Minnesota
Workers' Compensation System Report, 2011

MINNESOTA DEPARTMENT OF
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RESEARCH AND STATISTICS

Minnesota Workers' Compensation System Report, 2011

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Research and Statistics

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Executive summary

From the middle of the 1990s to the present, workers' compensation claim rates have declined nationwide. During the same period, benefits per claim, especially medical benefits, have increased more than wages. Indemnity benefits have risen less than medical benefits, and have been largely stable relative to wages since the early 2000s. These same trends have occurred in Minnesota. A falling claim rate in Minnesota has counteracted increases in benefits per claim, causing total benefits per $100 of payroll to be lower in 2011 than in 1997.

This report, part of an annual series, presents data for 1997 through 2011 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.[1]

- There were 4.6 paid claims per 100 full-time-equivalent workers in 2011, down 48 percent from 1997.
- The total cost of Minnesota's workers' compensation system was an estimated $1.45 billion for 2011, or $1.28 per $100 of payroll. The latter figure was just above the low point of $1.24 reached in 2010.
- In 2011, on a current-payment basis, the three largest components of total workers' compensation system cost were medical benefits (35 percent), insurer expenses (31 percent) and indemnity benefits other than vocational rehabilitation (29 percent).
- Pure premium rates for 2013 were down 29 percent from 1997, at their lowest level since that year.
- Adjusting for average wage growth, medical benefits per insured claim rose 111 percent from 1997 to 2010 while indemnity benefits rose 40 percent. All of the increase for indemnity benefits occurred by 2003. The average 2010 workers' compensation claim cost $10,040 for medical and indemnity benefits combined (including vocational rehabilitation).
- Relative to payroll, indemnity benefits were down 14 percent between 1997 and 2011, while medical benefits were about the same; this reflects the net effect of the falling claim rate and higher benefits per claim. Medical and indemnity benefits (including vocational rehabilitation) amounted to $.85 per $100 of payroll for 2011.
  - By counteracting the increasing trend in benefits per claim, the falling claim rate has kept system cost per $100 of payroll at historically low levels.
- After adjusting for average wage growth, per paid indemnity claim:
  - total disability benefits rose 18 percent from 1997 to 2011 (all of the increase occurred by 2000);
  - temporary partial disability benefits fell 16 percent from 1997 to 2011;
  - permanent partial disability benefits fell 31 percent from 1997 to 2010;[2] and
  - stipulated benefits rose 91 percent from 1997 to 2011 (stipulated benefits include indemnity, medical and vocational rehabilitation benefits).
- Claims with stipulated benefits made up 25 percent of paid indemnity claims for 2011, up from 17 percent for 1997.

[1] See Glossary in Appendix A (p. 45). The time periods involved in these findings vary because of data availability.

[2] Statistics on PPD benefits are not yet available for 2011.

- In vocational rehabilitation:
  - the participation rate increased from 15 to 24 percent of paid indemnity claimants from 1997 to 2011; and
  - average service cost per participant was $8,830 for 2011, 22 percent higher than 1998 after adjusting for average wage growth, but about the same as for 2002.

- Vocational rehabilitation accounted for an estimated 3.1 percent of total workers' compensation system cost in 2011.

- Twenty-two percent of paid indemnity claims for 2011 had one or more disputes of any type, an increase from 16 percent for 1997.
  - The leading components of this increase were medical disputes, up 89 percent, and vocational rehabilitation disputes, up 60 percent.
  - The medical, vocational rehabilitation and discontinuance dispute rates stabilized during the past three to four years, but the rate of claim petitions continued to increase.
  - The percentage of paid indemnity claims with claimant attorney involvement rose from 17 to 25 percent from 1997 to 2011.

- Among dispute resolutions in 2012 at the Department of Labor and Industry, 83 percent were by agreement of the parties. This was down from 87 percent for 1999, but above the 77 percent for 2007.

- At the Office of Administrative Hearings, the numbers of administrative conference decisions (for medical and rehabilitation disputes and for discontinuance disputes), findings-and-orders, and awards on stipulation have all fallen since since 2003. This to a large degree reflects falling numbers of disputes.

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Introduction

From the middle of the 1990s to present, workers' compensation claim rates have declined nationwide. During the same period, benefits per claim, especially medical benefits, have increased more than wages. Indemnity benefits have risen less than medical benefits, and have been largely stable relative to wages since the early 2000s.[3] These same trends have occurred in Minnesota. A falling claim rate in Minnesota has counteracted increases in benefits per claim, causing total benefits per $100 of payroll to be lower in 2011 than in 1997.

This report, part of an annual series, presents data for 1997 through 2011 about several aspects of Minnesota's workers' compensation system — claims, benefits and costs; vocational rehabilitation; and disputes and dispute resolution.[4] 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 (monetary) benefit trends. Chapters 4 and 5 provide statistics about vocational rehabilitation and about disputes and dispute resolution. *For understanding the major findings at the beginning of each chapter, readers may need to refer to the background material immediately following the major findings in question.*

Appendix A presents a glossary. Appendix B summarizes portions of the 2000 and 2008 law changes relevant to trends in this report. Appendix C describes data sources and estimation procedures.

Developed statistics — Most statistics in this report are presented by injury year or insurance policy year.[5] 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.[6]

By means of this technique, 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 other than those expressed relative to payroll are adjusted for average wage growth. The adjusted trends reflect the extent to

[3] DLI analysis of data in National Council on Compensation Insurance, "State of the Workers' Compensation Line," May 2013, available at www.ncci.com/NCCIMain/IndustryInformation/ResearchOutlook/Pages/default.aspx (click "News from Annual Issues Symposium 2013" then "Complete State of the Line Presentation from AIS 2013").

[4] "Benefits" in this report refers to monetary benefits, medical benefits and vocational rehabilitation benefits. "Costs" refers to the combined costs of these benefits and other costs such as insurer expenses.

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

[6] See Appendix C for more detail.

which cost growth exceeds (or falls short of) average wage growth.[7]

[7] 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 total number of paid claims dropped 48 percent relative to the number of full-time-equivalent (FTE) workers from 1997 to 2011 (Figure 2.1).
- The total cost of Minnesota's workers' compensation system relative to payroll was 20 percent lower in 2010 than in 1997 (Figure 2.2).
- In 2011, on a current-payment basis, the three largest components of total workers' compensation system cost were medical benefits (35 percent), insurer expenses (31 percent) and indemnity benefits other than vocational rehabilitation (29 percent) (Figure 2.3).
- Adjusting for average wage growth, medical benefits per insured claim rose 111 percent from 1997 to 2010 (the most recent year available) while indemnity benefits rose 40 percent. All of the increase for indemnity benefits occurred by 2003 (Figure 2.5).
- Relative to payroll, indemnity benefits were down 14 percent between 1997 and 2011, while medical benefits were about the same (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 2012 were down 29 percent from 1997 and 17 percent from 1998 (Figure 2.8).

Background

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

Workers' compensation benefits and claim types

Workers' compensation provides three basic types of benefits.

- ***Monetary benefits*** compensate the injured or ill worker (or dependents) for wage loss, permanent functional impairment or death. These benefits are often called ***"indemnity benefits."*** They are considered in detail in Chapter 3.
- ***Medical benefits*** consist of reasonable and necessary medical services and supplies related to the injury or illness.
- ***Vocational rehabilitation (VR) benefits*** consist of a variety of services to help eligible injured workers return to work. With very few exceptions, only workers receiving monetary benefits receive VR benefits. VR benefits are counted as indemnity benefits in insurance data but are counted separately in DLI data. They are considered in detail in Chapter 4.

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

Insurance arrangements

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 Minnesota 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 "advisory 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 (which are filed with the Department of Commerce).

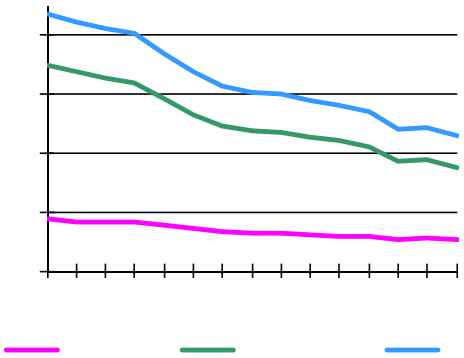
The pure premium rates are calculated from data for two to three years prior, which produces a lag between benefit trends and pure premium rate changes.

Claim rates

A starting point for understanding trends in the Minnesota workers' compensation system is the claim rate — the number of paid claims per 100 full-time-equivalent (FTE) workers. With one exception (for 2010), claim rates declined continually from 1997 to 2011.

- In 2011, there were:
  - 1.05 paid indemnity claims per 100 FTE workers, down 37 percent from 2000;
  - 3.5 paid medical-only claims per 100 FTE workers, down 45 percent from 2000; and
  - 4.6 total paid claims per 100 FTE workers, down 43 percent from 2000.
- The overall paid claim rate for 2011 was 48 percent below the rate for 1997.
- Since 1997, indemnity claims have made up 20 to 23 percent of all paid claims, while medical-only claims have constituted the remaining 77 to 80 percent.
- The dip in the claim rate between 2008 and 2009 coincides with the onset of the Great Recession.[8] Whether it was *caused* by that recession is uncertain.[9]
- Since 1997, the total claim rate has followed a similar trend to Minnesota's total reportable case rate from the Survey of Occupational Injuries and Illnesses.[10]

Figure 2.1 Paid claims per 100 full-time-equivalent workers, injury years 1997-2011 [1]



Injury year	Indemnity claims	Medical-only claims	Total claims
1997	1.74	7.0	8.7
2000	1.66	6.4	8.0
2007	1.19	4.4	5.6
2008	1.16	4.2	5.4
2009	1.07	3.7	4.8
2010	1.10	3.8	4.9
2011	1.05	3.5	4.6

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

- Because of the falling claim rate, the number of claims also fell. In 2011, there were 21,600 paid indemnity claims and 93,600 total paid claims, down 36 percent and 45 percent, respectively, from 1997.

[8] For 2006 to 2011, Minnesota's annual average unemployment rate was (as a percentage, by year) 4.1, 4.7, 5.4, 8.0, 7.4 and 6.5; for the same years, total unemployment-insurance-covered employment was (in millions) 2.68, 2.69, 2.68, 2.57, 2.56 and 2.60. Data from the Minnesota Department of Employment and Economic Development (www.positivelyminnesota.com).

[9] The literature has cited a number of ways in which an economic downturn may affect the claim rate. A downturn *may reduce* the claim rate because (1) lower production rates may lead to greater safety, (2) less-experienced (and more injury-prone) workers may be less often hired and more often laid off during a downturn and (3) injured workers who are employed may have a heightened fear of being laid off in response to filing a claim during a recession. However, a downturn *may increase* the claim rate if injured workers who have been laid off file a claim as a consequence (because of economic hardship or because lay-off is no longer a risk). See, for example, "Workers' Comp and the Business Cycle" (with editor's introduction) in *On Workers' Compensation*, vol. 3, issue 9, Nov. 1994.

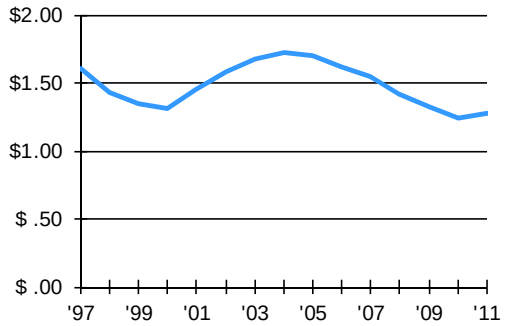
[10] This survey (the "SOII") is conducted jointly by state agencies and the U.S. Bureau of Labor Statistics. See www.dli.mn.gov/RS/DlisSaf1.asp for Minnesota injury and illness rates from SOII. See the *Minnesota Workplace Safety Report* (www.dli.mn.gov/RS/WorkplaceSafety.asp) for a description of the SOII itself.

System cost

The total cost of Minnesota's workers' compensation system per $100 of payroll has followed a cycle since 1997, with low-points reached in 2000 and 2010 and a slight increase for 2011.

- The total cost of the system was an estimated $1.28 per $100 of payroll in 2011, 20 percent less than in 1997 and slightly above the 2010 figure of $1.24.
- The total cost of workers' compensation in 2011 was an estimated $1.45 billion.
- These figures reflect benefits (indemnity, medical and vocational rehabilitation) plus other costs such as insurance brokerage, underwriting, claim adjustment, litigation, and taxes and assessments. They are computed primarily from actual premium for insured employers (adjusted for costs under deductible limits) and experience-modified pure premium for self-insured employers (see Appendix C).
- These figures partly reflect year-to-year changes in the cost of benefits and other expenses; however, they also reflect a nationwide insurance pricing cycle, in which the ratio of premium to insurance losses (e.g., workers' compensation benefits paid) varies over time.[11]

Figure 2.2 System cost per $100 of payroll, 1997-2011 [1]



	Cost per $100 of payroll
1997	$1.61
2000	1.31
2004	1.72
2007	1.55
2008	1.42
2009 [2]	1.32
2010 [2]	1.24
2011 [2]	1.28

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

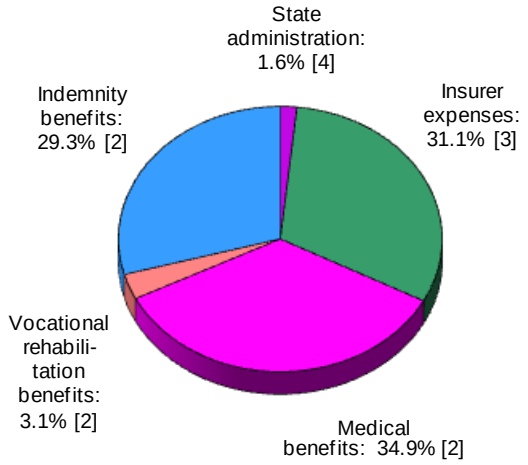
[11] One indicator of this pricing cycle is the nationwide ratio of employers' cost of workers' compensation insurance (primarily reflecting premium payments) to workers' compensation benefits paid, computed by the National Academy of Social Insurance (NASI). This ratio varied from 1.42 for 1993 to 1.21 for 1998 and 1999, 1.58 for 2006 and 1.23 for 2010 (*Workers' compensation coverage, benefits, and costs, 2010*, NASI, August 2012, www.nasi.org/sites/default/files/research/NASI_Workers_Comp_2010.pdf). See also National Council on Compensation Insurance, "State of the Workers' Compensation Line," May 2013, at www.ncci.com/NCCIMain/IndustryInformation/ResearchOutlook/Pages/default.aspx, "News from Annual Issues Symposium 2013" and "The Insurance Cycle Under the Microscope," Peter Rousmaniere, www.peterrousmaniere.com/mt/2006/04/the_insurance_cycle_under_the.html.

System cost components

The largest share of total workers' compensation system cost goes to medical benefits.

- In 2011, on a current-payment basis, medical benefits accounted for an estimated 35 percent of total system cost, followed by insurer expenses at 31 percent and indemnity benefits other than vocational rehabilitation at 29 percent.
- Total benefit payments accounted for 67 percent of total system cost.
- As shown in Figure 2.7, the medical share of total benefits has increased since 1997.
- As shown in Figure 3.8, state agency administrative cost has declined relative to payroll since 1997.

Figure 2.3 System cost components, 2011 [1]



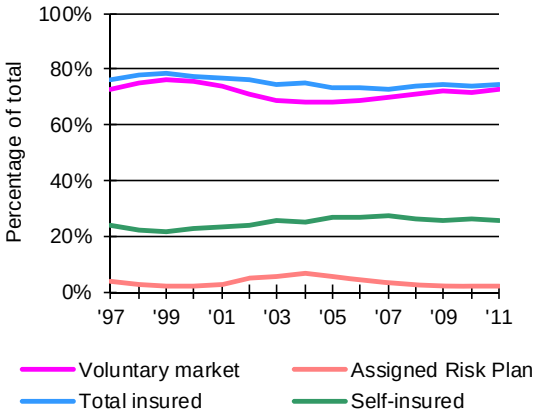
1. Estimated by DLI with data from several sources. These numbers are on a current payment basis, and therefore differ from others estimated on an injury year or policy year basis. Because these numbers follow a multi-year cycle, they are averaged over the most recent complete cycle (see Appendix C).
2. Indemnity and medical benefits include those reimbursed through DLI programs (including supplementary and second-injury benefits) and those paid through insurance guaranty entities (the Minnesota Insurance Guaranty Association and the Self-Insurers' Security Fund). Indemnity benefits include those claimant attorney costs that are paid out of indemnity benefits. Indemnity benefits here exclude vocational rehabilitation.
3. Includes underwriting, brokerage, claim adjustment, litigation, general operations, taxes, fees and profit. Litigation costs include defense attorney costs plus those claimant attorney costs that do not come out of indemnity benefits but are paid by the insurer. Excludes assessments on insurers and self-insurers because the benefits and state administration financed with those assessments are counted elsewhere in the figure.
4. Includes costs of workers' compensation functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the state share of the cost of Minnesota's OSHA compliance 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.

Insurance arrangements

The voluntary market has increased its share of the total workers' compensation market since the mid-2000s.

- The voluntary market share of paid indemnity claims was about 73 percent in 2011, an increase from the low-point of 68 percent in 2005 but down from 76 percent in 1999.
- The self-insured share has ranged from 25 to 27 percent since 2003; its low-point was 22 percent for 1999.
- The Assigned Risk Plan share fell from a high of 6.4 percent in 2004 to 1.9 percent in 2010 and 2.1 percent in 2011.
- 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 in the voluntary market tend to cause shifts in the opposite direction.
- These numbers have generally followed similar trends to those based on pure premium, but the two have diverged somewhat in the last few years.[12]

Figure 2.4 Market shares of different insurance arrangements as measured by paid indemnity claims, injury years 1997-2011 [1]



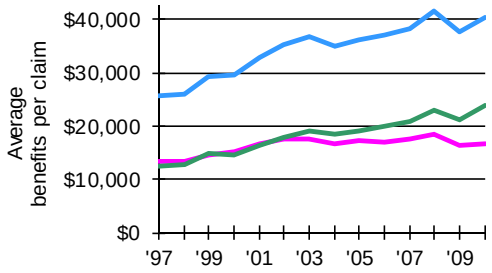
Injury year	Voluntary market	Assigned Risk Plan	Total insured	Self-insured
1997	72.7%	3.6%	76.3%	23.7%
1999	76.3	2.0	78.3	21.7
2004	68.4	6.4	74.7	25.3
2005	68.1	5.4	73.5	26.5
2007	70.0	3.0	73.0	27.0
2008	71.2	2.5	73.7	26.3
2009	72.1	2.1	74.2	25.8
2010	71.8	1.9	73.7	26.3
2011	72.5	2.1	74.6	25.4

1. Data from DLI.

[12] The pure premium figures used in this comparison are from the Minnesota Workers' Compensation Reinsurance Association. For 2005, the insured share of the market (including the ARP) stood at 73.5 percent by both measures; for 2011, the insured share was 74.6 percent with respect to indemnity claims and 70.3 percent with respect to pure premium.

Figure 2.5 Average indemnity and medical benefits per insured claim, adjusted for wage growth, policy years 1997-2010 [1]

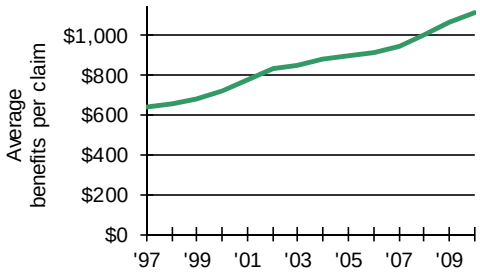
A: Indemnity claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$13,400	$12,300	$25,800
2003	17,600	19,200	36,700
2007	17,500	20,900	38,400
2008	18,600	23,000	41,600
2009	16,400	21,300	37,800
2010	16,500	23,800	40,400

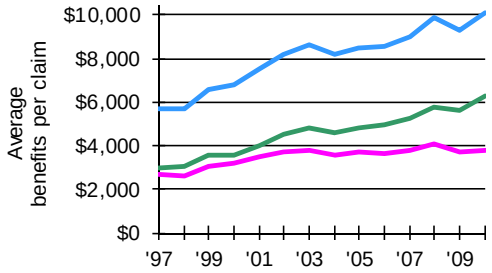
Indemnity [2] Medical Total

B: Medical-only claims



Policy year		Medical benefits	Total benefits
1997		$641	$641
2003		849	849
2007		949	949
2008		1,002	1,002
2009		1,065	1,065
2010		1,111	1,111

C: All claims



Policy year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$2,690	$2,980	$5,680
2003	3,800	4,810	8,610
2007	3,760	5,230	8,990
2008	4,040	5,800	9,840
2009	3,700	5,630	9,320
2010	3,770	6,290	10,070

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 2011. 2010 is the most recent year available. Statistics are developed to a greater maturity than in prior reports (see Appendix C).
2. Since these statistics are from insurance data, indemnity benefits include vocational rehabilitation benefits.

Benefits per claim

Adjusting for average wage growth, average medical benefits per insured claim rose rapidly between 1997 and 2003, but more slowly from 2003 to 2010. Indemnity benefits per claim also rose through 2003, but were stable from that point until 2010.

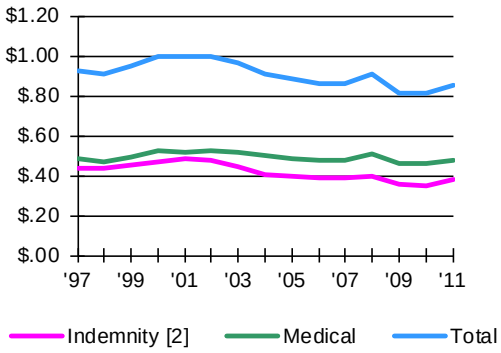
- For all claims combined, in 2010 relative to 2003:
  - average indemnity benefits were down 1 percent;
  - average medical benefits were up 31 percent; and
  - average total benefits were up 17 percent.
- For all claims combined, in 2010 relative to 1997:
  - average indemnity benefits were up 40 percent;
  - average medical benefits were up 111 percent; and
  - average total benefits were up 77 percent.

Benefits relative to payroll

Relative to payroll, medical benefits were about the same in 2011 as in 1997, but indemnity benefits were lower.

- Both indemnity and medical benefits rose relative to payroll from 1997 to 2000 or 2001, but fell thereafter.
- In 2011 compared to 1997, relative to payroll:
  - indemnity benefits were 14 percent lower;
  - medical benefits were about the same; and
  - total benefits were 7 percent lower.
- These changes are the net result of a decreasing claim rate (Figure 2.1) and higher indemnity and medical benefits per claim (Figure 2.5). The different trends in indemnity and medical benefits relative to payroll occur because medical benefits per claim have risen more than indemnity benefits per claim (Figure 2.5).

Figure 2.6 Benefits per $100 of payroll in the voluntary market, accident years 1997-2011 [1]



Accident year	Indemnity benefits [2]	Medical benefits	Total benefits
1997	$.44	$.48	$ .92
2000	.47	.52	1.00
2001	.48	.51	1.00
2002	.48	.52	1.00
2007	.39	.48	.86
2008	.40	.51	.91
2009	.36	.46	.82
2010	.35	.46	.81
2011	.38	.47	.85

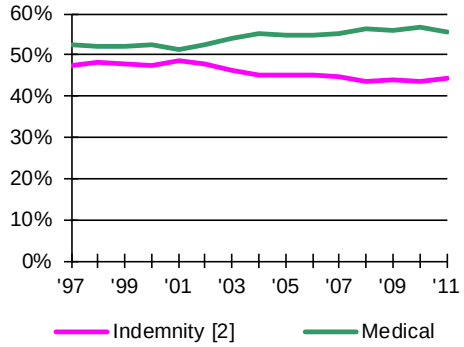
1. Developed statistics from MWCIA data (see Appendix C). Excludes self-insured employers, the Assigned Risk Plan and those benefits paid through DLI programs (including supplementary and second-injury benefits).
2. Includes vocational rehabilitation benefits.

Indemnity and medical shares

The medical share of total benefits rose between 1997 and 2011. 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 56 percent in 2011; and
  - indemnity benefits fell from 48 percent of total benefits to 44 percent during the same period.

Figure 2.7 Indemnity and medical benefit shares in the voluntary market, accident years 1997-2011 [1]



Accident year	Indemnity benefits [2]	Medical benefits
1997	47.6%	52.4%
2001	48.6	51.4
2007	44.9	55.1
2008	43.7	56.3
2009	44.0	56.0
2010	43.4	56.6
2011	44.4	55.6

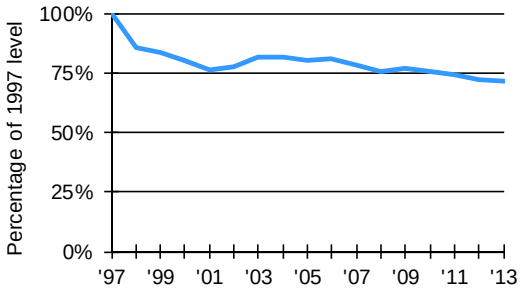
1. Note 1 in Figure 2.6 applies here.
2. Includes vocational rehabilitation benefits.

Pure premium rates

Pure premium rates have generally moved downward since 1997.

- Pure premium rates for 2013 were the lowest since 1997. The 2013 rates were down 29 percent from 1997 and 17 percent from 1998.[13]
- 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.[14]
- 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 2.8 Average pure premium rate as percentage of 1997 level, 1997-2013 [1]



Effective year	Percentage of 1997
1997	100.0%
1998	85.7
2001	76.1
2003	81.7
2009	77.1
2010	75.3
2011	74.0
2012	72.0
2013	71.4

1. Data from the MWCIA. Pure premium rates represent expected indemnity and medical losses per $100 of covered payroll in the voluntary market. The MWCIA computes the pure premium rates for each year ("effective year") from insurers' most recent pure premium and losses (see Appendix A for details).

[13] A "percent change" means the proportionate change in the initial percentage, not the number of percentage points of change. For example, a change from 10 percent to either 5 or 15 percent is a 50-percent change.

[14] Changes in pure premium rates directly following law changes also include anticipated effects of those law changes estimated by the Minnesota Workers' Compensation Insurers Association.

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.

This report does not present the total amount of indemnity benefits per claim from DLI data because of the possibility that a significant portion of stipulated benefits — the largest component of the total — may be medical benefits (see p. 16 and note 21).

Major findings

- The average duration of total disability benefits for 2011 was 46 percent longer than 1997 and about the same as for 2008; average temporary partial disability (TPD) showed relatively little change (Figure 3.3).

- After adjusting for average wage growth:

  - Stipulated benefits per paid indemnity claim rose 91 percent from 1997 to 2011 (Figure 3.6). This resulted from a 44-percent increase in the proportion of claims with stipulated benefits (Figure 3.2) and a 32-percent increase in the average amount of these benefits where they were paid (Figure 3.5).
  - Total disability benefits per paid indemnity claim rose 18 percent from 1997 to 2011 (Figure 3.6). This resulted from an increase in average total disability duration (Figure 3.3).
  - TPD benefits per paid indemnity claim fell 16 percent from 1997 to 2011 (Figure 3.6).
  - Permanent partial disability (PPD) benefits per paid indemnity claim fell 31 percent from 1997 to 2010 (Figure 3.6).[15] This occurred because, under the fixed PPD benefit schedule, PPD benefits became smaller relative to rising wages.[16]

- State agency administrative costs in 2011 amounted to about 2.2 cents per $100 of covered payroll, down from 3.9 cents in 1997 (Figure 3.8).[17]

Background

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

Benefit types

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

- ***Temporary partial disability (TPD)*** — A weekly wage-replacement benefit paid to an injured employee who has returned to work at less than 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.

[15] The PPD figure for 2011 is not yet available.

[16] The PPD benefit increase in the 2000 law change (see Appendix B) had a relatively small effect on this overall trend.

[17] Because of a revision in the computation formula, this number is less than in prior reports.

- ***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, medical and/or vocational rehabilitation benefits included 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.

- ***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.

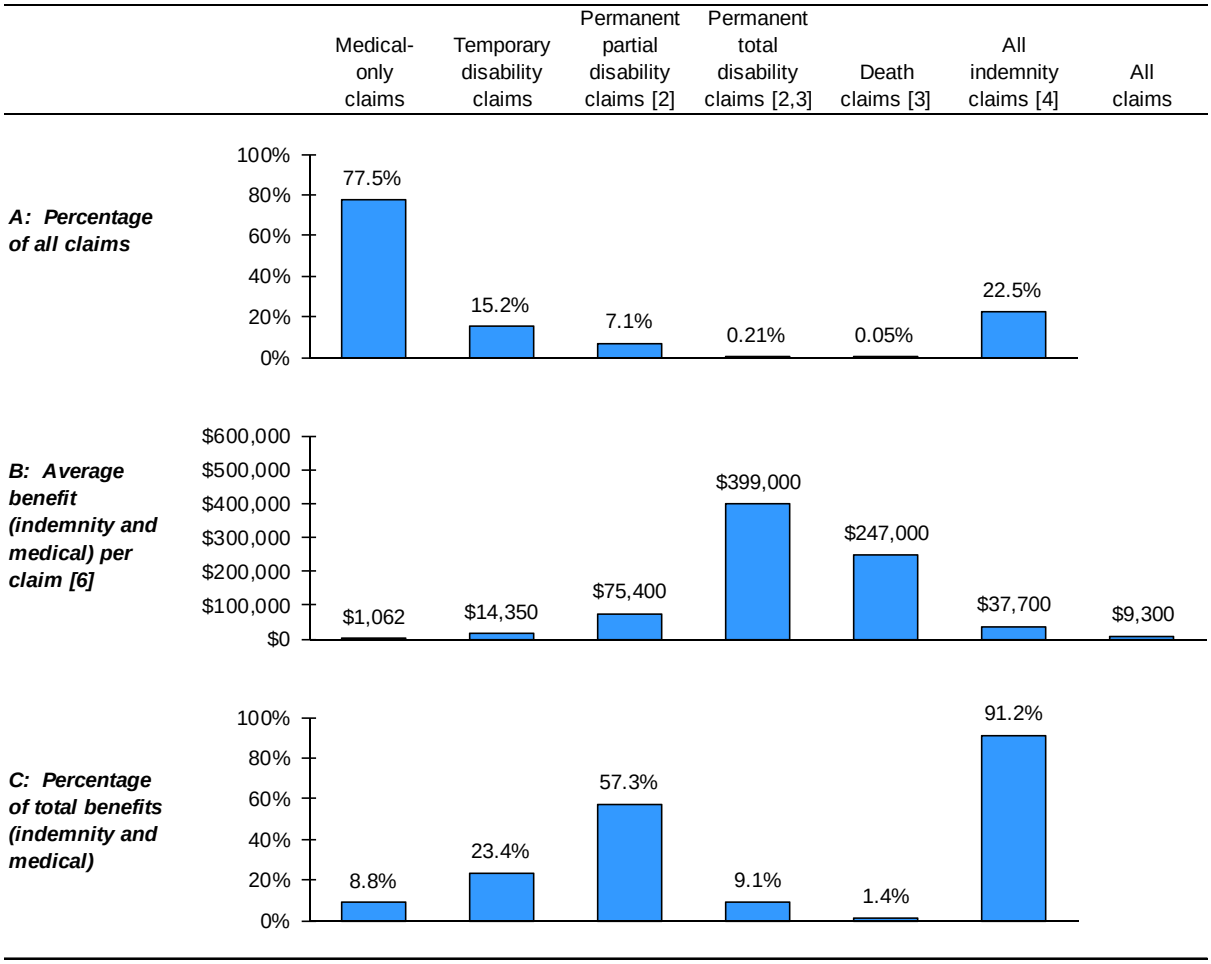
In the insurance data, claims and benefits are categorized by "claim type," defined according to the most severe type of benefit on the claim. In increasing severity, the benefit types are medical, temporary disability (TTD or TPD), PPD, PTD and death. For example, a claim with medical, TTD and PPD payments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

In the DLI data, by contrast with the insurance data, 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 Appendix A). The assessment (or benefits and administrative costs paid with the assessment) is included in total workers' compensation system cost (Figures 2.2 and 2.3).

Figure 3.1 Benefits by claim type for insured claims, policy year 2009 [1]



1. Developed statistics from MWCIA data (see Appendix C). 2009 is the most recent year available.
2. PPD claims here include any claims with stipulated settlements or with temporary disability lasting more than 130 weeks, in addition to claims with permanent partial disability.
3. Because of large annual fluctuations, data for PTD and death claims is averaged over 2005 to 2009 (see Appendix C).
4. Indemnity claims consist of all claim types other than medical-only.
5. Benefit amounts in panel B are adjusted for overall wage growth between 2009 and 2011.

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 in the introduction to this chapter (p. 12), 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 57 percent of total benefits in 2009 (panel C in Figure 3.1) 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).

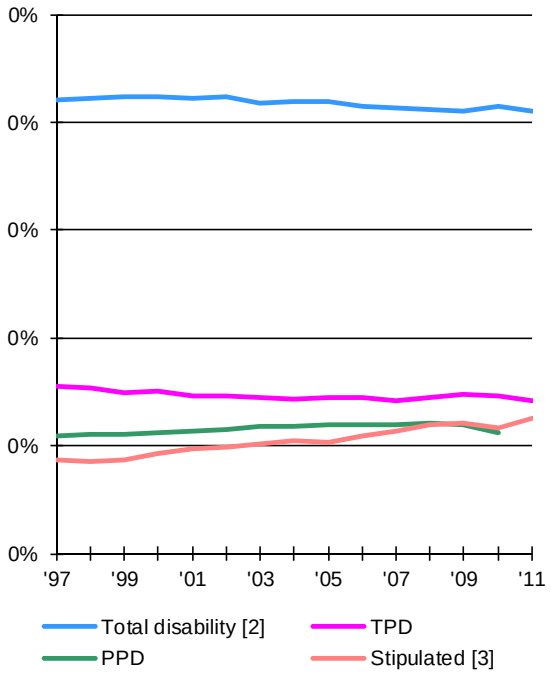
- Indemnity claims were 23 percent of all paid claims, but accounted for 91 percent of total benefits because they have far higher benefits on average than medical-only claims ($37,700 vs. $1,062 for 2009). Medical-only claims accounted for 77 percent of claims but only 9 percent of total benefits.

Claims by benefit type

Since 1997, the proportion of paid indemnity claims with stipulated benefits has increased significantly; the proportions of claims with other types of benefits have changed by smaller amounts.

- The percentage of claims with stipulated benefits rose about eight percentage points from 1997 to 2011. In proportionate terms, the increase for the overall period was 44 percent.[18] This is related to a similar increase in the dispute rate (Figure 5.1).
- The percentage of claims with total disability benefits fell about two percentage points during the overall period; the percentage with TPD benefits fell about three points.
- The percentage of claims with PPD benefits rose about two percentage points from 1997 to 2009, but showed a decrease for 2010.[19]

Figure 3.2 Percentages of paid indemnity claims with selected types of benefits, injury years 1997-2011 [1]



Injury year	Total disab.[2]	TPD	PPD	Stipu-lated [3]
1997	84.2%	30.9%	21.7%	17.4%
2007	82.7	28.2	23.9	22.6
2008	82.3	29.0	24.1	23.8
2009	82.0	29.5	23.9	24.1
2010	82.9	29.2	22.4	23.3
2011	82.1	28.3	[4]	25.0

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.
4. The PPD claim percentage for 2011 is not yet available.

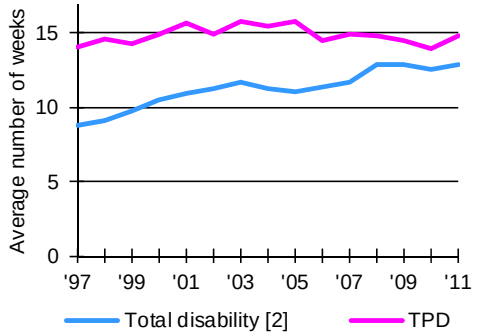
[18] See note 13 on p. 11.
[19] See note 4 in Figure 3.2.

Benefit duration

The average duration of total disability benefits rose significantly between 1997 and 2008, but has been stable since that time; the duration of TPD benefits has not showed a consistent trend.

- Total disability duration averaged 12.8 weeks for 2011, 46 percent above 1997. A majority of this increase occurred by 2003, and all of it by 2008.
- TPD duration averaged 14.8 weeks for 2011. The latter part of the 1997 to 2011 period shows about the same TPD duration as the earlier part.
- The data suggests the Great Recession affected total disability duration. The Minnesota unemployment rate began increasing in 2008 and peaked in 2009.[20] TPD duration, however, does not show a correlation with the recession.

Figure 3.3 Average duration of wage-replacement benefits, injury years 1997-2011 [1]



Injury year	Total disab. [2]	TPD
1997	8.8	14.1
2003	11.7	15.8
2007	11.6	14.9
2008	12.8	14.8
2009	12.9	14.5
2010	12.6	14.0
2011	12.8	14.8

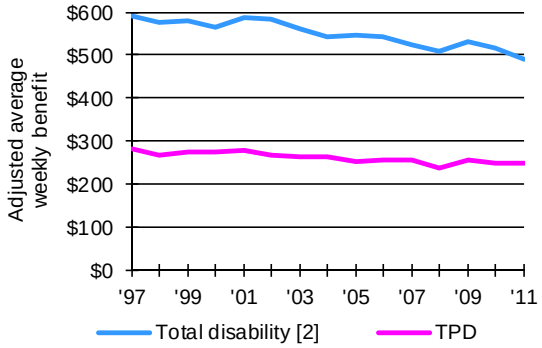
1. Developed statistics from DLI data (see Appendix C).
2. Total disability includes TTD and PTD.

Weekly benefits

After adjusting for average wage growth, average weekly total disability and TPD benefits decreased between 1997 and 2011.

- Adjusted average weekly total disability and TPD benefits, respectively, were down 17 and 13 percent from 1997.[21]
- The reported average pre-injury wage of injured workers (the primary basis for average weekly benefits) fell about 10 percent relative to the statewide average weekly wage from 1997 to 2010. This explains 56 percent of the estimated decrease in adjusted average weekly benefits for total disability and 76 percent for TPD.

Figure 3.4 Average weekly wage-replacement benefits, adjusted for wage growth, injury years 1997-2011 [1]



Injury year	Total disab. [2]	TPD
1997	$591	$284
2007	526	258
2008	508	240
2009	530	258
2010	516	250
2011	489	248

1. Developed statistics from DLI data. Benefit amounts are adjusted for average wage growth between the respective year and 2011. See Appendix C.
2. Total disability includes TTD and PTD.

[20] See note 8 on p. 5.

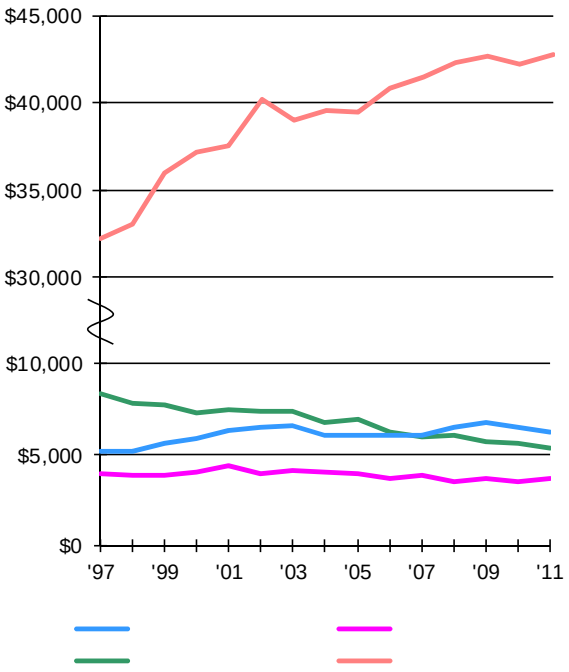
[21] *Unadjusted* average weekly benefits rose during the period examined, but less rapidly than the statewide average weekly wage (SAWW), causing *adjusted* average weekly benefits to decline as shown here.

Average benefits by type

Adjusting for average wage growth, average total disability and average stipulated benefits (per claim with the given benefit type) increased from 1997 to 2011, while average PPD and average TPD benefits fell.

- From 1997 to 2011, after adjusting for average wage growth:
  - average total disability benefits rose 21 percent;
  - average TPD benefits fell 8 percent;
  - average PPD benefits fell 35 percent; and
  - average stipulated benefits rose 32 percent.
- The increase in average total disability benefits occurred between 1997 and 2003.
- 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 2003 because of rising duration (with average weekly benefits falling proportionately less) and were little-changed after 2003 because of opposing trends in duration and average weekly benefits (Figures 3.3 and 3.4).
  - The slightly falling trend in average TPD benefits occurred because of falling average weekly benefits with relatively little change in duration (Figures 3.3 and 3.4).
- Adjusted average PPD benefits have fallen nearly continually since 1997. This has occurred primarily because the PPD benefit schedule is fixed in statute, apart from legislated changes. Under the fixed schedule, PPD benefits become smaller relative to rising wages, which is reflected in the adjusted average benefits. The only statutory increase during the period concerned was in the 2000 law change (see Appendix B), which produced a slight increase in average PPD benefits in 2001.[22]
- The large increase in average stipulated benefits is notable given the smaller increase in average total disability benefits and the decreases in TPD and PPD benefits. Stipulated benefits depend in part on the value of benefits the claimant might receive without a settlement. Since stipulated benefits may include medical and vocational rehabilitation (VR) benefits as well as indemnity benefits, and since VR benefits are relatively small, these trends suggest that settlements of some medical benefits may be playing a role in increasing stipulated benefits.[23]

Figure 3.5 Average benefit by type per claim with the given benefit type, adjusted for wage growth, injury years 1997-2011 [1]



Injury year	Total disability [2]	TPD	PPD	Stipulated [3]
1997	$5,180	$3,990	$8,360	$32,260
2007	6,120	3,860	6,030	41,490
2008	6,520	3,550	6,110	42,280
2009	6,820	3,740	5,760	42,710
2010	6,480	3,490	5,610	42,240
2011	6,270	3,670	5,400	42,730

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2011.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.

[22] The average PPD rating, which also affects average PPD benefits, varied somewhat during the period and was somewhat lower in 2011 than in 1997 (6.3 vs. 6.7 percent).

[23] Under current DLI protocols, insurers do not separate the indemnity, medical and vocational rehabilitation components of stipulation awards in their reporting to DLI (see note 3 in Figure 3.5). (Footnote continued on next page.)

Benefits by type per indemnity claim

Adjusting for average wage growth, average benefit amounts per paid indemnity claim showed widely different trends from 1997 to 2011: stipulated benefits rose more than 90 percent, total disability benefits increased by a smaller amount, and TPD and PPD benefits fell.

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

- After adjusting for average wage growth:
  - ➢ total disability benefits per indemnity claim were 18 percent higher in 2011 than in 1997, but all of the increase occurred by 2000;
  - ➢ TPD benefits per indemnity claim fell 16 percent from 1997 to 2011;
  - ➢ PPD benefits per indemnity claim fell 31 percent from 1997 to 2010;[24] and
  - ➢ stipulated benefits per indemnity claim rose 91 percent from 1997 to 2011.

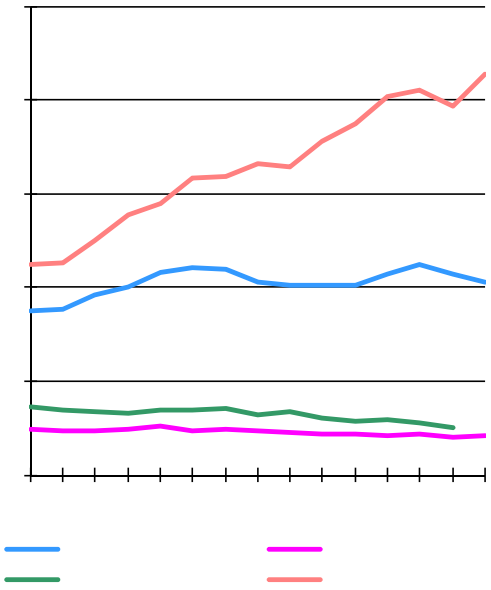
  The total amount of indemnity benefits per indemnity claim is not shown because of the possibility that a significant portion of stipulated benefits may be medical benefits (see previous page and note 23).

- The increase in total disability benefits per indemnity claim from 1997 to 2002 resulted from an increase in adjusted average total disability benefits per claim where these were paid (Figure 3.5), given the flat trend in the proportion of indemnity claims with these benefits for the same period (Figure 3.2).

- The decline in TPD benefits per indemnity claim is attributable to declines in the percentage of indemnity claims with these benefits (Figure 3.2) and in adjusted average TPD benefits where these were paid (Figure 3.5).

- The decline in average PPD benefits per indemnity claim resulted from a decrease in adjusted average PPD benefits where these were paid (Figure 3.5), given the slight increase in the percentage of claims with these benefits (Figure 3.2).

Figure 3.6 Average benefit by type per paid indemnity claim, adjusted for wage growth, injury years 1997-2011 [1]



Injury year	Total disabilty [2]	TPD	PPD	Stipulated [3]
1997	$4,360	$1,230	$1,810	$5,610
2002	5,530	1,160	1,710	7,910
2007	5,060	1,090	1,440	9,380
2008	5,370	1,030	1,470	10,080
2009	5,590	1,100	1,380	10,270
2010	5,370	1,020	1,260	9,850
2011	5,150	1,040	[4]	10,700

1. Developed statistics from DLI data (see Appendix C). Benefit amounts are adjusted for average wage growth between the respective year and 2011.
2. Total disability includes TTD and PTD.
3. Includes indemnity, medical and vocational rehabilitation components.
4. The PPD amount for 2011 is not yet available.

Another factor supporting the possibility of an increasing role of medical benefits in stipulated settlements is that, as shown in Figure 5.1, while all dispute rates rose during the past 13 years in varying degrees, the medical request dispute rate rose significantly faster than the others. It also rose faster than the others from 2005 to 2011 (29 percent vs. 8 to 22 percent). Settlements rarely close out all medical benefits, but they often close out certain types of these benefits. In a large sample of medical request disputes filed in 2003 and 2007, 21 percent of the 2003 disputes and 19 percent of the 2007 disputes ended with awards on stipulation. (These disputes were part of a larger dispute issue tracking study conducted by DLI Research and Statistics between 2006 and 2010. The 2003 percentage is reported in "Minnesota Workers' Compensation Dispute Issue Tracking Study: Report 1," May 2009, available at www.dli.mn.gov/RS/ WcDispTrack.asp.)

[24] See note 4 in Figure 3.6.

- The increase in stipulated benefits per indemnity claim resulted from an increase in the proportion of claims with these benefits (Figure 3.2) and an increase in adjusted average stipulated benefits where they were paid (Figure 3.5).

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 45 percent during the next 10 years and to disappear by 2053.

- The 2013 projected cost of $48 million consists of roughly $38 million for supplementary benefits and $10 million for second injuries.
- Without settlements, supplementary benefit claims are projected to continue until 2053 and second-injury claims until 2041.
- Claim settlements will reduce future projections of these liabilities. Settlements amounted to $3.8 million in fiscal year 2012.
- The total cost of supplementary and second-injury benefits for 2012, including settlements, amounted to 3.5 percent of total workers' compensation system cost.[25]

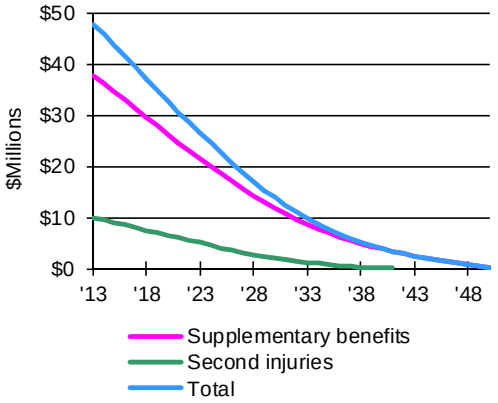
State agency administrative cost

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

- In fiscal year 2011, state agency administrative cost (see note in Figure 3.8) came to 2.2 cents per $100 of payroll.
- Administrative cost for 2011 was about $24 million. As indicated in Figure 2.3, state administration accounts for about 1.6 percent of total workers' compensation system cost.

[25] This percentage was calculated with techniques similar to those for Figure 2.3 to reduce the effects of annual fluctuations in system cost.

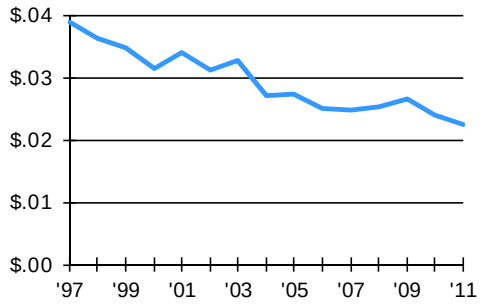
Figure 3.7 Projected cost of supplementary benefit and second-injury reimbursement claims, fiscal claim-receipt years 2013-2050 [1]



Fiscal year of claim receipt	Projected amount claimed ($millions) Supplementary benefits	Second injuries	Total
2013	$37.8	$10.0	$47.8
2018	29.5	7.5	37.0
2023	21.5	5.0	26.5
2031	10.6	1.7	12.3
2050	.3	.0	.3

1. Projected from DLI data, assuming no future settlement activity. See Appendix A for definitions.

Figure 3.8 Net state agency administrative cost per $100 of payroll, fiscal years 1997-2011 [1]



Fiscal year	State agency admin. cost per $100 of payroll
1997	$.039
2007	.025
2008	.025
2009	.026
2010	.024
2011	.022

1. Data from DLI, MWCIA and WCRA. Includes costs of workers' compensation administrative functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the state share of the cost of Minnesota's OSHA compliance program, beyond what is paid from revenues other than the Special Compensation Fund assessment. Estimated as described in Appendix C.

4

Vocational rehabilitation

This chapter provides data about vocational rehabilitation (VR) services in Minnesota's workers' compensation system. With the exception of the VR participation rate, the VR data only goes back to 1998.

Major findings

- Participation in vocational rehabilitation rose from 15 percent of paid indemnity claims for injury year 1997 to 24 percent for 2011 (Figure 4.1).
- After adjusting for average wage growth, the average cost of VR services was 22 percent higher for injury year 2011 ($8,830) than for 1998, but about the same as for 2002 (Figure 4.3). VR services account for an estimated 3.1 percent of total workers' compensation system cost (Figure 2.3).
- The percentage of VR plans closed because of plan completion fell from 61 percent for 1998 to 45 percent for 2011; during the same period, the percentage of closures resulting from claim settlement or agreement of the parties increased from 36 percent to 50 percent. A return to work is reported for most participants who complete their plans, but for only a minority of those who do not (Figure 4.7).
- The percentage of VR participants with a job reported at plan closure decreased from 72 percent for injury year 1998 to 55 percent for 2011 (Figure 4.8).
- The return-to-work wage of VR participants varies widely relative to their pre-injury wage (Figure 4.10). Between injury years 1998 and 2011, the average return-to-work wage fell from 89 to 79 percent of the pre-injury wage for those going to a different employer (with all of the decrease occurring by 2003), but stayed near 100 percent for those returning to their pre-injury employer (Figure 4.11).

Background

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

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

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 or causation 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. Any annual increases in hourly charges through 2012 were limited to the lesser of the percent increase in the statewide average weekly wage (SAWW) or 2 percent.

The maximum hourly fee levels for QRCs and for job development and placement services, effective Oct. 1, 2011, through Sept. 30, 2012, were $94.68 and $71.87, respectively. These rates increased to $96.57 and $73.31, respectively, for Oct. 1, 2012, through Sept. 30, 2013.

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. Reported results may change in subsequent reports because of newer plan closure filings.

As in other chapters, all trend statistics in this chapter are by injury year and are developed as described in Appendix C. Results reported by closure year are not developed.

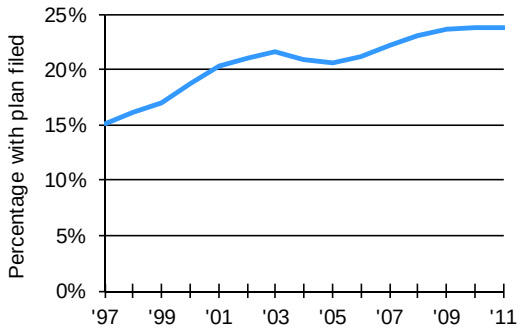
With the exception of the VR participation rate, the VR data only goes back to 1998.

Participation

VR participation increased substantially from 1997 to 2011.

- The VR participation rate — the percentage of paid indemnity claims with a VR plan filed — increased from 15 percent in 1997 to 24 percent in 2011.
- The participation rate remained between 23 and 24 percent from 2008 to 2011.
- An estimated 5,000 workers injured in 2011 are expected to receive VR services (some of these people have not yet begun services).
- The increase in the VR participation rate between 2005 and 2009 coincides with the Great Recession; however, it is uncertain to what degree the recession has affected VR participation.[26]

Figure 4.1 Percentage of paid indemnity claims with a VR plan filed, injury years 1997-2011 [1]



Injury year	Percentage with plan
1997	15.3%
2007	22.1
2008	23.0
2009	23.7
2010	23.7
2011	23.8

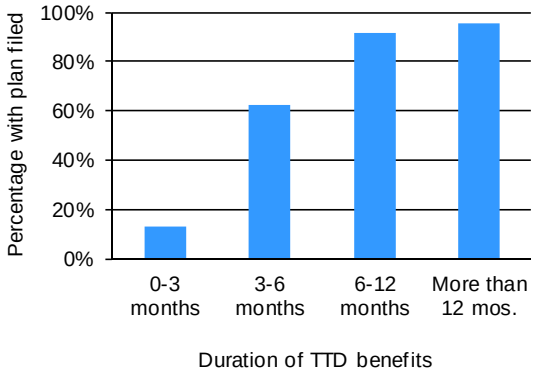
1. Developed statistics from DLI data (see Appendix C).

Participation and injury severity

VR participation varies with injury severity as measured by the amount of time the injured worker has been off the job and by the worker's degree of permanent partial disability.

- For paid indemnity claimants injured from 2008 to 2010:
  - VR participation ranged from 13 percent for workers with no more than three months of TTD benefits to 95 percent for workers with more than 12 months of TTD benefits; and
  - VR participation ranged from 18 percent for workers without PPD benefits to 79 percent for workers with PPD ratings of 20 percent or more (no figure shown).

Figure 4.2 Percentage of paid indemnity claims with a VR plan filed by TTD duration, injury years 2008-2010 combined [1]



1. Data from DLI.

[26] See note 8 on p. 5. Since the statistics here are by year of injury, the recession could affect claim duration for workers injured before it began, and could therefore affect VR participation for those years.

Cost

Adjusted for average wage growth, the estimated average cost of VR services was substantially higher for 2011 than for 1998.

- The adjusted average service cost per participant was 22 percent higher for injury year 2011 than for 1998; the median was 28 percent higher. The 2011 average service cost was about the same as 2002.
- The total cost of VR services for injury year 2011 was an estimated $44 million. As shown in Figure 2.3, VR service costs account for an estimated 3.1 percent of total workers' compensation system cost.[27]
- Average VR service cost per indemnity claim (counting claims with and without plans) was $2,100 for 2011, an increase of 80 percent from 1998. Most of this increase took place by 2002. These changes reflect the trends in the participation rate (Figure 4.1) and average service cost (Figure 4.3).
- Among plans closed in 2011, 72 percent of total cost was for QRC services other than job development and placement, 28 percent was for job development and placement (14 percent by QRCs, 14 percent by outside vendors) and one percent was for other items (including mileage, supplies and tuition for retraining).

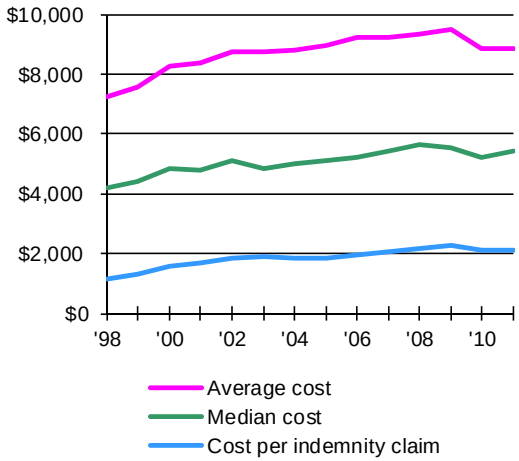
Cost and injury severity

VR service cost increases with injury severity as measured by PPD rating.

- For plan-closure years 2009 to 2011 combined, participants with higher PPD ratings had progressively higher VR costs. For PPD ratings of 20 percent or more, the average cost of VR services was more than double the cost for PPD ratings of one to five percent.

[27] The percentages in Figure 2.3 are calculated in a way that reduces the effects of annual fluctuations in system cost (see Appendix C).

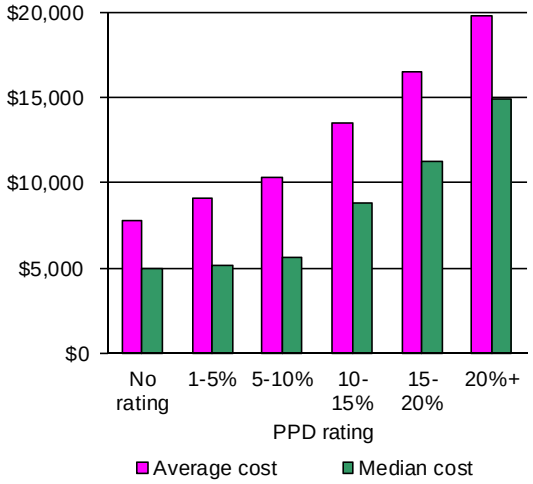
Figure 4.3 VR service costs, adjusted for wage growth, injury years 1998-2011 [1]



Injury year	Average cost	Median cost	Cost per indemnity claim
1998	$7,220	$4,220	$1,170
2002	8,740	5,100	1,830
2006	9,210	5,230	1,940
2007	9,250	5,430	2,050
2008	9,320	5,620	2,140
2009	9,500	5,530	2,250
2010	8,870	5,230	2,100
2011	8,830	5,410	2,100

1. Developed statistics from DLI data. Costs are adjusted for average wage growth between the respective year and 2011.

Figure 4.4 VR service cost by PPD rating, adjusted for wage growth, plan-closure years 2009-2011 combined [1]



1. Data from DLI. Plan-closure years 2009 to 2011 are used to provide enough cases for statistical reliability in all categories. Costs are adjusted for average wage growth between the year of injury and 2011.

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 from 1998 to 2002, but has changed relatively little since then.

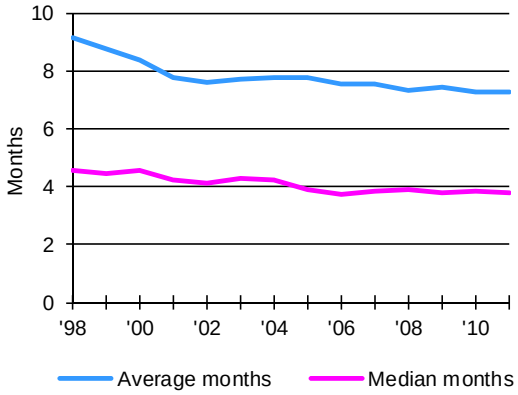
- The average time from injury to the start of VR services was 7.3 months for injury year 2011, down 20 percent from 1998 but only 0.3 months less than 2002; the median time fell 16 percent from 1998 to 2011.
- Among plans closed in 2011, 36 percent of service starts were within three months of the date of injury and 61 percent were within six months.
- Among VR participants whose plans closed in 2011, those who began services within three months of injury, as compared to those beginning more than one year after their injury, had:
  - lower service costs by 41 percent ($8,190 vs. $13,800);
  - shorter service durations by 29 percent (12.7 months vs. 17.9 months); and
  - higher chances of returning to work (61 percent vs. 56 percent).

Service duration

VR service duration has increased since 1998.

- Average duration was an estimated 13.8 months for injury year 2011; median duration was 9.5 months. These figures were more than a month higher than for 2003, which was about the same as 1998.
- Service duration for 2008 through 2011 was greater than in the years just prior to 2008, suggesting an effect from the Great Recession.
- Among plan closures in 2011, average service duration was shortest for participants who returned to work with their pre-injury employer (9.3 months); it was longest for those who went to a different employer (19.1 months) or had their plans closed before returning to work (16.8 months).

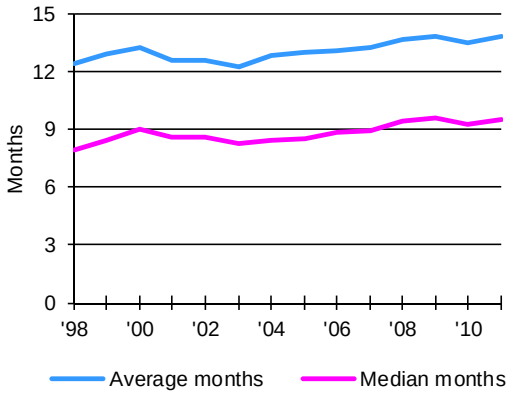
Figure 4.5 Time from injury to start of VR services, injury years 1998-2011 [1]



Injury year	Average months	Median months
1998	9.1	4.5
2002	7.6	4.1
2007	7.5	3.8
2008	7.3	3.9
2009	7.4	3.8
2010	7.3	3.8
2011	7.3	3.8

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

Figure 4.6 VR service duration, injury years 1998-2011 [1]



Injury year	Average months	Median months
1998	12.4	8.0
2003	12.2	8.2
2007	13.2	8.9
2008	13.7	9.4
2009	13.8	9.6
2010	13.4	9.2
2011	13.8	9.5

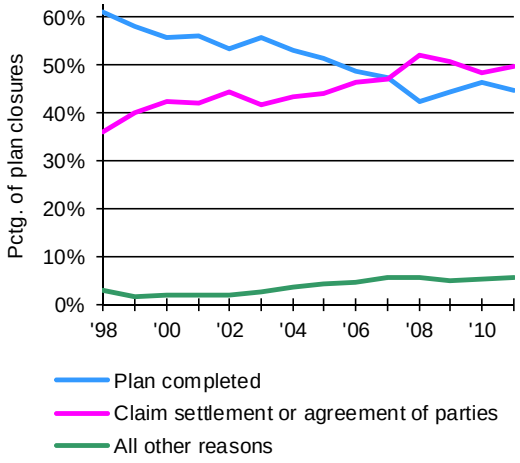
1. Developed statistics from DLI data (see Appendix C).

Reason for plan closure

The percentage of VR plans closed because of plan completion has fallen substantially since 1998, while the percentage closed because of claim settlement or agreement of the parties has increased by almost the same amount.

- The proportion of VR plans closed because they were completed fell from 61 percent in 1998 to 45 percent in 2011. During the same period, the proportion of plans closed by claim settlement or agreement of the parties grew from 36 percent to 50 percent.
  - ➢ The proportion of plans closed because of completion bears almost an exact inverse relationship to the proportion closed because of settlement or agreement of the parties.
- The increased proportion of VR plans closed because of claim settlement or agreement of the parties is to be expected given the increase in the percentage of paid indemnity claims with stipulated settlements (Figure 3.2).
- A return to work is reported for most participants who complete their plans (98 percent for 2011), but for only a minority of those who do not (whose plans close for any other reason) (22 percent). It is uncertain to what degree plan completion actually contributes to the participant's likelihood of having a job at plan closure.[28]
- Plan costs vary by reason for closure: for closures in 2011, costs averaged $6,280 for completed plans, $12,740 for plans closed by settlement and agreement; and $10,220 for plans closed for other reasons.

Figure 4.7 Reason for plan closure, injury years 1998-2011 [1]



Injury year	Plan completed	Claim settlement or agreement of parties	All other reasons [2]
1998	61.0%	36.1%	2.9%
2007	47.4	47.1	5.5
2008	42.3	52.2	5.4
2009	44.3	50.8	4.8
2010	46.3	48.5	5.2
2011	44.8	49.6	5.6

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 through July 2005 were coded as due to decision-and-orders or agreement of the parties. None of the subcategories of "all other reasons" accounted for more than 3 percent of closures in this category in any year.

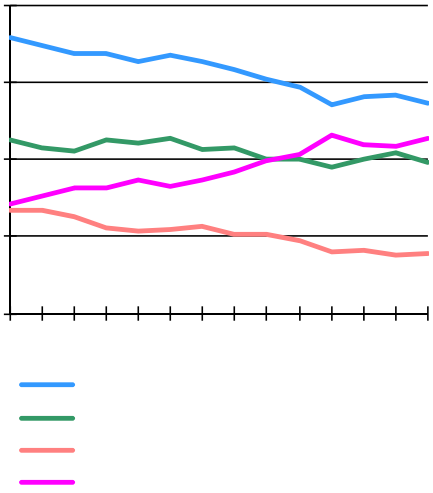
[28] Completing a plan may lead to job placement, or job placement may lead the QRC to deem the plan completed. Also, a return to work may be less likely to be reported if the plan closes for reasons other than completion (e.g., claim settlement or agreement of the parties).

Return-to-work status

The goal of VR is to return injured workers to appropriate employment. Return to work is affected by many factors, including VR services, the job market, injury severity, availability of job modifications and claim litigation. The estimated percentage of VR participants with a job reported at plan closure fell substantially between 1998 and 2011, although 2011 represented a slight increase from the low-point reached in 2008.[29]

- The estimated percentage of VR participants with a job reported at plan closure fell from 72 percent in 1998 to 55 percent in 2011. This decline had two components:
  - the percentage with a job at their pre-injury employer fell from 45 percent to 39 percent; and
  - the percentage with a job at a different employer fell from 27 percent to 15 percent.
- The percentage of participants with a job reported at plan closure almost exactly parallels the percentage of plans closed because of completion (Figure 4.7). This is expected since, as indicated on the previous page, a job is reported at closure for almost all who complete their plans but for only a minority of others. Again, the reason for the correlation between plan completion and having a job reported at plan closure is uncertain.[30]
- The percentage of participants with a job reported at plan closure reached a low-point for 2008 claims and recovered somewhat in the following years. This may be partly due to the Great Recession.[31] This is uncertain, however, because of the previously described interplay among reported job placement, plan completion, and plan closure by reason of claim settlement.

Figure 4.8 Return-to-work status, injury years 1998-2011 [1]



Injury year	Job reported [2]			Job not reported [2]
	With same employer	With different employer	Total with job reported	
1998	44.9%	26.6%	71.5%	28.5%
2007	39.9	18.9	58.8	41.2
2008	38.1	15.9	54.0	46.0
2009	40.0	16.2	56.2	43.8
2010	41.5	15.0	56.5	43.5
2011	39.1	15.4	54.5	45.5

1. Developed statistics from DLI data (see Appendix C).
2. See note 26 in text.

- For plan closures in 2011, the average cost of VR services for participants returning to work with their pre-injury employer ($5,160) was less than half the cost for those going to a different employer ($14,290) and for those not returning to work ($12,000).

[29] The term "reported" is used to emphasize that the available information about whether the VR participant has a job at plan closure is what the QRC reports to DLI. Especially where the plan closes for reasons other than completion (e.g., claim settlement), the participant may have a job without this being known and reported by the QRC.

Since these are "developed statistics," the term "reported" should be taken to mean "projected to be reported when all claims are mature" (see Appendix C).

[30] See note 28 on previous page.

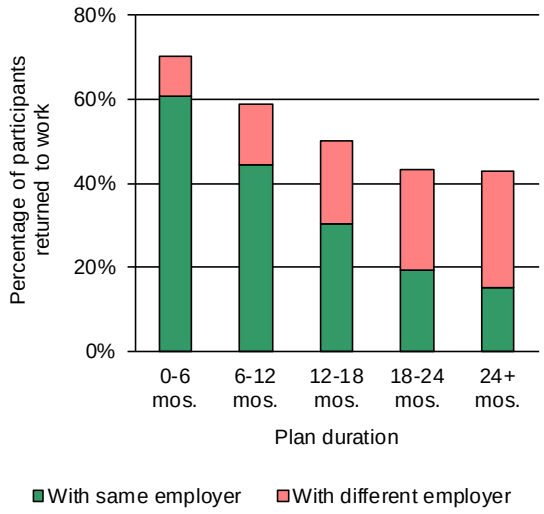
[31] See note 8 on p. 5.

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 2009 to 2011 combined, the percentage of participants who had returned to work ranged from 69 percent for plans lasting no more than six months to 43 percent for plans lasting 24 months or more.
- The percentage of participants returning to their pre-injury employer ranged from 61 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 10 percent for the shortest plans to 28 percent for the longest plans.
- After the 18-month mark in plan duration, the majority of workers who return to work return to a different employer.

Figure 4.9 Return-to-work status by plan duration, plan-closure years 2009-2011 combined [1]



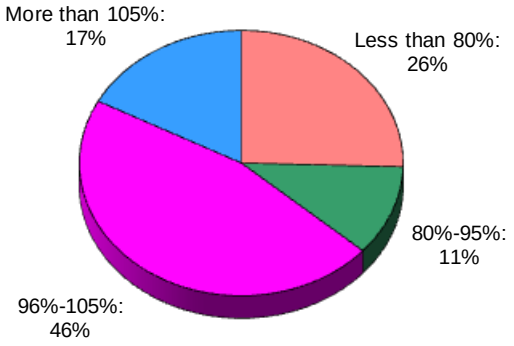
1. Data from DLI.

Return-to-work wages: distribution

For VR participants returning to work, the return-to-work wage on average is somewhat less than the pre-injury wage, but this varies widely.

- For plan closures in 2009 to 2011 combined, 63 percent of VR participants returning to work earned at least 96 percent of their pre-injury wage, but 26 percent earned less than 80 percent.
- Return-to-work wage experience varies widely with the amount of time worked in the pre-injury job. For example, workers returning to jobs paying at least 96 percent of their pre-injury wage made up 68 percent of returnees with more than five years of job tenure, compared to 55 percent of those with less than three months.
- Return-to-work wage experience also varies with plan duration. For 2009 to 2011 closures, the average return-to-work wage ratio was 98 percent for VR plans of less than 12 months of duration, 89 percent for plans between 12 and 18 months, but only 77 percent for plans with longer service durations.

Figure 4.10 Ratio of return-to-work wage to pre-injury wage for participants returning to work, plan-closure years 2009-2011 combined [1]



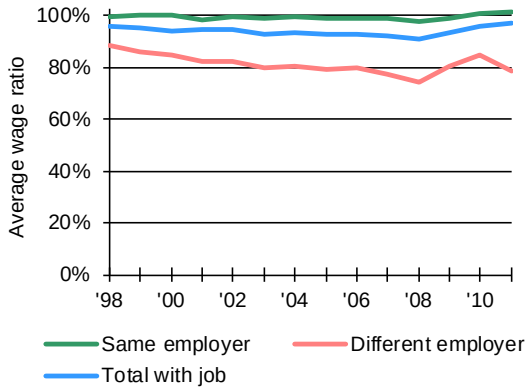
1. Data from DLI.

Return-to-work wages: trend

Among VR participants returning to work at plan completion, the ratio of the return-to-work wage to the pre-injury wage changed little between 1998 and 2011 for those returning to their pre-injury employer, but declined for those going to a different employer.

- For workers returning to their pre-injury employer, the average wage ratio stayed near 100 percent.
- For workers going to a different employer, the ratio stood at 79 percent for closures in 2011; this was less than the 89 percent for 1998 but about the same as 2003.
- For all returnees, the average wage ratio of 97 percent represented an increase from the low-point of 91 percent for 2008 and was slightly above 1998.

Figure 4.11 Average ratio of return-to-work wage to pre-injury wage by employer type, injury years 1998-2011 [1]



Injury year	Average ratio of return-to-work wage to pre-injury wage		
	Same employer	Different employer	Total with job
1998	99.7%	88.5%	95.7%
2003	99.1	79.7	92.7
2007	98.9	77.3	92.3
2008	97.5	74.5	90.9
2009	98.8	80.5	93.5
2010	100.9	84.8	96.1
2011	101.6	78.7	97.4

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

5

Disputes and dispute resolution

This chapter presents data about workers' compensation disputes and dispute resolution. Statistics that are on a basis *other than* year of injury (e.g., year of dispute filing) are presented through 2012 because such statistics are already mature and do not need to be "developed" (projected to full maturity).[32]

Major findings

- The overall dispute rate increased from 15.5 percent of filed indemnity claims in 1997 to 22.0 percent in 2011, a 42-percent increase.[33] Leading the way were medical disputes (up 89 percent) and vocational rehabilitation disputes (up 60 percent). The medical, vocational rehabilitation and discontinuance dispute rates stabilized during the most recent three to four years, but the rate of claim petitions continued to increase (Figure 5.1).

- The percentage of paid indemnity claims with claimant attorney involvement rose from 16.9 percent for 1997 to 24.8 percent for 2011, a 46-percent increase (Figure 5.2).[34]

- Total claimant attorney fees are estimated at $51 million for injury year 2011.[35] These fees account for an estimated 3.2 percent of total workers' compensation system cost.

- The rate of denial of filed indemnity claims was 12.3 percent for 2011, down from 15.8 percent for 1997. The decrease took place primarily from 2004 to 2007. This coincided with a step-up in DLI's denial review process, in which the agency requires that insurers clearly indicate their reasons for claim denials in a manner compliant with statute and rule. The stepped-up enforcement remains in effect (Figure 5.3).

- The total number of filed disputes fell 19 percent from 1997 to 2012. This occurred, despite the increased dispute rate, because of falling numbers of claims (Figures 2.1 and 5.6).

- At DLI:
  - Between 1999 and 2012, the percentage of medical and vocational rehabilitation disputes that were certified dropped from 66 to 48 percent (Figure 5.7).[36]
  - Resolutions by agreement of the parties (usually through informal intervention) accounted for 83 percent of all resolutions in 2012. This was a decrease from 87 percent for 1999, but an increase from 77 percent for 2007. Resolutions by decision-and-order accounted for 17 percent of the resolutions for 2012 (Figures 5.9 and 5.10).

- At the Office of Administrative Hearings, the numbers of administrative conference decisions (for medical and rehabilitation disputes and for discontinuance disputes), findings-and-orders, and awards on stipulation have all fallen since 2003. This to a large degree reflects falling numbers of disputes (Figure 5.12); where medical disputes are concerned, it also reflects the 2005 law change that raised the monetary threshold for OAH jurisdiction in these disputes.

[32] See "Developed statistics" on p. 1.

[33] See note 13 on p. 11.

[34] A claimant attorney is deemed to be involved if there are claimant attorney fees. For this purpose, prior reports only considered those attorney fees that are paid out of indemnity benefits. This and future reports consider all claimant attorney fees, so the degree of attorney involvement and total attorney fees are shown to be somewhat higher than in prior reports.

[35] See note 34.

[36] See description of DLI dispute certification process on p. 32.

- At the Workers' Compensation Court of Appeals, the number of cases received on appeal from OAH decision-and-orders fell by 61 percent from fiscal year 1997 to 2011 (Figure 5.13).

Background

The following basic information is necessary for understanding the figures in this chapter. See the glossary in 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. [37]

The injured worker and the insurer may disagree about whether the benefit or service should be provided, the level at which it should be provided or how long it should continue. Often, the disagreement is about whether the worker's claimed injury, medical condition or disability is work-related (see "primary liability" and "causation" in Appendix A). Disputes may also occur about payment for a service already provided. Payment disputes typically involve a medical or vocational rehabilitation provider and the insurer, and may also involve the injured worker.

Counting disputes

Four "dispute" categories are used in this report.

Claim petition disputes — Disputes about primary liability and monetary benefit issues are typically filed on a claim petition, which triggers a formal hearing or settlement conference at the Office of Administrative Hearings (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 if 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) if DLI certifies the dispute.

Many disputes are resolved through informal intervention by DLI (see below). This often occurs before the point where one of the parties would officially file the dispute in one of the above categories. In this event, the dispute is not tracked as such in the DLI database; however, the related DLI dispute resolution activity is recorded (and related statistics are presented in this chapter).

Dispute resolution

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

Dispute resolution at the Department of Labor and Industry

DLI carries out a variety of dispute-resolution activities.

Informal intervention — Through informal intervention, DLI provides information and assistance to the claim parties and communicates with them to resolve potential and actual disputes at an early stage and/or determine whether a dispute should be certified (see

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

below). Informal intervention is often initiated when a party, usually a claimant, medical provider or vocational rehabilitation provider, contacts DLI because they have had difficulty obtaining a workers' compensation benefit or service or payment for it. Resolution through informal intervention may occur before, during or after the dispute certification 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.[38] The certification process is triggered by either a certification request or a medical or rehabilitation request. DLI specialists attempt to resolve the dispute informally during the certification process.

Mediation — If the parties agree to participate, a DLI specialist conducts a mediation to seek agreement on the issues. Any type of dispute is eligible. A DLI mediation agreement is usually recorded in a "mediation award," but may be incorporated into a stipulation for settlement and submitted to OAH for approval via an award on stipulation.

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.[39] 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 at the Office of Administrative Hearings

OAH performs the following dispute-resolution activities.

Mediation — If the parties agree to participate, OAH offers mediation to seek agreement on the issues. Any type of dispute is eligible. An OAH mediation agreement is usually recorded in a stipulation for settlement and submitted to an OAH judge for approval via an award on stipulation, but the agreement is sometimes recorded in a "mediation award" issued by an OAH judge.

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

Administrative conference — With some exceptions, OAH conducts administrative conferences 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.[40] If agreement is not reached at the conference, the OAH judge issues a decision-and-order. A party may appeal an OAH decision-and-order by requesting a *de novo* formal hearing at OAH.

Formal hearing — OAH conducts formal hearings 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

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

[39] Minnesota Statutes §176.106. The 2005 Legislature increased the monetary limit on DLI jurisdiction in medical disputes from $1,500 to $7,500. (The 2013 legislature removed this limit for certain types of disputes, but that does not affect the statistics in this report.) 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.

[40] Minnesota Statutes §176.239.

consolidation, discontinuance disputes where the parties have requested a hearing and disputes about miscellaneous issues such as attorney fees. OAH also conducts *de novo* hearings when a party files a request for hearing to appeal an administrative-conference decision-and-order from DLI or OAH. If the parties do not reach agreement, the judge issues a "findings-and-order."

Dispute resolution by the parties

Often, the parties in a dispute reach agreement outside of the dispute-resolution process at DLI or OAH, although this is often spurred by DLI or OAH initiatives, such as 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. An award on stipulation may occur in any type of dispute, but occurs most commonly in claim petition disputes.

Dispute rates

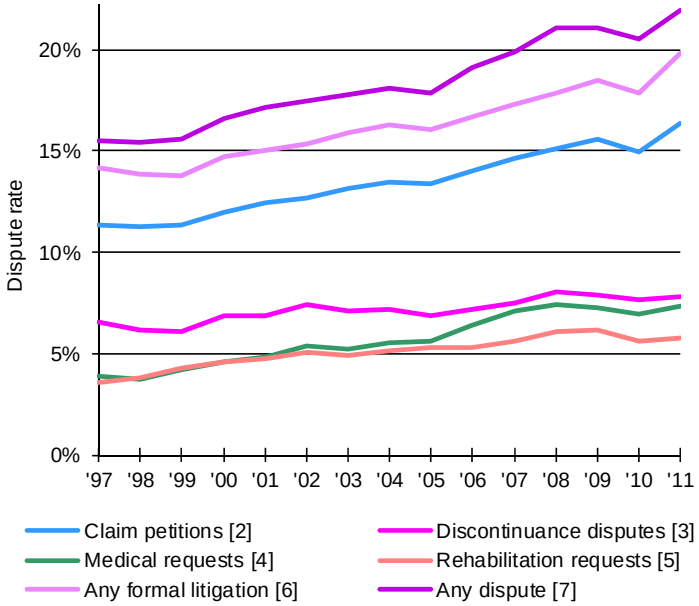
The overall dispute rate showed a large increase from 1997 to 2011. The increase was most pronounced for the proportion of claims with medical requests.

- The overall dispute rate was 22.0 percent in 2011, 42 percent higher than in 1997.[41] From 1997 to 2011:
  - the rate of claim petitions rose 4.9 percentage points (44 percent);
  - the rate of discontinuance disputes rose 1.3 points (20 percent);
  - the rate of medical requests rose 3.5 points (89 percent);
  - the rate of rehabilitation requests rose 2.2 points (60 percent); and
  - the rate of formal litigation rose 5.6 points (40 percent).[42]

- The rates of discontinuance disputes, medical requests and rehabilitation requests seem to have leveled off during the past three years, but the rates of claim petitions and formal litigation are still showing increases.

- Since these figures are developed statistics, the ones for recent years are subject to change and should therefore be viewed as preliminary.

Figure 5.1 Incidence of disputes, injury years 1997-2011 [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	11.4%	6.5%	3.9%	3.6%	14.2%	15.5%
1999	11.3	6.1	4.2	4.3	13.8	15.6
2007	14.7	7.5	7.1	5.6	17.3	19.9
2008	15.1	8.0	7.4	6.1	17.9	21.1
2009	15.6	7.9	7.2	6.2	18.5	21.1
2010	15.0	7.6	6.9	5.6	17.9	20.6
2011	16.3	7.8	7.4	5.8	19.8	22.0

1. Developed statistics from DLI data (see Appendix C).
2. Percentage of filed indemnity claims with at least one claim petition. (Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.)
3. Percentage of paid wage-loss claims with at least one discontinuance dispute.
4. Percentage of paid indemnity claims with at least one medical request.
5. Percentage of paid indemnity claims with at least one rehabilitation request.
6. Percentage of filed indemnity claims with at least one dispute that leads to a hearing at OAH (unless the parties settle beforehand). This includes claim petitions, requests for formal hearing, objections to discontinuance, petitions to discontinue benefits and petitions for dependency benefits.
7. Percentage of filed indemnity claims with at least one dispute of any type.

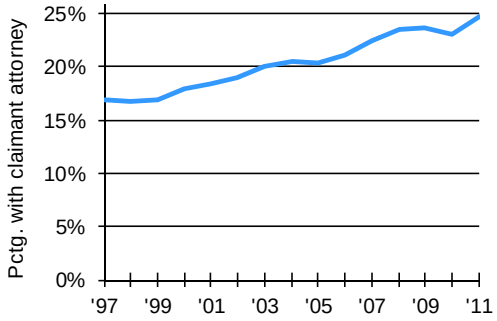
[41] See note 13 on p. 11.
[42] See not 6 in Figure 5.1.

Claimant attorney involvement

Claimant attorney involvement has increased substantially since 1997.[43]

- The percentage of paid indemnity claims with claimant attorney involvement rose from 16.9 percent for injury year 1997 to a projected 24.8 percent for 2011.[44] This is a 46-percent increase.[45]
- This parallels a similar pattern in the dispute rate (Figure 5.1).
- Total claimant attorney fees are projected at $51 million for injury year 2011.[46] These fees account for an estimated 3.2 percent of total workers' compensation system cost.[47]

Figure 5.2 Percentage of paid indemnity claims with claimant attorney involvement, injury years 1997-2011 [1]

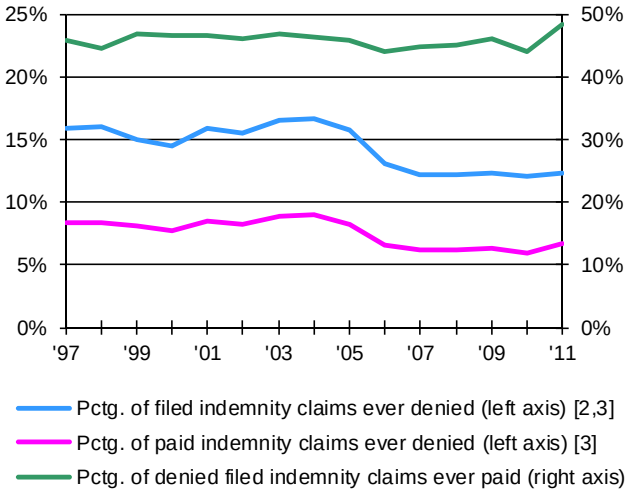


Injury year	Percentage with claimant attorney
1997	16.9%
2007	22.4
2008	23.5
2009	23.7
2010	23.1
2011	24.8

1. Developed statistics from DLI data (see Appendix C). A claimant attorney is deemed to be involved if claimant attorney fees of any type are reported.

[43] DLI does not track defense attorney involvement.
[44] See note 1 in Figure 5.2.
[45] See note 13 on p. 11.
[46] All types of claimant attorney fees are counted here.
[47] This percentage was calculated with techniques similar to those for Figure 2.3 to reduce the effects of annual fluctuations in system cost.

Figure 5.3 Indemnity claim denial rates, injury years 1997-2011 [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	39,100	15.8%	33,700	8.4%	45.8%
2000	39,900	14.4	34,800	7.7	46.5
2004	31,100	16.6	26,900	8.9	46.4
2007	28,200	12.2	25,000	6.2	44.8
2008	27,100	12.2	24,300	6.2	45.1
2009	23,900	12.3	21,400	6.4	46.1
2010	24,400	12.0	21,800	5.9	44.0
2011	24,100	12.3	21,600	6.7	48.3

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 a steep drop from 2004 to 2007, the denial rate has been rather steady.

- The rate of denial of filed indemnity claims stood at 12.3 percent for 2011, down 3.5 points (22 percent) from 1997. The decrease occurred primarily between 2004 and 2007.

- The proportion of paid indemnity claims that had also been denied was 6.7 percent for 2011, down from 8.4 percent for 1997. This decrease also occurred primarily between 2004 and 2007. These claims include cases denied but then paid and cases paid but then denied.

- The decreases in denial rates for filed and paid claims between 2004 and 2007 coincide with an enhancement in DLI's denial review process initiated in November 2005.[48] In this enhancement, still in effect, DLI requires insurers to indicate their reasons for claim denials in a manner compliant with statute and rule. 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.

- Among filed indemnity claims with denials, 44 to 48 percent have received payment during the period shown.

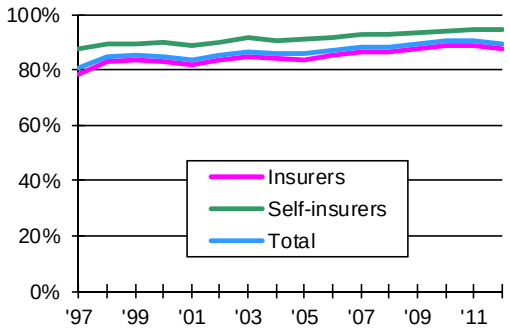
[48] See "DLI Primary Liability Determination Review Process," in *COMPACT*, August 2006, available from DLI Research and Statistics, 651-284-5025.

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.[49] 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.

- The fiscal year 2012 prompt-first-action rate was 89 percent, about 9 percentage points higher than 1997.
- The prompt-first-action rate is higher for self-insurers than for insurers.
- The rate for self-insurers has continued to increase. The rate for insurers dropped somewhat in 2012, to about the same level as for 2009
- In compliance with statute[50] and to improve workers' compensation system performance, DLI publishes the annual *Prompt First Action Report*, which indicates the prompt-first-action rates of individual insurers and self-insurers and of the overall system.

Figure 5.4 Percentage of lost-time claims with prompt first action, fiscal claim-receipt years 1997-2012 [1]



Fiscal year of claim receipt	Insurers	Self-insurers	Total
1997	78.5%	87.3%	80.7%
2008	86.5	93.0	88.3
2009	87.7	93.4	89.3
2010	88.9	94.2	90.3
2011	88.7	94.3	90.2
2012	87.6	94.6	89.4

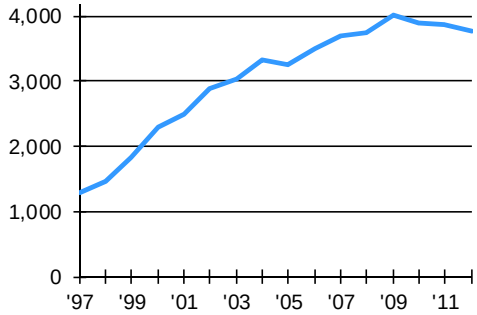
1. Computed from DLI data by DLI Compliance, Records and Training. See DLI Benefit Management and Resolution, *2012 Prompt First Action Report.Fiscal claim-receipt year* means the fiscal year in which DLI received the claim. Fiscal years are from July 1 through June 30; for example, July 1, 2011 through June 30, 2012 is fiscal year 2012.

Dispute certification requests

The absolute numbers of disputes and of dispute certification requests are important for understanding the data to be presented in Figures 5.7 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 1,290 in 1997 to 4,010 in 2009, but fell back to 3,760 by 2011.
- 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 5.5 Dispute certification requests filed, calendar years 1997-2012 [1]

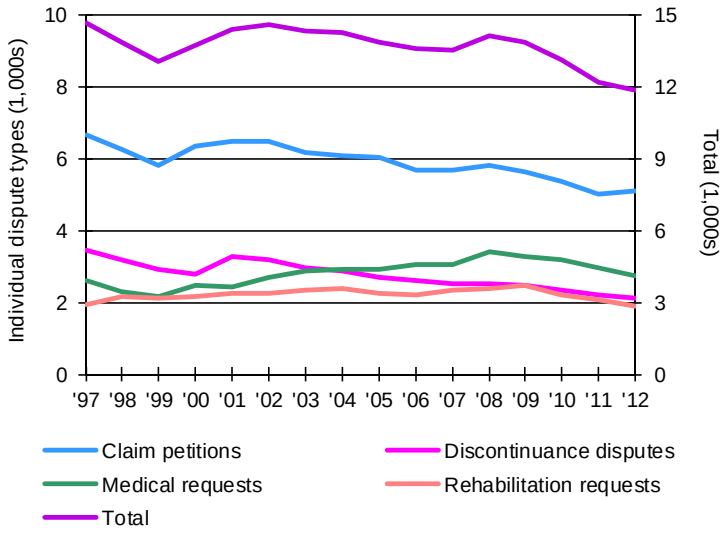


Calender year	Requests filed
1997	1,290
2008	3,740
2009	4,010
2010	3,880
2011	3,870
2012	3,760

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

[49] Minnesota Statutes §176.221.
[50] Minnesota Statutes §176.223.

Figure 5.6 Disputes filed, calendar years 1997-2012 [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
2001	6,450	45	3,250	23	2,410	17	2,250	16	14,370
2003	6,150	43	2,980	21	2,880	20	2,330	16	14,330
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
2010	5,370	41	2,320	18	3,190	24	2,210	17	13,080
2011	4,990	41	2,210	18	2,940	24	2,050	17	12,190
2012	5,070	43	2,120	18	2,740	23	1,890	16	11,820

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

Disputes filed

The four major dispute types showed different trends from 1997 to 2012. Claim petitions and discontinuance disputes fell significantly. Medical and rehabilitation requests rose through 2008 or 2009 but fell in the most recent 3 to 4 years.

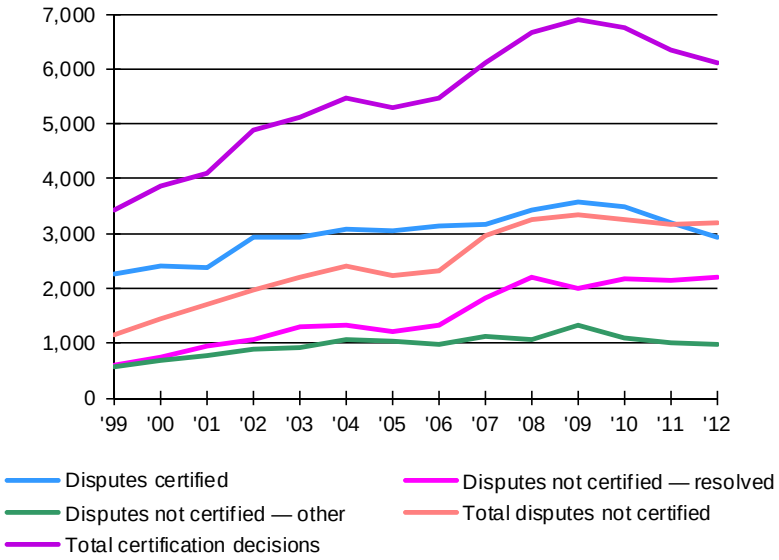
- From 1997 to 2012:
  - claim petitions fell 24 percent;
  - discontinuance disputes fell 38 percent;
  - medical requests rose 6 percent;
  - rehabilitation requests fell 3 percent; and
  - the total number of these disputes fell 19 percent.

- These trends are the net result of rising dispute rates (Figure 5.1) and falling numbers of claims (Figure 2.1).

- Because of these trends, the mix of dispute types changed from 1997 to 2011:
  - claim petitions fell from 46 percent to 43 percent of total disputes filed;
  - discontinuance disputes fell from 23 percent to 18 percent;
  - medical requests rose from 18 percent to 23 percent; and
  - rehabilitation requests rose from 13 percent to 16 percent.

- While claim petitions remained the most frequent dispute type in 2011, medical requests surpassed discontinuance disputes during the period examined as the second most frequent type.

Figure 5.7 Dispute certification activity at the Department of Labor and Industry, calendar years 1999-2012 [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
2008	3,420	51	2,200	33	1,060	16	3,260	49	6,680
2009	3,560	52	2,000	29	1,330	19	3,340	48	6,900
2010	3,480	52	2,180	32	1,080	16	3,270	48	6,750
2011	3,200	50	2,150	34	1,000	16	3,150	50	6,350
2012	2,940	48	2,210	36	970	16	3,180	52	6,130

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

Dispute certification

The number of DLI dispute certification decisions doubled from 1999 to 2009 but has decreased in more recent years.

- DLI rendered 6,130 certification decisions in 2012, down 11 percent from the peak in 2009.
  - ➢ This parallels the trend in certification requests in Figure 5.5.
  - ➢ The number of certification decisions is greater than the number of certification requests in Figure 5.5 because many medical and rehabilitation requests are not preceded by certification requests, but dispute certification still occurs in those cases.
- Between 1999 and 2012, the percentage of disputes certified fell from 66 percent to 48 percent. This was entirely attributable to an increase in the percentage of disputes not certified because they were resolved, which rose from 17 to 36 percent.

Mediations and administrative conferences at DLI

The numbers of administrative conferences and mediations at DLI have increased since 1999. Since 2006, the number of mediations has grown while the number of administrative conferences has fallen.

- From 1999 to 2012:
  - mediations rose by 400;
  - administrative conferences rose by 150; and
  - total conferences and mediations increased by 550.

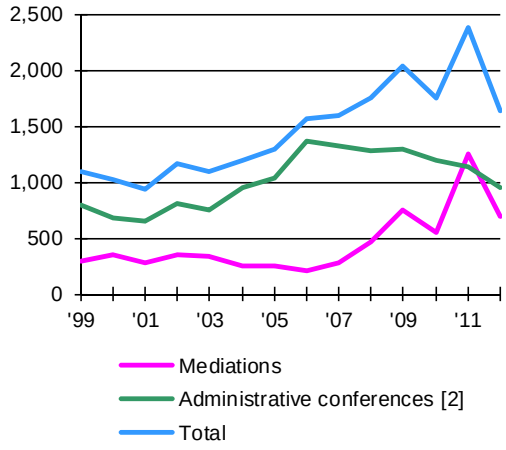
- 2006 was a turning point in the relative numbers of conferences and mediations. From 2006 to 2012, mediations rose by 490 while conferences fell by 410. This occurred because of an increased DLI emphasis on mediation and other early dispute-resolution activities.

- The number of mediations fluctuated significantly between 2009 and 2012, with a slight overall decrease during those three years.

- The increase in total conferences and mediations from 1999 to 2011 was 50 percent. By contrast, total medical and rehabilitation requests increased 8 percent during the same period (Figure 5.6). Thus the trend in medical and rehabilitation requests explains only part of the trend in conferences and mediations.

- Another contributing factor is that the 2005 Legislature raised the monetary limit on DLI jurisdiction in medical request disputes from $1,500 to $7,500.[51]

Figure 5.8 Mediations and administrative conferences at the Department of Labor and Industry, calendar years 1999-2012 [1]



Calendar year	Mediations	Administrative conferences [2]	Total
1999	290	800	1,090
2006	200	1,360	1,560
2007	280	1,320	1,600
2008	460	1,280	1,740
2009	750	1,290	2,040
2010	550	1,200	1,750
2011	1,250	1,130	2,380
2012	690	950	1,640

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

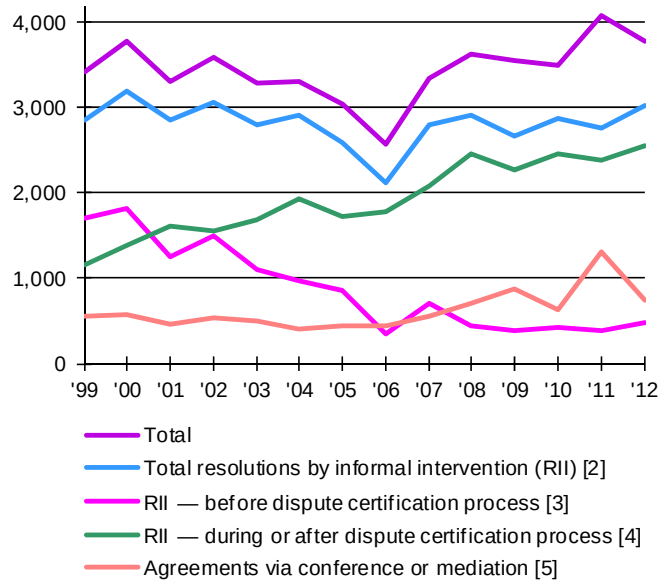
[51] See note 39 on p. 32.

Resolutions by agreement at DLI

The total number of resolutions by agreement at DLI was somewhat higher in 2012 than in 1999.

- Most resolutions by agreement occurred through informal intervention, prior to a mediation or conference (see notes 2 to 4 in figure). Consequently, the total number of resolutions by agreement followed approximately the same trend as resolutions by intervention.
- Resolutions by intervention that occurred before the dispute certification process declined from 1,700 to 470 from 1999 to 2011, while those occurring during or after the certification process increased from 1,160 to 2,550.
  - ➢ These trends were offsetting: the total number of resolutions by intervention in 2012 was just somewhat higher than 1999.
- The increase in total resolutions by agreement after 2007 was due to increases in resolutions by informal intervention and in agreements via mediation or conference. The latter, in turn, is explained by the increase in mediations shown in Figure 5.8.

Figure 5.9 Resolutions by agreement at the Department of Labor and Industry, calendar years 1999-2012 [1]



Calendar year	Resolutions by informal 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
2007	720	2,080	2,800	550	3,350
2008	450	2,470	2,910	700	3,620
2009	390	2,280	2,670	890	3,550
2010	420	2,450	2,870	630	3,500
2011	390	2,380	2,760	1,310	4,070
2012	470	2,550	3,030	750	3,770

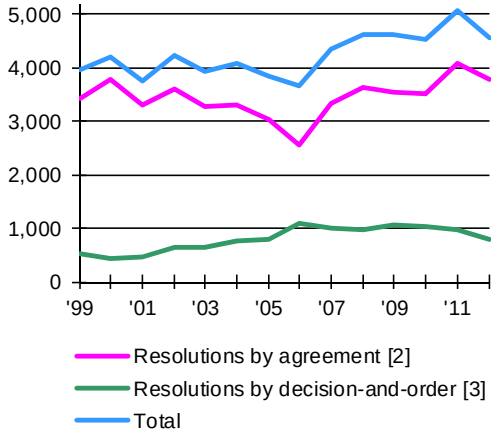
1. Data from DLI. Data not available before 1999. Numbers rounded to nearest 10.
2. These are instances in which a DLI specialist, through phone or walk-in contact or correspondence, resolves a dispute prior to a mediation or conference. Many of these resolutions occur through the dispute certification process. See pp. 31-32 for more detail.
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.

Total resolutions at DLI

The total number of resolutions at DLI consists of resolutions by agreement — discussed previously — and resolutions by decision-and-order. Decision-and-orders account for a minority of total DLI resolutions, but were a higher proportion of the total in 2012 than in 1999.

- The number of decision-and-orders doubled from 1999 to 2006, showed little change through 2011, and declined in 2012.
- Decision-and-orders accounted for 13 percent of all DLI resolutions in 1999 and 17 percent in 2012.
- From 2007 to 2012, resolutions by agreement increased their share of total resolutions from 77 percent to 83 percent. As indicated in Figure 5.9, 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 1999-2012 [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
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
2010	3,500	77	1,030	23	4,530
2011	4,070	81	980	19	5,050
2012	3,770	83	800	17	4,570

1. Data from DLI. Data not available before 1999. Numbers rounded to nearest 10.
2. From Figure 5.9.
3. Virtually all decision-and-orders are via administrative conference. Since 2004, nonconference decision-and-orders have numbered three or fewer a year.

Dispute resolution at OAH: 2012

By far the most common form of dispute resolution at OAH is an award on stipulation. As previously indicated (p. 33), stipulation awards occur most commonly in claim petition disputes, but occur sometimes in other disputes as well.

- In fiscal year 2012, there were 5,370 awards on stipulation, accounting for 77 percent of OAH dispute resolutions.[52]
- Decision-and-orders on discontinuance issues accounted for 13 percent of the OAH resolutions; findings-and-orders, 9 percent; and decision-and-orders on medical and rehabilitation issues, 1 percent.[53]

Dispute resolution at OAH: trends

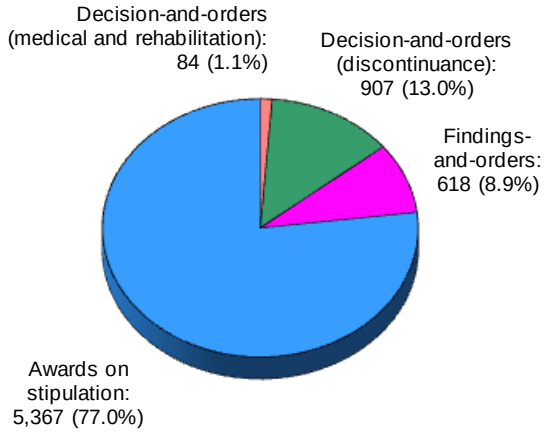
The numbers of decision-and-orders, findings-and-orders and awards on stipulation at OAH all declined during the past decade.

- From 2003 to 2012:
  - decision-and-orders (medical and rehabilitation) fell 75 percent;
  - decision-and-orders (discontinuance) fell 32 percent;
  - findings-and-orders fell 30 percent; and
  - awards on stipulation fell 24 percent.
- These decreases are partly due to the decreases in numbers of disputes shown in Figure 5.6 for the same period.
- The decrease in decision-and-orders (medical and rehabilitation) between 2005 and 2006 occurred at least in part because, as mentioned earlier, the 2005 Legislature increased the limit on DLI jurisdiction in medical request disputes from $1,500 to $7,500.
- One factor in the decrease in decision-and-orders (medical and rehabilitation) after 2010 is that OAH gave judges more discretion to send medical issues presented on a medical request straight to hearing.

[52] See note 1 in Figure 5.11.

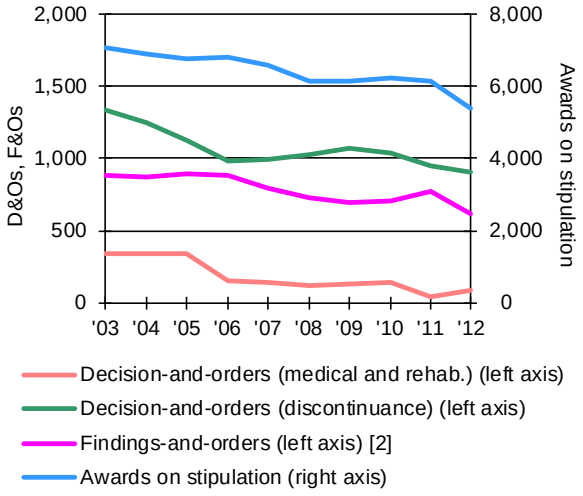
[53] For reasons described on p. 32, a majority of medical issues and most vocational rehabilitation issues are dealt with at DLI.

Figure 5.11 Dispute resolutions at the Office of Administrative Hearings, fiscal year 2012 [1]



1. Data from OAH. Some dispute outcomes are excluded — for example, cases where the dispute is withdrawn or dismissed.

Figure 5.12 Dispute resolutions at the Office of Administrative Hearings, fiscal years 2003-2012 [1]



Fiscal year	Decision-and-orders: Medical and rehabilitation	Decision-and-orders: Discontinuance	Findings-and-orders [2]	Awards on stipulation
2003	337	1,331	883	7,056
2008	124	1,021	725	6,116
2009	134	1,067	695	6,144
2010	138	1,042	708	6,246
2011	46	945	767	6,141
2012	84	907	618	5,367

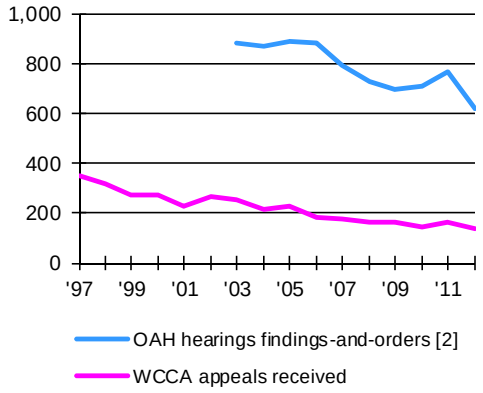
1. Data from OAH. Not available before 2003.
2. Includes finding-and-orders from hearings de novo. Excludes findings-and-orders on attorney fees.

Appeals of OAH findings-and-orders to the WCCA

The number of OAH findings-and-orders appealed to the WCCA has fallen since 1997.

- WCCA received 138 cases on appeal from OAH findings-and-orders during 2012, down 61 percent from 1997 and 46 percent from 2003. This at least partly reflects the decline in findings-and-orders from OAH.[54]
- From 2006 to 2012, appeals received at WCCA ranged from 21 to 23 percent of OAH findings-and-orders.

Figure 5.13 Findings-and-orders at the Office of Administrative Hearings and appeals received at the Workers' Compensation Court of Appeals, fiscal years 1997-2012 [1]



Fiscal year	OAH findings-and-orders [2]	WCCA appeals received [3]
1997		351
2003	883	255
2008	725	163
2009	695	162
2010	708	146
2011	767	163
2012	618	138

1. Data from OAH and WCCA.
2. From Figure 5.12; not available before 2003. Includes finding-and-orders from hearings de novo. Excludes findings-and-orders on attorney fees.
3. Includes appeals with and without oral arguments at WCCA. Both types of appeals are usually disposed of by decisions but sometimes by settlement. Statistics are unavailable about the number of WCCA appeals with oral arguments. Currently, about 50 percent of appeals have oral arguments. This percentage has risen over time.

[54] Although statistics about findings-and-orders (F&Os) are not available before 2003, it can be inferred that F&Os were falling from 1997 to 2003 because the number of OAH hearings, which is followed closely by the number of F&Os, fell from 1,240 to 895 during that period.

Appendix A

Glossary

The following terms are used in this report.[54]

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;[55] they are also conducted on disputes about discontinuance of wage-loss benefits presented by a claimant's request for administrative conference. Medical and rehabilitation conferences are conducted at either the Department of Labor and Industry (DLI) or the Office of Administrative Hearings (OAH) depending on whether DLI has referred the issues concerned to OAH.[56] 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 the medical condition or disability for which the employee requests benefits or services was caused by an admitted injury (one for which the insurer or employer has admitted primary liability). An insurer denying benefits or services on the basis of causation is claiming the medical condition or disability in question did not arise from the admitted work injury.

Claim petition — A form by which the injured worker contests a denial of primary liability or requests an award of indemnity, 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).[57] 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

[54] 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.

[55] As indicated on p. 31, 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.

[56] See discussion of DLI administrative conferences on p. 32 (including note 39) for types of medical and VR disputes referred to OAH.

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

injuries from Oct. 1, 1995 through September 30, 2013, the cost-of-living adjustment was limited to 2 percent a year and was delayed until the fourth anniversary of the injury. For injuries on or after Oct. 1, 2013, the cost-of-living adjustment is limited to 3 percent a year and delayed until the third anniversary of the injury.

Dependents' benefits — Benefits paid to dependents of a worker who has died from a work-related injury or illness. These benefits are equal to a percentage of the worker's gross pre-injury wage and are paid for a specified period 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.[58] 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, surgery disputes[59] and disputes about miscellaneous issues such as attorney fees. Finally, OAH conducts *de novo* formal hearings when requested by a party to an administrative-conference decision-and-order

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

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

from DLI or OAH or a nonconference decision-and-order from DLI.

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 disability 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 statewide average weekly wage. 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 (2011) 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 Oct. 1, 1995, after 104 weeks of TTD have been paid, or for injuries on or after Oct. 1, 2008, after 130 weeks of TTD have been paid (with an exception for approved retraining). Minimum and maximum weekly benefit provisions are described in Appendix B. Cost-of-living adjustments are described in this appendix.

Vocational rehabilitation (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

Workers' compensation law changes

For the period covered in this report, a few workers' compensation law changes are relevant: those occurring in 2000, 2008 and 2011. This appendix summarizes those components of these law changes that are relevant for the statistics in this report.[60]

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.)

2011 law change

The following provisions are effective as of Aug. 1, 2011.

Scheduling of proceedings at OAH — OAH must schedule a settlement conference to occur within 180 days of the filing of a claim petition, and within 45 days of the filing of a petition to discontinue benefits, objection to discontinuance or request for *de novo* hearing. If settlement is not reached, OAH must schedule a hearing to occur no more than 90 days after the scheduled settlement conference, or sooner if statute requires an expedited hearing on the issues concerned.

[60] Other legislative changes, such as the 2013 changes, are not described because they do not affect the trends presented 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 an "eighth-report" basis. The developed insurance statistics in this report were computed by DLI Research and Statistics using tabulated numbers and associated development factors from the MWCIA.

Research and Statistics has adapted this technique to DLI data. It tabulates statistics at regular intervals from the DLI database, computes development factors representing historical development for given injury years and then derives developed statistics by applying the development factors to the most recent tabulated statistics. In this manner, the annual numbers in any given time series are developed to a constant maturity, e.g., a 27-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. For example, in Figure 2.1, the developed number of indemnity claims for injury year 2011 (in the numerator of the indemnity claim rate) is 21,570 (rounded to the nearest hundred). This is equal to the tabulated number as of Jul. 1, 2013, 20,270, times the appropriate development factor, 1.064.

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 2011 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 2011 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).[61] 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 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 2010 is available from the MWCIA. The 2011 figure was estimated by applying the ratio of deductible credits to written premium for the prior two years to the 2011 premium figure. When the actual amount becomes available for 2011, 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 2011. 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 — The percentages in this figure were derived from payment year data to avoid significant issues that would arise with injury year (or accident year) data.[62] A major issue is that both paid benefits and total system cost vary substantially from year to year, causing major variation in the ratio of the two. Therefore, the percentages in this figure were derived by averaging data over time.

Data on benefits and state agency administrative cost came from DLI, the Minnesota Workers' Compensation Insurers Association, the Minnesota Insurance Guaranty Association and the Minnesota Self-Insurers' Security Fund. Total system cost was calculated as indicated in connection with Figure 2.2. The percentage of cost going to insurer expenses was calculated as a residual as described below.

Because written premium — the primary element in system cost — relates to policies originating in a given year, it is paid during that year and the year following. Therefore, the ratio of benefits to system cost was computed using system cost for the year prior to the benefit payment year. An analysis of the data reveals that this ratio varies through approximately an

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

[62] With injury year data, there would be a significant time-discounting issue in comparing benefits with written premium, because injury year benefits include projected payments to be made several years or sometimes decades after the injury. The ratio of discounted benefits to premium would be quite sensitive to the choice of discount rate, even within a reasonable range. This would be in addition to the issue of accurately projecting total injury year benefits in the first place.

11-year cycle. To minimize annual fluctuation, an average over this cycle was used. To further reduce annual fluctuation, an average of averages was used, corresponding to the 11-year cycles ending with the most recent year and the prior two years. This yielded the ratio 67.3 percent as the ratio of total paid benefits to total system cost.

The indemnity, medical and vocational rehabilitation (VR) components of the 67.3 percent were then computed using the relative totals of these payments for 2011. VR benefits (counted separately here from indemnity benefits) are not directly available on a payment year basis, and so a payment year version of these benefits was estimated from the injury year series used for Figure 4.3.

The portion of total system cost not accounted for by benefit payments, 32.7 percent, was then allocated between state agency administrative expenses and insurer expenses. State agency administrative expenses (using the same numbers as for Figure 3.8) were estimated to account for 1.6 percent of total system cost, leaving an estimated 31.1 percent attributable to insurance expenses (for insurers and self-insurers).

Figure 2.4 — 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 2.5 — Claim and loss data is from the MWCIA's *2013 Minnesota Ratemaking Report.* This data comes from insurance company reports on 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 an eighth-report basis using the development factors in the *Ratemaking Report,* which produces statistics at an average maturity of 8.5 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, because paid losses are 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 18 years (an "18^{th}-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 on policy experience.

Figure 3.1 — Statistics are derived in the same manner as for Figure 2.5, 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 2009.

Figures 3.3 and 3.4 — Average benefit duration (Figure 3.3) is computed by dividing the average weekly benefit (Figure 3.4) into the average benefit per claim where it was paid (Figure 3.5) (using developed statistics). This method is used because of issues relating to relatively more frequent non-reporting of duration for longer claims.

Figure 3.5 — A modified procedure was used to compute the percentage of indemnity claims with stipulated benefits, 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 claims with stipulated benefits for recent injury years. Data about these benefits 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 is used to compute the percentage of claims with stipulated benefits. The percentages of claims with these benefits for the three most recent injury years (2009 through 2011) were projected from their 2008 values using the growth rate in the percentage of claims with claim petition disputes. The latter percentage was used for this projection because the percentage of claims with stipulated benefits closely follow the percentage of claims with disputes.

Figure 3.8 — Administrative cost is computed to capture that portion of the workers' compensation assessment (see "Special Compensation Fund" in Appendix A) that pays for state administration. Consequently, administrative cost is computed as the total of costs other than workers' compensation benefits that are paid for by the assessment or other revenues with which it is combined, minus those other revenues.

Figure 5.2 — A modified procedure was used to compute the percentage of indemnity claims with claimant attorney fees. The procedure was similar to that described for the percentage of claims with stipulated benefits in connection with Figure 3.5, and was employed for the same reason.