Minnesota
Workers' Compensation System Report, 2008

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Minnesota Workers' Compensation System Report, 2008

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Executive summary

Since the middle of the 1990s, workers' compensation claim rates have declined nationwide. During the same period, medical and indemnity benefits per claim — particularly medical benefits — have increased faster than wages. These same general trends have occurred in Minnesota. A decreasing claim rate has counteracted increases in benefits per claim, so that total benefits relative to payroll were somewhat lower in 2008 than in 1997.

This report, part of an annual series, presents data for 1997 through 2008 about several aspects of Minnesota's workers' compensation system — claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

These are the report's major findings:

- The claim rate fell continually from 1997 through 2008.

- The total cost of Minnesota's workers' compensation system per $100 of payroll has fluctuated since 1997. The 2008 cost per $100 of payroll was near the low-point for 1997 to 2008.

- Adjusted for average wage growth, average medical and indemnity benefits per insured claim rose substantially between 1997 and 2007.[1]

- Relative to payroll, medical benefits were at approximately the same level in 2008 as in 1997, but indemnity benefits were lower, reflecting the net effect of the falling claim rate and higher benefits per claim.

  - By counteracting the increasing trend in benefits per claim, the falling claim rate has been a major factor in keeping system cost per $100 of payroll at historically low levels.

- The increase in indemnity benefits per claim is due primarily to increasing benefit duration and increases in the frequency and amounts of stipulated benefits.

- In vocational rehabilitation (VR):

  - The participation rate increased during most years from 1997 to 2008.
  - Average cost per participant rose substantially from 1998 to 2008, as did average VR cost per indemnity claim (adjusting for average wage growth).
  - Average service duration showed little change from 1998 to 2008.
  - The percentage of participants with a job at the conclusion of services declined steadily between 1998 and 2008, with a sharp downturn in 2008. In 2008, 47 percent of participants did not have a job at the conclusion of services.

- The dispute rate rose substantially from 1997 to 2008, as did the percentage of paid indemnity claims with claimant attorney involvement.

- The annual number of dispute resolutions at DLI was substantially higher from 2007 to 2009 than in prior years.

[1] 2007 is latest year for which these particular statistics were available at the time of this report.

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Introduction

Since the middle of the 1990s, workers' compensation claim rates have declined nationwide. Over the same period, medical and indemnity benefits per claim — particularly medical benefits — have increased faster than wages. For both benefit types, the rate of increase in the 2000s has been less than in the late 1990s.[2] These same general trends have occurred in Minnesota. A decreasing claim rate has counteracted increases in benefits per claim (particularly medical benefits), so that total benefits relative to payroll were somewhat lower in 2008 than in 1997.

This report, part of an annual series, presents data from 1997 through 2008 about several aspects of Minnesota's workers' compensation system — claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution. Its purpose is to describe statistically the current status and direction of workers' compensation in Minnesota and to offer explanations, where possible, for recent developments.

Chapter 2 presents overall claim, benefit and cost data. Chapter 3 provides more detailed data about indemnity (cash) benefit trends. Chapters 4 and 5 provide statistics about vocational rehabilitation and about disputes and dispute resolution.

Appendix A contains a glossary with descriptions of, among other things, the major types of benefits. Appendix B summarizes portions of the 2000 and 2008 law changes relevant to trends in this report.[3] Appendix C describes data sources and estimation procedures.

The following points should be kept in mind throughout the report:

Developed statistics — Most statistics in this report are presented by injury year or insurance policy year.[4] An issue with such data is that the originally reported numbers for more recent years are not mature because of longer claims and reporting lags. In this report, all injury year and policy year data is "developed" to a uniform maturity to produce statistics that are comparable over time. The technique uses "development factors" (projection factors) based on observed data for older claims.[5] *The injury year (and policy year) statistics are projections of what the actual numbers will be when all claims are complete and all data is reported. Therefore, the statistics for any given injury year (especially for more recent years) are subject to change when more recent data becomes available. When revisions occur, however, the trends generally show little change from the prior versions.*

Adjustment of cost data for wage growth — Several figures in the report present costs over time. As wages and prices grow, a given cost in dollar terms represents a progressively smaller economic burden from one year to the next. If the total cost of indemnity and medical benefits grows at the same rate as wages, there is no net change in cost as a percentage of payroll. Therefore, all costs (except those costs expressed relative to payroll) are adjusted for

[2] National Council on Compensation Insurance research brief, "Workers' compensation claim frequency continues its decline in 2008," July 2009, available at www.ncci.com/NCCIMain/IndustryInformation/ResearchOutlook/Pages/default.aspx. "Benefits" in this report refers to monetary benefits, medical benefits and vocational rehabilitation benefits. "Costs" refers to the combined costs of these benefits and other costs such as insurer expenses.

[3] The 2008 law changes are included because they took effect during the period covered by the report, even though they are unlikely to be perceptible in trends ending with injury year 2008.

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

[5] See Appendix C for more detail.

average wage growth. The adjusted trends reflect the extent to which cost growth exceeds (or falls short of) average wage growth.[6]

[6] See Appendix C for computational details.

2

Claims, benefits and costs: overview

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

Major findings

- The number of paid claims dropped 38 percent relative to the number of full-time-equivalent (FTE) workers from 1997 to 2008 (Figure 2.1).
- The total cost of Minnesota's workers' compensation system relative to payroll was 16 percent lower in 2008 than in 1997 (Figure 2.2).
- Adjusted for average wage growth, average indemnity benefits per insured claim rose 34 percent from 1997 to 2007 (the most recent year available); average medical benefits per claim rose 81 percent (Figure 2.4).
- Relative to payroll, indemnity benefits were down 18 percent between 1997 and 2008, while medical benefits were down 2 percent (Figure 2.6). The trends in benefits relative to payroll are the net result of a falling claim rate and higher benefits per claim.
- Pure premium rates for 2010 were down 25 percent from 1997 and 12 percent from 1998 (Figure 2.9).

Background

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

Workers' compensation benefits and claim types

Workers' compensation provides three basic types of benefits:

- ***Indemnity benefits*** compensate the injured or ill worker (or dependents) for wage loss, permanent functional impairment or death.
- ***Medical benefits*** consist of reasonable and necessary medical services and supplies related to the injury or illness.
- ***Vocational rehabilitation benefits*** consist of a variety of services to help eligible injured workers return to work. These benefits are counted as indemnity benefits in insurance data but are counted separately in DLI data. They are considered separately in Chapter 4.

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

Insurance arrangements

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

Rate-setting

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

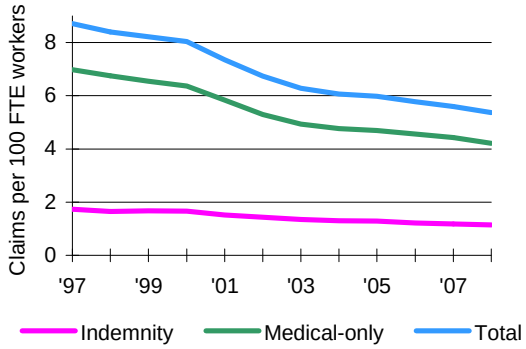
Since the pure premium rates are calculated from prior data, a lag of two to three years exists between benefit trends and pure premium rate changes.

Claim rates

Claim rates declined continually from 1997 to 2008.

- In 2008, there were:
  - 5.4 paid claims per 100 FTE workers, down 33 percent from 2000;
  - 1.15 paid indemnity claims per 100 FTE workers, down 31 percent from 2000; and
  - 4.2 paid medical-only claims per 100 FTE workers, down 34 percent from 2000.
- The overall paid claim rate for 2008 was down 38 percent from 1997.
- Since 1997, indemnity claims have made up 20 to 21 percent of all paid claims, while medical-only claims have constituted the remaining 79 to 80 percent.

Figure 2.1 Paid claims per 100 full-time-equivalent workers, injury years 1997-2008 [1]



Injury year	Indemnity claims	Medical-only claims	Total claims
1997	1.74	7.0	8.7
2000	1.66	6.4	8.0
2004	1.30	4.8	6.1
2005	1.28	4.7	6.0
2006	1.22	4.6	5.8
2007	1.18	4.4	5.6
2008	1.15	4.2	5.4

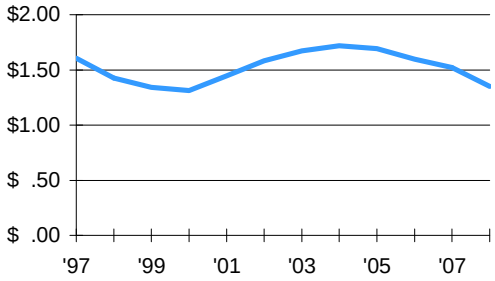
1. Developed statistics from DLI data and other sources (see Appendix C).

System cost

The total cost of Minnesota's workers' compensation system per $100 of payroll has fluctuated since 1997. The 2008 cost per $100 of payroll was near the low-point for 1997 to 2008.

- The total cost of the system was an estimated $1.35 per $100 of payroll in 2008, 16 percent less than in 1997 and just above the low-point of $1.31 for 2000.
- The total cost of workers' compensation in 2008 was an estimated $1.48 billion.
- These figures reflect benefits (indemnity, medical and vocational rehabilitation) plus other costs such as brokerage, claim adjustment, litigation, and taxes and assessments. The figures are computed primarily from actual premium for insured employers (adjusted for costs under deductible limits) and experience-modified pure premium for self-insured employers (see Appendix C).
- Although these figures partly reflect year-to-year changes in the cost of benefits and other expenses, they partly reflect cycles in insurance markets nationwide.

Figure 2.2 System cost per $100 of payroll, 1997-2008 [1]



	Cost per $100 of payroll
1997	$1.61
2000	1.31
2004	1.72
2005	1.69
2006 [2]	1.60
2007 [2]	1.52
2008 [2]	1.35

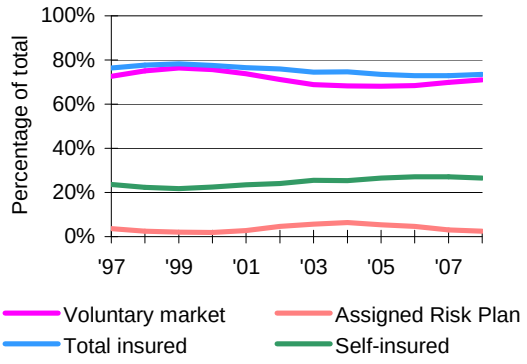
1. Data from several sources (see Appendix C). Includes insured and self-insured employers.
2. Subject to revision.

Insurance arrangements

The voluntary market has increased market share in the past three years.[7]

- The voluntary market share of paid indemnity claims was 71 percent in 2008, slightly above the prior few years but down from 76 percent in 1999.
- The self-insured share has remained near 26 to 27 percent for the past few years, with a slight decrease in 2008.
- The Assigned Risk Plan share fell from a high of 6.4 percent in 2004 to 2.5 percent in 2008.
- These shifts are at least partly due to changes in insurance costs shown in Figure 2.2. Cost increases in the voluntary market tend to cause shifts from the voluntary market to both the Assigned Risk Plan and self-insurance, while cost decreases tend to cause shifts in the opposite direction.

Figure 2.3 Market shares of different insurance arrangements as measured by paid indemnity claims, injury years 1997-2008 [1]



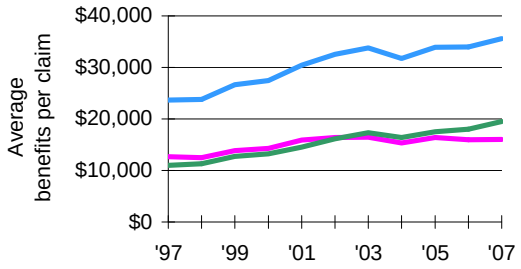
Injury year	Voluntary market	Assigned Risk Plan	Total insured	Self-insured
1997	72.7%	3.6%	76.3%	23.7%
1999	76.3	2.0	78.3	21.7
2004	68.3	6.4	74.7	25.3
2005	68.1	5.4	73.6	26.4
2006	68.4	4.6	73.0	27.0
2007	69.8	3.0	72.9	27.1
2008	71.1	2.5	73.5	26.5

1. Data from DLI.

[7] When market share is measured by pure premium (not shown here), the trends are similar.

Figure 2.4 Average indemnity and medical benefits per insured claim, adjusted for wage growth, policy years 1997-2007 [1]

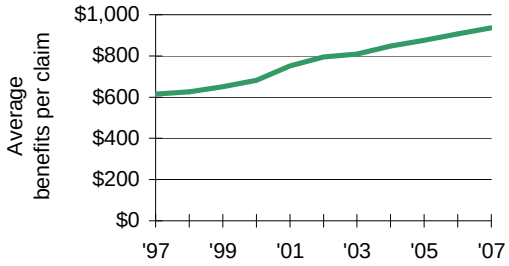
A: Indemnity claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$12,700	$11,000	$23,700
2003	16,400	17,300	33,800
2004	15,300	16,400	31,700
2005	16,400	17,500	33,900
2006	15,900	18,000	34,000
2007	16,000	19,500	35,600

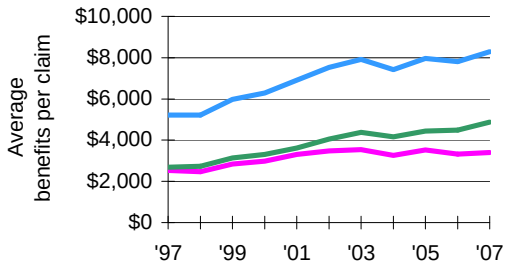
Indemnity [2] Medical Total

B: Medical-only claims



Policy year		Medical benefits	Total benefits
1997		$615	$615
2003		810	810
2004		847	847
2005		876	876
2006		907	907
2007		936	936

C: All claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$2,530	$2,690	$5,230
2003	3,550	4,380	7,920
2004	3,260	4,160	7,420
2005	3,520	4,440	7,970
2006	3,330	4,480	7,810
2007	3,410	4,880	8,290

Indemnity [2] Medical Total

1. Developed statistics from MWCIA data (see Appendix C). Includes the voluntary market and Assigned Risk Plan; excludes self-insured employers. Benefits are adjusted for average wage growth between the respective year and 2008. 2007 is the most recent year available.
2. Since these statistics are from insurance data, indemnity benefits include vocational rehabilitation benefits.

Benefits per claim

Adjusted for wage growth, average medical benefits per insured claim rose rapidly between 1997 and 2003, but more slowly from 2003 to 2007. Indemnity benefits per claim rose through 2002, but were stable from that point until 2007.

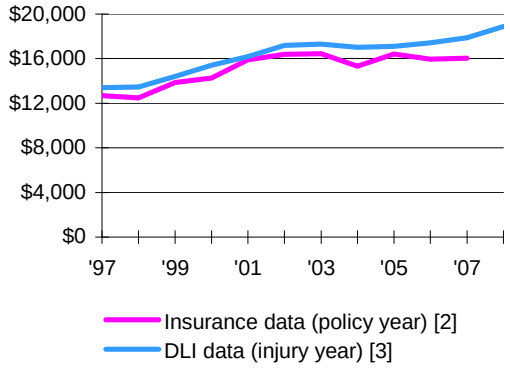
- For all claims combined, in 2007 relative to 1993:
  - ➢ average indemnity benefits were down 4 percent;
  - ➢ average medical benefits were up 11 percent; and
  - ➢ average total benefits were up 5 percent.
- For all claims combined, in 2007 relative to 1997:
  - ➢ average indemnity benefits were up 34 percent;
  - ➢ average medical benefits were up 81 percent; and
  - ➢ average total benefits were up 59 percent.

Indemnity benefits per indemnity claim: insurance and DLI data

DLI data broadly corroborates the insurance data on average indemnity benefits per indemnity claim.

- Adjusting for wage growth, both the DLI and insurance data show increases in average indemnity benefits per claim through 2002. After 2002, the insurance data shows average indemnity benefits holding steady through 2007, but the DLI data shows these benefits increasing after 2005.

Figure 2.5 Average indemnity benefits per indemnity claim, adjusted for wage growth, 1997-2008: insurance and DLI data [1]



Policy or injury year	Insurance data [2]	DLI data [3]
1997	$12,700	$13,400
2002	16,400	17,200
2004	15,300	17,000
2005	16,400	17,100
2006	15,900	17,400
2007	16,000	17,900
2008	[4]	18,900

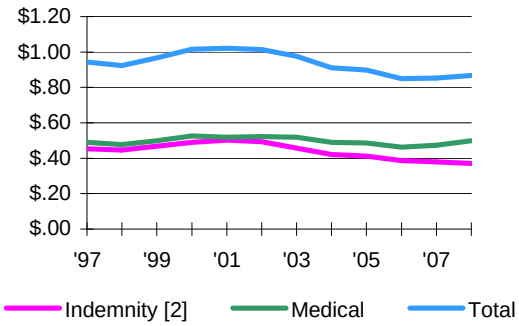
1. Benefits are adjusted for average wage growth between the respective year and 2009.
2. From Figure 2.4. Excludes self-insured employers, supplementary benefits and second-injury claims. Includes the Assigned Risk Plan and vocational rehabilitation benefits.
3. Developed statistics (see Appendix C). Includes self-insured employers, the Assigned Risk Plan, supplementary benefits and second-injury claims. Excludes vocational rehabilitation benefits.
4. Not yet available.

Benefits relative to payroll

Relative to payroll, medical benefits were at approximately the same level in 2008 as in 1997, but indemnity benefits were significantly lower.

- Both indemnity and medical benefits rose relative to payroll from 1997 to 2000 or 2001 but fell thereafter, although medical benefits turned upward again in 2007.
- In 2008 compared to 1997, relative to payroll:
  - indemnity benefits were 18 percent lower;[8]
  - medical benefits were 2 percent higher; and
  - total benefits were 8 percent lower.
- These changes are the net result of a decreasing claim rate (Figure 2.1) and higher indemnity and medical benefits per claim (Figures 2.4, 2.5). The different trends in indemnity and medical benefits relative to payroll occur because medical benefits per claim rose more than indemnity benefits per claim (Figure 2.4).

Figure 2.6 Benefits per $100 of payroll in the voluntary market, accident years 1997-2008 [1]



Accident year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$.45	$.49	$ .94
2000	.49	.53	1.02
2001	.50	.52	1.02
2004	.42	.49	.91
2005	.41	.49	.90
2006	.39	.46	.85
2007	.38	.47	.85
2008	.37	.50	.87

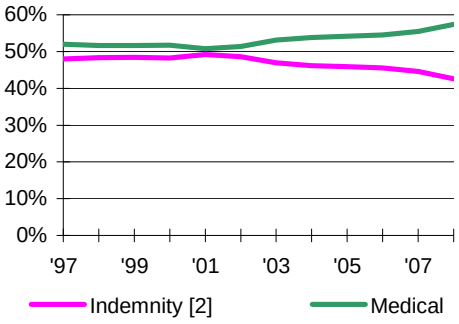
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan and those benefits paid through DLI programs (including supplementary and second-injury benefits). These trends are different from those in prior reports, because they are based on paid benefits while those in prior reports were based on paid benefits plus case reserves. Details in Appendix C.
2. Includes vocational rehabilitation benefits.

Indemnity and medical shares

The medical share of total benefits rose between 1997 and 2008. The increase occurred primarily during the latter part of the period.

- Reflecting the data in Figure 2.6:
  - **medical benefits rose from a 52-percent share of total benefits in 1997 to 57 percent in 2007; and**
  - **indemnity benefits fell from 48 percent of total benefits to 43 percent during the same period.**

Figure 2.7 Indemnity and medical benefit shares in the voluntary market, accident years 1997-2008 [1]



Accident year	Indemnity benefits [2]	Medical benefits
1997	48.0%	52.0%
2001	49.2	50.8
2004	46.2	53.8
2005	45.9	54.1
2006	45.5	54.5
2007	44.6	55.4
2008	42.6	57.4

1. Note 1 in Figure 2.6 applies here.
2. Includes vocational rehabilitation benefits.

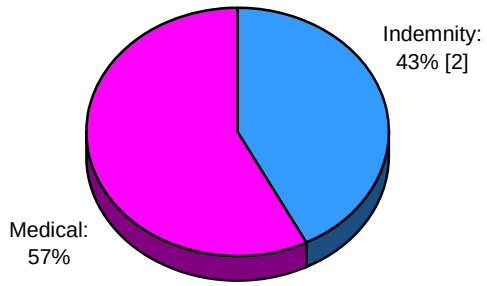
[8] The indemnity benefit trend in Figure 2.6, from insurance data, is corroborated by DLI data.

Indemnity and medical shares, 2008

Medical benefits accounted for 57 percent of total benefits in the voluntary market for accident year 2008.

- Figure 2.8 presents the 2008 data from Figure 2.7.

Figure 2.8 Indemnity and medical benefit shares in the voluntary market, accident year 2008 [1]



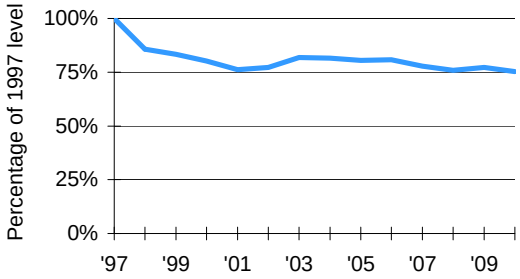
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan and those benefits paid through DLI programs (including supplementary and second-injury benefits).
2. Includes vocational rehabilitation benefits.

Pure premium rates

After a large decrease in 1998, pure premium rates have drifted downward slightly.

- Pure premium rates in 2010 were down 25 percent from 1997 and 12 percent from 1998.[9] They were just slightly below the low-point reached in 2001.
- Pure premium rates are ultimately driven by the trend in benefits relative to payroll (Figure 2.6). However, this occurs with a lag of two to three years because the pure premium rates for any period are derived from prior premium and loss experience.[10]
- Insurers in the voluntary market consider the pure premium rates, along with other factors, in determining their own rates, which in turn affect total system cost (Figure 2.2).

Figure 2.9 Average pure premium rate as percentage of 1997 level, 1997-2010 [1]



Effective year	Percentage of 1997
1997	100.0%
1998	85.7
2001	76.1
2003	81.7
2007	77.9
2008	75.8
2009	77.1
2010	75.3

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

[9] A "percent increase" means the proportionate increase in the initial percentage, not the number of percentage points of increase. For example, an increase from 10 percent to 15 percent is a 50-percent increase.

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

3

Claims, benefits and costs: detail

This chapter presents additional data about claims, benefits and costs. Most of the data provides further detail about the indemnity claim and benefit information in Chapter 2. Some of the data relates to costs of special benefit programs and state agency administrative functions.

Major findings

- The average duration of total disability benefits was 33 percent higher in 2008 than in 1997. Average temporary partial disability (TPD) benefit duration was 16 percent higher (Figure 3.3).
- Average indemnity benefits per indemnity claim (adjusted for wage growth) were 41 percent higher in 2008 than in 1997 (Figure 3.6).[11] This is primarily attributable to:
  - the increase in total disability duration; and
  - increases in the frequency and average amount of stipulated benefits (Figures 3.2, 3.5).
- State agency administrative costs in 2008 amounted to about 2.9 cents per $100 of covered payroll. This figure has fallen since 1997 (Figure 3.8).

Background

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

Benefit types

- ***Temporary total disability (TTD)*** — A weekly wage-replacement benefit paid to an employee who is temporarily unable to work because of a work-related injury or illness, equal to two-thirds of pre-injury earnings subject to a weekly minimum and maximum and a duration limit. TTD ends when the employee returns to work (among other reasons).
- ***Temporary partial disability (TPD)*** — A weekly wage-replacement benefit paid to an injured employee who has returned to work at less than his or her pre-injury earnings, generally equal to two-thirds of the difference between current earnings and pre-injury earnings subject to weekly maximum and duration provisions.
- ***Permanent partial disability (PPD)*** — A benefit that compensates for permanent functional impairment resulting from a work-related injury or illness. The benefit is based on the employee's impairment rating and the total amount paid is unrelated to wages.
- ***Permanent total disability (PTD)*** — A weekly wage-replacement benefit paid to an employee who sustains one of the severe work-related injuries specified in law or who, because of a work-related injury or illness in combination with other factors, is permanently unable to secure gainful employment (subject to a permanent impairment rating threshold).
- ***Stipulated benefits*** — Indemnity and/or medical benefits specified in a claim settlement — "stipulation for settlement" — among the parties to a claim. A stipulation usually occurs in a dispute, and stipulated benefits are usually paid in a lump sum.

[11] These figures are somewhat different from comparable figures in Chapter 2, because they are from a different data source (DLI vs. insurance industry) and they include self-insured employers.

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

Counting claims and benefits: insurance data and department data

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

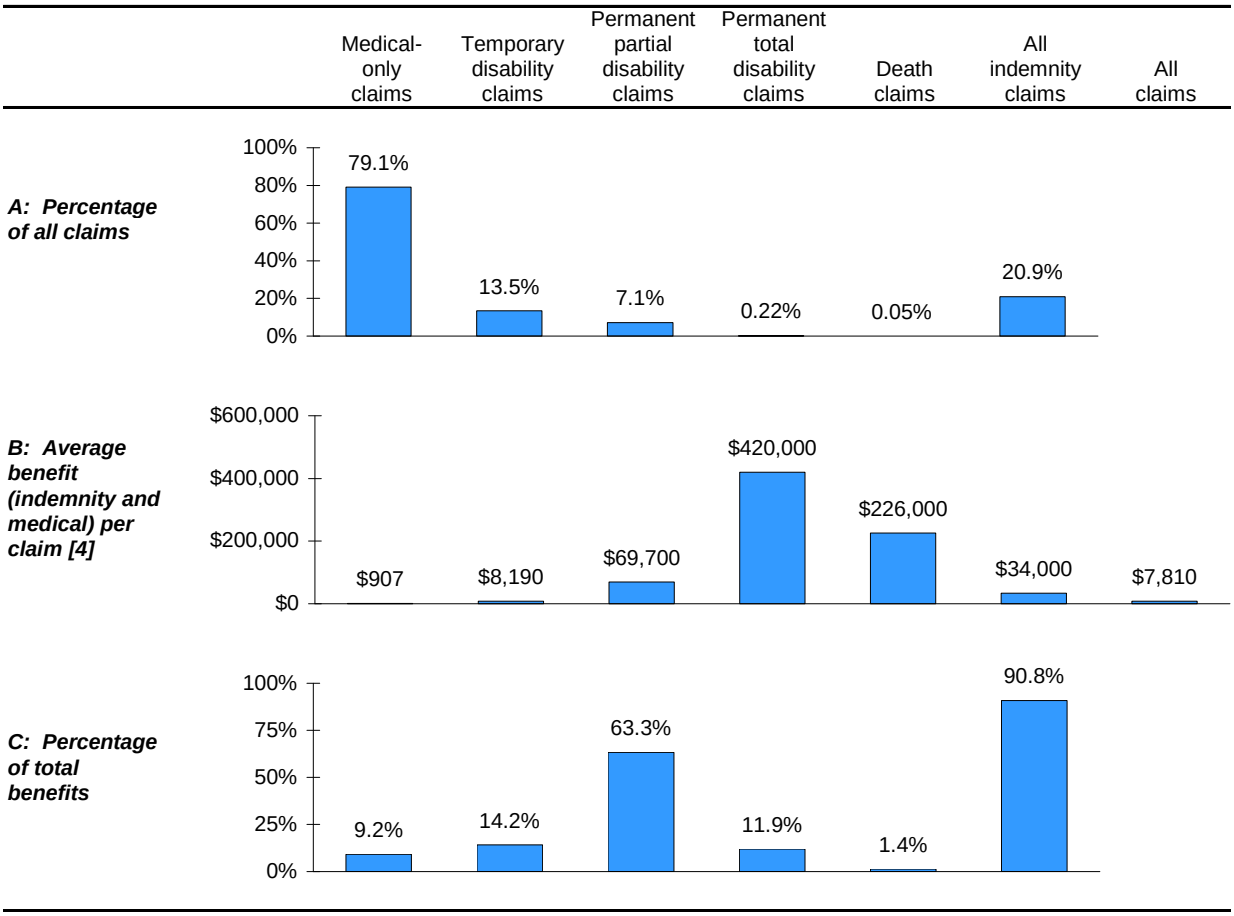
In the insurance data, claims and benefits are categorized by "claim type," defined according to the most severe type of benefit on the claim. In increasing severity, the benefit types are medical, temporary disability (TTD or TPD), PPD, PTD and death. For example, a claim with medical, TTD and PPD payments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

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

Costs supported by Special Compensation Fund assessment

DLI, through its Special Compensation Fund (SCF), levies an annual assessment on insurers and self-insured employers to finance (1) costs in DLI, the Office of Administrative Hearings and other state agencies to administer the workers' compensation system and (2) certain benefits for which DLI is responsible. Primary among these benefits are supplementary benefits and second-injury benefits. Although these programs have been eliminated, benefits must still be paid on old claims (see Appendices B and C). Insurers collect the assessment amount from employers through a premium surcharge, and this is included in total workers' compensation system cost (Figures 2.2).

Figure 3.1 Benefits by claim type for insured claims, policy year 2006 [1]



1. Developed statistics from MWCIA data (see Appendix C). 2006 is the most recent year available.
2. Because of large annual fluctuations, data for PTD and death claims is averaged over 2004-2006 (see Appendix C).
3. Indemnity claims consist of all claim types other than medical-only.
4. Benefit amounts in panel B are adjusted for overall wage growth between 2006 and 2008.

Benefits by claim type

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

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

- PPD claims accounted for 63 percent of total benefits in 2006 (panel C in figure) through a combination of moderately low frequency (panel A) and higher-than-average benefits per claim (panel B).
- Other claim types contributed smaller amounts to total benefits because of very low frequency (PTD and death claims) or relatively low average benefits (medical-only and temporary disability claims).
- **Indemnity claims were 21 percent of all paid claims, but accounted for 91 percent of total benefits because they have far higher benefits on average than medical-only claims ($34,000 vs. $907 for 2006).**
- The percentages and relative benefit amounts shown in the figure have been fairly stable during the past several years.

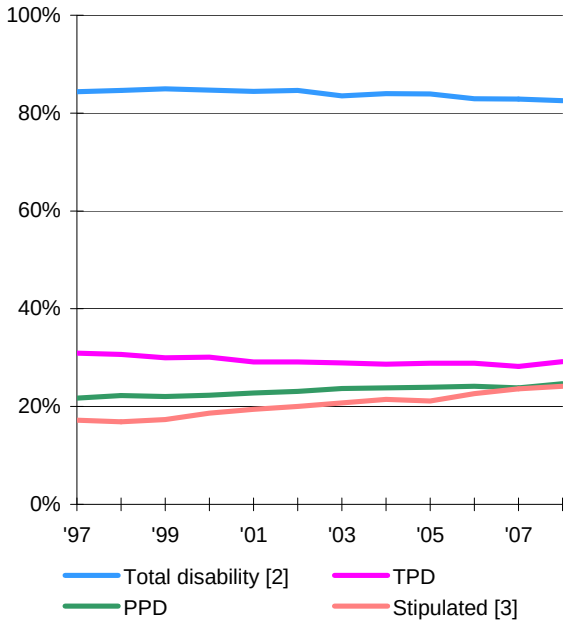
Claims by benefit type

Since 1997, the proportions of all paid indemnity with PPD benefits and with stipulated benefits have increased, while the proportions with total disability benefits and with TPD benefits have decreased slightly.

- From 1997 to 2008:
  - the percentage of claims with PPD benefits rose three percentage points;
  - the percentage of claims with stipulated benefits rose about seven percentage points; and
  - the percentages of claims with total disability benefits and with TPD benefits fell somewhat less than two percentage points.

- **The increase in the percentage of claims with stipulated benefits is related to a similar increase in the dispute rate (Figure 7.1).**

Figure 3.2 Percentages of paid indemnity claims with selected types of benefits, injury years 1997-2008 [1]



Injury year	Total disab.[2]	TPD	PPD	Stipu-lated [3]
1997	84.4%	31.0%	21.7%	17.2%
2004	83.9	28.6	23.8	21.5
2005	83.9	28.8	24.0	21.1
2006	82.9	28.9	24.2	22.7
2007	82.9	28.2	23.8	23.6
2008	82.6	29.2	24.7	24.1

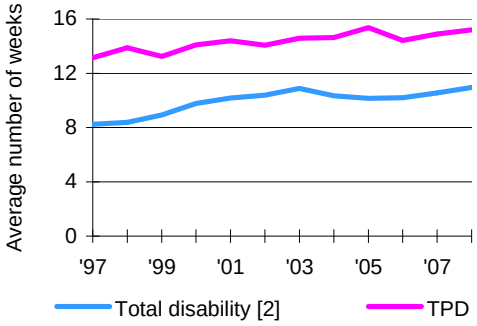
1. Developed statistics from DLI data (see Appendix C). An indemnity claim may have more than one type of benefit paid. Therefore, the sum of the figures for the different benefit types is greater than 100 percent.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.

Benefit duration

The average durations of total disability benefits and TPD benefits rose between 1997 and 2008.

- Total disability duration averaged 11.0 weeks in 2008, 33 percent above 1997. Most of the increase occurred between 1997 and 2003; between 2003 and 2007, total disability duration ranged between 10.2 and 11.0 weeks.
- TPD duration averaged 15.2 weeks in 2008, 16 percent above 1997.
- These trends in duration affect indemnity cost per claim (Figures 2.4, 2.5, 3.5, 3.6). As a result, they also affect pure premium rates and system cost (Figures 2.2, 2.9).

Figure 3.3 Average duration of wage-replacement benefits, injury years 1997-2008 [1]



Injury year	Total disab.[2]	TPD
1997	8.2	13.2
2003	10.9	14.6
2004	10.3	14.6
2005	10.2	15.4
2006	10.2	14.4
2007	10.6	14.9
2008	11.0	15.2

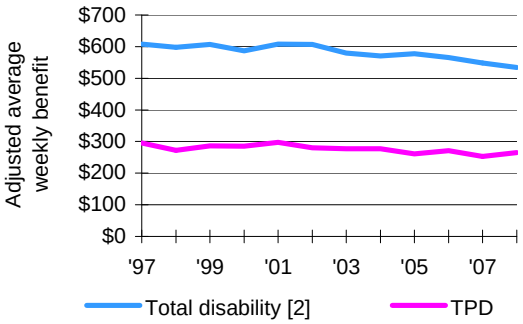
1. Developed statistics from DLI data (see Appendix C).
2. Total disability includes TTD and PTD.

Weekly benefits

After adjusting for average wage growth, average weekly total disability and TPD benefits decreased slightly between 1997 and 2008.

- Adjusted average weekly total disability benefits were 12 percent lower in 2008 than in 1997; average weekly TPD benefits were down 10 percent.
  - ➢ *Unadjusted* average weekly benefits rose during the period examined, but at a somewhat less rapid pace than the statewide average weekly wage (SAWW), causing the declines in *adjusted* average weekly benefits shown here.
- The average pre-injury wage of injured workers (which affects average weekly benefits) fell about 8 percent relative to the statewide average weekly wage from 1997 to 2008. This explains a majority of the decline in adjusted average weekly total disability benefits and most of the decline in adjusted average weekly TPD benefits.

Figure 3.4 Average weekly wage-replacement benefits, adjusted for wage growth, injury years 1997-2008 [1]



Injury year	Total disab. [2]	TPD
1997	$608	$295
1999	607	286
2004	571	277
2005	577	261
2006	566	271
2007	548	253
2008	534	265

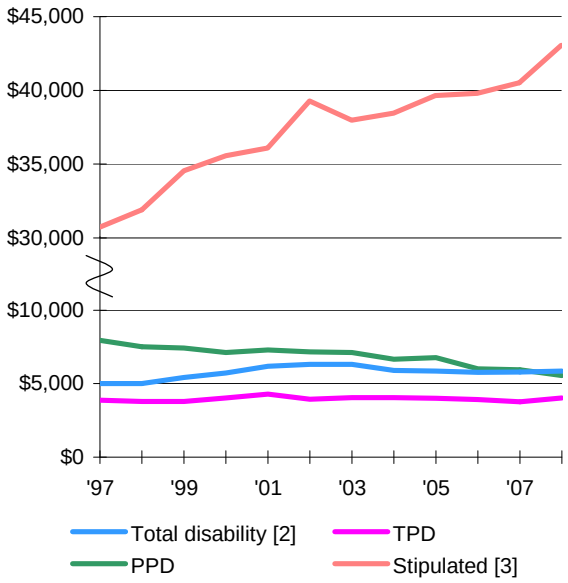
1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2008.
2. Total disability includes TTD and PTD.

Average indemnity benefits by type

Adjusting for average wage growth, average benefit amounts (per claim with the given benefit type) showed different trends from 1997 to 2008: average total disability benefits and average stipulated benefits increased, average PPD benefits fell and average TPD benefits showed little change.

- From 1997 to 2008, after adjusting for average wage growth:
  - average total disability benefits rose 17 percent;
  - average TPD benefits rose 4 percent;
  - average PPD benefits fell 30 percent; and
  - average stipulated benefits rose 40 percent.
- The increase in average total disability benefits occurred between 1997 and 2002. After 2002, average total disability benefits declined.
- The trends in average total disability and TPD benefits are driven by the trends in average benefit duration and average weekly benefits.
  - Average total disability benefits increased between 1997 and 2002 because of rising duration (with average weekly benefits steady) and fell after 2002 because of decreasing average weekly benefits (Figures 3.3 and 3.4).
  - The essentially flat trend in average TPD benefits occurred because of offsetting trends in average weekly benefits and duration (Figures 3.3 and 3.4).
- Adjusted average PPD benefits have fallen nearly continually since 1997, with exceptions in 2001 and 2005. This falling trend has occurred primarily because the PPD benefit schedule is fixed, apart from statutory changes.[12] Under the fixed schedule, PPD benefits become smaller relative to rising wages, which is reflected in the adjusted average benefits. The PPD benefit increase in the 2000 law change (see Appendix B) is responsible for the slight increase in average PPD benefits in 2001.

Figure 3.5 Average indemnity benefit by type per claim with the given benefit type, adjusted for wage growth, injury years 1997-2008 [1]



Injury year	Total disability [2]	TPD	PPD	Stipulated [3]
1997	$5,010	$3,880	$7,940	$30,750
2002	6,310	3,930	7,160	39,280
2004	5,890	4,050	6,670	38,450
2005	5,860	4,010	6,760	39,650
2006	5,770	3,910	6,010	39,800
2007	5,790	3,760	5,950	40,510
2008	5,850	4,030	5,550	43,060

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2008.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.

[12] The average PPD rating was fairly stable during the period concerned, ranging from 6.5 to 7.0 percent.

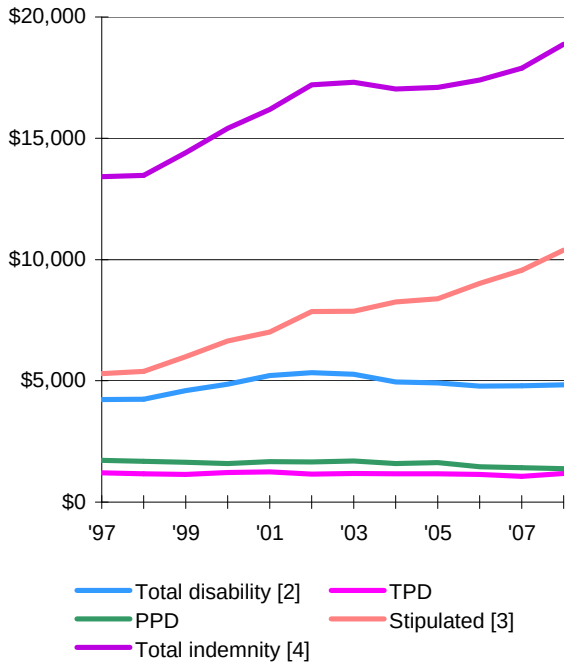
Indemnity benefits by type per indemnity claim

Adjusting for average wage growth, average indemnity benefits per indemnity claim rose rapidly between 1997 and 2002, were steady through 2005, but began increasing again after 2005. The overall increase resulted from increases in total disability and stipulated benefits per claim, but was counteracted by falling adjusted PPD benefits per claim.

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

- Adjusting for average wage growth, total indemnity benefits per indemnity claim were 41 percent higher in 2008 than in 1997. These numbers (last column of Figure 3.6) are the DLI numbers in Figure 2.5.
- The increase in total indemnity benefits per claim resulted from increases in total disability benefits and stipulated benefits.
  - The increase in total disability benefits per indemnity claim resulted from an increase in duration (Figure 3.3). (The proportion of indemnity claims with total disability benefits fell slightly (Figure 3.2) and average weekly total disability benefits decreased (Figure 3.4).)
  - The increase in stipulated benefits per indemnity claim resulted from an increase in average stipulated benefit amounts (Figure 3.5) and an increase in the proportion of claims with these benefits (Figure 3.2).
- In 2008, total disability benefits were four times as large as total TPD benefits and 3.5 times as large as total PPD benefits. Stipulated benefits were more than twice as great as total disability benefits.
- As a proportion of total indemnity benefits, stipulated benefits increased from 39 percent in 1997 to 55 percent in 2008. The increase in total benefits from 1997 to 2008 is about the same as the increase in stipulated benefits.

Figure 3.6 Average indemnity benefit by type per paid indemnity claim, adjusted for wage growth, injury years 1997-2008 [1]



Injury year	Total disabilty [2]	TPD	PPD	Stipulated [3]	Total indemnity [4]
1997	$4,230	$1,200	$1,720	$5,290	$13,410
2002	5,340	1,140	1,650	7,860	17,200
2004	4,950	1,160	1,590	8,250	17,030
2005	4,920	1,160	1,620	8,390	17,090
2006	4,780	1,130	1,450	9,020	17,410
2007	4,800	1,060	1,420	9,560	17,890
2008	4,830	1,180	1,370	10,390	18,880

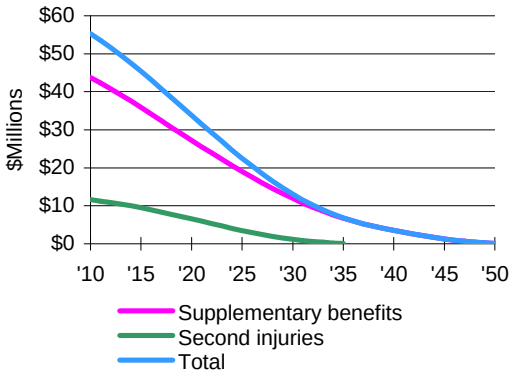
1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2008.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.
4. Excludes vocational rehabilitation benefits (except those included in stipulated benefits). Because dependency benefits are not shown, and because individual benefit types are sometimes under-reported relative total indemnity, total indemnity benefits are greater than the sum of the benefit types shown.

Supplementary benefit and second-injury costs

DLI produces an annual projection of supplementary benefit and second-injury reimbursement costs as they would exist without future settlement activity. The total annual cost is projected to fall about 40 percent by 2020 and to disappear by 2050.

- **The total projected cost for 2010, $55 million, is about 3.5 percent of projected total workers' compensation system cost for that year.**
- The 2010 cost consists of roughly $44 million for supplementary benefits and $12 million for second injuries.
- Without settlements, supplementary benefit claims are projected to continue until 2050 and second-injury claims until 2035.
- Claim settlements will reduce future projections of these liabilities. Settlements amounted to $5.7 million in fiscal year 2009.

Figure 3.7 Projected cost of supplementary benefit and second-injury reimbursement claims, fiscal claim-receipt years 2010-2050 [1]



Fiscal year of claim receipt	Projected amount claimed ($millions)		
	Supplementary benefits	Second injuries	Total
2010	$43.7	$11.6	$55.3
2015	35.9	9.5	45.4
2020	27.2	6.6	33.8
2030	11.9	1.2	13.1
2050	.1	.0	.1

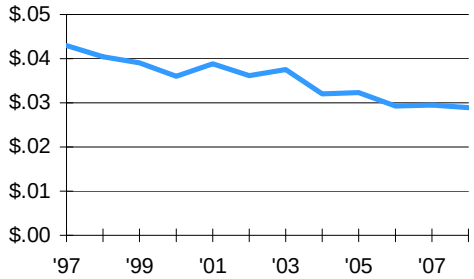
1. Projected from DLI data, assuming no future settlement activity. See Appendix C.

State agency administrative cost

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

- In fiscal year 2008, state agency administrative cost (see note in figure) came to 2.9 cents per $100 of payroll.
- **Administrative cost for 2008 was about $31 million, or about 2.0 percent of total workers' compensation system cost.[13]**

Figure 3.8 Net state agency administrative cost per $100 of payroll, fiscal years 1997-2008 [1]



Fiscal year	Admin. cost per $100 of payroll
1997	$.043
2004	.032
2005	.032
2006	.029
2007	.029
2008	.029

1. Includes costs of workers' compensation functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the cost of Minnesota's OSHA program. Excludes costs of benefit payments reimbursed by the Special Compensation Fund (such as supplementary and second-injury benefits). Costs are net of fees for service. Data from DLI, MWCIA and WCRA.

[13] Administrative cost for 2007 was incorrectly reported in last year's report as $29 million. The correct figure for 2007 is $30 million.

4

Vocational rehabilitation

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

Major findings

- Participation in vocational rehabilitation rose from 15 percent of paid indemnity claims for injury year 1997 to 23 percent for 2008. A projected 5,480 workers injured in 2008 will receive VR services (Figure 4.1).
- **The average cost of VR services was an estimated $8,350 for workers injured in 2008, 34 percent higher than for 1998 after adjusting for average wage growth.** The total cost of VR services for workers injured in 2008 is projected at $46 million, about 3.1 percent of workers' compensation system cost (Figure 4.3).
- The average time from injury to the start of VR services was 7.2 months for injury year 2008, down 17 percent from 1998 (Figure 4.5).
- Average VR service duration for injury year 2008 was 13.0 months, the same as for 2007 claims, and slightly longer than in 1998 (12.5 months) (Figure 4.6).
- **The percentage of VR participants with a job at plan closure decreased from 71 percent for injury year 1998 to 53 percent for 2008 (Figure 4.7).**
- The average VR participant returning to work received about 92 percent of their pre-injury wage, but this varied widely among individuals (Figures 4.9 and 4.10).
- For VR participants injured in 2008, about 44 percent of plan closures are projected to result from plan completion, down from 61 percent in 1998; 49 percent of plan closures for injury year 2008 are projected to result from claim settlement or agreement of the parties (Figure 4.11).

Background

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

VR services include:

- vocational evaluation;
- counseling;
- job analysis;
- job modification;
- job development;
- job placement;
- vocational testing;
- transferable skills analysis;
- job-seeking skills training;
- retraining; and
- arrangement of on-the-job training.

Except for retraining, these services are delivered by qualified rehabilitation consultants (QRCs) and job-placement vendors. These providers are registered with DLI and must follow professional conduct standards specified in Minnesota Rules.

QRCs work mostly in private-sector VR firms, and may also provide services to non-workers' compensation clients. Some VR firms also have job-placement staff. Some QRCs are employed by insurers and self-insured employers. DLI's Vocational Rehabilitation unit provides VR

services to injured workers whose claims are involved in primary liability disputes.

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

VR plan costs are generated by hourly charges for services by QRCs and vendors and by the costs for certain services, such as retraining and vocational testing. Annual increases in hourly charges are limited to the lesser of the percent increase in the statewide average weekly wage (SAWW) or two percent. From services provided from Oct. 1, 2007 through Sept. 30, 2008, the maximum hourly fee for QRCs was $88.06 and for job development and placement services the maximum rate was $67.73.

The 2008 workers' compensation law increased the maximum hourly fee for QRCs to $91.00 effective on Oct. 1, 2008 and the maximum hourly rate for job development and placement services, whether provided by rehabilitation vendors or by QRC firms, to $69.08. The maximum levels for QRCs and for job development and placement services, effective Oct. 1, 2009, are $92.82 and $70.46, respectively.

Data sources and time period covered

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

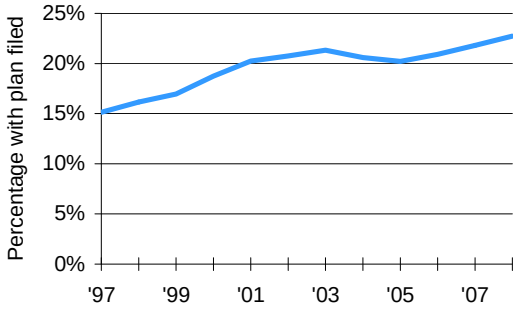
As in other chapters, all trend statistics in this chapter are by injury year, and are therefore developed as described in Appendix C.

Participation

The VR participation rate increased during most years from 1997 to 2008.

- The participation rate — the percentage of paid indemnity claims with a VR plan filed — increased from 15 percent in 1998 to 23 percent in 2008.
- About 5,480 workers injured in 2008 are expected to receive VR services. (Some of these people have not yet begun services.)

Figure 4.1 Percentage of paid indemnity claims with a VR plan filed, injury years 1997-2008 [1]



Injury year	Percentage with plan
1997	15.1%
2004	20.6
2005	20.2
2006	20.9
2007	21.8
2008	22.7

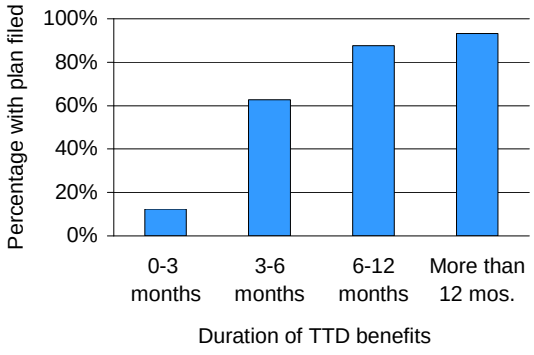
1. Developed statistics from DLI data (see Appendix C).

Participation and disability duration

The VR participation rate varies directly with the amount of time the injured worker has been off the job.

- For workers injured between 2004 and 2007, the proportion receiving VR services varied from 12 percent for workers with no more than three months of TTD benefits to 92 percent for workers with more than 12 months of TTD benefits.
- The VR participation rate also varies with the PPD rating. For injury years 2004 to 2007 combined, it ranged from 15 percent for injured workers without PPD benefits to 78 percent for workers with PPD ratings of 20 percent or more.

Figure 4.2 Percentage of paid indemnity claims with a VR plan filed by TTD duration, injury years 2004-2007 combined [1]



1. Data from DLI.

Cost

Adjusted for average wage growth, the average cost of VR services increased steadily from 1998 to 2008.

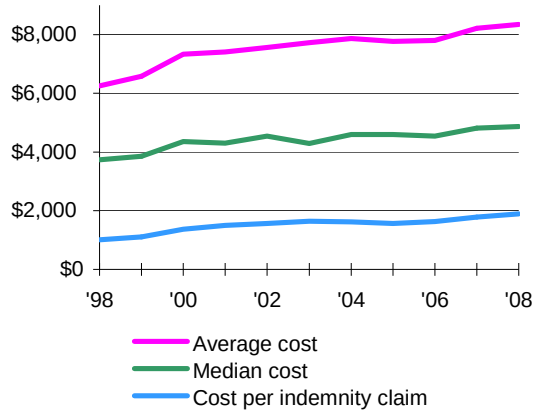
- **Average service cost was $8,350 per participant for injury year 2008. Average cost rose 34 percent from 1998 to 2008, while median cost rose 30 percent.**
- The estimated total cost of VR for 2008 was $45.8 million, about 3.1 percent of total workers' compensation system cost.
- Average VR service cost per indemnity claim (counting claims with and without plans) was $1,900 for 2008, an 88-percent increase from 1998 and 15 percent higher than in 2003. These increases reflect the trends in the participation rate (Figure 4.1) and average cost per plan (Figure 4.3).
- Among plans closed in 2008, 74 percent of total cost was for QRC services other than job development and placement, 25 percent was for job development and placement (16 percent by QRCs, 10 percent by outside vendors) and one percent was for other items, such as mileage, supplies and tuition.

Cost and injury severity

VR service cost varies with injury severity as measured by PPD benefit ratings.

- For plan-closure year 2008, workers with higher PPD ratings had progressively higher VR costs for ratings up to 15 percent. However, both average and median cost leveled off for ratings above 15 percent.

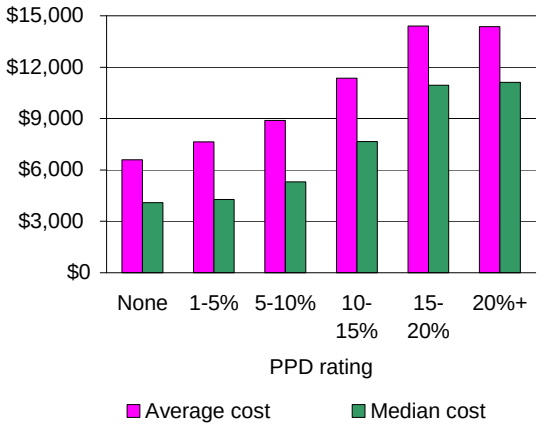
Figure 4.3 VR service costs, adjusted for wage growth, injury years 1998-2008 [1]



Injury year	Average cost	Median cost	Cost per indemnity claim
1998	$6,250	$3,730	$1,010
2004	7,860	4,600	1,620
2005	7,770	4,590	1,570
2006	7,810	4,550	1,630
2007	8,210	4,820	1,790
2008	8,350	4,870	1,900

1. Developed statistics from DLI data (see Appendix C). Costs are adjusted for average wage growth between the respective year and 2008.

Figure 4.4 VR service cost by PPD rating, adjusted for wage growth, plan-closure year 2008 [1]



1. Data from DLI. Costs are adjusted for average wage growth between the year of service and 2008.

Timing of services

The success of VR is closely linked to prompt service provision. The average time from injury to the start of VR services decreased between 1998 and 2008, with most of the decrease occurring between 1998 and 2001.

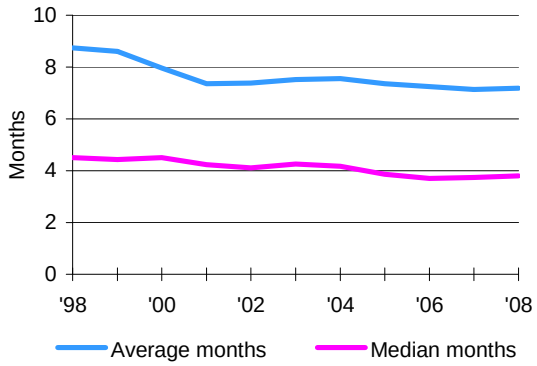
- **The average time from injury to the start of VR services was 7.2 months for injury year 2008, about the same as for 2006 and 2007. The 2008 figure was down 1.5 months (17 percent) from 1998; the median time was down 16 percent during the same period.**
- Among plans closed in 2008, 37 percent of VR service starts were within three months of the date of injury.
- Among VR participants whose plans closed in 2008, those who started receiving VR services more than one year after their injury, as compared to those starting within three months of injury, had:
  - higher VR costs by 13 percent ($8,180 vs. $7,230);
  - longer VR service durations by 17 percent (14.3 months vs. 12.2 months); and
  - lower chances of returning to work (55 percent vs. 66 percent).

Service duration

Average VR service duration showed little change from 1998 to 2008.

- Average service duration for injury year 2008 was 13.0 months, slightly longer than in 1998 (12.5 months). Median duration for 2008 was 8.8 months, also somewhat longer than for 1998.
- Among plan closures in 2008, average service duration was shortest for participants returning to work with their pre-injury employer (9.5 months); it was longest for those going to a different employer (17.9 months) and for those whose plans closed before they returned to work (16.9 months).

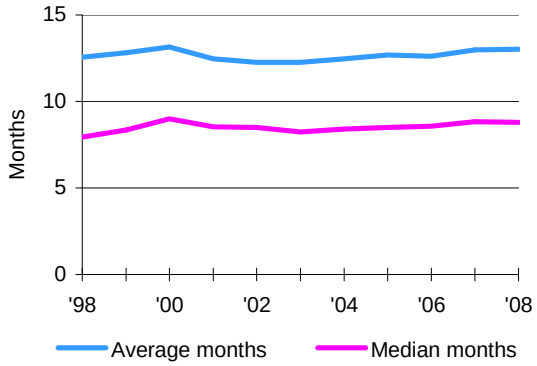
Figure 4.5 Time from injury to start of VR services, injury years 1998-2008 [1]



Injury year	Average months	Median months
1998	8.7	4.5
2001	7.4	4.2
2004	7.6	4.2
2005	7.4	3.9
2006	7.2	3.7
2007	7.1	3.7
2008	7.2	3.8

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

Figure 4.6 VR service duration, injury years 1998-2008 [1]



Injury year	Average months	Median months
1998	12.5	8.0
2004	12.5	8.4
2005	12.7	8.5
2006	12.6	8.6
2007	13.0	8.8
2008	13.0	8.8

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

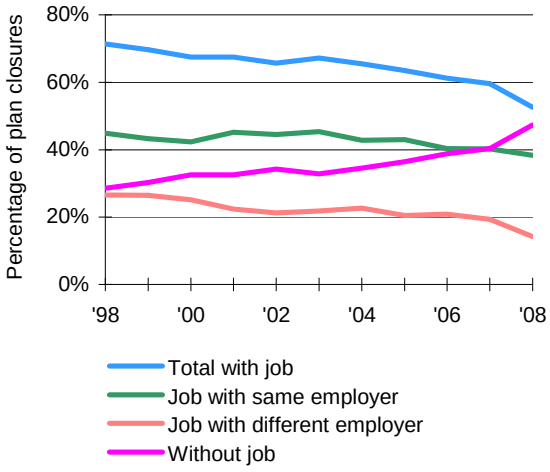
Return-to-work status: same vs. different employer

A key measure of VR performance is whether the injured workers receiving VR services return to work when the VR plans are closed. Return to work is affected by many factors, including the job market, injury severity, availability of job modifications and claim litigation. The percentage of VR participants with a job at plan closure decreased between 1998 and 2008, with a sharp drop in 2008.

- **The percentage of VR participants with a job at plan closure fell from 71 percent in 1998 to 53 percent in 2008.** Seven percentage points of this decline occurred in 2008 alone; it seems likely that this at least partly reflects the poor job market. The decline since 1998 involved participants finding jobs with the same employer and those going to a different employer:
  - The percentage with a job at the same employer fell from 45 percent to 38 percent.
  - The percentage with a job at a different employer fell from 27 percent to 14 percent.

- Among plan closures in 2008, the average cost of VR services for participants returning to work with their pre-injury employer ($4,700) was less than half the cost for those going to a different employer ($11,660) and for those not returning to work ($9,870).[14]

Figure 4.7 Return-to-work status: same vs. different employer, injury years 1998-2008 [1]



Injury year	With job: Same employer	With job: Different employer	With job: Total with job	Without job
1998	44.9%	26.5%	71.4%	28.6%
2004	42.8	22.7	65.5	34.5
2005	43.0	20.5	63.5	36.5
2006	40.4	20.9	61.2	38.8
2007	40.2	19.4	59.6	40.4
2008	38.4	14.2	52.6	47.4

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

[14] These figures include private-sector providers and the VR unit of DLI.

Return-to-work status: type of job

Another way of viewing return-to-work status among VR participants is to consider the type of job for those employed at plan closure. The percentage of participants finding the same type of job as their pre-injury job dropped slightly between 1998 and 2008 (after peaking in 2003), while the percentage finding a different type of job fell significantly.

- From 1998 to 2008, the percentage of participants finding a different type of job than their pre-injury job decreased from 31 percent to 17 percent.

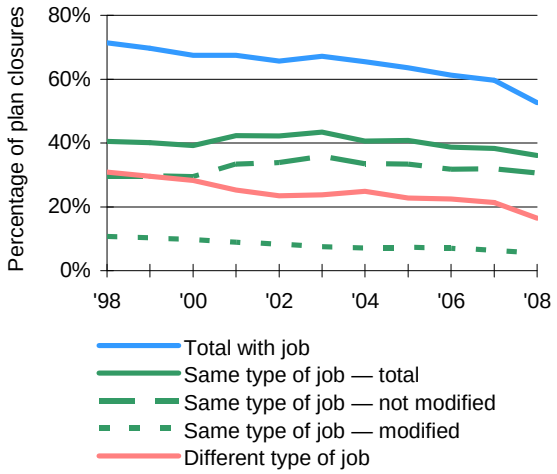
- This decline seems to explain much of the decreasing percentage finding employment (including in particular the large decrease in 2008), and in this respect is similar to the decreasing percentage of participants going to a *different employer* (Figure 4.5).

  - The trends in placements *with a different employer* (Figure 4.5) and in placements *in a different type of job* (Figure 4.6) are similar because most placements with a different employer are in a different type of job, while most placements with the pre-injury employer are in the same type of job (with or without modifications).

- Most placements into the same type of job as the pre-injury job involve no job modifications, and this became increasingly true between 1998 and 2008.

- Among plan closures in 2008, the average cost of VR services for injured workers returning to the same type of job *without modifications* was $3,950, just more than a third of the cost for injured workers returning to a different type of job ($11,450). The average service cost for injured workers returning to the same type of job *with modifications* was $6,710.[15]

Figure 4.8 Return-to-work status: type of job, plan-closure years 1998-2008 [1]



Injury year	With job				
	Same type of job			Different type of job	Total with job
	Not Modifed	Modifed	Total		
1998	29.8%	10.7%	40.5%	30.9%	71.4%
2003	35.8	7.5	43.4	23.8	67.2
2004	33.5	7.1	40.6	24.9	65.5
2005	33.4	7.4	40.8	22.8	63.5
2006	31.8	7.0	38.7	22.5	61.2
2007	31.9	6.5	38.3	21.3	59.6
2008	30.6	5.5	36.1	16.5	52.6

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

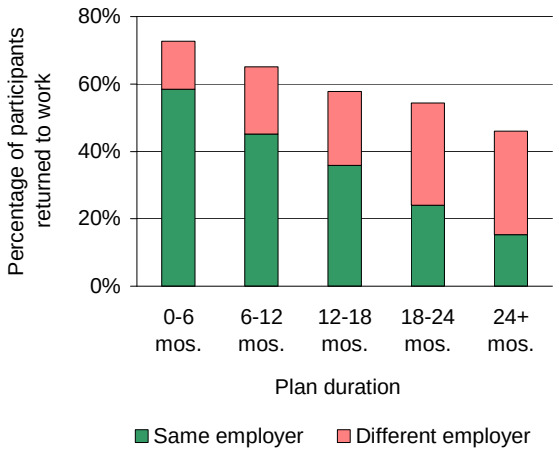
[15] These figures include private-sector providers and the VR unit of DLI.

Return-to-work status and plan duration

The percentage of VR participants who have returned to work at plan closure decreases with plan duration.

- For plan closures in 2008, the percentage of participants who had returned to work ranged from 73 percent for plans lasting no more than six months to 46 percent for plans lasting 24 months or more.
- The percentage of participants returning to their pre-injury employer ranged from 58 percent for the shortest plans to 15 percent for the longest plans.
- The percentage of participants finding a job with a different employer ranged from 14 percent for the shortest plans to 31 percent for the longest plans.

Figure 4.9 Return-to-work status by plan duration, plan-closure year 2008 [1]



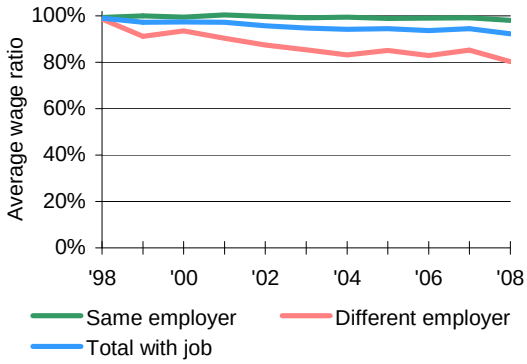
1. Data from DLI.

Return-to-work wages

The average return-to-work (RTW) wage of VR participants is somewhat less than their pre-injury wage. On average, the ratio of the RTW wage to the pre-injury wage for VR participants has declined over the past 10 years. This is almost entirely attributable to a decline for those taking a job with a different employer.

- From 1998 to 2008, the ratio of the RTW wage to the pre-injury wage dropped from 99 percent to 92 percent on average; the ratio dropped from 99 percent to 80 percent for those finding a job with a different employer, but by only a percentage point for those returning to work with their pre-injury employer.

Figure 4.10 Average ratio of return-to-work wage to pre-injury wage by employer type, plan-closure years 1998-2008 [1]



Plan-closure year	Average ratio of return-to-work wage to pre-injury wage		
	Same employer	Different employer	Total with job
1998	99.3%	98.7%	99.2%
2004	99.6	83.2	94.3
2005	98.9	85.2	94.5
2006	99.1	83.0	93.7
2007	99.3	85.3	94.6
2008	98.2	80.3	92.3

1. Data from DLI.

Return-to-work wage detail

As a percentage of the pre-injury wage, the RTW wage for VR participants varies widely.

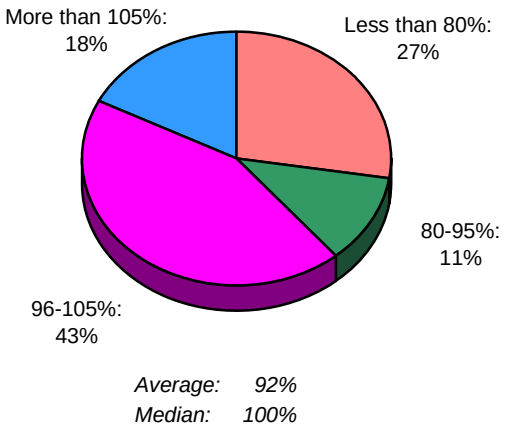
- For plan closures in 2008, 61 percent of VR participants returning to work earned at least 96 percent of their pre-injury wage, but 27 percent earned less than 80 percent of their pre-injury wage.
- For 2008, the median RTW wage ratio was 100 percent for VR plans of less than 12 months duration, 99 percent for plans between 12 and 18 months, but only 75 percent for plans with longer service durations.
- RTW wage experience also varies by occupation. For example, 21 percent of office and administrative support workers returned to jobs paying less than 80 percent of their pre-injury wage, compared to 36 percent of sales workers.

Reasons for plan closure

The percentage of VR plans closed because of plan completion has decreased steadily since 1998.

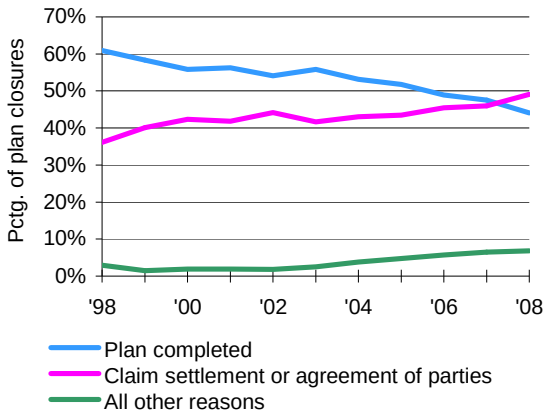
- **The proportion of VR plans closed because they were completed fell from 61 percent to 44 percent between injury years 1998 and 2008.**
- During the same period, the proportion of plans closed by claim settlement or agreement of the parties grew from 36 percent to 49 percent.
- Plan completion almost always involves a return to work. For plans closed for reasons other than completion in 2008, only 25 percent indicated the participants had returned to work.
- Plan costs vary by type of closure: among closures in 2008, completed plans averaged $5,490; settlements and agreements, $11,140; and all other closure types, $7,400.

Figure 4.11 Ratio of return-to-work wage to pre-injury wage for participants returning to work, plan-closure year 2008 [1]



1. Data from DLI.

Figure 4.12 Reason for plan closure, injury years 1998-2008 [1]



Injury year	Plan completed	Claim settlement or agreement of parties	All other reasons [2]
1998	61.0%	36.1%	2.9%
2004	53.1	43.1	3.8
2005	51.8	43.5	4.8
2006	48.9	45.4	5.7
2007	47.5	46.0	6.5
2008	44.1	49.1	6.8

1. Developed statistics from DLI data (see Appendix C).
2. "All other reasons" includes closures due to decision-and-orders and, starting with forms filed after July 2005, closures due to inability to locate the employee, death of the employee or QRC withdrawal. Closures for these reasons were previously coded as due to decision-and-orders or agreement of the parties. None of the subcategories of "all other reasons" accounted for more than three percent of closures in this category in any year.

5

Disputes and dispute resolution

This chapter presents data about workers' compensation disputes and dispute resolution. At the time this report was released, statistics about dispute filings and dispute-resolution activity through 2009 were available, and are therefore included.

Major findings

- The overall dispute rate increased from 15.4 percent of filed indemnity claims in 1997 to 20.6 percent in 2008, a 34-percent increase.[16] Leading the way were medical disputes (up 136 percent) and vocational rehabilitation disputes (up 72 percent) (Figure 5.1).

- Because of the increase in the dispute rate from 1997 to 2008, the annual number of disputes has remained steady even with a 31-percent drop in the annual number of filed indemnity claims.

- After several years of relative stability, the rate of denial of filed indemnity claims fell from 16.7 percent in 2004 to 12.1 percent in 2008, a 27-pecent decrease. This decrease coincides with the initiation of the DLI denials project, in which DLI requires insurers that have not indicated reasons for claim denials in a manner compliant with statute and rules to do so (Figure 5.2).

- At DLI:
  - Between 1999 and 2009, the percentage of medical and vocational rehabilitation disputes certified dropped from 66 to 52 percent (Figure 5.6).
  - From 1999 to 2009, the number of agreements via mediation or administrative conference rose from 560 to 890 (Figure 5.8). The increase began in 2006, coinciding with an increased DLI emphasis on early dispute resolution.
  - Resolutions by agreement of the parties (usually through informal intervention) accounted for 77 percent of all resolutions in 2009. This was a decrease from 87 percent in 1999. Resolutions by decision-and-order accounted for 23 percent of the resolutions in 2009 (Figure 5.10).

- At the Office of Administrative Hearings, the numbers of settlement conferences, discontinuance conferences, medical and rehabilitation conferences and hearings have fallen since 2001 (the earliest year with data available). Hearings in fiscal year 2009 were down 44 percent from 1997 (Figure 5.11).

- At the Workers' Compensation Court of Appeals, the number of cases received fell by 54 percent from fiscal year 1997 to 2009 (Figure 5.12).

- The percentage of paid indemnity claims with claimant attorney involvement rose from 14.8 percent in 1997 to 20.4 percent in 2008, a 37-percent increase (Figure 5.13). During the same period, the percentage of indemnity benefits that were in claims with claimant attorney involvement rose from 60 percent to 84 percent (Figure 5.14).[17]

- Total claimant attorney fees are estimated at $40 million for injury year 2008, or about 2.7 percent of total workers' compensation system cost for that year.[18]

[16] See note 9 on p. 10. The decrease in paid claims was estimated from DLI and MWCIA data.

[17] The claimant attorney fees counted here are those calculated as a percentage of indemnity benefits, and claimant attorney involvement is determined according to the presence of these fees. Roraff and Heaton fees (those paid in medical and rehabilitation disputes) are not considered in this report, but will be in future reports.

[18] See note 17.

Background

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

Types of disputes

Disputes in Minnesota's workers' compensation system generally concern one or more of the three types of workers' compensation benefits and services:

- monetary benefits;
- medical services; and
- vocational rehabilitation services. [19]

The injured worker and the insurer may disagree about initial eligibility for the benefit or service, the level at which it should be provided or how long it should continue. Disputes may also occur about payment for a service already provided. Payment disputes typically involve a medical or vocational rehabilitation provider and the insurer, and may also involve the injured worker.

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

Dispute-resolution activities at the Department of Labor and Industry

DLI carries out a variety of dispute-resolution activities:

Informal intervention — Through informal intervention, DLI provides information or assistance to prevent a potential dispute, or communicates with the parties to resolve a dispute and/or determine whether a dispute should be certified. A resolution through intervention may occur before, during or after the dispute certification process. The goal is to avoid a longer, more formal and costly process.

Dispute certification — In a medical or vocational rehabilitation dispute, DLI must certify that a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services.[20] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

Mediation — If the parties in a dispute agree to participate, a DLI specialist conducts a mediation to seek agreement on the issues. Any type of dispute is eligible. Mediation agreements are usually recorded in a "mediation award," or sometimes in a "stipulation for settlement" (see below).

Administrative conference — DLI conducts administrative conferences on medical or vocational rehabilitation (VR) issues presented on a medical or rehabilitation request unless it has referred the issues to OAH or the issues have otherwise been resolved. DLI refers medical disputes involving more than $7,500 to OAH, and it may refer medical or VR disputes for other reasons.[21] The DLI specialist usually attempts to bring the parties to agreement during the conference. If agreement is not reached, the specialist issues a "decision-and-order." If agreement is reached, the specialist issues an "order on agreement." A party may appeal a DLI decision-and-order by requesting a *de novo* hearing at OAH.

Dispute-resolution activities at the Office of Administrative Hearings

OAH performs the following dispute-resolution activities:

[19] Disputes also occur about other types of issues, such as attorney fees.

[20] Minnesota Statutes §176.081, subd. 1(c).

[21] Minnesota Statutes §176.106. The 2005 Legislature increased the monetary threshold for OAH jurisdiction in medical disputes from $1,500 to $7,500. DLI also refers medical disputes to OAH if surgery is involved, and it may refer medical or VR disputes if litigation is pending at OAH or the issues are unusually complex. Primary liability disputes are outside of administrative conference jurisdiction and must be filed on a claim petition, which leads to a settlement conference or hearing at OAH.

Mediation — If the parties agree to participate, OAH offers mediation to seek agreement on the issues. Any type of dispute is eligible. Mediation agreements are usually recorded in a "mediation award," or sometimes in a "stipulation for settlement" (see below).

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

Administrative conference — With some exceptions, OAH conducts administrative conferences on issues presented on a medical or rehabilitation request that have been referred from DLI (see above). In some cases, medical and rehabilitation request disputes referred from DLI are heard in a formal hearing (see below). OAH also conducts administrative conferences where requested by the claimant in a dispute about discontinuance of wage-loss benefits.[22] If agreement is not reached at the conference, the OAH judge issues a "decision-and-order." A party may appeal an OAH decision-and-order by requesting a *de novo* formal hearing at OAH.

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

Dispute resolution by the parties

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

Counting disputes

Four "dispute" categories are used in this report:

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

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

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

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

[22] Minnesota Statutes §176.239.

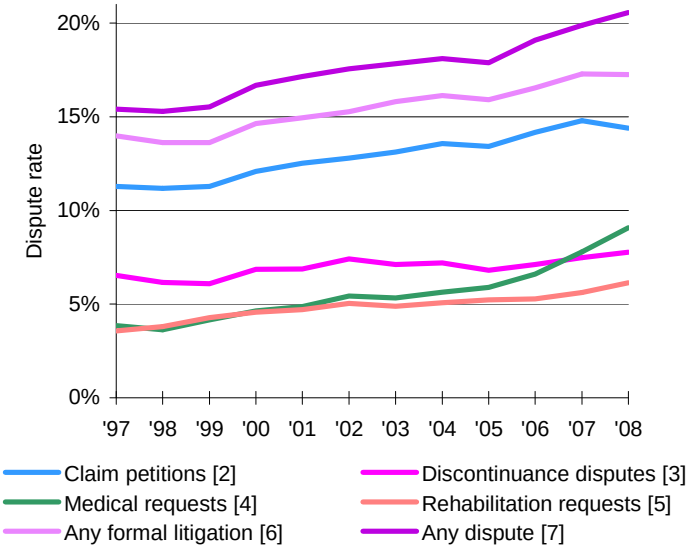
Many disputes, especially those handled by DLI through informal intervention, are not counted in these categories.

Dispute rates

After a period of stability from 1997 to 1999, the dispute rate rose sharply from 1999 to 2008. The increase was most pronounced for the proportion of claims with medical requests, which more than doubled during this period.

- The overall dispute rate increased from 15.4 percent in 1997 to 20.6 percent in 2008, a 34-percent increase.[23] During the same period:
  - the rate of claim petitions rose 3.1 percentage points (28 percent);
  - the rate of discontinuance disputes rose 1.3 points (19 percent);
  - the rate of medical requests rose 5.3 points (136 percent);
  - the rate of rehabilitation requests rose 2.5 points (72 percent); and
  - the rate of formal litigation rose 3.3 points (23 percent).

Figure 5.1 Incidence of disputes, injury years 1997-2008 [1]

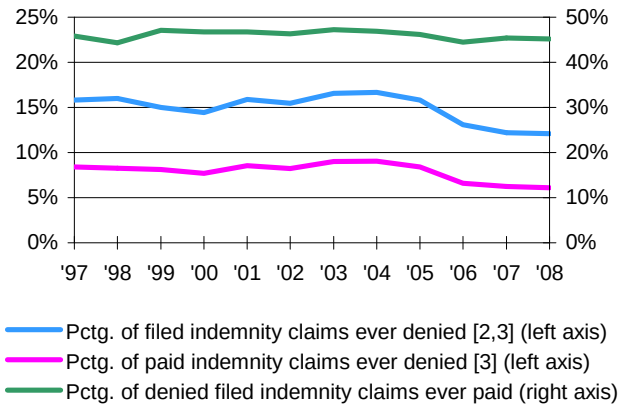


Injury year	Dispute rate: Claim petitions [2]	Discontinuance disputes [3]	Medical requests [4]	Rehabilitation requests [5]	Any formal litigation [6]	Any dispute [7]
1997	11.3%	6.5%	3.8%	3.6%	14.0%	15.4%
1999	11.3	6.1	4.2	4.3	13.6	15.5
2004	13.6	7.2	5.6	5.1	16.1	18.1
2005	13.4	6.8	5.9	5.2	15.9	17.9
2006	14.2	7.1	6.6	5.3	16.6	19.1
2007	14.8	7.5	7.8	5.6	17.3	19.9
2008	14.4	7.8	9.1	6.1	17.3	20.6

1. Developed statistics from DLI data (see Appendix C).
2. Percentage of filed indemnity claims with claim petitions. (Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.)
3. Percentage of paid wage-loss claims with discontinuance disputes.
4. Percentage of paid indemnity claims with medical requests.
5. Percentage of paid indemnity claims with rehabilitation requests.
6. Percentage of filed indemnity claims with disputes that lead to a hearing at OAH (unless the parties settle beforehand). These disputes include claim petitions, requests for formal hearing, objections to discontinuance, petitions to discontinue benefits, petitions for permanent total disability benefits and petitions for dependency benefits.
7. Percentage of filed indemnity claims with any disputes.

[23] See note 9 on p. 10.

Figure 5.2 Indemnity claim denial rates, injury years 1997-2008 [1]



Injury year	Filed indemnity claims [2] Total	Filed indemnity claims [2] Pctg. ever denied [3]	Paid indemnity claims Total	Paid indemnity claims Pctg. ever denied [3]	Pctg. of denied filed indemnity claims ever paid
1997	39,000	15.8%	33,700	8.4%	45.8%
2000	39,900	14.4	34,800	7.7	46.7
2004	31,100	16.7	26,800	9.1	46.9
2005	31,000	15.8	26,900	8.4	46.2
2006	29,400	13.1	25,900	6.6	44.5
2007	28,100	12.2	25,000	6.2	45.4
2008	26,900	12.1	24,100	6.1	45.2

1. Developed statistics from DLI data.
2. Filed indemnity claims are claims for indemnity benefits, including claims paid and claims never paid.
3. Denied claims include claims denied and never paid, claims denied but eventually paid and claims initially paid but later denied.

Denials

Denials of primary liability are of interest because they frequently generate disputes. After several years of moderate variation with no significant upward or downward trend, the denial rate moved sharply downward from 2004 to 2007.

- The rate of denial of filed indemnity claims was 12.1 percent in 2008, down 4.6 points (27 percent) from its high point in 2004.
- The proportion of paid indemnity claims that had also been denied was roughly 8 to 9 percent from 1997 through 2005, but fell to 6.6 percent in 2006 and 6.1 percent by 2008. These include cases denied but then paid and cases paid but then denied.
- Among filed indemnity claims with denials, the proportion ever paid stood at 45 percent in 2008, a slight decrease from 47 percent in 2004.
- The sharp decreases in the denial rates for filed and paid claims coincide with the initiation of the DLI denials project, which began in November 2005.[24] In this project, DLI is requiring insurers to indicate reasons for claim denials in a manner compliant with statute and rules where they have not done so. The pronounced decreases in the denial rates suggest insurers may be refraining from making some denials they otherwise would have made, believing those denials might not withstand DLI scrutiny.

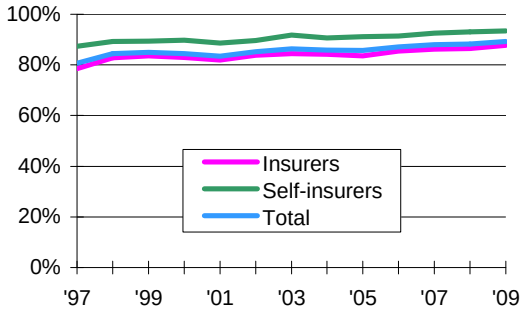
[24] See "DLI primary liability determination review process," in *COMPACT*, August 2006, www.dli.mn.gov/WC/PDF/0806c.pdf.

Prompt first action

Insurers must either begin payment on a wage-loss claim or deny the claim within 14 days of when the employer has knowledge of the injury.[25] This "prompt first action" is important not only for the sake of the injured worker, but also because disputes are less likely if the insurer responds promptly to the claim. The prompt-first-action rate has increased since 1997.[26]

- The fiscal year 2009 prompt-first-action rate was 89 percent, a 9-percentage-point increase from 1997.
- The prompt-first-action rate is higher for self-insurers than for insurers.

Figure 5.3 Percentage of lost-time claims with prompt first action, fiscal claim-receipt years 1997-2009 [1]



Fiscal year of claim receipt	Insurers	Self-insurers	Total
1997	78.5%	87.3%	80.7%
2005	83.6	91.2	85.7
2006	85.5	91.4	87.1
2007	86.2	92.5	88.0
2008	86.5	93.0	88.3
2009	87.7	93.4	89.3

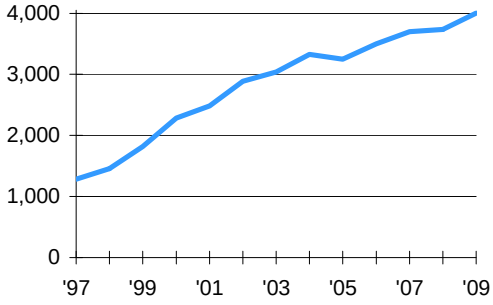
1. Computed from DLI data by DLI Benefit Management and Resolution. See DLI Benefit Management and Resolution, *2009 Prompt First Action Report.* Fiscal claim-receipt year means the fiscal year in which DLI received the claim. Fiscal years are from July 1 through June 30; for example, July 1, 2008 through June 30, 2009 is fiscal year 2009.

Dispute certification requests

The absolute numbers of disputes and of dispute certification requests are important for understanding data to be presented in Figures 5.6 through 5.12 about the volume of dispute-resolution activity at DLI, the Office of Administrative Hearings and the Workers' Compensation Court of Appeals.

- **The number of dispute certification requests grew from about 1,300 in 1997 to 4,000 in 2009.**
- These requests constitute only part of the demand for dispute certification at DLI because many medical and rehabilitation requests are not preceded by certification requests, but the dispute certification process still occurs in those cases.

Figure 5.4 Dispute certification requests filed, calendar years 1997-2009 [1]



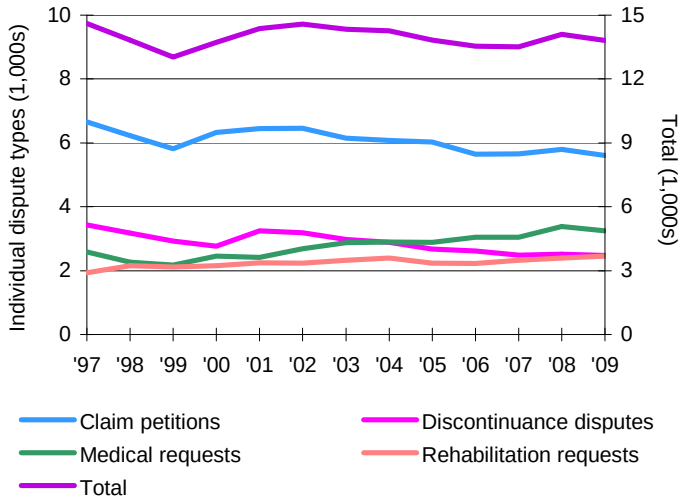
Calender year	Requests filed
1997	1,280
2005	3,250
2006	3,500
2007	3,700
2008	3,740
2009	4,000

1. Data from DLI. Numbers rounded to nearest 10.

[25] Minnesota Statutes §176.221.

[26] In compliance with Minnesota Statutes §176.223, and to improve system performance, DLI publishes the annual *Prompt First Action Report* about the prompt-first-action performance of individual insurers and self-insurers and of the overall system.

Figure 5.5 Disputes filed, calendar years 1997-2009 [1]



Calendar year filed	Claim petitions		Discontinuance disputes		Medical requests		Rehabilitation requests		Total [2]
	Number	Pctg. of total	Number	Pctg. of total	Number	Pctg. of total	Number	Pctg. of total	
1997	6,660	46%	3,430	23%	2,580	18%	1,940	13%	14,620
2005	6,030	44	2,680	19	2,890	21	2,230	16	13,830
2006	5,650	42	2,620	19	3,050	23	2,220	16	13,540
2007	5,650	42	2,490	18	3,050	23	2,320	17	13,520
2008	5,800	41	2,520	18	3,380	24	2,400	17	14,100
2009	5,610	41	2,480	18	3,250	24	2,460	18	13,800

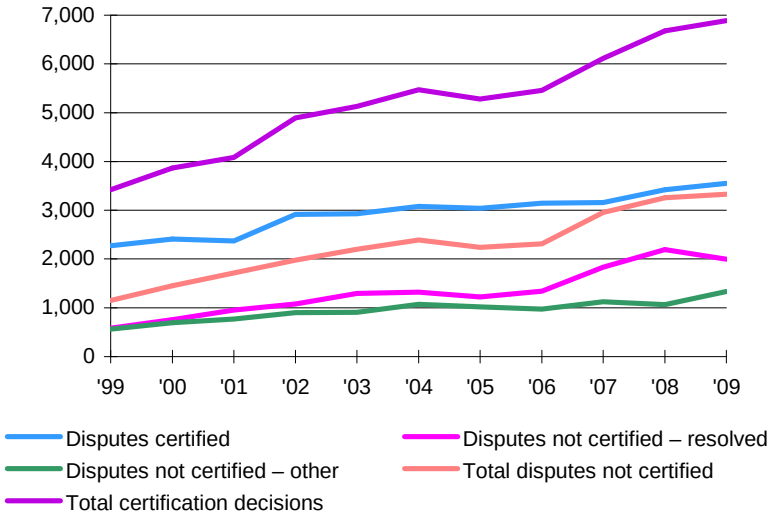
1. Data from DLI. Numbers rounded to nearest 10.
2. Total of those dispute types shown here.

Disputes filed

The numbers of claim petitions and of discontinuance disputes decreased between 1997 and 2009; the numbers of medical and rehabilitation requests increased; the total number of these disputes was fairly stable.

- From 1997 to 2009:
  - claim petitions fell 16 percent;
  - discontinuance disputes fell 28 percent;
  - medical requests rose 26 percent;
  - rehabilitation requests rose 27 percent; and
  - the total number of these disputes fell 6 percent.
- These trends are the net result of rising dispute rates (Figure 5.1) and falling numbers of claims (Figure 5.2). For example, the relatively stable trend in the number of disputes occurred despite a 31-percent decrease in the number of filed indemnity claims, because the overall dispute rate increased 34 percent.
- Because of these trends, the mix of dispute types changed significantly from 1997 to 2009:
  - claim petitions fell from 46 percent to 41 percent of total disputes filed;
  - discontinuance disputes fell from 23 percent to 18 percent;
  - medical requests rose from 18 percent to 24 percent; and
  - rehabilitation requests rose from 13 percent to 18 percent.
- While claim petitions remained the most frequent dispute type in 2008, medical requests surpassed discontinuance disputes during the period examined as the second most frequent.

Figure 5.6 Dispute certification activity at the Department of Labor and Industry, calendar years 1999-2009 [1]



Calendar year	Disputes certified		Disputes not certified						Total certification decisions
			Resolved		Other reasons		Total not certified		
	Number	Pctg. of total	Number	Pctg. of total	Number	Pctg. of total	Number	Pctg. of total	
1999	2,270	66%	590	17%	570	17%	1,150	34%	3,420
2001	2,370	58	950	23	770	19	1,720	42	4,090
2005	3,040	58	1,220	23	1,020	19	2,240	42	5,280
2006	3,140	58	1,340	25	980	18	2,310	42	5,460
2007	3,160	52	1,830	30	1,120	18	2,960	48	6,110
2008	3,420	51	2,200	33	1,060	16	3,260	49	6,680
2009	3,550	52	2,000	29	1,330	19	3,330	48	6,890

1. Data from DLI. Data not available before 1999. Numbers rounded to nearest 10.

Dispute certification

Dispute certification activity at DLI doubled from 1999 to 2009.

- DLI rendered 6,890 certification decisions in 2009, an increase of 101 percent from 1999.
  - ➢ This parallels the increase in certification requests in Figure 5.4.
  - ➢ The number of certification decisions is greater than the number of certification requests in Figure 5.4 because many medical and rehabilitation requests are not preceded by certification requests, but dispute certification still occurs in those cases.
- Between 1999 and 2009, the percentage of disputes certified fell from 66 percent to 52 percent. This was primarily attributable to an increase in the percentage of disputes not certified because they were resolved. Much of the decrease in the percentage of disputes certified occurred between 2006 and 2007 after a period of relative stability from 2001 to 2006.
- The large increases in 2007 and 2008 in disputes not certified because they were resolved coincides with recent changes at DLI: earlier identification of dispute-resolution opportunities, greater emphasis on early dispute resolution and more active management of the dispute resolution-process.

Mediations and administrative conferences at DLI

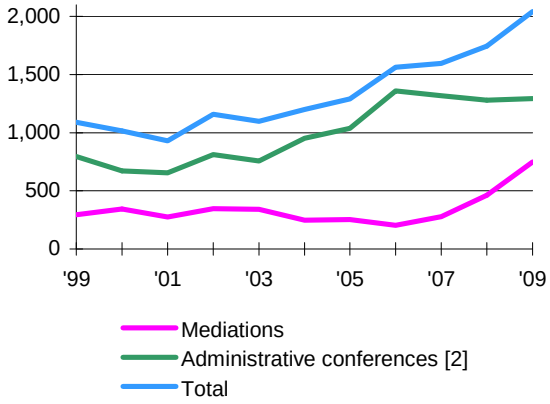
The number of administrative conferences at DLI has increased since 1999, while the number of mediations has recently reversed a downward trend.

From 1999 to 2009:

- administrative conferences rose by 490;
- mediations rose by 460; and
- total conferences and mediations increased by 950.

The increase in total conferences and mediations is to be expected in view of the increase in medical and rehabilitation requests during the same period (Figure 5.5). Another contributing factor is that, as mentioned above, the 2005 Legislature increased the monetary threshold for referring medical requests from DLI to OAH from $1,500 to $7,500. A shift from administrative conferences to mediations occurred between 2006 and 2009. This coincides with a recently increased emphasis at DLI on mediation and other early dispute-resolution activities.

Figure 5.7 Mediations and administrative conferences at the Department of Labor and Industry, calendar years 1999-2009 [1]



Calendar year	Mediations	Administrative conferences [2]	Total
1999	290	800	1,090
2005	250	1,040	1,290
2006	200	1,360	1,560
2007	280	1,320	1,600
2008	460	1,280	1,740
2009	750	1,290	2,040

1. Data from DLI. Data not available before 1999. Numbers rounded to nearest 10.
2. Includes conferences where agreement was reached.

Resolutions by agreement at DLI

The total number of resolutions by agreement at DLI was about the same in 2009 as in 1999, after reaching a low point in 2006.

- Most resolutions by agreement occurred through "intervention," prior to a mediation or conference. The total number of resolutions by agreement followed approximately the same trend as resolutions by intervention.

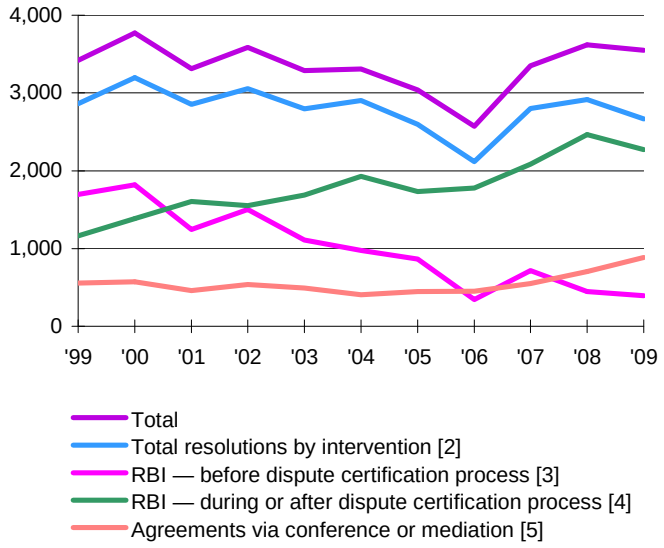
- Resolutions by intervention fell sharply in 2005 and 2006 but substantially returned to earlier levels in 2007 to 2009.

  - Resolutions by intervention that occurred before the dispute certification process declined from 1,700 to 390 from 1999 to 2009, while those occurring during or after the certification process increased from 1,160 to 2,270.
  - These trends were roughly offsetting: the total number of resolutions by intervention in 2009 was just slightly below the number for 1999.

- The number of agreements via mediation or conference decreased from 1999 to 2004, but increased from 410 to 890 between 2004 and 2009.

- Recent enhancements in the DLI dispute-resolution process, described on page 32, probably explain at least some of the increase in resolutions by intervention and in agreements via mediation or conference in 2007 and 2008.

Figure 5.8 Resolutions by agreement at the Department of Labor and Industry, calendar years 1999-2009 [1]



Calendar year	Resolutions by intervention [2]			Agreements via mediation or con-ference [5]	Total
	Before dispute certification process [3]	During or after dispute certification process [4]	Total		
1999	1,700	1,160	2,860	560	3,420
2004	970	1,930	2,900	410	3,310
2005	860	1,730	2,590	450	3,040
2006	340	1,780	2,120	450	2,570
2007	720	2,080	2,800	550	3,350
2008	450	2,470	2,910	700	3,620
2009	390	2,270	2,670	890	3,550

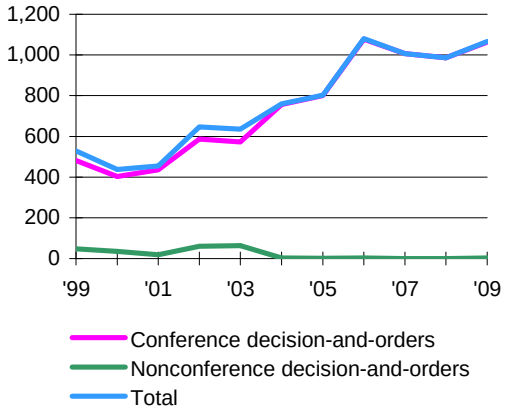
1. Data from DLI. Data not available before 1999. Numbers rounded to nearest 10.
2. These are instances in which a DLI specialist, through phone or walk-in contact or correspondence, resolves a dispute prior to a mediation or conference. Many of these resolutions occur through the dispute certification process.
3. These resolutions occur before a dispute certification request or a medical or rehabilitation request has been submittted.
4. These resolutions occur after a dispute certification request and/or a medical or rehabilitation request has been submittted. If they occur during the dispute certification process, the dispute is not certified. If they occur after that process, this means a dispute has been certified.
5. These include mediation awards and other agreements.

Resolutions by decision-and-order at DLI

The number of resolutions by decision-and-order at DLI increased dramatically from 1999 to 2006, but was relatively stable from 2006 to 2009.

- The total number of decision-and-orders increased from 530 to 1,080 between 1999 and 2006, and finished the period at 1,070 for 2009.
- The vast majority of decision-and-orders are via conference; there have been fewer than five nonconference decision-and-orders a year from 2004 to present.
- The trend in conference decision-and-orders parallels the trend in administrative conferences (Figure 5.7).
- The decrease in decision-and-orders after 2006 coincides with the recently increased emphasis at DLI on mediation and other early dispute-resolution activities.

Figure 5.9 Resolutions by decision-and-order at the Department of Labor and Industry, calendar years 1999-2009 [1]



Calendar year	Conference decision-and-orders	Non-conference decision-and-orders	Total
1999	480	50	530
2005	800	[2]	800
2006	1,080	[2]	1,080
2007	1,010	0	1,010
2008	990	0	990
2009	1,060	[2]	1,070

1. Data from DLI. Data not available before 1999. Numbers rounded to nearest 10.
2. Fewer than five cases.

Total resolutions at DLI

The total number of resolutions at DLI was higher in 2009 than in 1999. Resolutions by agreement rose slightly between the two years, while resolutions by decision-and-order increased substantially.

- Resolutions by agreement fell by 850 (25 percent) from 1999 to 2006, but by 2008 were 4 percent above their 1999 level.
- Resolutions by decision-and-order in 2009 were about double their 1999 level, about the same as their peak in 2006.
- Resolutions by agreement accounted for 77 percent of all resolutions in 2009, down from 87 percent in 1999. As indicated in Figure 5.8, most resolutions by agreement are by intervention in disputes before they reach mediation or conference.

Figure 5.10 Total resolutions at the Department of Labor and Industry, calendar years 1999-2009 [1]

Calendar year	Resolutions by agreement [2]		Resolutions by decision-and-order [3]		Total
	Number	Pctg.	Number	Pctg.	
1999	3,420	87%	530	13%	3,950
2005	3,040	79	800	21	3,840
2006	2,570	70	1,080	30	3,650
2007	3,350	77	1,010	23	4,350
2008	3,620	79	990	21	4,600
2009	3,550	77	1,070	23	4,620

1. Data from DLI. Data not available before 1999. Number rounded to nearest 10.
2. From Figure 5.8.
3. From Figure 5.9.

Dispute resolution at OAH

At OAH, the numbers of settlement conferences, discontinuance conferences, medical and rehabilitation conferences and hearings have fallen since 2001.

- From fiscal year 2001 to 2008:
  - settlement conferences fell by about 870 (27 percent);
  - discontinuance conferences fell by about 110 (8 percent);
  - medical and rehabilitation conferences fell by 230 (45 percent); and
  - hearings decreased by about 50 (7 percent).

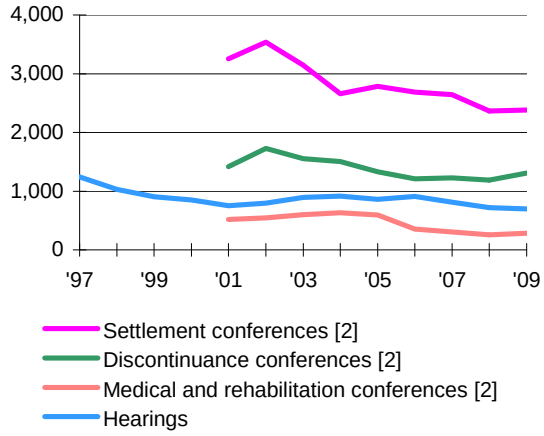
- Hearings decreased substantially during the late 1990s. Hearings in 2008 were down by about 540 from 1997 (44 percent).

- Settlement conferences, discontinuance conferences and medical and rehabilitation conferences all turned upward in 2009.

- The trends for discontinuance conferences and hearings roughly follow the associated dispute trends in Figure 5.5.[27] The upturn in discontinuance conferences in 2009 is notable, however, because there is no similar increase in discontinuance disputes in 2009 (Figure 5.5).

- The decrease in medical and rehabilitation conferences between 2005 and 2006 is to be expected because, as mentioned earlier, the 2005 Legislature increased the monetary threshold for OAH jurisdiction in medical request disputes from $1,500 to $7,500.

Figure 5.11 Dispute resolution activity at the Office of Administrative Hearings, fiscal years 1997-2009 [1]



Fiscal year	Settle-ment confer-ences [2]	Discon-tinuance confer-ences [2]	Medical and rehab confer-ences [2]	Hearings
1997				1,240
2001	3,254	1,415	516	753
2005	2,784	1,328	595	860
2006	2,687	1,211	356	910
2007	2,643	1,224	306	814
2008	2,366	1,188	258	718
2009	2,381	1,307	282	700

1. Data from OAH.
2. Not available before 2001.

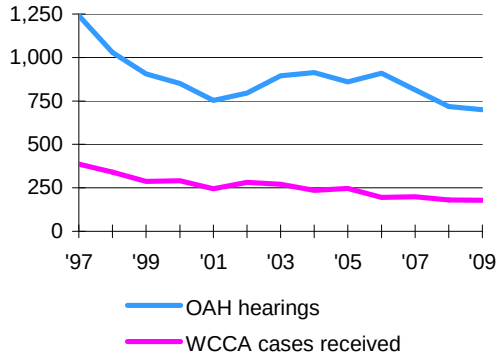
[27] Claim petitions and hearings both decreased between 1997 and 2009; discontinuance disputes (most of which involve requests for conference) and discontinuance conferences both decreased between 2001 and 2009. The relationship between medical and rehabilitation requests and OAH medical and rehabilitation conferences is ambiguous because many medical conferences and most rehabilitation conferences occur at DLI. The relationship between settlement conferences and disputes is also ambiguous because these conferences involve all dispute types.

OAH hearings and WCCA cases

Both OAH hearings and cases received at WCCA have declined since 1997.

- The number of cases received at WCCA fell by 54 percent from 1997 to 2009, from 386 to 178.
- This is a larger proportionate decline than for the number of hearings at OAH, which fell by 44 percent during the same period.

Figure 5.12 Hearings at the Office of Administrative Hearings and cases received at the Workers' Compensation Court of Appeals, fiscal years 1997-2009 [1]



Fiscal year	OAH hearings [2]	WCCA cases received [3]
1997	1,240	386
2001	753	245
2005	860	247
2006	910	196
2007	814	199
2008	718	180
2009	700	178

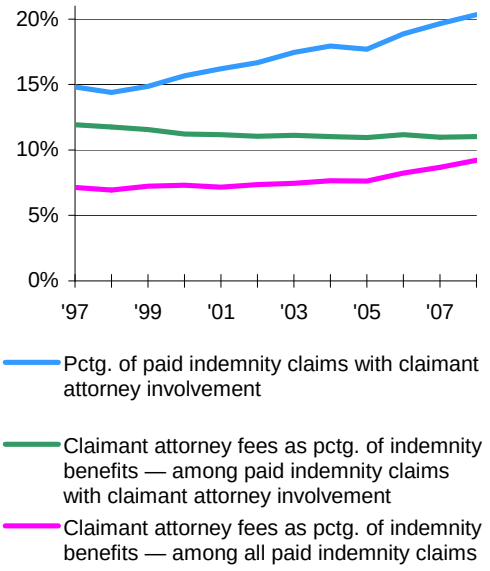
1. Data from OAH and WCCA.
2. From Figure 5.11.
3. Includes cases with and without oral arguments at WCCA. Both types of cases are usually disposed of by decisions but sometimes by settlement. Statistics are unavailable about the number of WCCA cases with oral arguments. Currently, about 35 percent of cases received have oral arguments. This percentage has risen over time.

Claimant attorney involvement

Claimant attorney involvement has increased substantially since 1997.

- From 1997 to 2008, the percentage of paid indemnity claims with claimant attorney involvement[28] rose from 14.8 percent to 20.4 percent, a 37-percent increase.[29] This parallels a similar increase in the dispute rate (Figure 5.1).
- Among paid indemnity claims with claimant attorney fees, the ratio of attorney fees to indemnity benefits fell from 11.9 percent to 11.1 percent during the same period. Most of this decrease occurred by 2002.
- From 1997 to 2008, claimant attorney fees rose from 7.1 percent of total indemnity benefits to 9.2 percent.
- **Total claimant attorney fees are estimated at $40 million for injury year 2008. This represents 2.7 percent of total workers' compensation system cost for that year.**

Figure 5.13 Claimant attorney fees paid with respect to indemnity benefits, injury years 1997-2008 [1]



Injury year	Percentage of paid indemnity claims with claimant attorney involvement	Claimant attorney fees as pctg. of indemnity benefits: Among paid indemnity claims with claimant attorney involvement	Claimant attorney fees as pctg. of indemnity benefits: Among all paid indemnity claims
1997	14.8%	11.9%	7.1%
2004	17.9	11.0	7.7
2005	17.7	11.0	7.6
2006	18.9	11.2	8.2
2007	19.7	11.0	8.7
2008	20.4	11.0	9.2

1. Developed statistics from DLI data (see Appendix C). Claimant attorney fees counted here are those determined as a percentage of indemnity benefits plus additional amounts awarded to the claimant attorney upon application to a judge. A claimant attorney is deemd to be involved if claimant attorney fees are reported.

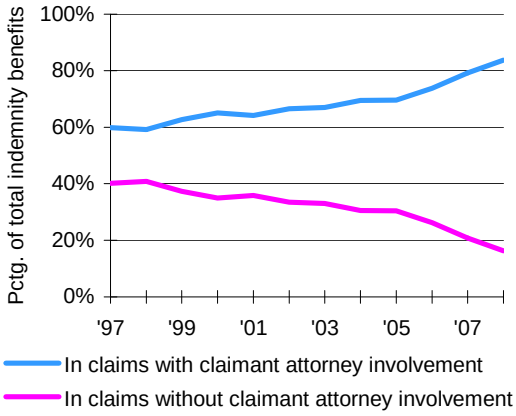
[28] See note 1 in figure.
[29] See note 9 on p. 10.

Proportion of indemnity benefits in claims with claimant attorney involvement

The proportion of total indemnity benefits in claims with claimant attorney involvement has grown dramatically since 1997.

- From 1997 to 2008, the percentage of indemnity benefits that were in claims with claimant attorney involvement[30] rose from 60 percent to 84 percent; by 2008, only 16 percent of indemnity benefits were in claims without a claimant attorney involved.
- The most rapid changes in these percentages occurred between 2005 and 2008.
- The percentage of indemnity benefits in claims with claimant attorney involvement (Figure 5.14) is higher than the percentage of paid indemnity claims with claimant attorney involvement (Figure 5.13) because attorneys are more likely to be involved in higher-value claims.

Figure 5.14 Proportion of indemnity benefits in indemnity claims with and without claimant attorney involvement, injury years 1997-2008 [1]



Injury year	Pctg. of total indemnity benefits in claims — With claimant attorney involvement	Without claimant attorney involvement
1997	59.8%	40.2%
2004	69.5	30.5
2005	69.6	30.4
2006	73.8	26.2
2007	79.2	20.8
2008	83.7	16.3

1. Developed statistics from DLI data (see Appendix C). A claimant attorney is deemed to be involved if the claim includes claimant attorney fees determined as a percentage of indemnity benefits or additional amounts awarded to the claimant attorney upon application to a judge.

[30] See note 1 in figure.

Appendix A

Glossary

The following terms are used in this report.[31]

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

Administrative conference — An expedited, informal proceeding where parties present and discuss viewpoints in a dispute. With some exceptions, administrative conferences are conducted on medical and vocational rehabilitation (VR) disputes presented on a medical or rehabilitation request;[32] they are also conducted on disputes over discontinuance of wage-loss benefits presented by a claimant's request for administrative conference. Medical and rehabilitation conferences are conducted at either the Department of Labor and Industry (DLI) or the Office of Administrative Hearings (OAH) depending on whether DLI has referred the issues concerned to OAH.[33] Discontinuance conferences are conducted at OAH. If agreement is not achieved in the conference, the DLI specialist or OAH judge issues a "decision-and-order" which is binding unless appealed. If agreement is achieved, an "order on agreement" is issued. A party may appeal a DLI or OAH decision-and-order by requesting a *de novo* hearing at OAH.

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

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

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

Cost-of-living adjustment — An annual adjustment of temporary total disability, temporary partial disability, permanent total disability or dependents' benefits computed from the annual change in the statewide average weekly wage (SAWW).[34] The percent adjustment is equal to the proportion by which the SAWW in effect at the time of the adjustment differs from the SAWW in effect one year earlier, not to exceed a statutory limit. For

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

[32] As indicated on p. 30, some issues presented on a medical or rehabilitation request are heard in a formal hearing at the Office of Administrative Hearings rather than an administrative conference.

[33] See discussion of DLI administrative conferences on p. 29 (including note 21) for types of medical and VR disputes referred to OAH.

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

injuries on or after Oct. 1, 1995, the cost-of-living adjustment is limited to 2 percent a year and delayed until the fourth anniversary of the injury.

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

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

Development — The change over time in a claim statistic (e.g., number or cost of claims) for a particular accident year, policy year or injury year. The reported numbers develop both because of the time necessary for claims to mature and, in the case of Department of Labor and Industry data, because of reporting lags.

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

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

Dispute certification — A process required by statute in which, in a medical or rehabilitation dispute, the Department of Labor and Industry (DLI) must certify that a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services.[35] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

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

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

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

[35] Minnesota Statutes §176.081, subd. 1(c).

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

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

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

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

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

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

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

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

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

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

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

Notice of Intention to Discontinue (NOID) — A form by which the insurer informs the worker

of its intention to discontinue temporary total, temporary partial or unadjudicated permanent total benefits. In contrast with a petition to discontinue benefits, the NOID brings about benefit termination if the worker does not contest it.

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

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

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

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

Petition to discontinue benefits — A document by which the insurer requests a formal hearing to allow a discontinuance of wage-loss benefits (temporary total disability (TTD), temporary partial disability (TPD) or permanent total disability (PTD)). The hearing is conducted at the Office of Administrative Hearings for TTD or TPD benefits or at the Workers' Compensation Court of Appeals for adjudicated PTD benefits.

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

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

Pure premium — A measure of expected losses, equal to the sum, over all insurance classes, of payroll times the class-specific pure premium rates, adjusted for individual employers' prior loss experience. It is different from (and somewhat lower than) the actual premium charged to employers, because actual premium

includes other insurance company costs plus taxes and assessments.

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

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

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

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

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

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

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

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

Statewide average weekly wage (SAWW) — The average wage used by insurers and the Department of Labor and Industry to adjust certain workers' compensation benefits. This report uses the SAWW to adjust average benefit amounts for different years so they are all expressed in constant (2008) wage dollars. The SAWW, from the Department of Employment and Economic Development, is the average weekly wage of nonfederal workers covered under unemployment insurance.

Stipulated benefits — Indemnity and medical benefits specified in a "stipulation for settlement," which states the terms of settlement of a claim among the affected parties. A stipulation usually occurs in the context of a dispute, but not always. The stipulation may be reached independently by the parties or in a settlement conference or associated preparatory activities. A stipulation is approved by a judge at the Office of Administrative Hearings. It may be

incorporated into a mediation award or an award on stipulation, usually the latter. The stipulation usually includes an agreement by the claimant to release the employer and insurer from future liability for the claim other than for medical treatment. Stipulated benefits are usually paid in a lump sum.

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

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

Temporary total disability (TTD) — A wage-replacement benefit paid if the worker is unable to work because of a work-related injury or illness. (The benefit is not payable for the first three calendar days of total or partial disability unless the disability lasts, continuously or intermittently, for at least 10 days.) The benefit is equal to two thirds of the worker's gross pre-injury wage, subject to minimum and maximum weekly amounts, and is paid at the same intervals as wages were paid before the injury. Currently, TTD stops if the employee returns to work; the employee withdraws from the labor market; the employee fails to diligently search for work within his or her physical restrictions; the employee is released to work without physical restrictions from the injury; the employee refuses an appropriate offer of employment; 90 days have passed after the employee has reached maximum medical improvement or completed an approved retraining plan; the employee fails to cooperate with an approved vocational rehabilitation plan or with certain procedures in the development of such a plan. TTD also stops, for injuries on or after October 1, 1995, after 104 weeks of TTD have been paid, or for injuries on or after October 1, 2008, after 130 weeks of TTD have been paid (with an exception for approved retraining). Minimum and maximum weekly benefit provisions are described in Appendix B. Cost-of-living adjustments are described in this appendix.

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

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

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

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

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

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

Appendix B

2000 and 2008 workers' compensation law changes

For the period covered in this report, two workers' compensation law changes are relevant: those occurring in 2000 and 2008. This appendix summarizes those components of the 2000 and 2008 law changes that are of interest for this report.[36]

2000 law change

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

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

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

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

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

2008 law change

The following provisions are effective for injuries on or after Oct. 1, 2008:

Temporary total disability (TTD), temporary partial disability (TPD) and permanent total disability (PTD) maximum benefit — The maximum weekly TTD, TPD and PTD benefit was raised from $750 to $850.

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

[36] The 2008 law changes are included because they took effect during the period covered by the report, even though they are unlikely to be perceptible in trends ending with injury year 2008. This appendix does not summarize other changes enacted by the legislature because they do not affect the trends in this report.

Appendix C

Data sources and estimation procedures

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

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

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

PDRS has adapted this technique to DLI data. It tabulates statistics at regular intervals from the DLI database, computes development factors representing historical development for given injury years and then derives developed statistics by applying the development factors to the most recent tabulated statistics. In this manner, the annual numbers in any given time series are developed to a constant maturity, e.g., a 25-year maturity for the claim and cost statistics in Chapters 2 and 3 because the DLI database extends back to injury year 1983 for claim and cost data. An example: In Figure 2.1, the developed number of indemnity claims for injury year 2008 (in the numerator of the indemnity claim rate) is 24,100 (rounded to the nearest hundred). This is equal to the tabulated number as of Oct. 1, 2009, 21,559, times the appropriate development factor, 1.1178.

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

Adjustment of cost data for wage growth — For reasons explained in Chapter 1, all costs in this report (except those expressed relative to payroll) are adjusted for average wage growth. The cost number for each year is multiplied by the ratio of the 2008 statewide average weekly wage (SAWW) to the SAWW for that year, using the SAWW reflecting wages paid during the respective year. Thus, the numbers for all years represent costs expressed in 2008 wage-dollars.

Figure 2.1 — The developed number of paid indemnity claims for each year is calculated from the DLI database. The annual number of medical-only claims is estimated by applying the ratio of medical-only to indemnity claims for insured employers to the total number of indemnity claims. (The ratio is unavailable for self-insured employers.) The MWCIA, through special tabulations, provides this ratio by injury year for compatibility with the injury-year indemnity claims numbers.

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

Figure 2.2 — For insured employers, total cost is computed as written premium adjusted for deductible credits, minus paid policy dividends. Written premium and paid dividends for the voluntary market are obtained from the Department of Commerce. Written premium for the Assigned Risk Plan (ARP) is obtained from the AON Risk Services, the plan administrator. (There are no policy dividends in the ARP.)

Written premium is adjusted upward by the amount of premium credits granted with respect to policy deductibles to reflect that portion of cost for insured employers that falls below deductible limits. Deductible credit data through policy year 2007 is available from the MWCIA. The 2008 figure was estimated by applying the ratio of deductible credits to written premium for 2007 to the 2008 premium figure. When the actual amount becomes available for 2008, that year's total cost figure will be revised.

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

Total workers' compensation covered payroll is computed as the sum of insured payroll, from the MWCIA, and self-insured payroll, from the WCRA. Insured payroll was not yet available for 2008. This figure was extrapolated from actual figures using the trend in nonfederal UI-covered payroll (from DEED) and the trend in the relative insured and self-insured shares of total pure premium (from the WCRA).

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

Figure 2.4 — Claim and loss data is from the MWCIA's *2010 Minnesota Ratemaking Report.* This data comes from insurance company reports about claim and loss experience for individual policies for the voluntary market and the ARP. The reported losses include paid losses plus case-specific reserves. Data is developed to a fifth-report basis using the development factors in the *Ratemaking Report,* which produces statistics at an average maturity of 5.5 years from the injury date; the statistics are then adjusted for average wage growth.

Figures 2.6 and 2.7 — Figures 2.6 and 2.7 are based on paid losses, in contrast with prior reports in which they were based on paid losses plus cases reserves following the procedure in the MWCIA's ratemaking report. The switch to paid losses only was made because the paid-loss data is more stable from year to year than are paid losses plus case reserves. The data is from financial reports to the MWCIA by voluntary market insurers only. Paid losses are developed to a uniform maturity of eighteen years (an "eighteenth-report basis") using development factors computed from year-to-year loss development data supplied by the MWCIA. Payroll data for Figure 2.6 is from insurer reports about policy experience.

Figure 3.1 — Statistics are derived in the same manner as for Figure 2.4, with one modification. Figure 3.1 presents data by claim type. For permanent total disability (PTD) and death cases, the number of claims and their average cost fluctuate widely from one policy year to the next because of small numbers of cases. Therefore, to produce more meaningful comparisons among claim types, PTD and death claims and losses were estimated by applying respective percentages of claims and losses (relative to the total) during the most recent three years to total claims and losses for 2006.

Figures 3.2, 3.5 and 3.6 — Figure 3.6 shows the average indemnity benefit of each type per paid indemnity claim; this is the product of the percentage of paid indemnity claims with the respective benefit type (Figure 3.2) and the average indemnity benefit of that type for cases where it is paid (Figure 3.5). Theoretically, the sum of the average amounts of the different types per indemnity claim in Figure 3.6 should equal the average total indemnity amount in the same figure.

However, this does not occur in practice. One reason is that dependency benefits are not included along with the other benefit types in these figures because they are relative small overall, about three percent of total indemnity benefits. A second reason is that on some claims, the individual types of indemnity benefits tend to be under-reported to DLI relative to the total indemnity paid. Although this only happens with a minority of claims, the resulting discrepancy is significant overall (the claims concerned tend to have higher benefits and more different types of benefits than average). The third reason is that because the statistics are developed, there is no guarantee that the individually developed numbers will add up to the developed total even if the undeveloped components add up to the undeveloped total.

For injury years 1997 through 2005, as ordinarily computed, the developed total indemnity amount per claim exceeds the sum of the four developed benefit types (other than dependency benefits) per indemnity claim by 6.3 percent to 8.2 percent. For 2006 to 2008, the discrepancies decline significantly, to 5.0 percent, 1.7 percent, and -3.3 percent, respectively, meaning that for 2008 the sum of the four benefit types *exceeds* the total by 3.3 percent. Clearly, the changing discrepancy makes it impossible to explain the trend in the average total indemnity benefit in terms of the trends in the components for recent years.

Therefore, a procedure was applied to adjust the numbers for the most recent three years, assuming that the changing discrepancies for those years occur because the developed statistics for those years have relatively large projected components. The procedure was to adjust downward, for 2006 to 2008, the developed percentages of paid indemnity claims with each benefit type (Figure 3.2) and the developed average indemnity amount of each type per claim with that benefit type (Figure 3.5), and adjusting upward the developed total indemnity amount per claim (Figure 3.6). The adjustments were done so as to cause the sum of the components in Figure 3.6 to fall short of the total for each year from 2006 to 2008 by 6.3 percent, the same as for 2005.

The adjustments for each year were *not* of the same proportion for all numbers concerned. Some developed statistics show more variability from earlier maturities to later ones, and this was taken into account. A factor was computed for each developed statistic reflecting the degree of variability from earlier to later maturities, and the adjustment applied to each developed statistic was directly proportional to this variability factor. More detail is available upon request from DLI Policy Development, Research and Statistics.

Figures 5.13 and 5.14 — These figures present statistics about claims with attorney fees. A modified procedure was used to compute these statistics, for the following reason:

In computing developed statistics, historical rates of development are used to project relatively immature data for recent injury years to a greater level of maturity than it has yet attained. The accuracy of the projection depends on the extent to which the immature data for these years will actually develop to the same degree as projected. In general, there is more room for error where relatively little actual development has occurred and the developed statistics contain relatively large projected components.

This is the case with developed statistics relating to claimant attorney fees for recent injury years. Data about these items is usually not established until fairly late in a claim, most commonly after a settlement conference or hearing has occurred at the Office of Administrative Hearings. Consequently, insurers report this data at a later point in the claim than they do most other data. This may impair the reliability of the associated developed statistics for recent injury years.

Therefore, a modified procedure was used to compute these statistics. In particular, the percentages of claims with claimant attorney fees for the three most recent injury years (2006 through 2008) were projected from their 2005 values using the growth rate in the percentage of claims with disputes. The latter percentage was used for this projection because the percentages of claims with attorney fees closely follow the percentage of claims with disputes.

In next year's report, this procedure will also be used to project the numbers of claims with stipulated benefits for the three most recent injury years, which will be used in turn as the input to the process described immediately above for Figures 3.2, 3.5 and 3.6.