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Workers' Compensation and Older Workers

By John F. Burton, Jr. and Emily Spieler

Summary

After rising sharply in the 1980s, workers' compensation costs and benefits declined during the 1990s. The recent decline may reflect, in part, a decline in the availability and adequacy of these benefits. Workers in the second half of their work lives are particularly likely to be affected by these changes. Although workers' compensation continues to compensate workers for acute short-term injuries, the availability of benefits for permanent disabilities associated with aging appears to be declining in many states. This trend is likely to shift benefit costs to other social and private insurance. To the extent that other programs do not replace earnings lost due to permanent disability, these costs are shifted to workers and their families.

Workers' compensation pays partial wage-replacement and medical benefits to workers who become disabled by work-related injuries and diseases (Box 1). This brief summarizes policy changes and issues facing workers' compensation, with a focus on aging workers. Workers' compensation programs draw few overt distinctions based on the claimant's age. Perhaps more important than overt age distinctions, however, is the inescapable fact that older workers are different from younger workers. Compared to younger workers, the data available indicate that older workers:

- Are less prone to injuries resulting from traumatic events;
- Are more prone to impairments associated with aging, including heart disease and back conditions;
- Take longer to heal and have greater impairments resulting from injuries; and,
- May experience more restricted mobility in the labor market as a result of occupational disabilities.

Workers' compensation is second in size only to Social Security disability insurance in providing benefits to disabled workers. In 1998, workers' compensation programs paid $41.7 billion in cash and medical benefits compared to $75.8 billion for Social Security disability insurance and associated Medicare benefits. Workers' compensation is different from Social Security disability insurance in several ways. For workers' compensation:

- The injury or illness must be work-related;
- Benefits are paid for temporary and partial disability, as well as long-term disability;
- Each state has its own program, with no federal guidelines;
- Benefits are administered through private insurers and self-insurance, as well as state run funds;
- Claims involve a great deal of litigation in some jurisdictions; and,
- Disputed cases can be, and often are, resolved by compromise and release agreements that pay a compromised amount in a lump sum and release the employer from further liability for cash benefits and usually from future medical benefits.

Costs Rose in the 1980s; Declined in the 1990s

In 1998, total employers' costs for workers' compensation were $52.1 billion while total benefits paid to

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workers were $41.7 billion. The $10.4 billion difference between benefits and employers' costs is attributable to various factors, including administrative expenses, profits for carriers, and attorneys' fees.

Over the past 15 years, costs and benefits changed sharply in two distinct periods. During 1984-1991 costs and benefits rose rapidly. As a share of covered payroll, total costs rose from 1.66 percent in 1984 to 2.16 percent in 1991. During this period many employers and insurance carriers became concerned, if not alarmed, about the rising costs and supported a series of changes designed to control costs. Between 1991 and 1998, benefits and costs declined (Figure 1). By 1998, costs as a share of covered payroll had dropped to 1.35 percent. The drop appears to reflect declining accident rates, the active management of medical treatment, and a tightening of eligibility for workers' compensation benefits. This brief focuses on those policy changes that may have a disproportionate effect on older workers.

Box 1. An Overview of Workers' Compensation

Benefits. Workers' compensation pays benefits to workers who sustain work-related injuries or illnesses. These benefits include medical treatment for the work-related condition; temporary total disability (TTD) benefits while the worker is recovering and unable to perform his or her regular job; permanent partial disability (PPD) benefits to compensate for the worker's permanent loss of earnings (or, in some states, permanent level of impairment), although the worker is expected to return to work; permanent total disability (PTD) benefits for workers who are unable to work; and survivor benefits to dependents when a worker dies as a result of an occupational injury or illness.

Financing. Employers pay for workers' compensation through premiums to private insurance companies, to state insurance funds, or through self-insuring. There is no direct employee contribution, although economic studies find that much of the cost is shifted to employees in the form of lower wages. Premiums are experience-rated and vary among firms based on the benefits paid by all the firms in the employer's industry and, for large employers, on the amount of previous benefits paid to the firm's own employees.

No-fault system. Unlike the civil justice system for compensating injuries, workers' compensation is a "no-fault" system. Employers are liable without regard to fault, and employees have to prove only that the injury or disease is "work-related," not that the employer was negligent. Employers' liability is limited to the benefits in the program, and employees cannot (with very limited exceptions) bring a tort suit against the employer to recover full economic losses or non-pecuniary losses, such as pain and suffering.

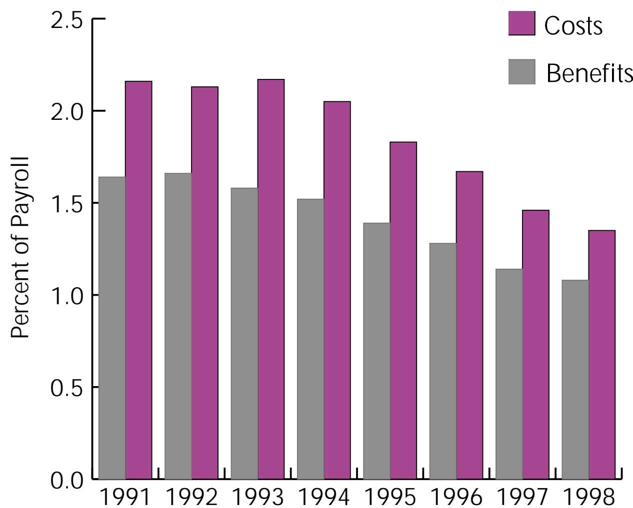
Injuries, Disabilities, and Older Workers

Three relationships are relevant to concerns about workers' compensation and older workers; the relationship between age and the prevalence of impairments or chronic conditions; the relationship between age and work disability; and the relationship between age and workers' compensation benefits paid.

Age and impairment. Work-related injuries are less common at older ages, but the severity of these conditions tend to increase with age according to data from the National Health Interview Survey (Table 1). For those aged 45-64, work injuries resulted in an average of 5 weeks (34.6 days) in bed, compared to about 3½ weeks (24.5 days) for younger persons age 25-44. Similarly, restricted activity resulting from work injuries lasted about 20 weeks for older persons, compared to 14½ weeks for younger persons.

While older workers are less likely to sustain work injuries, they are more likely than younger persons to have chronic conditions. The number of chronic conditions per 1,000 persons is considerably higher for 45-64 year olds than for younger persons for several of the most common conditions, including intervertebral disc disorders, orthopedic impairments of the back, hearing impairment, heart disease, and high blood pressure (Table 2). It is these conditions that present the most difficult issues regarding work-relatedness for workers' compensation.

Age and work disability. "Work disability" represents a limitation in the kind or amount of work a



Source: Mont, Burton, and Reno, 2000.

person can do because of a physical or mental impairment. It is influenced by vocational factors — the person's age, education, and prior work experience — as well as the nature of the impairment.[1]

The prevalence of work disability rises steadily with age (Figure 2). Among 25-34 year-olds, about 6 percent had a work disability, while among 55 to 64 year-olds about 22 percent were limited in the kind or amount of work they could do. Severe work disabilities, which generally preclude work, affected about 4 percent of 25-34 year olds, compared to 16 percent of those 55-64 years old.

Age and workers' compensation. Evidence on the relationship between age and the receipt of workers' compensation benefits is limited and inconclusive. Biddle, Boden, and Reville (2000) find that older workers are more likely than young workers to receive permanent partial disability benefits, as opposed to only temporary disability benefits from workers' compensation. In addition, older workers have larger earnings losses and are less likely to be re-employed after the injury. Finally, they find that workers' compensation replaces a smaller share of lost earnings for older workers than for younger workers. Tattrie (2000) examined employers' average costs per workers' compensation claim and found that while young workers have much lower average costs than middle-aged workers, costs for older workers are only modestly higher than for middle-aged workers.

Both of these studies provide clues that age is an important factor in determining the award and payment of benefits, but they are more tantalizing than conclusive about the exact nature of the relationship between age and workers' compensation.

Some impairments and disabilities that increase with age may reflect the "pure" effect of aging. With its work-related test, workers' compensation presumably should not have a higher incidence of awards for older workers that are due solely to aging. But conditions that are substantially aggravated by work may be more prevalent among older workers. Workers with these conditions are likely to be affected by recent policy changes in workers' compensation.

Recent Policy Responses to Rising Costs during 1984-1991[2]

Over half of state legislatures amended their workers' compensation laws between 1989 and 1997, largely in response to escalating costs in the 1980s and early 1990s. The specific changes varied considerably among states. Because each state's program has its

Table 1
Episodes of Injuries at Work and Their Consequences, by Age, United States, 1996

	All Ages[a]	25-44 Years	45-64 Years
Number of work injuries per 100 people	3.9	6.4	*1.7
Average number of bed days per injury	21.9	24.5	34.6
Average number of restricted activity days per injury	91.1	100.5	142.5

[a] Includes persons age 18-21.
* Means the "figure does not meet the standard of reliability or precision."
Source: Adams, Hendershot and Marano (1999), Tables 51, 53, and 55.

Table 2
Number of Selected Chronic Conditions Reported per 1,000 Persons, by Age, United States, 1996

Type of Chronic Condition	18-44 Years	45-64 Years
Arthritis	50.1	240.1
Intervertebral Discs	21.1	62.7
Hearing impairment	41.9	131.5
Deformity or orthopedic impairment	122.4	177.8
Back	80.6	102.8
Upper Extremity	13.3	29.4
Lower Extremity	43.2	82.5
Heart disease	39.3	116.4
High blood pressure (hypertension)	49.6	214.1
Chronic bronchitis	45.4	59.1

Source: Adams, Hendershot, and Marano (1999), Table 57.

own history of tradeoffs, care must be taken in generalizing about trends. To date, the specific effects of these changes on older workers have not yet been subjected to careful empirical research. But they can influence costs by affecting the number of approved claims, the amount paid for those claims, administrative costs in processing claims.

Reducing the number of approved claims. More restrictive rules governing eligibility for benefits is a prevalent feature of workers' compensation changes in the 1990s. They include: (1) limiting compensability when an injury aggravates a pre-existing condition; (2) stricter evidentiary requirements; (3) restricting compensability for particular conditions; (4) restricting compensability for permanent disability; and (5) discouraging fraudulent claims.

Limiting compensability when an injury aggravates a pre-existing condition may be the most significant development for aging workers. A predisposition to an injury or illness may now bar a worker from receiving workers' compensation benefits for an injury or illness caused by current workplace exposures in some states. Under traditional workers' compensation theory, compensation was not barred if the disability resulting from a work injury was increased because of a prior injury or an underlying chronic condition.

A number of states have now limited compensation when the current injury is not the sole or major cause of the disabling condition. These limitations come in a variety of forms:

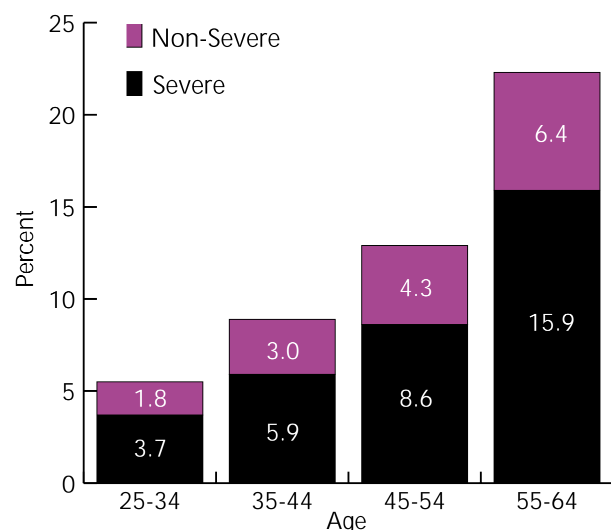
- Requiring that work be the primary cause of any disability (e.g. Oregon, Florida, South Dakota, Nevada);
- Excluding claims when current work is merely the triggering factor (Missouri); and,
- Requiring that any pre-existing condition be aggravated by a discrete accident, rather than chronic work exposure (Idaho).

Some of these changes specifically target older workers or the conditions that are prevalent among older workers. For example,

- Excluding from compensability conditions that are the effects of "the natural aging process" (e.g. Kentucky, Missouri, and Wyoming); and
- Requiring proof of a discrete injury if there is an underlying aging-related condition (New Hampshire).

In addition, some states are imposing stricter rules and shorter time limits for reopening prior claims when progression of a condition occurs (e.g. West Virginia, Kentucky, Wyoming, and Idaho). All of these changes can result in the denial of claims that are more prevalent among older workers.

Figure 2
Percent of Persons with a Work Disability by Age, 1999



Source: U.S. Census Bureau, tabulations of the 1999 Current Population Survey

Stricter evidentiary requirements can affect whether claims are approved. Statutory changes in a number of states now require that claimants prove that their injuries were both primarily work-related and that the resulting medical conditions can be documented by "objective medical" evidence. Requiring objective evidence excludes from coverage those claims based on the subjective reports by patients that cannot be substantiated by objective medical testing, such as reports of pain or psychological impairment. In addition, some jurisdictions are requiring claimants to meet increasingly strict burdens of proof.

Restrictions on compensability for particular conditions have targeted certain medical conditions that are regarded as primary cost drivers in workers' compensation. Some states have sought to exclude these conditions in order to limit aggregate workers' compensation costs. Two primary areas of restriction are psychological injuries and cumulative trauma disorders, also known as repetitive stress injuries. As the reported incidence of injuries caused by repetitive trauma skyrocketed, some state legislatures responded by tightening the eligibility standards for compensation. This was done using a variety of mechanisms: heightened burdens of proof; more specific causation requirements; and requirements for positive findings on specific diagnostic tests.

Stress and other psychological injuries present a more extreme picture. A number of states have made psychological conditions in the absence of a physical injury non-compensable. A very small number of states restrict compensation for a psychological injury even when it develops as a result of a physical injury and impairment.

Restrictions on compensability of permanent disability have been adopted to lower long-term costs. Until recently, many states considered the claimant's age, education and skills, in addition to physical impairment, in determining eligibility for PTD benefits. These vocational rules tended to benefit older, less educated workers with a history of working in manual jobs. Recently, several states have instituted more stringent requirements for physical impairment before a worker's other vocational factors will be considered.

Discouraging fraudulent claims has been a common focus of state programs. Although expanding criminal liability for fraud and publicizing fraud prosecutions of claimants deters intentionally fraudulent claims, it also may discourage workers from filing legitimate claims. Current research indicates that large numbers of workers with occupationally-caused disabilities do not file claims for workers' compensation (Biddle, et al, 1998; Pranksy, et al, 1999; Michaels, 1998; Morse, et al, 1999 and 2000). The decision by a worker not to seek benefits has been found to be affected by several factors including the worker's own fears regarding how the employer and others will react to the filing of a claim (Morse, 2000). Older workers may have more access to alternative benefits, such as Social Security disability insurance and vested pension benefits. To the extent that other programs lack the same level of stigmatization, workers may preferentially seek these alternative benefits, thereby shifting costs from workers' compensation to these other programs.

Reducing amounts paid in approved claims. Workers' compensation permanent partial disability benefits are designed to compensate the worker for loss of income resulting from the injury or illness, even though the worker is expected to remain active in the labor market. These benefits are the largest component of workers' compensation costs and were a primary target for reform in the 1990s. These changes have particular consequence to older workers, whose injuries tend to be more severe (Wegman, 2000). Three patterns of reform are evident:

- Reducing the duration or weekly amount of permanent partial disability benefits;
- Curtailing the wage-loss approach to calculating the benefits; and
- Moving toward benefits that are primarily determined on the basis of the impairment, rather than on the loss of earning capacity.

Medical care cost containment. Because workers' compensation experienced rapidly rising health care costs in the late 1980s, many states in the 1990s made changes to limit these health care costs. These changes included fee schedules; limits on the choice of treating physicians and on the amount or duration of health care; use of managed care networks, and some movement toward "twenty-four hour coverage," which integrated workers' compensation health care with other coverage. Most of these changes were designed to reduce the costs of health care in workers' compensation and to limit cost shifting from other payers. The likely results of these changes include: the transfer

of health care costs to the worker and to other health payers; decreases in medical costs in workers' compensation; increases in the control that the insurer or employer has over medical management; and, conversely, decreases in the worker's own control of his or her health care. This could be especially important to older workers, who are more likely to have chronic health conditions.

Rise of disability management and return to work programs. As with federal disability programs, there has been a significant growth in disability management and "return to work" programs in workers' compensation. Disability management can accomplish two critical goals:

1) Reducing costs by shortening the length of time a worker is out of work and lowering the permanent partial disability rating that results from longer absence from work; and
2) Improving the quality of life for workers by increasing successful post-injury employment.

The focus on return to work supports the decrease in the availability of permanent disability benefits. It may therefore affect older workers in two ways. First, if it results in successful extension of work life through appropriate workplace accommodations, it will tend to expand both earnings and retirement income levels. On the other hand, to the extent that it results in reduced benefits without successful extensions of work, it will erode the cushion provided by workers' compensation benefits to those who face reduced earnings as a result of partial disabilities.

Older Workers and Workers' Compensation

Several factors that must be considered in analyzing the adequacy of workers' compensation programs for older workers are:

1) Workers' compensation does not provide compensation for all occupationally-induced disabilities nor does it fully replaced lost wages when a worker is eligible for benefits. Workers' compensation is most adequate for workers who suffer short-term, acute injuries. Occupational diseases, chronic conditions resulting from long-term job exposures, and conditions that are caused by multiple factors have never been fully compensated by these programs.
2) Recent developments in some states reduce the likelihood that workers with chronic impairments will replace their lost wages through workers' compensation due to changes in eligibility rules and the approach to permanent disability.
3) The combined effect of changes in compensability will have their greatest impact on conditions that are most medically ambiguous, such as musculoskeletal conditions, hearing loss, arthritis, respiratory ailments, and heart diseases — all of which are more prevalent in older workers.
4) Aging workers face barriers in the labor market when they lose their jobs. The job mobility of disabled workers generally is also limited. Aging workers with disabilities are likely to face even greater barriers.
5) The decline in permanent disability benefits means that workers' compensation will be less of a source for ongoing wage replacement for aging workers in the future. This problem is exacerbated by the practice of compromise and release settlements.
6) To the extent that reductions in the availability of permanent disability benefits from workers' compensation affect injured workers who may be eligible for Social Security disability benefits or Supplemental Security Income (SSI), the federal programs bear more of the costs for these disabled workers.
7) State legislatures and those who lobby for restrictions on workers' compensation benefits focus only on the costs of workers' compensation programs and not on the costs that are externalized to other programs or to workers and their families.

The implications of these factors for older workers and for other social and private insurance programs are troubling. Like other social insurance programs, workers' compensation was designed to provide protection against economic insecurity and catastrophic losses. But more than other programs, workers' compensation was also expected to provide disabled workers with a substantial proportion of the income lost as a result of the work-related injury or illness. We are concerned that workers' compensation may be increasingly failing to meet both goals, especially for older workers.

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Endnotes

1. For a good discussion of this issue, see Berkowitz (1988).
2. Much of the information in this section is drawn from Berreth (1992, 1994, 1996, 1997).

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