CompScope™ Benchmarks for Minnesota

22nd Edition

Rebecca Yang
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To be a catalyst for significant improvements in workers’ compensation systems, providing the public with objective, credible, high-quality research on important public policy issues.

THE INSTITUTE:

Founded in 1983, the Workers Compensation Research Institute (WCRI) is an independent, not-for-profit research organization which strives to help those interested in making improvements to the workers’ compensation system by providing highly regarded, objective data and analysis.

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- Original research studies of major issues confronting workers’ compensation systems (for example, worker outcomes)
- Studies of individual state systems where policymakers have shown an interest in change and where there is an unmet need for objective information
- Studies of states that have undergone major legislative changes to measure the impact of those reforms and draw possible lessons for other states
- Presentations on research findings to legislators, workers’ compensation administrators, industry groups, and other stakeholders

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COMPScOPE™ BENCHMARKS FOR MINNESOTA, 22ND EDITION

Rebecca Yang

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Note to Reader: For full functionality of the links and buttons, please save this report to your computer and open it using Adobe Acrobat Reader. While we do our best to ensure that the report is fully functional for all users, there may be rare cases where user computer settings reduce the functionality. We would appreciate these instances being brought to our attention. Readers may choose to use a paper copy of the report, in which case the option of using the interactive links will not be available.
SUMMARY OF MAJOR FINDINGS FOR MINNESOTA

This 22nd edition CompScope™ Benchmarks study for Minnesota helps policymakers and other system stakeholders identify current cost drivers and emerging trends in total costs per claim and key components. The study compares the performance of state workers’ compensation systems in Minnesota and 17 other states, focusing on income benefits, overall medical payments, use of benefits, duration of temporary disability, frequency and payments of permanent partial disability (PPD)/lump-sum claims, benefit delivery expenses, litigiousness, timeliness of payments, and other metrics. The study also examines how these metrics have changed, mainly from 2015 to 2020, for claims at various maturities. Trends during this period reflect experience after the 2016 inpatient fee schedule change and Minnesota House File 3873 (enacted in 2018), legislation that includes changes in hospital outpatient and ambulatory surgery center (ASC) fee schedules, increases in income benefits, a rebuttable presumption for post-traumatic stress disorder (PTSD) for first responders, and other provisions. In some cases, we use a longer time frame to supply historical context.

Note that the results we report reflect experience on claims through March 2021, including non-COVID-19 claims only from the early pandemic period (March–September 2020). The study, therefore, provides a look at how the pandemic impacted non-COVID-19 workers’ compensation claims in the early months of the pandemic.¹

TOTAL COSTS PER CLAIM IN MINNESOTA GREW 2–3 PERCENT PER YEAR FROM 2015 TO 2020

Total costs per claim in Minnesota experienced little growth of 2–3 percent per year from 2015 to 2020 for claims with more than seven days of lost time at all maturities. In 2020/2021,² this measure increased 3.6 percent for non-COVID-19 claims in the latest 12-month valuation, a result of a large increase in indemnity benefits per claim offsetting a decrease in medical payments per claim and stability in benefit delivery expenses per claim with expenses. Growth in total costs per claim in Minnesota since 2015 has been similar to the experience in many study states.

INDEMNITY BENEFITS PER CLAIM STABLE 2016–2019; GROWTH IN 2020 DRIVEN BY INCREASE IN TEMPORARY DISABILITY DURATION AND LUMP-SUM SETTLEMENT PAYMENTS

Indemnity benefits per claim in Minnesota changed little from 2016 to 2019 after an increase from 2015 to 2016 at all claim maturities. In 2020/2021, this measure experienced a large growth of 18 percent for non-COVID-19 claims, driven by an increase of nearly one week in duration of temporary disability (TD) benefits, and growth in lump-sum settlement frequency and payments per claim.

Like in most study states, Minnesota experienced an increase in TD duration in 2020 (9 percent in

¹ This report focuses on experience of non-COVID-19 claims because we found COVID-19 claims accounted for a small percentage of total costs and COVID-19 claims were fundamentally different from non-COVID-19 claims. Additional details are available in the Technical Appendix. Other WCRI research reports describe the early impact of COVID-19 on the composition of claims and their costs, how COVID-19 may have affected the delivery of care to workers, and the impact of that on worker and claims outcomes, including duration of disability.
² 2020/2021 refers to claims with injuries arising from October 1, 2019, through September 30, 2020, with experience through March 31, 2021 (12 months on average). Other injury year/evaluation year combinations are denoted similarly.
Minnesota, 3–11 percent across 15 states). In contrast, this measure remained fairly stable in all states from 2015 to 2019. The economic slowdown during the pandemic may be a factor underlying this general pattern. For example, an increase in the unemployment rate may affect workers’ ability to return to work, and therefore lead to longer duration of TD benefits. Minnesota experienced a sharp increase in the unemployment rate in April and May 2020. We observed growth in TD duration in 2020 in most industry groups in Minnesota. For instance, TD duration increased one week in high-risk services (the industry group with the biggest claim share), which includes industry sectors with significant job loss in Minnesota during the early period of the pandemic, such as restaurants and hotels, health care, and transportation. TD duration also increased in trade, manufacturing, construction, and low-risk services in Minnesota.

The average weekly wage of Minnesota workers with injuries increased less than 2 percent in 2020, a slower growth rate compared with the increase of 3.3 percent per year from 2015 to 2019. We found little change or decreases in wages for workers in manufacturing, construction, clerical and professional services, and other industries in 2020.

Another driver of indemnity growth in Minnesota since 2015 has been the increase in lump-sum settlement payments per claim, including a double-digit increase in 2020. The percentage of claims with lump-sum settlements also increased 1 percentage point in the latest study year.4

OVERALL LITTLE CHANGE IN MEDICAL PAYMENTS PER CLAIM 2015–2019, FOLLOWED BY A DECREASE IN 2020

Medical payments per claim in Minnesota overall have changed little from 2015 to 2019. According to CompScope™ Medical Benchmarks for Minnesota, 22nd Edition (Yang, 2021), hospital outpatient payments per claim remained stable and ASC facility payments per claim had a decrease in 2019, following the 2018 fee schedule changes. Hospital inpatient payments per episode decreased in 2016 after the adoption of the Medicare diagnosis-related group (DRG)-based fee schedule. These results were consistent with the expected impact of the regulation changes. In 2020/2021, medical payments per claim decreased 5 percent for non-COVID-19 claims with more than seven days of lost time. Prices paid for nonhospital professional services in Minnesota remained stable in 2020, according to the 13th edition of the WCRI Medical Price Index study (Yang and Fomenko, 2021). We will examine the changes in other key components underlying the 2020 decrease, such as hospital and ASC facility payments, and nonhospital utilization, in the next edition of CompScope™ Medical Benchmarks.

EXPENSES PER CLAIM FAIRLY STABLE FROM 2015 TO 2020

Benefit delivery expenses per claim in Minnesota overall grew little since 2015 for claims with more than seven days of lost time and those expenses. This measure remained stable in 2020/2021, a result from a decrease in medical cost containment expenses offsetting the increases in litigation-related expenses.

3 High-risk services mainly include hospitals, facility living arrangements, restaurants and hotels, transportation, food service industry, package delivery, electric light or power, building maintenance, etc. Low-risk services mainly include physicians and dentists, schools, day care, museums and theaters, personal services, etc.

4 We also examined claims with periodic PPD payments only and no lump-sum settlements, and found the average PPD payment per claim for these claims in Minnesota decreased slightly at 2–3 percent per year since 2015.
MINNESOTA TOTAL COSTS PER CLAIM AND KEY COMPONENTS LOWER THAN MANY STUDY STATES

Minnesota ranked lower than many study states for total costs per claim with more than seven days of lost time and their key components. Each component masks offsetting factors that may reflect system features.

Indemnity benefits per claim in Minnesota were 17 percent lower than the 18-state median for 2018/2021 claims. Minnesota had a typical average weekly temporary total disability (TTD) benefit rate of the study states. Compared with other states with a PPD benefit system, duration of TD benefits in Minnesota was typical, likely related to the rules about terminating TTD benefits. Minnesota had the lowest percentage of claims with PPD/lump-sum payments among the PPD states, driven by the less frequent lump-sum settlement behavior in the state. Offsetting this result was higher PPD/lump-sum payments per claim in Minnesota than in many other PPD states.

The lower medical payments per claim in Minnesota mask several offsetting factors. Nonhospital payments per claim in Minnesota were lower than typical, reported in CompScope™ Medical Benchmarks for Minnesota, 22nd Edition. This result came from the lowest utilization of nonhospital services offsetting slightly higher prices paid for professional services, which were related to the slightly higher fee schedule rates. In addition, Minnesota had higher ASC facility payments per claim, higher hospital outpatient payments per claim, and typical hospital inpatient payments per episode.

Benefit delivery expenses per claim in Minnesota were also lower than in many study states, stemming from the lowest medical cost containment expenses per claim offsetting higher litigation-related expenses per claim.

See the section titled “Discussion of Major Findings” for details of the major findings summarized above and the system features that may contribute to the results we report.
INTRODUCTION AND HOW TO USE THIS ANALYSIS

This is the 22nd edition of an annual series of analyses that benchmarks the performance of state workers' compensation systems. This study focuses on income benefits, costs, use of benefits, duration of temporary disability, litigiousness, benefit delivery expenses, timeliness of payments, and other metrics. The CompScope™ benchmarking series focuses on the performance of the benefit delivery system and does not address insurance markets, pricing, or regulations. A companion study to this annual series—the CompScope™ Medical Benchmarks—focuses on the costs, prices, and utilization of medical care received by workers with injuries. It examines these medical services in the aggregate, by type of provider, and by type of medical service. Related Workers Compensation Research Institute (WCRI) studies benchmark state fee schedules and worker outcomes.

The unit of analysis in the CompScope™ benchmarking series is the individual workers' compensation claim, so most results are reported on a per claim basis. Therefore, changes in claim frequency do not affect the measures we report.

The annual benchmark studies provide dual perspectives:

- How have the Minnesota system performance metrics changed over time (trends) using claims that arose between October 2014 and September 2020, usually with an average of 12, 24, and/or 36 months of experience?
- How does Minnesota compare with other states—specifically with 17 other mostly large states that were selected because they are geographically diverse; represent a range of system features; and represent the range of states that are higher, near the middle, and lower on costs per claim? Income benefit payments per claim in the median state in this group are similar to the median among all U.S. states (see “Data and Methods”).

HOW TO USE THIS BENCHMARKING REPORT

The format of this edition of the CompScope™ study is designed to make the findings easily accessible and still provide a rich and detailed set of benchmarks for those who want to drill down beneath the major findings.

- For those who want to get quickly to the bottom line, there is a short narrative summary of major findings and a slide presentation on major findings. The slides provide explanatory figures and charts, along with interactive links to the more detailed figures and tables that underlie the highlighted major findings.
- For those who want to drill down on a specific issue, the narrative summary and slide presentation both have links from each finding or slide to the underlying detailed tables and graphs. In addition, we provide

1 Note that the results we report reflect experience on claims through March 2021, including non-COVID-19 claims only from the early pandemic period (March–September 2020). The study, therefore, provides a look at how the pandemic impacted non-COVID-19 workers’ compensation claims in the early months of the pandemic. We focus on experience of non-COVID-19 claims because we found COVID-19 claims accounted for a small percentage of total costs and COVID-19 claims were fundamentally different from non-COVID-19 claims. Additional details are available in the Technical Appendix. Other WCRI reports describe the early impact of COVID-19 on the composition of claims and their costs, how COVID-19 may have affected the delivery of care to workers, and the impact of that on worker and claims outcomes, including duration of disability. For state counts of reported COVID-19 cases published by the New York Times, see https://www.nytimes.com/interactive/2021/us/minnesota-covid-cases.html.
a narrative discussion of major findings and a separate slide presentation on other key findings and supplemental material.

- For those who are not familiar with the CompScope™ benchmarking studies, there is an “Information for First-Time Users” section in the supporting materials to provide detail about the key benchmarks we analyze, the data we use and the adjustments we make to those data, and some presentational explanations.

- For those seeking a wide-ranging reference book to address questions of interest, there are many detailed tables and graphs that are available for browsing or that may be accessed through links in the “Quick Reference Guide to Figures and Tables.”

- The glossary and list of common abbreviations help readers navigate this report. The references include other WCRI studies of interest for the audience in Minnesota.

- The data and methods are fully described in the Technical Appendix. The following sub-section contains a short summary of the data and methods, with more explanation provided in the supporting materials.

Note: Each page of this report contains a “Back to Previous View” button which allows the reader to click on a link to another section and then return to the original page, eliminating the need for bookmarking.

**DATA AND METHODS**

This section contains a short summary of data and methods used in this report. This analysis uses data from data sources that include national and regional insurers, claims administration organizations, state funds, and self-insured employers. The data are collected in the Detailed Benchmark/Evaluation (DBE) database, which presently includes nearly 7 million claims that are reasonably representative of the entire system in each of the 18 states, including all market segments: self-insurance, residual market, voluntary insurance, and state funds. These data include 52 percent of Minnesota claims in 2020 evaluated in 2021 (40 to 71 percent of the claims from each state).

We used a variety of techniques to increase the comparability of the measures from state to state, including (1) standardizing definitions of variables that state regulators might have defined differently from state to state, (2) standardizing the reporting on cases with more than seven days of lost time to control for differences in state waiting periods for income benefits, and (3) adjusting for interstate differences in injury and industry mix and in wage levels of workers with injuries. The interstate differences in the performance measures presented in this report, therefore, should largely reflect variations in system features and/or in the practices and behavior of system participants.

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2 The full DBE includes about 51.5 million claims across 39 jurisdictions.
INTRODUCTION TO MAJOR FINDINGS SLIDES

The following pages present a slide discussion of CompScope™ Benchmarks for Minnesota, 22nd Edition. The slides highlight the major findings discussed in the “Summary of Major Findings” section and provide explanatory figures and charts. Notation on the bottom of the slides specifies the injury year and/or maturity of the data shown, as applicable. The notes to the right of some slides provide additional technical or substantive information pertinent to that slide. For example, the notes might contain links to external summaries of legislation or workers’ compensation agency reports, a reference to a related figure or table, or an explanation of a relevant workers’ compensation system feature. References to source information and definitions of key terms or abbreviations are located below the slide to which they apply. To view the notes, references, and/or definitions, the document magnification on your computer may need to be set at 100 percent or lower. Please note that the slides are also interactive, linking to other areas of this report where useful. For example, bar charts generally link to the box plot figures that contain the numbers underlying the chart. Links in the slides are indicated by underlining.

When describing the performance of a state in this report, we generally use the criteria and key terms in the chart below. Words used to describe an increase include growth and rise. Words used to describe a decrease include fall, drop, and decline. For some measures, such as those based on percentages of payments and percentages of claims, often specific numeric criteria are not used to apply the characterization of a state’s value relative to the median, as the distributions of states’ values on different percentage measures are often subject to different degrees of variation. Instead, we apply the characterization by reviewing where each state’s value falls relative to other states in the overall distribution. A characterization is assigned after taking into consideration the magnitude of the values, the range and clusters of states’ values, and the homogeneity or heterogeneity of the overall distribution.

<table>
<thead>
<tr>
<th>Multistate Values</th>
<th>Comparison with Median State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher</td>
<td>More than 10 percent above median</td>
</tr>
<tr>
<td>Lower</td>
<td>More than 10 percent below median</td>
</tr>
<tr>
<td>Typical or close to</td>
<td>Within 10 percent above or below median</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trends</th>
<th>Change in Cost Measures (annual average percentage)</th>
<th>Change in Frequency Measures (annual average percentage points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very rapid increase</td>
<td>+9% and higher</td>
<td>+4 points and higher</td>
</tr>
<tr>
<td>Rapid increase</td>
<td>+6% to 8.9%</td>
<td>+2 to 3.9 points</td>
</tr>
<tr>
<td>Moderate increase</td>
<td>+3% to 5.9%</td>
<td>+1 to 1.9 points</td>
</tr>
<tr>
<td>Flat, little change</td>
<td>+2.9% to -2.9%</td>
<td>+0.9 to -0.9 points</td>
</tr>
<tr>
<td>Moderate decrease</td>
<td>-3% to -5.9%</td>
<td>-1 to -1.9 points</td>
</tr>
<tr>
<td>Rapid decrease</td>
<td>-6% to -8.9%</td>
<td>-2 to -3.9 points</td>
</tr>
<tr>
<td>Very rapid decrease</td>
<td>-9% and lower</td>
<td>-4 points and lower</td>
</tr>
</tbody>
</table>

The thresholds in the multistate comparison above were chosen because a data point 10 percent above or below the median usually, but not always, indicates that the data point is notably different from the median.
There are two exceptions. Sometimes the median state is part of a cluster of states with similar values that are all higher or lower than the remaining states. In that case, we describe a report state as being in the higher, lower, or middle group based on its cluster, not its relation to the median. In other cases, the range of states includes very different values, and even a state near the median differs from it by 10 percent or more. In that case, we would call that state fairly typical despite the criteria in the table. Review of the boxplots may help resolve any confusion.
The following pages are a slide discussion of *CompScope™ Benchmarks for Minnesota, 22nd Edition*. The slides highlight the major findings and provide explanatory figures and charts. Please note that the slides are also interactive, linking to other areas of this study where useful. Links are indicated by underlining.

Note that trends in costs per claim and their components in Minnesota since 2015 reflect experience after the adoption of the Medicare DRG-based fee schedule for hospital inpatient care in 2016, the adoption of Medicare-based fee schedules for hospital outpatient and ambulatory surgery center (ASC) services in 2018, and other provisions in the 2018 legislation House File 3873 (such as increases in income benefits for workers, and establishment of a rebuttable presumption that post-traumatic stress disorder [PTSD] is work-related for first responders). See Supplemental Slide S9 for a timeline of selected provisions in House File 3873. See Supplemental Slides S13–S15 for the summaries of the hospital outpatient, ASC, and inpatient fee schedule changes.

**Key:**
- **DRG:** Diagnosis-related group.
- **TD:** Temporary disability.

**Note:** Total costs per claim and their components are based on non-COVID-19 claims with more than seven days of lost time.

**Naming convention (example 2020/21):** The first year (2020) is the injury year, which we define as claims arising from October 1, 2019, through September 30, 2020; the second year (21) is the maturity of the claims (experience through March 31, 2021). This indicates 2020 claims at an average maturity of 12 months. Other injury year/evaluation year combinations are denoted similarly.

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**Major Findings For Minnesota From CompScope™ Benchmarks, 22nd Edition**

- **Total costs/claim** in MN grew 2–3% per year 2015–2020*
  - **Indemnity benefits/claim** stable 2016–2019; growth in 2020 driven by increase in TD duration & lump-sum payments
  - Overall little change in **medical payments/claim** 2015–2019, followed by a decrease in 2020
  - **Expenses/claim** fairly stable from 2015 to 2020
  - **MN costs per claim & key components lower** than many study states; offsetting factors may reflect system features

The most recent injury year/evaluation year in this report (2020/21) includes claims from October 1, 2019, through September 30, 2020, evaluated as of March 31, 2021. That period partly covers the early months of the COVID-19 pandemic—specifically claims from March 1 through September 30, evaluated as of March 31, 2021. Thus, the most recent injury year/evaluation year includes 7 months of COVID-19 claims, with an average experience of 9.5 months.


See the Technical Appendix for more information on the exclusion of COVID-19 claims from this report.


Key: AAPC: Annual average percentage change. Mos.: Months.

Definition: Total costs per claim: Combination of medical payments, indemnity benefits, and benefit delivery expenses. Total costs per claim also include vocational rehabilitation expenses, which are discussed in the “Other Key Findings” section.
Cost growth in Minnesota from 2015 to 2020 was close to the typical experience of the 18 states; it masks different patterns in key components. While the stability in medical payments per claim and benefit delivery expenses per claim with expenses in 2020/21 was similar to the experiences in most states, indemnity benefits per claim in Minnesota grew faster than in other states, driven by a large increase in 2020/21.

Note that we generally describe a change of less than 3 percent (plus or minus) as stable or little change. See Table 1.

The decrease in medical payments per claim in 2020/21 was a change in pattern from the previous stable trend from 2015/16 to 2019/20.

The larger-than-usual increase in indemnity benefits per claim in 2020/21 was driven by a growth in duration of temporary disability benefits, which may be related to the economic conditions in Minnesota during the early pandemic period, as well as increases in lump-sum settlement frequency and payments.

Additionally, in 2020, the percentage of claims with more than seven days of lost time increased 1.5 percentage points in Minnesota, and 1 to 3 points in all study states. In contrast, this metric changed little in earlier years. In 2020, there was a large decrease in the total number of claims, mostly due to medical-only claims. This shift in the mix of claims may reflect changes in claiming behavior during the pandemic. For example, some workers may not report minor injuries due to fear of losing their job in the economically uncertain time. Also, some workers may have not sought medical care for less severe injuries due to the higher risk of infection in doctors’ offices or health care facilities. These may have led to only more severe claims being reported, and resulted in a higher proportion of claims with more than seven days of lost time.
The main drivers of the rapid growth in indemnity benefits per claim in 2020/21 were an increase of nearly one week in duration of temporary disability benefits and growth in lump-sum settlement frequency and payments per claim. The next few slides provide detailed analysis.

Key: **TD:** Temporary disability.

**Definition:** Indemnity benefits: Payments for temporary disability (total and partial), permanent partial disability benefits, and benefits paid in the form of a lump-sum settlement. All lump-sum payments (indemnity and medical) are reported as indemnity payments. This achieves consistency and comparability in this measure across all states because lump-sum payments to close out future obligations are rarely separated into medical and indemnity components in the data.
Note that the nearly-one-week increase in TD duration in 2020 accounted for nearly half of the indemnity growth in that year. The increases in lump-sum settlement payments per claim and the percentage of claims with lump-sum settlements together represented roughly 40 percent of the indemnity growth (see the table below).

<table>
<thead>
<tr>
<th>% Contribution Of Key Components To Indemnity Growth In 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>TD duration                                              47%</td>
</tr>
<tr>
<td>AWW of workers with injuries                                10%</td>
</tr>
<tr>
<td>Lump-Sum payments (both frequency and payments per claim)   42%</td>
</tr>
<tr>
<td>Other indemnity components (e.g., claims with periodic PPD payments only and no lump-sum settlements and the average PPD payment per claim for these claims, etc.) 1%</td>
</tr>
</tbody>
</table>

From 2015 to 2019, moderate increases in wages and lump-sum settlement payments per claim were the main drivers underlying the indemnity trend.

The growth in TD duration may be related to the economic conditions in Minnesota during the early pandemic period, as discussed on the next few slides.

Key: TD: Temporary disability. AWW: Average weekly wage. PPD: Permanent partial disability. ppt: Percentage points.

Note: Minnesota had less frequent lump-sum settlements than in most study states and these settlements tended to occur later in the claims. Therefore, fewer claims received settlement payments at 12 months of experience (for example, only 7 percent in 2020), and lump-sum settlement payments per claim often fluctuated year to year for this small group of less mature claims. Future CompScope™ reports will monitor if the large increase in lump-sum settlement payments per claim in 2020 was a one-time phenomenon or the beginning of a trend with more mature data.

Among the 18 states, 15 of them (including Minnesota) experienced increases in the average TD duration in 2020, ranging from 3 percent in North Carolina and Texas to 11 percent in Wisconsin. Many states had a one-week or more increase in the average duration of TD benefits for non-COVID-19 claims with more than seven days of lost time in 2020. In contrast, this measure had been fairly stable in all study states from 2015 to 2019.

The economic slowdown during the pandemic may be a factor underlying this general pattern. For example, an increase in the unemployment rate may affect workers’ ability to return to work, and therefore lead to longer duration of TD benefits. For more details, see the “Discussion of Major Findings.”

Other factors may have contributed to the trends in different states, such as differences in the timing and severity of the COVID-19 pandemic and related state policies, recovery of jobs lost, and so forth.

Here we summarize a few metrics describing the economic conditions in Minnesota in 2020, particularly since the COVID-19 pandemic began. See the “Discussion of Major Findings” for more details.

Key: **AAPC**: Annual average percentage change. **TD**: Temporary disability.
The unemployment rate in Minnesota has been lower than the national average for decades, including the period of the Great Recession and slow recovery. Right before the pandemic, the unemployment rate in Minnesota was at an average of 3.2 percent from the fourth quarter of 2019 to February 2020. With the onset of the pandemic, the Minnesota unemployment rate increased sharply in April 2020, and peaked at 11.3 percent in May 2020. There were pervasive job losses across major industries in Minnesota (for example, mining, trade, health care, transportation, and manufacturing), with the most significant employment decreases in accommodation and food services as well as entertainment industries during the early period of the pandemic. Starting in June 2020, the unemployment rate in Minnesota began to decrease. As of October 2021, the Minnesota unemployment rate fell back to 3.5 percent, close to the pre-pandemic level in February 2020. During the pandemic, the unemployment rate in Minnesota remained below the national average. However, some Minnesota people dropped out of the labor force altogether, and hence were not counted in the unemployment rate (see more details in footnote 4 in the “Discussion of Major Findings”).

In 2020, TD duration grew at least one week for claims in high-risk services, trade, manufacturing, construction, and low-risk services. Note that high-risk services include industry sectors with significant decreases in employment in Minnesota during the early period of the pandemic, such as restaurants and hotels, health care, and transportation. The trade and manufacturing industries also had noticeable job loss in Minnesota.

Descriptions:
High-risk services mainly include hospitals, facility living arrangements, restaurants and hotels, transportation, food service industry, package delivery, electric light or power, building maintenance, and so forth.

Low-risk services mainly include physicians and dentists, schools, day care, museums and theaters, personal services, etc.
The slower wage growth for Minnesota workers with injuries in 2020 was driven by multiple industries (see the next slide).

Overall, the average weekly wage for workers with injuries in Minnesota increased 3 percent per year from 2015 to 2020, a faster growth rate than in many study states.

Key: AAPC: Annual average percentage change. AWW: Average weekly wage (of workers with injuries). SAWW: Statewide average weekly wage.

The slower wage growth in Minnesota in 2020 was mainly from the manufacturing industry, a category representing one-fifth of the claim share in the state. The average weekly wage for Minnesota workers with injuries in manufacturing changed little in 2020, after increasing 3 percent per year from 2015 to 2019. Wages for workers injured in Minnesota also changed little or decreased in 2020 in the construction, clerical and professional services, and "other" industries.

Key: AWW: Average weekly wage (of workers with injuries). ppt: Percentage points.

Descriptions: High-risk services mainly include hospitals, facility living arrangements, restaurants and hotels, transportation, food service industry, package delivery, electric light or power, building maintenance, and so forth.

Low-risk services mainly include physicians and dentists, schools, day care, museums and theaters, personal services, etc.

Trade includes both retail trade (such as retail grocery stores, clothing and wearing apparel retail stores, department stores, gas stations, etc.) and wholesale trade (e.g., wholesale stores and operations, such as meat, fish, and poultry wholesale dealers, wholesale furniture dealers, building materials dealers).
Another driver of indemnity growth in Minnesota since 2015 has been the increase in lump-sum settlement payments per claim, including a double-digit increase in 2020 for claims with 12 months of experience. Supplemental Slide S10 shows that there were proportionally more settlements with larger payment amounts in 2020. With more mature data, future CompScope™ reports will monitor if the large increase in 2020 was a one-time phenomenon or the beginning of a trend. Additionally, the frequency of lump-sum settlements increased 1 percentage point in 2020.

For claims with periodic PPD payments only and no settlements, a factor underlying the small decrease in the average PPD payment per claim since 2015 may be that PPD benefits are not adjusted annually for changes in weekly wage levels. In addition, the PPD benefit schedule amount for each PPD rating was increased by 5 percent in 2018, and the average PPD payment per claim overall remained fairly stable for claims arising after this policy change at 12 and 24 months of maturity. A potential factor underlying this result might be a decrease in the average PPD rating, as reported by the Minnesota Department of Labor and Industry.


Notes: Claims with PPD/lump-sum payments in this study include claims that received periodic PPD payments but no lump-sum settlements (the bottom charts) and claims that received lump-sum settlements (the top charts). See Table 13 for the numbers underlying this slide. Figures 22–25 show the numbers for claims with periodic PPD and/or lump-sum payments. All lump-sum payments are reported as indemnity payments to achieve consistency and comparability in this measure across all states because lump-sum payments to close out future obligations are rarely separated into medical and indemnity components in the data.
Key: **AAPC**: Annual average percentage change. **ASC**: Ambulatory surgery center. **DRG**: Diagnosis-related group. **Mos.**: Months.

**Definition**: Medical payments: Payments for all medical services delivered to workers with injuries. Included are services rendered by physicians, physical/occupational therapists, chiropractors, ambulatory surgery centers, and hospital outpatient and inpatient facilities.

**Note**: See Supplemental Slide S10 for a summary of Minnesota medical fee regulations. See Supplemental Slides S13–S15 for summaries of the hospital outpatient, ASC, and inpatient fee schedule changes.

Note that the median medical payment per claim in Minnesota decreased 10 percent in 2020 for non-COVID-19 claims with more than seven days of lost time at 12 months’ maturity. Medical payments per claim for non-COVID-19 claims with fewer than or equal to seven days of lost time in Minnesota remained stable in 2020.

Trends in several key components of medical payments per claim between 2015 and 2019 in Minnesota reflected experience after the implementation of multiple fee schedule changes. According to *CompScope™ Medical Benchmarks for Minnesota, 22nd Edition* (Yang, 2021), hospital outpatient payments per claim remained stable and ASC facility payments per claim had a decrease in 2019, following the 2018 fee schedule changes. Hospital inpatient payments per episode decreased in 2016 after the adoption of the Medicare DRG-based fee schedule. These results were consistent with the expected impact of the regulation changes.

Prices paid for nonhospital professional services in Minnesota remained stable in 2020, according to WCRI Medical Price Index for Workers’ Compensation, 13th Edition. In the next edition of the CompScope™ Medical Benchmarks study, we will examine the changes in the other key components of medical payments underlying the decrease in 2020, such as hospital and ambulatory surgery center facility payments, as well as utilization of nonhospital services.

Effective October 1, 2010, Minnesota made several changes to its medical fee schedule, including replacing 1998 Medicare relative value units (RVUs) with 2009 Medicare RVUs. Subsequently, effective October 1, 2013, the April 2013 Medicare RVUs were referenced and replaced the 2009 RVUs. Effective October 1, 2016, the Minnesota fee schedule was updated to reference the February 2016 Medicare RVUs. With each update, conversion factors were adjusted so that total payments for services covered under both the old and new RVUs were held constant for each of the four service categories designated under the fee schedule.


Key and definitions: **AAPC**: Annual average percentage change. **FS**: Fee schedule. **Nonhospital services**: Services provided outside of a hospital setting. Providers of nonhospital services include physicians, chiropractors, and physical/occupational therapists. Other nonhospital providers include nurses, clinical social workers, and other ancillary practitioners. **Prices**: Measures the unit prices paid holding utilization constant. It is based on a marketbasket of common medical procedures used in workers’ compensation cases, using detailed Current Procedural Terminology (CPT) billing codes. Prices paid may reflect network discounts and/or other price negotiations between the payors and medical providers. Price information is reported on a calendar-year basis, as opposed to an injury/evaluation-year basis as used for the medical payments per claim in this study.

Following the adoption of new APC-based hospital outpatient and ASC fee schedules in October 2018, hospital outpatient payments per claim in Minnesota remained stable and ASC facility payments per claim decreased 11 percent in 2019. These results were consistent with the expected impact of the 2018 fee schedule changes.

Lower ASC facility payments per claim were the main driver of the 8 percent decrease in nonhospital payments per claim in 2019. Note that nonhospital payments include ASC facility payments and payments for professional services. In 2019, both the prices and utilization of professional services changed little in Minnesota (see the table below).

<table>
<thead>
<tr>
<th>% Change 2018/19 To 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonhospital Payments/Claim</td>
</tr>
<tr>
<td>ASC Facility Payments/Claim</td>
</tr>
<tr>
<td>Professional Service Prices</td>
</tr>
<tr>
<td>Professional Service Utilization</td>
</tr>
</tbody>
</table>

Inpatient payments per episode had a double-digit decrease in 2019 after a one-time increase in 2018, which was mainly driven by higher incidences of more severe injuries and changes in the Medicare IPPS fee schedule.

The stability in benefit delivery expenses per claim in 2020 resulted from a decrease in medical cost containment expenses offsetting the increases in litigation-related expenses (see the next slide).


Definition: Benefit delivery expenses: Payments for managing medical costs as well as litigation expenses that are allocated to individual claims.
Note that the decrease in MCC expenses per claim in 2020 was not a surprising result given the decrease in medical payments per claim in Minnesota in that year. Included in MCC expenses are fees for bill review, utilization review, case management, and preferred provider networks.

Offsetting the decrease in MCC expenses in 2020 were the increases in defense attorney payments per claim and medical-legal expenses per claim, two major components of litigation-related expenses. Note that medical-legal expenses include payments for medical-legal evaluations and reports, independent medical examinations, depositions, medical expert fees, and medical testimony.

From 2015 to 2019, little growth in benefit delivery expenses per claim stemmed from small increases in litigation-related expenses and fairly stable MCC expenses per claim.

### Stable Expenses Per Claim in MN in 2020

<table>
<thead>
<tr>
<th>Expense Metrics in MN</th>
<th>2015/16 To 2019/20</th>
<th>2019/20 To 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Delivery Expenses Per Claim With Expenses</td>
<td>2.5%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Medical Cost Containment (MCC) Expenses Per Claim</td>
<td>-1.9%</td>
<td>-5.3%</td>
</tr>
<tr>
<td>% Of Claims With MCC Expenses</td>
<td>0.7 ppt</td>
<td>-3.0 ppt</td>
</tr>
<tr>
<td>Medical-Legal Expenses Per Claim</td>
<td>2.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>% Of Claims With Medical-Legal</td>
<td>0.6 ppt</td>
<td>-0.9 ppt</td>
</tr>
<tr>
<td>Defense Attorney* Expenses Per Claim</td>
<td>2.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>% Of Claims With Defense Attorneys*</td>
<td>0.5 ppt</td>
<td>0.9 ppt</td>
</tr>
</tbody>
</table>

* Defense attorney measures are for claims with defense attorney payments > $500.

Non-COVID-19 Claims With > 7 Days Of Lost Time At 12 Months Of Experience. Not Adjusted For Injury/Industry Mix And Wages

Key: **MCC**: Medical cost containment. **ppt**: Percentage points.

Note: Benefit delivery expenses include payments for managing medical costs and litigation-related expenses that are allocated to individual claims.

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### Major Findings For Minnesota From CompScope™ Benchmarks, 22nd Edition

- Total costs/claim in MN grew 2–3% per year 2015–2020*
  - Indemnity benefits/claim stable 2016–2019; growth in 2020 driven by increase in TD duration & lump-sum payments
  - Overall little change in medical payments/claim 2015–2019, followed by a decrease in 2020
  - Expenses/claim fairly stable from 2015 to 2020

- MN costs per claim & key components lower than many study states; offsetting factors may reflect system features

Notes: We adjusted the data for interstate differences in injury and industry mix and for wages of workers with injuries to make the interstate comparisons more meaningful. Using more mature claims provides a more appropriate basis for interstate comparisons because the results are a better reflection of the ultimate costs per claim than for less mature claims.

Compared with other Midwest states included in this study, total costs per claim in Minnesota were similar to those in Indiana and Wisconsin, lower than those in Iowa and Illinois, and higher than those in Michigan. Note that for non-COVID-19 claims with 12 months of experience, total costs per claim with more than seven days of lost time in Minnesota were also lower than typical of the study states in 2020/21.

For 2018/21 claims with more than seven days of lost time, medical payments per claim in Minnesota were 14 percent lower than the 18-state median, indemnity benefits per claim in Minnesota were 17 percent below the median state, and benefit delivery expenses per claim with expenses in Minnesota were 13 percent lower than the median state. Each component masks several offsetting factors, which may reflect some system features in Minnesota. The following slides discuss these results and features.

Key: BDE: Benefit delivery expenses.

Note: See Table 8 for the share of total costs per claim each key component represents in Minnesota compared with other study states. See Table 14 for the interstate comparison results for claims at 72 months’ maturity. Another component of total costs per claim is vocational rehabilitation expenses, which are discussed in the “Other Key Findings” section.
Here we summarize the interstate comparison results for the key components of indemnity benefits per claim in Minnesota. The next few slides discuss these offsetting factors underlying the lower indemnity benefits per claim in detail.

Key: **AWW**: Average weekly wage (of workers with injuries). **PPD**: Permanent partial disability. **TD**: Temporary disability, includes temporary total and temporary partial disability.

In most study states, benefits are paid at 66⅔% percent of the average weekly wage of the worker, and most states limit benefits to 100 percent of the SAWW.

Minnesota’s benefit structure, with benefit rates set at 66⅔% percent of the average weekly wage and benefits limited to 102 percent of the SAWW since 2013, is generally similar to that of most states.

Note that we observed a lower percentage of claims with temporary disability benefits capped at the statutory maximum in Minnesota after the implementation of Senate File 1234 (see Supplemental Slide S17). Note that Senate File 1234 is a workers’ compensation reform legislation enacted in May 2013 that includes various changes related to indemnity benefits, medical treatments, attorney fees, rehabilitation, and other aspects of the Minnesota workers’ compensation system (see Table 17).
In the CompScope™ studies, we generally classify states into two groups—wage-loss benefit systems and PPD benefit systems—based on different approaches used to compensate income loss due to work-related injuries.

In a wage-loss benefit system, workers typically continue to receive TD benefits as long as they experience wage loss because of the work-related injury. PPD benefits are typically paid for scheduled injuries only. Unscheduled impairments are typically compensated only if workers actually experience a wage loss or a loss of wage-earning capacity.

In a PPD state, by contrast, TTD benefits typically end when the worker reaches maximum medical improvement (MMI) and the worker may be entitled to PPD benefits. Typically, PPD benefits in these states cover most or all impairments, including unscheduled impairments.

Two states, GA and NC, have aspects of both a wage-loss system and a PPD system. In GA, a worker continues to receive TD benefits as long as there is no return to work or there is a return to work with lower wages, up to the statutory limit of 400 weeks for TTD or 350 weeks for TPD. PPD benefits can be paid based on impairment only and cover loss or loss of use of body members. In NC, a worker who has not returned to work at the end of the healing period either continues to receive TTD benefits (as in a wage-loss benefit system) or elects to receive PPD benefits based on an impairment rating. A worker who has returned to work at full wages can receive PPD benefits (as in a PPD system).

In general, the duration of disability is likely affected by state-specific rules about terminating temporary disability benefits—for example, whether benefits can be terminated unilaterally or a hearing is required before benefits can be terminated. In addition, the speed of the dispute resolution process likely affects the duration of temporary disability. Several system features in Minnesota may impact the duration of temporary disability benefits (see Supplemental Slide S18).

Key: PPD: Permanent partial disability. TD: Temporary disability, includes temporary total disability (TTD) and temporary partial disability (TPD).

Note: See the “Glossary” for definitions of scheduled and unscheduled injuries.
Minnesota had the lowest percentage of claims with PPD/lump-sum payments among the PPD states, driven by a lower percentage of claims with lump-sum settlements in Minnesota. System stakeholders indicated that although there is no statutory prohibition, settling future medical benefits is not the norm in Minnesota.

PPD/lump-sum payments per claim in Minnesota were 28 percent higher than the median of the PPD states for 2018/21 claims with more than seven days of lost time that received PPD/lump-sum payments. This result was driven by higher lump-sum settlement payments per claim—the average payment for lump-sum settlements in Minnesota was 50 percent higher than the median of the PPD states for 2018/21 claims.

Key: PPD: Permanent partial disability.

Notes: PPD/lump-sum payments per claim is a broad measure consisting of payments for three components: (1) claims with lump-sum settlements but no periodic PPD payments, (2) claims with periodic PPD payments but no lump-sum settlements, and (3) claims with both lump-sum settlements and periodic PPD payments. The terms settlement and lump-sum payment are used interchangeably throughout this report to refer to lump-sum settlements. All lump-sum payments are reported as indemnity payments to achieve consistency and comparability in this measure across all states because lump-sum payments to close out future obligations are rarely separated into medical and indemnity components in the data. Lump-sum settlements for future medical payments are not permitted in Texas and Massachusetts (under most circumstances) and are not common practice in Minnesota and New Jersey.
Medical payments per claim with more than seven days of lost time in Minnesota were 21 percent below the 18-state median for 2020/21 non-COVID-19 claims at 12 months’ maturity, and 14 percent lower than the median state for 2018/21 claims at 36 months’ maturity.

In addition, medical payments per claim in Minnesota were lower than most other Midwest states included in this study, namely Illinois, Indiana, Iowa, and Wisconsin. Compared with Michigan, this measure in Minnesota was higher for 2018/21 claims and similar for 2020/21 claims.

In CompScope™ Medical Benchmarks for Minnesota, 22nd Edition, we examined the offsetting factors underlying the lower-than-typical medical payments per claim in Minnesota—summarized here.

Offsetting Factors Underlying Lower Medical Payments Per Claim In Minnesota

- Lower nonhospital payments per claim
  - Slightly higher prices paid for professional services, related to fee schedule
  - Lowest utilization of nonhospital care, esp. for physical medicine
  - Higher ASC facility payments per claim

- Higher hospital outpatient payments per claim
  - MN remained among states with higher hospital outpatient payments for common surgeries in 2019

- Typical hospital payments per inpatient episode

Source: CompScope™ Medical Benchmarks For Minnesota, 22nd Edition (2021)

Lower benefit delivery expenses per claim with expenses in Minnesota resulted from the lowest medical cost containment expenses per claim offsetting the higher litigation-related expenses per claim. Higher litigation-related expenses per claim in Minnesota were driven by higher medical-legal expenses per claim and higher defense attorney payments per claim. Meanwhile, Minnesota had a typical percentage of claims with medical-legal expenses, and defense attorneys were involved less often in Minnesota than in many other states. These results may be related to the Minnesota dispute resolution system (see Supplemental Slide S19).

<table>
<thead>
<tr>
<th>Measure</th>
<th>MN</th>
<th>Median State</th>
<th>Difference (% or ppt)</th>
<th>Relative To Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCC Expenses/Claim</td>
<td>$1,751</td>
<td>$3,467</td>
<td>-49%</td>
<td>Lowest</td>
</tr>
<tr>
<td>Litigation Expenses/Claim</td>
<td>$6,637</td>
<td>$5,637</td>
<td>+18%</td>
<td>Higher</td>
</tr>
<tr>
<td>Defense Attorney* Expenses/Claim</td>
<td>$9,003</td>
<td>$6,169</td>
<td>+46%</td>
<td>Among The Highest</td>
</tr>
<tr>
<td>% Of Claims With Defense Attorneys*</td>
<td>26.1%</td>
<td>34.7%</td>
<td>-8.6 ppt</td>
<td>Lower</td>
</tr>
<tr>
<td>Medical-Legal Expenses/Claim</td>
<td>$3,550</td>
<td>$2,585</td>
<td>+37%</td>
<td>Among The Highest</td>
</tr>
<tr>
<td>% Of Claims With Medical-Legal</td>
<td>23.6%</td>
<td>25.3%</td>
<td>-1.7 ppt</td>
<td>Typical</td>
</tr>
</tbody>
</table>

* Defense attorney measures are for claims with defense attorney payments > $500. 2018/21 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix

Key: MCC: Medical cost containment. ppt: Percentage points.

Notes: Medical cost containment expenses include fees for bill review, case management, preferred provider networks, and utilization review. Defense attorney payments include payments for either or both in-house and outside defense counsel. Medical-legal expenses include payments for medical-legal evaluations and reports, independent medical examinations, depositions, medical expert fees, and medical testimony. Measures of medical-legal expenses are not reported for Florida, North Carolina, and Tennessee because underlying data in our sample are not necessarily representative of each state’s experience.
Total costs per claim in Minnesota grew 2–3 percent per year from 2015 to 2020

Total costs per claim in Minnesota experienced little growth of 2–3 percent per year from 2015 to 2020 for claims with more than seven days of lost time at all maturities. This trend was a continuation of little cost growth since 2010. In 2020/2021, total costs per claim in Minnesota increased 3.6 percent for non-COVID-19 claims with more than seven days of lost time at 12 months of experience. The key components of total costs include medical payments, indemnity benefits, and benefit delivery expenses, which include expenses for managing medical costs and litigation-related expenses allocated to individual claims. The moderate cost growth in 2020/2021 resulted from a large increase in indemnity benefits per claim offsetting a decrease in medical payments per claim and stability in benefit delivery expenses per claim with expenses.

Compared with the other 17 states, growth in costs per claim in Minnesota from 2015 to 2020 was similar to the experience in many study states. Trends in key cost components in Minnesota showed different patterns. Growth in indemnity benefits per claim in Minnesota between 2015 and 2020 was faster than in other study states, driven by a large increase in the latest 12-month valuation. Medical payments per claim and benefit delivery expenses per claim with expenses remained fairly stable in Minnesota from 2015 to 2020, similar to the trends in most states. Note that changes in costs per claim and their components in Minnesota since 2015 reflect experience after the implementation of the 2016 inpatient fee schedule change, the 2018 hospital outpatient and ASC fee schedule changes, and other provisions in Minnesota House File (H.F.) 3873 (enacted in 2018).

Indemnity benefits per claim stable 2016–2019; growth in 2020 driven by increase in TD duration and lump-sum settlement payments

Indemnity benefits per claim in Minnesota remained fairly stable from 2016 to 2019 after an increase from 2015 to 2016 for claims with more than seven days of lost time at all maturities. In 2020/2021, this measure experienced a large growth of 18 percent for non-COVID-19 claims, driven by an increase of nearly one week

1 2020/2021 refers to claims with injuries arising from October 1, 2019, through September 30, 2020, with experience through March 31, 2021 (12 months on average). Other injury year/evaluation year combinations are denoted similarly. Note that the results we report reflect experience on claims through March 2021, including non-COVID-19 claims from the early pandemic period (March–September 2020). The study, therefore, provides a look at how the pandemic impacted workers’ compensation claims in the early months of the pandemic.

2 Minnesota enacted H.F. 3873 in October 2018. This study includes 24 months of injuries after this legislation went into effect. Besides the adoption of Medicare-based hospital outpatient and ASC fee schedules, H.F. 3873 also increased income benefits for workers. Examples of such provisions include increasing PPD amounts (by 5 percent), increasing the maximum number of weeks for temporary partial disability (TPD) benefits from 225 to 275 weeks, and deleting the retirement presumption at age 67 and, instead, providing that permanent total disability (PTD) benefits cease at age 72. Some of these provisions involve moderate changes; some others apply to a small group of workers. They may also be considered in lump-sum settlement amounts in some cases because of the potential of higher PPD, TPD, and PTD benefits. Given that lump-sum settlements in Minnesota happened less often than in most study states and these settlements tended to occur later in the claims, it may require more mature claims to observe the material effects of these provisions in future editions of CompScope™ Benchmarks. Additionally, H.F. 3873 established a rebuttable presumption that PTSD is work-related for first responders (for injuries on/after January 1, 2019). The Minnesota Department of Labor and Industry reported that the number of PTSD claims increased nearly every year after PTSD became compensable as its own illness; in 2020, this measure reached 290 claims.
in duration of TD benefits, and growth in lump-sum settlement frequency and payments per claim. The increase in TD duration in 2020 was a change in pattern as this measure in Minnesota had remained fairly stable in prior years. Wage growth for Minnesota workers with injuries was slower in 2020 compared with the period from 2015 to 2019. The indemnity growth and the underlying factors in 2020 may be related to the economic conditions in Minnesota during the early pandemic period.

The average duration of TD benefits per claim in Minnesota increased 9 percent, from nearly 10 weeks in 2019 to nearly 11 weeks in 2020 for non-COVID-19 claims with more than seven days of lost time at 12 months’ maturity. The median duration of TD benefits for the typical claim grew 12 percent in that year. Both claims with TD benefits and claims with PPD and/or lump-sum settlement payments in Minnesota had increases of about one week in the average duration of TD benefits in 2020. Previously, TD duration in Minnesota had changed little since 2009, including the period from 2015 to 2019. Minnesota was one of many study states experiencing growth in duration of TD benefits in 2020. Fifteen of the 18 states had increases in the average TD duration in 2020, ranging from 3 percent in North Carolina and Texas to 11 percent in Wisconsin. Many states had growth of one week or more in this measure in 2020.

The economic slowdown during the pandemic may have affected this general pattern. A WCRI report, Indemnity Benefits, Use of Medical Care, and Economic Conditions (Savych, 2021), discussed several dynamics in labor market supply and demand that may affect TD duration. An increase in the unemployment rate may affect workers’ ability to return to work, as it is more difficult to find a job after an injury if the economy is not doing well. Therefore, increases in the unemployment rates during the pandemic may have led to longer duration of TD benefits. In addition, concerns about exposure to COVID-19 at work and uncertainty about availability of childcare during the pandemic may have caused some workers to delay their return to work, and therefore resulted in longer duration of TD benefits. Furthermore, changes in claiming behavior for non-COVID-19 claims may have also influenced TD duration. Workers may not have sought medical care for less severe injuries due to higher risk of infection in doctors’ offices or health care facilities. Some workers may have had concerns about their job security in the economically uncertain time. These may have led to only more severe claims being reported, and therefore duration of TD benefits being longer. In 2020, the percentage of claims with more than seven days of lost time increased 1 to 3 percentage points in all study states, after little change in prior years. There was a large decrease in the total number of claims, mostly due to medical-only claims. This shift in the mix of claims may reflect changes in claiming behavior during the pandemic.

The economic conditions in Minnesota, particularly since the COVID-19 pandemic began, may have influenced the changes in TD duration and indemnity benefits. The unemployment rate in Minnesota has been lower than the national average for decades, including during the period of the Great Recession and slow recovery. Right before the pandemic, the unemployment rate in Minnesota was, on average, 3.2 percent from the fourth quarter of 2019 to February 2020. With the onset of the pandemic, the Minnesota unemployment rate increased sharply in April 2020, and peaked at 11.3 percent in May 2020. There were pervasive job losses across major industries in Minnesota (for example, mining, trade, health care, transportation, and manufacturing), with the most significant employment decreases in accommodation and food services as well as entertainment industries during the early period of the pandemic. Starting in June 2020, the unemployment rate in Minnesota began to decrease. As of October 2021, the Minnesota unemployment rate fell back to 3.5 percent, close to the pre-pandemic level in February 2020. During the pandemic, the unemployment rate in

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3 According to the WCRI report The Early Impact of COVID-19 on Workers’ Compensation Claim Composition, the number of all claims decreased 30–40 percent across most study states in the second quarter of 2020 compared with the second quarter of 2019, and the decrease in the number of lost-time claims was smaller (Fomenko and Ruser, 2021).
Minnesota remained below the national average. However, some Minnesota residents have dropped out of the workforce altogether, and therefore were not being counted in the unemployment rate. The Minnesota Chamber of Commerce reported that, by October 2020, employment in Minnesota had come back to nearly 93 percent of the pre-pandemic level. The real gross domestic product (GDP) in Minnesota had rebounded since the third quarter of 2020, and climbed back to nearly 98 percent of its pre-pandemic peak by the fourth quarter of 2020.

From 2019/2020 to 2020/2021, duration of TD benefits in Minnesota increased in most industry groups. TD duration increased one week for high-risk services, an industry category that accounted for 24 percent of claims in 2020/2021. High-risk services include industry sectors with significant decreases in employment in Minnesota during the early period of the pandemic, such as restaurants and hotels, health care, and transportation. Trade and manufacturing, two other major industry categories with noticeable job loss in Minnesota, each had an increase in TD duration of nearly one week in 2020/2021. The average TD duration per claim also increased more than a week in claims from low-risk services and the construction industry in 2020/2021.

The average weekly wage of Minnesota workers with injuries increased less than 2 percent in 2020, a slower growth rate compared with the increase of 3.3 percent per year from 2015 to 2019. The wage increase for workers with injuries in 2020 was also smaller than the growth of 3.2 percent in the Minnesota state average weekly wage in that year. The slower wage growth in Minnesota in 2020/2021 was mainly from the manufacturing industry, a category representing one-fifth of the claim share in the state. The average weekly wage for Minnesota workers with injuries in manufacturing changed little in 2020/2021, after growth of 3 percent per year from 2015/2016 to 2019/2020. Wages for workers injured in Minnesota also had little change or decreased in 2020/2021 in several other industry groups, namely construction, clerical and professional services, and other industries.

Another driver of indemnity growth in Minnesota over time has been the increase in lump-sum settlement payments per claim, including in 2020. The average lump-sum settlement payment per claim in Minnesota has grown 8 percent per year since 2015 for claims with 12 months of experience, and 3–4 percent per year for claims at 24 and 36 months of maturity. In 2020/2021, this measure experienced a double-digit increase for non-COVID-19 claims, reflecting proportionally more settlements with larger payment amounts. Additionally, the percentage of claims with lump-sum settlements in Minnesota increased 1 percentage point in 2020/2021. These were also key drivers of the bigger-than-usual growth in indemnity benefits per claim in that year.

We also examined claims with periodic PPD payments only and no lump-sum settlements. The average PPD payment per claim for these claims in Minnesota had small decreases of 2–3 percent per year since 2015

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4 The labor force participation rate in Minnesota decreased 2.5 percentage points from January 2020 to April 2021. Minnesota was not alone in this issue, but the labor force participation rate in Minnesota has fallen more than in many other states with the highest labor force participation rates in April 2021, according to a report by the Minnesota Chamber of Commerce (2021). Note that with the decrease in labor force participation, the unemployment rate may not fully reflect the labor market conditions in Minnesota.

5 High-risk services mainly include hospitals, facility living arrangements, restaurants and hotels, transportation, food service industry, package delivery, electric light or power, building maintenance, etc.

6 Low-risk services mainly include physicians and dentists, schools, day care, museums and theaters, personal services, etc.

7 Note that Minnesota had less frequent lump-sum settlements than most study states and these settlements tended to occur later in the claims. Therefore, fewer claims received lump-sum settlement payments at 12 months of experience, and lump-sum settlement payments per claim often fluctuated year to year for this small group of less mature claims. With more mature data, future CompScope™ reports will monitor if the large increase in lump-sum settlement payments per claim in 2020 is a one-time phenomenon or the beginning of a trend.
at all claim maturities. According to the Minnesota Department of Labor and Industry’s Minnesota Workers’ Compensation System Report, 2019, under the fixed PPD benefit schedule, PPD benefits are not adjusted annually for changes in weekly wage levels, and these benefits became smaller relative to rising wages over time. The PPD benefit schedule amount for each impairment rating category was increased by 5 percent for injuries on/after October 1, 2018, per H.F. 3873. We observed that the average PPD payment per claim overall remained fairly stable for claims arising after this policy change at 12 and 24 months of maturity. A potential factor underlying this result might be changes in the mix of claims with different PPD ratings. The Minnesota Workers’ Compensation System Report, 2019 also showed a decrease in the average PPD rating over time. Because the PPD benefit in Minnesota is computed as the PPD rating times a statutorily specified benefit amount per rating point, the lower PPD rating could offset the higher PPD benefit schedule amount to a certain extent.

**MEDICAL PAYMENTS PER CLAIM OVERALL CHANGED LITTLE 2015–2019, DECREASED IN 2020**

The average medical payment per claim with more than seven days of lost time in Minnesota overall changed little from 2015 to 2019 at all claim maturities, followed by a decrease of 5 percent in 2020/2021 for non-COVID-19 claims at 12 months of experience. The median medical payment per claim in Minnesota also decreased (10 percent) in 2020/2021 for non-COVID-19 claims with more than seven days of lost time. Prices paid for nonhospital professional services in Minnesota remained stable in 2020, according to WCRI Medical Price Index for Workers’ Compensation, 13th Edition (Yang and Fomenko, 2021). In the next edition of the CompScope™ Medical Benchmarks study, we will examine the changes in the other key components of medical payments per claim underlying the decrease in 2020, such as hospital and ASC facility payments, as well as utilization of nonhospital services.

Trends in several key components of medical payments per claim between 2015 and 2019 in Minnesota reflect experience after the implementation of multiple fee schedule changes. According to CompScope™ Medical Benchmarks for Minnesota, 22nd Edition (Yang, 2021), hospital outpatient payments per claim in Minnesota remained stable in 2019/2020, following the transition from the predominately charge-based fee regulation to the new ambulatory payment classification (APC)-based fee schedule in October 2018. The Minnesota ASC fee schedule also changed from a predominately charge-based fee regulation to an APC-based fee schedule effective in October 2018, and ASC facility payments per claim in Minnesota decreased 11 percent in 2019/2020 after the new fee schedule went into effect. These results were consistent with the expected impact of the 2018 fee schedule changes.

Effective January 2016, Minnesota adopted a Medicare DRG-based fee schedule for hospital inpatient care. The 22nd edition of the CompScope™ Medical Benchmarks study found decreases in both the average and the median hospital inpatient payment per episode in 2016 for all types of episodes (regardless of whether surgery was involved or not), likely reflecting the impact of the inpatient fee schedule change. Inpatient payments per episode in Minnesota overall changed little from 2016/2017 to 2019/2020, with some variations in recent years. This measure had a double-digit decrease in 2019/2020 after a one-time increase in 2018/2019, which was mainly driven by higher incidences of more severe injuries and changes in the Medicare Inpatient Prospective

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8 Many study states, including Minnesota, experienced decreases or slower growth in medical payments per claim in 2020/2021 for non-COVID-19 claims with more than seven days of lost time.

9 Note that medical payments per claim for non-COVID-19 claims with fewer than or equal to seven days of lost time in Minnesota remained stable in 2020/2021.

10 This analysis excluded inpatient episodes exempted by the DRG-based fee schedule, namely episodes identified with charges beyond $175,000 (threshold updated annually), critical access hospitals, and out-of-state hospitals.
Note that both prices and utilization of nonhospital professional services in Minnesota remained stable from 2014 to 2019, according to the 13th edition of the WCRI Medical Price Index study (Yang and Fomenko, 2021) and the 22nd edition of the CompScope™ Medical Benchmarks report (Yang, 2021).

**EXPENSES PER CLAIM REMAINED FAIRLY STABLE FROM 2015 TO 2020**

Benefit delivery expenses per claim with more than seven days of lost time and those expenses in Minnesota overall have grown little (1.5 to 2.5 percent per year) since 2015 at all claim maturities. In 2020/2021, this measure remained stable for non-COVID-19 claims, a result of offsetting trends in key components of expenses per claim. Medical cost containment (MCC) expenses per claim in Minnesota decreased 5 percent in 2020/2021, and the percentage of claims with MCC expenses fell 3 percentage points in that year. Offsetting the decreasing MCC expenses were increasing litigation-related expenses in the latest 12-month valuation. Medical-legal expenses per claim and defense attorney payments per claim in Minnesota increased 5 percent and 4 percent in 2020/2021, respectively. The frequency of defense attorney involvement in Minnesota grew nearly 1 percentage point in 2020/2021, while the proportion of claims with medical-legal expenses had a small decrease of similar magnitude.

**MINNESOTA TOTAL COSTS PER CLAIM AND KEY COMPONENTS LOWER THAN MANY STUDY STATES; OFFSETTING FACTORS MAY REFLECT SYSTEM FEATURES**

At nearly $39,000, the average total cost per claim with more than seven days of lost time in Minnesota was lower than in many study states for 2018 claims at 36 months of maturity. Compared with the 18-state median, Minnesota was lower for all key components of total costs per claim, including medical payments per claim, indemnity benefits per claim, and benefit delivery expenses per claim. Each of these key cost components masks several offsetting factors, which likely reflect system features in Minnesota.

The average indemnity benefit per claim in Minnesota was about $16,400 for 2018/2021 claims with more than seven days of lost time, 17 percent lower than the 18-state median. Several offsetting factors underlie this result. Minnesota had a typical average weekly TTD benefit rate among the study states. The average duration of TD benefits per claim in Minnesota was nearly 13 weeks for 2018/2021 claims with more than seven days of lost time, typical of the study states with a PPD benefit system. This may be related to the rules about terminating TTD benefits. In Minnesota, TTD benefits can be terminated by employers if the worker is released to work and fails to make a diligent job search for appropriate work or refuses an offer of gainful work or work consistent with an approved rehabilitation plan. Temporary disability benefits can also be discontinued if it is 90 days after the employee has received a report of maximum medical improvement or it is 90 days after the end of an approved retraining plan (whichever is later), or 130 weeks of TTD benefits have been paid (except

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11 MCC expenses include fees for bill review, utilization review, case management, and preferred provider networks.
12 Litigation-related expenses mainly include defense attorney payments, medical-legal expenses, and ancillary legal expenses. Medical-legal expenses include payments for medical-legal evaluations and reports, independent medical examinations, depositions, medical expert fees, and medical testimony. Ancillary legal expenses include payments associated with the preparation and/or production of reports and transcripts, filing fees, performance of autopsies, conduct of surveillance and investigation, translator’s fees, witnesses’ fees, and costs associated with arbitration and alternate dispute resolution; note that ancillary legal expenses do not include attorney fees.
13 Compared with other Midwest states included in this study, total costs per claim in Minnesota were similar to those in Indiana and Wisconsin, lower than those in Iowa and Illinois, and higher than those in Michigan.
in the case of retraining).

Minnesota had the lowest percentage of claims with PPD/lump-sum payments among the PPD states included in this study. Thirty-five percent of 2018/2021 claims with more than seven days of lost time in Minnesota received PPD/lump-sum payments, compared with 40 percent in the median state. This result was driven by a lower percentage of claims with lump-sum settlements in the state. System stakeholders indicated that although there is no statutory prohibition, settling future medical benefits is not the norm in Minnesota, and this may result in less frequent lump-sum settlements in Minnesota compared with other states. Offsetting the lowest percentage of claims with PPD/lump-sum payments were higher PPD/lump-sum payments per claim with those payments. At about $23,900, the average PPD/lump-sum payment per claim in Minnesota was 28 percent higher than the median of the PPD states for 2018/2021 claims. This result was mainly from higher lump-sum settlement payments per claim in Minnesota, which were 50 percent above the median of the PPD states for 2018/2021 claims with more than seven days of lost time and settlements.

At $15,369, the average medical payment per claim in Minnesota was 14 percent lower than the median state for 2018/2021 claims with more than seven days of lost time at 36 months of experience. For 2020/2021 non-COVID-19 claims at 12 months’ maturity, medical payments per claim in Minnesota were 21 percent below the 18-state median. These results mask several offsetting factors.

CompScope™ Medical Benchmarks for Minnesota, 22nd Edition reported that nonhospital payments per claim in Minnesota were lower than typical. Minnesota had slightly higher prices paid for professional services by nonhospital providers, according to the 13th edition of WCRI’s Medical Price Index study (Yang and Fomenko, 2021). This was likely related to the slightly higher fee schedule rates in the state, reported in Designing Workers’ Compensation Medical Fee Schedules, 2019 (Fomenko and Liu, 2019). Offsetting higher prices was the lowest utilization of nonhospital services among the study states, mainly driven by lower utilization of physical medicine services in Minnesota. Additionally, Minnesota had higher-than-typical ASC facility payments per claim, and a typical percentage of claims with ASC facility services.

As to hospital services, outpatient payments per claim in Minnesota were higher than the median state. Hospital Outpatient Payment Index: Interstate Variations and Policy Analysis, 10th Edition found that states with a predominately percent-of-charge-based fee schedule, like Minnesota prior to the fee schedule change in 2018, had higher hospital outpatient payments for common knee and shoulder surgeries than most states with a fixed-amount fee schedule (Fomenko and Yang, 2021). Minnesota adopted an APC-based fee schedule in October 2018, and Fomenko and Yang found that Minnesota remained among the states with higher hospital outpatient payments in 2019. This result is consistent with the expected impact of the new fee schedule, as it aimed to be overall payment neutral. Hospital inpatient payments per episode in Minnesota were close to the median study state.

Benefit delivery expenses per claim in Minnesota were about $5,770 for 2018/2021 claims with more than seven days of lost time and these expenses, 13 percent below the 18-state median. Underlying this result were the lowest MCC expenses per claim offsetting higher litigation-related expenses per claim. At about $1,750, the average MCC expense per claim in Minnesota was 49 percent lower than the median state for 2018/2021 claims. In contrast, the average litigation-related expense per claim in Minnesota was nearly $6,640, 18 percent higher than the median state for 2018/2021 claims. Higher litigation-related expenses per claim in Minnesota were driven by higher medical-legal expenses per claim and higher defense attorney payments per claim. Meanwhile, Minnesota had a typical percentage of claims with medical-legal expenses, and defense attorneys were involved less often in Minnesota than in many other states. These results may be related to the Minnesota dispute resolution system, which features a variety of informal activities and specialized issue-oriented forums that may
not involve attorney representation. This may have led to fewer cases requiring formal dispute resolution services and less frequent attorney involvement in the state. The cases that involve defense attorneys, therefore, may be somewhat more complicated and require more effort to resolve, thereby resulting in higher average payments for defense attorneys in comparison with other states.

**OTHER KEY FINDINGS**

The discussion of other findings for Minnesota focuses on time to first indemnity payment, and frequency and costs of vocational rehabilitation services.

**Time to first indemnity payment** for workers with injuries in Minnesota was faster than in most study states. Fifty-eight percent of non-COVID-19 claims with more than seven days of lost time in 2020/2021 in Minnesota had the first indemnity payment within 21 days of injury, compared with 49 percent in the median state. The main driver of faster first indemnity payments in Minnesota was faster payments after payor notice, while the **injury reporting speed** in Minnesota was typical of the 18 states. At 57 percent, the proportion of claims with first indemnity payment within 14 days once the payor was notified of the injury in Minnesota was among the highest of the study states for 2020/2021 claims. In Minnesota, the employer must report the injury to the insurer within 10 days, and the insurer must pay or deny the claim within 14 days of the first day of lost time. Note that the percentage of claims with **first indemnity payment within 21 days of disability** in Minnesota was the highest of the study states.

Vocational rehabilitation services were **used more frequently** in Minnesota than in any other state, and the **payments per claim** for these services in Minnesota were the highest of the study states. Twenty-one percent of claims with more than seven days of lost time in Minnesota received vocational rehabilitation services for 2018/2021 claims at 36 months’ maturity, compared with less than 3 percent in the median state. In Minnesota, an initial consultation is generally mandatory 90 days after injury with no return to work (unless a waiver request is granted). This may result in earlier provision of vocational rehabilitation services than in most study states. The average vocational rehabilitation provider expense per claim in Minnesota was about $6,940 for 2018/2021 claims with more than seven days of lost time and those expenses, the highest of the study states. **Rehabilitation services** in Minnesota are provided by qualified rehabilitation consultants and may include vocational evaluation and counseling; job analysis, modification, development, and placement; and vocational testing and retraining. **Since 2015**, the proportion of claims with vocational rehabilitation expenses in Minnesota has grown around 1 percentage point per year at all claim maturities. Note that in 2020/2021, this measure had a decrease of nearly 1 percentage point for non-COVID-19 claims with 12 months of experience. Vocational rehabilitation provider expenses per claim in Minnesota have remained fairly stable since 2015.
Other Key Findings

- Workers in MN received first indemnity payments faster than most states, due to faster payment after payor notice
- MN had the most frequent use and the highest costs of vocational rehabilitation services among study states
The main driver of faster first indemnity payments (the bottom charts) in Minnesota was faster payments after payor notice (the top chart on the right), while the injury reporting speed in Minnesota was typical of the 18 states (the top chart on the left).

In Minnesota, the employer must report the injury to the insurer within 10 days, and the insurer must pay or deny the claim within 14 days of the first day of lost time.

Note that Figure 14 reports two measures for timeliness of payments—the percentage of claims with first indemnity payment within 21 days of injury, and the percentage of claims with first indemnity payment within 21 days of disability. Minnesota was among the highest of the study states on the former one, and the highest on the latter one.

Notes: The data underlying this WCRI report include claims in which the workers were not continuously disabled from the date of injury, so the obligation to pay did not arise until later in the claim. Also included are claims that were denied and/or litigated but paid within the evaluation period. The WCRI measure does not purport to show compliance with individual state requirements for timely payment; we use the same interval across states to provide meaningful multistate comparisons. WCRI results differ from numbers reported by the Department of Labor and Industry in large part because of different definitions (See Slide 5d).

The DLI FY 2020 Prompt First Action Report shows an 88 percent rate of first indemnity payment, compared with 58 percent in the WCRI data, but the reports are measuring different things.

Compliance: The DLI report measures compliance with the statutory requirement for payment or denial; the WCRI report does not measure compliance but uses the same measure across states.

Time frame: The DLI report uses action (payment or denial) within 14 days of the first day of lost time; the WCRI report uses payment within 21 days of injury.

Claim base: The DLI report uses claims with more than three days of lost time; the WCRI report uses claims with more than seven days of lost time.

Denials: They are included in the DLI data because compliance with the requirement to pay or deny is the measure; they are included in the WCRI calculation only if paid by the valuation date.
Qualified rehabilitation consultants (QRCs) must be registered with DLI and follow professional conduct regulations. DLI’s Vocational Rehabilitation Unit provides services to workers involved in liability or causation disputes; it may also provide services in uncontested cases. Eligibility for services is determined by QRCs in a vocational consultation, which is generally mandatory within 90 days after injury with no return to work.


Key: **DLI**: Department of Labor and Industry. **QRC**: Qualified rehabilitation consultant.

In Minnesota, an initial consultation is generally mandatory 90 days after injury with no return to work (unless a waiver request is granted). This may result in earlier provision of VR services than in other states. Note that the VR expenses per claim measure in this study reflects only the payor portion of the costs of VR services as reported in the insurance data and not the portion provided through state agencies, which could be significant in some states. State policies differ greatly as to how and when eligibility for VR services is determined; what services are provided and by whom; and where the responsibility for screening, approval of services, and payment for services resides. Readers interested in more detailed information and analysis of the scope and nature of VR services in Minnesota can refer to Chapter 4 on page 33 of *Minnesota Workers’ Compensation System Report, 2019*.

Key: **VR**: Vocational rehabilitation.

Note: Arkansas, Georgia, Indiana, Iowa, New Jersey, Tennessee, Texas, and Wisconsin are excluded because the underlying data in our sample are not necessarily representative of each state’s experience.
The proportion of claims with vocational rehabilitation expenses in Minnesota has grown around 1 percentage point per year since 2015 at all claim maturities. Note that in 2020, this measure had a decrease of nearly 1 percentage point for non-COVID-19 claims with 12 months of experience.

Vocational rehabilitation provider expenses per claim in Minnesota have remained fairly stable since 2015.

This section includes supplemental slides for the following topics:

- Timeline of selected provisions in Minnesota H.F. 3873: Slide S9
- Trends in % distribution of lump-sum payments in MN: Slide S10
- Interstate comparison on % of claims with lump-sum settlements: Slide S11
- Summary of MN medical fee regulations: Slide S12
- Summaries of MN recent fee schedule changes: Slides S13–S15
- Trends in MN inpatient payments following the 2016 fee schedule change: Slide S16
- Trends in % of claims with TD benefits limited by statutory maximum in MN: Slide S17
- MN system features related to duration of TD benefits: Slide S18
- MN dispute resolution system features: Slide S19


Notes: The average VR provider expense per claim is based on claims for which VR expenses were paid.

Here we summarize several selected provisions from H.F. 3873. This study includes 24 months of injuries after this legislation went into effect.

Besides the adoption of Medicare-based hospital outpatient and ASC fee schedules, H.F. 3873 also increased income benefits for workers. Some of these provisions involve moderate changes; some others apply to a small group of workers. They may also be considered in lump-sum settlement amounts in some cases because of the potential of higher PPD, TPD, and PTD benefits. Given that lump-sum settlements in Minnesota happened less often than in most study states and these settlements tended to occur later in the claims, it may require more mature claims to observe the material effects of these provisions in future editions of CompScope™ Benchmarks.

Additionally, H.F. 3873 established a rebuttable presumption that PTSD is work-related for first responders. The Minnesota Department of Labor and Industry reported that the number of PTSD claims increased nearly every year after PTSD became compensable as its own illness; in 2020, this measure reached 290 claims. (See http://www.dli.mn.gov/sites/default/files/pdf/1221c.pdf.)

Note: Lump-sum settlement payment categories are inflation adjusted with 2015 as the base year.

In 2020/21, there were higher percentages of lump-sum settlements with payment amounts between $20,000 and $50,000 and beyond $100,000. In addition, for claims within each of these larger lump-sum settlement payment categories, the average lump-sum payment per claim also increased at a double-digit rate in 2020/21.
The overall height of the bar represents the 2015/21 claims with lump-sum settlement payments at 72 months in each state. Twenty-three percent of 2015 claims with more than seven days of lost time received lump-sum settlement payments at 72 months in Minnesota, lower than in most study states. At 12 months' maturity, 5 percent of 2015 claims with more than seven days of lost time had lump-sum settlements in Minnesota. In other words, among all 2015 claims that ever received lump-sum settlements as of 72 months’ maturity, nearly 22 percent of them occurred at 12 months’ maturity in Minnesota, lower than in many states.

Payments for nonhospital professional services in Minnesota are based on a Medicare RBRVS-based fee schedule. Prior to October 1, 2018, MN used a combination of a per-service and charge-based approach for regulating hospital outpatient and ASC reimbursement. For large hospitals (those with more than 100 beds) and ASCs, services such as laboratory, X rays, and physical and occupational therapy were subject to the Medicare/Medicaid relative value fee schedule; however, many expensive services that were not covered by the per-service fee schedule, such as facility (i.e., treatment, operating, and recovery room services) and emergency services, were subject to charge-based reimbursements. We characterize the approach in MN as a predominantly charge-based regulation. Effective October 1, 2018, payments for most hospital outpatient surgical and emergency facility services became subject to a Medicare OPPS-based fee schedule, and payments for ASC services became subject to a Medicare ASCPS-based fee schedule. Effective January 1, 2016, the hospital inpatient fee schedule in MN changed from a predominantly charge-based approach to a Medicare DRG-based fee schedule for discharges on or after the effective date.
Prior to October 1, 2018, Minnesota used a combination of per-service and charged-based approaches for regulating hospital outpatient reimbursement. Payments for facility services (primarily treatment, operating, and recovery room services) were predominately based on charges. In October 2018, Minnesota adopted a Medicare APC-based fee schedule. Payment amounts for hospital outpatient surgical facility, emergency room, and clinic services are divided into three categories: hospitals with more than 100 licensed beds (large hospitals), non-critical access hospitals with 100 or fewer licensed beds (small hospitals), and critical access hospitals. Fees for services not listed in the new fee schedules remain based on charges.

Key: **APC**: Ambulatory payment classification.

Note: Some services provided at large hospitals (those with more than 100 beds) before October 1, 2018, were subject to the physician fee schedule rates; but these services (such as laboratory, X rays, and physical/occupational therapy) were usually less expensive than services subject to charge-based reimbursement (such as facility and emergency services). Hence, we characterize the hospital outpatient fee schedule in Minnesota prior to October 2018 as a predominantly charge-based regulation.

Prior to October 1, 2018, Minnesota used a combination of per-service and charged-based approaches for regulating ASC reimbursement. Under this approach, payments for ASC facility services were predominately based on charges. In October 2018, Minnesota adopted a Medicare APC-based fee schedule.

Key: **APC**: Ambulatory payment classification. **ASC**: Ambulatory surgery center. **ASCPS**: Ambulatory Surgical Center Payment System.

Note: Some services provided at ASCs before October 1, 2018, were subject to the physician fee schedule rates; but these services (such as laboratory, X rays, and physical/occupational therapy) were usually less expensive than services subject to charge-based reimbursement (such as facility services). Hence, we characterize the ASC fee schedule in MN prior to October 2018 as a predominantly charge-based regulation.
Effective January 2016, inpatient reimbursement in Minnesota shifted from a predominantly charge-based system to the use of Medicare Severity Diagnosis Related Groups (MS-DRGs). Minnesota's DRG system provides for payment at 200 percent of the Medicare level, not to exceed the charged amount, with provisions for payment at 75 percent of charges in catastrophic (high-cost) cases and at 100 percent of charges for Medicare-designated critical access hospitals.

The DRG Evaluation Report by the Minnesota Department of Labor and Industry (DLI) estimated that in 2016, this fee schedule change reduced inpatient hospital cost by 9 to 16 percent and total workers' compensation medical cost by 1.3 to 2.3 percent (see http://www.dli.mn.gov/sites/default/files/pdf/drg_report.pdf).

The 2015 legislation (Minnesota House File 2193) also aimed to enhance electronic billing, reduce information that hospitals must submit with bills, and reduce payment disputes.

Key:
- **DRG**: Diagnosis-related group.

**Definition:**
- **Critical access hospital (CAH)**: A rural primary health care hospital that gives limited outpatient and inpatient hospital services to people in rural areas. CAHs offer essential services to Medicare patients, and their services are reimbursed by Medicare on a reasonable cost basis.

CompScope™ Medical Benchmarks for Minnesota, 22nd Edition (Yang, 2021) examined the impact of the 2016 fee schedule change on inpatient payments by excluding inpatient episodes with charges exceeding the catastrophic threshold and cases treated in CAHs, because payments for these cases are based on charges. Cases treated in out-of-state hospitals were also excluded, as these services may not be subject to the Minnesota fee schedule.* We focused the analysis on discharge year, as the DRG-based fee schedule became effective for discharges on or after January 1, 2016.

After controlling for the cases that are not subject to the DRG-based fee schedule in Minnesota, we found decreases in both the average and the median hospital inpatient payment per episode in discharge year 2016 for all types of episodes (i.e., involving surgery or not). These results likely reflect the impact of the DRG-based fee schedule. Note that our analysis using injury year/evaluation year saw similar results (see Table 16).
Under S.F. 1234, effective October 1, 2013 (and each October 1 thereafter), the maximum weekly temporary disability compensation payable to Minnesota workers was changed from a fixed amount of $850 to 102 percent of the statewide average weekly wage for the period ending December 31 of the preceding year. This reduced the percentage of workers with weekly temporary disability benefits limited by the statutory caps.

For a summary of selected provisions in S.F. 1234, refer to Table 17.


Note: The trend data shown above for the percentage of Minnesota workers with TD benefits capped by the statutory maximum weekly benefit are not adjusted for injury or industry mix or wages.

The termination of TTD benefits is a key system feature that may impact return to work and the duration of temporary disability benefits.

Key: MMI: Maximum medical improvement. TTD: Temporary total disability.

The dispute resolution system in Minnesota is aimed at resolving disputes at the earliest possible point using a funnel approach to reduce the number of cases that require formal hearings. Minnesota uses a variety of informal assistance activities and alternative dispute resolution (ADR) processes, including voluntary mediation and specialized issue-oriented forums that may not require attorney representation. This may have the effect of fewer cases requiring formal dispute resolution services and less frequent attorney involvement. Those that cannot be resolved may be more complex and require more effort to resolve, thereby resulting in a higher average payment for defense attorneys in comparison with other states.

A brief overview of Minnesota’s dispute resolution features and other outcomes can be found in Chapter 5 on page 43 of the most recent Minnesota Workers’ Compensation System Report, 2019 published in 2021. See https://www.dli.mn.gov/sites/default/files/pdf/wcfact19.pdf.

Key: DR: Dispute resolution.
## Quick Reference Guide to Figures and Tables

### Measure Interstate Comparison

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Of course, any errors or omissions that remain are the responsibility of the authors.

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