public assistance programs that provide benefits based on need.

The question of statutory maximum benefits raises different concerns. Disabled high income workers receive less than two-thirds of their weekly wage (or 80 percent of disposable income). Although imposition of a maximum is not consistent with the notion that the system should replace a fixed percentage of the pre-injury wage, high income workers are still receiving benefits (currently $376 per week) that, arguably, are adequate to sustain them until they can return to work. Furthermore, eliminating maximum benefit levels would increase workers compensation costs by about $13.6 million per year. Therefore,:

- **if cost control is a paramount concern, we recommend no change in the statutory maximum.**

TEMPORARY WAGE-REPLACEMENT BENEFITS

Injured workers who are unable to work receive two-thirds of their pre-injury wage tax free until they return to work. Workers who are able to work part-time or at a light-duty job during their recovery receive two-thirds of the difference between their pre-injury wage and their part-time or light duty wage. These benefits, called "temporary total disability benefits" and "temporary partial disability benefits", respectively, are designed to sustain injured workers until they are able to return to full-time work. However, in many instances, they have been construed as a benefit which injured workers receive until they actually return to work, rather than until they are physically able to return to work.

In 1975 the Legislature removed a 350-week limit on temporary total benefits. As a result, it is possible that some workers injured after 1975 who recovered from their injuries and did not return to work received temporary total benefits indefinitely. In 1983, the Legislature re-established a maximum duration for temporary total benefits. Temporary total benefits now cease 90 days after an injured worker achieves maximum medical improvement or completes an approved retraining program, whichever is later. At that time, wage replacement benefits cease. Workers who are partially disabled receive a disability rating and a permanency award as compensation for the disability. Those workers who are totally disabled and unable to return to work receive "permanent total disability benefits" for the remainder of their lives.

Recent decisions by the court have allowed workers to receive temporary partial benefits indefinitely at the temporary total rate.

The 1983 law put an end to indefinite temporary total disability benefits, but it did not specify a limit on the duration of temporary partial benefits. As a result of some recent decisions by the Workers Compensation Court of Appeals, discussed in Chapter 6, workers can currently receive temporary partial benefits indefinitely. In addition, the court has decreed that workers who have reached maximum medical improvement and have their temporary total benefits terminated can continue receiving temporary partial benefits at the temporary total rate. The legal reasoning behind these decisions is complex

and discussed in detail in Chapter 6. Important issues have not yet been settled by the Minnesota Supreme Court.

Nevertheless, the Legislature could clear up the confusion by amending state law to require that:

- **temporary partial benefits should cease ninety days after maximum medical improvement or the completion of an approved retraining program.**[4]

The argument here is that temporary benefits should be temporary. The statute provides for additional benefits to compensate workers for permanent disabilities. But the basic wage replacement benefits should end when the worker is fully recovered and able to work. Data presented in Chapter 3 suggest that many individuals who are not totally disabled receive total disability benefits for long periods, some indefinitely. For example, the median disability rating for those cases reported to the Reinsurance Association (because they potentially present a liability that will exceed the $170,000 or $370,000 threshhold) is only 16 percent. Significant numbers of expensive cases have disability ratings of less than five percent.

By paying benefits indefinitely, long after medical recovery, workers' compensation is being used to substitute for social insurance or welfare programs.

Many people who receive wage replacement benefits for life or who receive large settlements in lieu of lifetime benefits are not permanently totally disabled from the standpoint of being physically unable to work. One reason given for the long duration of workers compensation cases is the poor job prospects in certain parts of the state. Many injured workers are physically recovered and able to work but cannot find jobs without relocating. These workers would be eligible for unemployment compensation benefits, but those benefits last only six months. By paying benefits indefinitely, long after medical recovery, Minnesota's workers' compensation system is being used to substitute for limits in other social insurance or welfare programs.

The Legislature needs to consider whether it wants the workers' compensation system to function, in these instances, as unemployment compensation or even a a public assistance program. If so, it must be willing to bear the cost and accept possible inequities. If not, the Legislature should consider statutory changes to ensure that workers who are able to return to work do not collect wage replacement benefits indefinitely.

First, the Legislature could place more restrictions on eligibility for permanent total disability. This could be done by adding language to the permanent total disability statute (*Minn. Stat.* §176.101 subd. 5) to require that those receiving permanent total benefits have a minimum disability rating such as 25 or 50 percent of the body. In addition, specific language could be added so that the inability to obtain employment because of economic condi-

4 This could be accomplished by amending *Minn. Stat.* §176.101, subd. 3e, to state that "...the employee's temporary total compensation *and temporary partial compensation* shall cease..." and by repealing *Minn. Stat.* §176.101 subds. 3f and 3h. Additional changes may also be required.

tions or other non-medical factors is not a sufficient basis to receive permanent total disabilty benefits.

Second, the Legislature could restore the provision (repealed in 1975) that temporary total disability (and temporary partial disability) may not exceed 350 weeks. In most cases, this provision will be moot because maximum medical improvement will be reached well before 350 weeks (6.7 years). We believe, however, that this statutory change would ensure that temporary disability cases do not become *de facto* permanent disability cases. [5]

PERMANENT PARTIAL BENEFITS

Permanent partial benefits compensate workers for permanent disabilities resulting from injuries. In 1983, the Legislature radically changed the permanent partial benefit statute to provide for a two-tiered system of benefits. Injured workers who are offered a suitable job within 90 days of maximum medical improvement receive lower-tier impairment compensation benefits, and those who are not offered a suitable job receive substantially higher economic recovery benefits. The two-tiered permanent partial benefits system provides an incentive for employers to offer injured workers a suitable job upon their recovery. This aspect of the 1983 law, in theory, supports the goal of returning injured workers to work.

The schedules of impairment compensation and economic recovery benefits were designed to result in total benefit payments about equal to pre-1984 permanent partial benefits assuming that 80 percent of injured workers receiving temporary total benefits would be offered a suitable job and receive impairment compensation upon recovery. They were not designed primarily to reduce costs.[6] However, actual experience reported by the Department of Labor and Industry indicates that over 90 percent of those injured in 1984 and who received permanent partial benefits as of September 1987 received impairment compensation.[7] This suggests that there may be a reduction in the cost of permanent partial benefits as the result of the two-tiered system.

It takes several years before the financial impact of benefit changes are known. This is because early estimates of benefits to be paid are often inaccurate, especially for the most serious injuries. Although there are some preliminary indications that the changes may reduce workers' compensation costs, the long-term results are not yet known. Therefore:

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5 In Chapter 3, we estimated the cost of permanent disability (excluding amounts paid by self-insurers) to be $50 million in 1986. In addition, most of the $37 million paid in supplementary benefits went to permanent disability beneficiaries. Although we cannot precisely quantify the cost savings from adopting these statutory changes, they would be substantial.

6 The key change in 1983, which was expected to reduce costs, was the imposition of the 90-day post-maximum medical improvement limit on temporary total benefits, which we discussed earlier in this chapter.

7 Thornquist and Bogenschultz, *Income Replacement in Minnesota's Workers' Compensation System*, p. 47.

- **we see no reason to change the two-tiered system of permanent partial benefits at this time.**

In Minnesota, injured workers receive annual cost-of-living adjustments in wage replacement benefits.

THE COST-OF-LIVING ESCALATOR

Minnesota is one of eleven states with cost-of-living escalators for workers disabled for one or more years. In Minnesota, workers who receive temporary total, temporary partial, permanent total, or survivors' benefits receive an annual cost-of-living adjustment on the anniversary of the injury. The adjustment is based on the percentage change in the statewide average weekly wage up to six percent.

Our analysis in Chapter 3 reveals that the cost-of-living escalator accounts for 9.4 percent of the cost of Minnesota's workers' compensation benefits, or about $45 million per year. While eliminating the escalator would yield significant savings, those workers with long-term disabilities would see an erosion of the value of their benefits, especially during periods of high inflation. Therefore, we think that the cost-of-living escalator should be retained. However, if the Legislature is concerned about the cost of the escalator clause, especially in relation to neighboring states which do not have escalators, it could curtail the cost-of-living adjustment by delaying its effective date until two or three years after the injury or, by applying it only to permanent total and survivors' benefits. This would reduce costs without greatly affecting those who suffer serious or permanent injuries.

SUPPLEMENTARY BENEFITS

No other state has supplementary benefits that are as generous and inclusive as Minnesota's.

Minnesota is one of about twelve states with supplementary benefits, but no other state's benefits are as generous and inclusive as Minnesota. As we discuss in Chapter 5, most states with supplementary benefits only bring benefits for workers injured many years ago up to current levels. Many apply only to permanent total and survivors' benefits. In Minnesota, workers totally disabled for four years or more (two years if the injury occurred prior to October 1, 1983) are guaranteed benefits equal to 65 percent of the statewide average weekly wage. In FY 1987, the Special Compensation Fund reported $48.6 million in supplementary benefits expenses.

In our view, supplementary benefits make sense for workers injured prior to October 1, 1975 when the cost-of-living escalator became effective. Because those workers are not eligible for cost-of-living increases and were subject to existing maximum benefit levels that were very low, supplementary benefits are a reasonable means of bringing their wage replacement benefits to an adequate level. However, workers injured since the escalator went into effect do get annual adjustments. Guaranteeing them a level of benefits equal to 65 percent of the statewide average weekly wage means that some will receive benefits well above their pre-injury wage.

Supplementary benefits allow workers to receive both social security and workers' compensation benefits that, for many workers, exceed their pre-injury wage.

Perhaps the most costly aspect of supplementary benefits is that they restore most of the state reduction for social security benefits, thereby allowing workers to receive both social security (disability or old age) and workers' compensation in amounts that, for many workers, exceed their pre-injury wage. (See Table 5.2.) In addition, many workers receive employer-provided pension benefits. This is a clear disincentive for injured workers to return to work. The Department of Labor and Industry estimates that the restoration of the social security offset accounted for 38.5 percent of the supplementary benefits paid (excluding lump sum settlements) for the claim year ending September 30, 1986.

The workers' compensation system is designed primarily to replace lost wages that result from workplace injuries, not as an income maintenance or retirement program. Accordingly, we recommend that the Legislature consider the following prospective changes in supplementary benefits to reduce workers' compensation costs, ensure that benefits go to those who need them, and retain incentives for employees and employers to return injured workers to work:

- **Future supplementary benefits should be restricted to persons found to be permanently totally disabled.**

To the extent that persons determined to be permanently totally disabled are truly unable to return to work, the issue of providing improper incentives is less important.[8]

Minnesota's supplementary benefits are substantially more generous than other states. Supplementary benefits cost almost $50 million in FY 1987. To the extent that the Legislature wishes to reduce costs:

- **supplementary benefits could be reduced to provide a minimum benefit of, for example, 50 percent of the statewide average weekly wage instead of the current 65 percent.**

Adopting this recommendation will reduce costs and still leave Minnesota with one of the highest minimum benefit levels in the country.

Also, the Legislature should consider the following:

- **Social security old age and disability benefits and employer-provided pension benefits should be added to workers' compensation benefits in determining eligiblity for supplementary benefits.**

8 In 1983, the Legislature extended from two to four years the length of disability required to be eligible to receive supplementary benefits. In fact, most injured workers who are out of work over four years never go back to work. The change recommended here would make the provision of supplementary benefits consistent with our suggestions about limiting permanent total disability to those who are unable to work and ensuring that temporary disabilities do not become *de facto* permanent disabilities. Injured workers would have to meet the requirements of permanent total disability to receive supplementary benefits.

In Chapter 5, we discussed the interplay between social security old age and disability benefits and workers' compensation. Although federal and state law require offsets to require that injured workers do not receive both benefits, supplementary benefits restore this offset and allow some workers to receive both benefits. As a result, some injured workers collect total benefits in excess of their pre-injury wage. As noted above, 38.5 percent of the supplementary benefits paid in 1986 went to restore social security offsets. Adopting this recommendation would substantially reduce supplementary benefit payments and reduce the likelihood that workers would receive total benefits in excess of their pre-injury wage. It would not affect benefits for low-wage earners who do not receive social security or other pensions.

OTHER RECOMMENDATIONS

Medical Benefits

Medical benefits constitute about 28 percent of workers' compensation costs. Although we did not undertake a thorough review of medical costs, our discussion in Chapter 4 indicates widespread agreement among experts that workers' compensation medical costs are not adequately controlled. Although Minnesota does have a medical fee schedule, it covers only 19 percent of listed outpatient medical procedures and no hospital-based procedures.

Other medical insurance programs such as medicare and medicaid and privately financed health insurance have more well-developed cost control systems. One idea would be to certify physicians and clinics who agree to state approved fees as eligible to provide workers' compensation services. Another is to institute a preferred provider system for workers' compensation cases that would function like many private insurance programs. We recommend that:

- **the Department of Labor and Industry study the issue of medical costs and report to the Legislature on a plan to control medical costs.**

Minnesota law allows minors and apprentices of any age to receive wage replacement benefits at the maximum rate.

Minors and Apprentices

Minnesota law allows minors, and apprentices of any age to receive wage replacement benefits (temporary total, temporary partial, permanent total and economic recovery benefits) at the maximum rate (the statewide average weekly wage). While minors' wages do not reflect their potential earning power over their lifetimes, it does not follow that in all circumstances, wage replacement benefits for minors should be at the maximum level.

From the standpoint of equity, the Legislature must consider whether it is reasonable that a 17 year-old should receive a benefit of 100 percent of the statewide average weekly wage and a 22 year-old earning the same wage receives much less. Similarly, some trade occupations have apprentices, but al-

most all workers begin their careers in lower-paid positions which serve as training for higher-skilled jobs. Should apprentices receive higher benefits than other entry-level workers?

For the young, permanently-disabled worker whose career is cut short by a serious injury, supplementary benefits would ensure that they receive a minimum benefit, regardless of the wages they received as a minor or apprentice. We think the Legislature should consider whether it is fair to provide them with the maximum benefit. Like so many aspects of Minnesota's benefit system, such a benefit provides an economic incentive to remain out of work. Accordingly, we recommend that:

- **the Legislature should consider removing the preferential treatment of minors and apprentices.**

Seasonal and Part-Time Workers

Minnesota law allows some seasonal and part-time workers to determine their weekly wage as if they were working full time. This allows some workers to obtain workers' compensation benefits in excess of their pre-injury wage. While we cannot quantify the cost of this provision, it does provide a disincentive for workers benefiting from this provision to return to work. Accordingly, we recommend that:

- **the Legislature should consider requiring that all part-time and seasonal workers calculate their weekly wage on a pro-rated basis (i.e., hourly pay times the number of hours worked per week).**

Retired Workers

In theory, wage replacement benefits replace lost wages for persons who would be working if they had not been injured. Workers who reach retirement age ordinarily stop working and, therefore, might not be expected to be eligible for workers' compensation benefits. The issue is complicated by two factors. First, a worker permanently totally disabled at a young age does not accumulate normal pension benefits that many employers provide. Thus, terminating their benefits at retirement age may take away their only source of income. Second, there is no uniform age for retirement. Many workers claim that they intended to continue working. We noted in Chapter 5, for example, that 44 percent of workers collecting supplementary benefits are over 65 years old.

In 1983, the Legislature tried to deal with this issue by enacting a rebuttable presumption that a worker collecting social security old age benefits is retired from the labor market. Although this presumption has not been tested in court, department staff do not believe it will have much effect since, in order to rebut the presumption, workers need only state that they intended to keep working.

The Legislature could deal with this issue by terminating all workers' compensation benefits at a specified age, such as 65 or 70 years old. We suggest that a fairer and less contentious solution is to adopt the recommendation in Chapter 5 and summarized in this chapter to determine supplementary benefits after adding social security and other employer-provided pension benefits to workers' wage replacement benefits. This, together with the offset required by Social Security for disability benefits, will ensure that no worker receives more than 80 percent of their pre-injury wage.

CONCLUSIONS

In our opinion, one consequence of Minnesota's generous benefits system is to increase the cost of doing business in Minnesota relative to other states and particularly neighboring states. In addition, Minnesota's system provides many disincentives for injured workers to return to work, particularly in those cases where their workers' compenstaion benefits exceed their pre-injury take-home pay.

Our recommendations are aimed at reducing costs and restoring incentives for injured workers to return to work. We caution, however, that workers' compensation insurance rates lag behind benefit changes. Other things being equal, insurers usually require financial evidence of cost reductions before they lower their rates. Unfortunately, the full cost of a workplace injury is not known for several years. Thus, even if the Legislature adopts the cost-saving recommendations contained in this report, it may take several years before the changes are fully reflected in lower rates. However, some changes (for example, placing limits on temporary benefits) may result in immediate changes in insurance company estimates of reserves needed to pay future claims and should have an immediate effect on rates.

SELECTED PROGRAM EVALUATIONS

Board of Electricity, January 1980	80-01
Twin Cities Metropolitan Transit Commission, February 1980	80-02
Information Services Bureau, February 1980	80-03
Department of Economic Security, February 1980	80-04
Statewide Bicycle Registration Program, November 1980	80-05
State Arts Board: Individual Artists Grants Program, November 1980	80-06
Department of Human Rights, January 1981	81-01
Hospital Regulation, February 1981	81-02
Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill, February 1981	81-03
State Designer Selection Board, February 1981	81-04
Corporate Income Tax Processing, March 1981	81-05
Computer Support for Tax Processing, April 1981	81-06
State-sponsored Chemical Dependency Programs: Follow-up Study, April 1981	81-07
Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights, April 1981	81-08
Individual Income Tax Processing and Auditing, July 1981	81-09
State Office Space Management and Leasing, November 1981	81-10
Procurement Set-Asides, February 1982	82-01
State Timber Sales, February 1982	82-02
Department of Education Information System,* March 1982	82-03
State Purchasing, April 1982	82-04
Fire Safety in Residential Facilities for Disabled Persons, June 1982	82-05
State Mineral Leasing, June 1982	82-06
Direct Property Tax Relief Programs, February 1983	83-01
Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes,* February 1983	83-02
Community Residential Programs for Mentally Retarded Persons,* February 1983	83-03
State Land Acquisition and Disposal, March 1983	83-04
The State Land Exchange Program, July 1983	83-05
Department of Human Rights: Follow-up Study, August 1983	83-06
Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf,* January 1984	84-01
The Administration of Minnesota's Medical Assistance Program, March 1984	84-02
Special Education,* February 1984	84-03
Sheltered Employment Programs,* February 1984	84-04
State Human Service Block Grants, June 1984	84-05
Energy Assistance and Weatherization, January 1985	85-01
Highway Maintenance, January 1985	85-02
Metropolitan Council, January 1985	85-03
Economic Development, March 1985	85-04
Post Secondary Vocational Education: Follow-Up Study, March 1985	85-05
County State Aid Highway System, April 1985	85-06
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Health Plan Regulation, forthcoming	
Trends in Education Expenditures, forthcoming	
Remodeling of University of Minnesota President's House and Office, forthcoming	
University of Minnesota Physical Plant, forthcoming	
Medicaid: Prepayment and Postpayment Review - Follow-Up, forthcoming	
High School Education, forthcoming	

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.