Workers’ Compensation and Older Workers

John F. Burton, Jr.
Rutgers University

Emily A. Spieler
West Virginia University

Chapter 3 (pp. 41-83) in:
Ensuring Health and Income Security for an Aging Workforce
Peter P. Budetti, Richard V. Burkhauser, Janice M. Gregory,
and H. Allan Hunt, eds.
Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 2001
DOI: 10.17848/9780880994668.ch3

Copyright ©2001. W.E. Upjohn Institute for Employment Research. All rights reserved.
Workers’ Compensation and Older Workers

John F. Burton, Jr.
Rutgers University

Emily A. Spieler
West Virginia University

State and federal workers’ compensation programs provide cash payments and medical benefits to workers disabled by work-related injuries and diseases. This chapter summarizes major issues facing workers’ compensation, with a focus on aging workers. In the first section, we give an introductory overview of workers’ compensation that may be most useful to those relatively unfamiliar with the program. This section includes a description of eligibility requirements, particularly the work-relatedness tests; a brief summary of the critical ways in which workers’ compensation differs from other social insurance programs; and a description of recent cost trends.1 The second section examines the particular issues of older workers relating to chronic impairment and disability, and the third discusses the problem of applying the standard of work-relatedness to chronic health conditions that do not fit easily into the traditional definitions of compensable conditions, focusing on back conditions.2 The fourth section reviews some of the recent legislative and judicial changes that are most likely to impact older workers, particularly with regard to eligibility for benefits.

In the final section, we briefly address the following question: what are the likely effects of changes in workers’ compensation programs on the adequacy of this program for older workers with work-related or work-aggravated disabilities? Our attempt to answer this question must be read with the understanding that there has been little empirical investigation of the different experiences of older and younger workers in these programs. We are thus forced to speculate, and we hope to encourage additional research that will explore this question.
Workers' compensation programs draw few overt distinctions based upon the age of the applicant for benefits. Exceptions to this general rule are discussed later in this paper. Perhaps more important than overt age distinctions, however, is the inescapable fact that older workers are themselves different from younger workers: older workers are less prone to injuries resulting from traumatic events; they are more prone to impairments associated with aging, including heart disease and back conditions; they may take longer to heal and have greater impairments resulting from injuries than younger workers; and their mobility in the labor market may be more restricted than younger workers with occupational disabilities. Older workers may therefore be affected differently by certain aspects of the system. For example, because of the legal rules used to determine eligibility for workers' compensation benefits, health conditions associated with older age may be less likely to be compensated. We believe that recent developments in workers' compensation have increased the barriers to obtaining benefits for these conditions and have limited the amount of available benefits for permanent disabilities that are more common in older workers. As a result, costs of workplace injuries and diseases are likely to be shifted to other public and private programs or to the workers themselves and their families.

OVERVIEW OF WORKERS' COMPENSATION

Unlike the civil justice system for compensation of injuries, workers' compensation is a "no-fault" system: employers are liable without regard to fault, and employees only have to prove 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 and recover for full economic losses or for nonpecuniary losses such as pain and suffering. This limited liability/no fault scheme is often described as the two sides of the workers' compensation principle.

Workers' compensation provides benefits only to workers who suffer from work-related injuries or illnesses and, in some instances, to their dependents. These benefits include medical treatment for the
work-related condition; temporary total disability benefits for the period that the worker is recovering but is unable to perform his or regular job; permanent partial disability 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 active work; permanent total disability benefits for workers who are unable to work; and benefits to surviving dependents when a worker dies as a result of an occupational injury or illness.

Most employees are covered by the workers' compensation system, although in some states there are exclusions for very small employers or particular categories of workers (most commonly, agricultural and domestic employees). Persons who are not employees (e.g., independent contractors) are generally not covered. For a claim to be covered, the employee must incur medical expenses, suffer permanent impairment, or be absent from work because of a work-related health condition.

The most common type of workers' compensation claim involves an injury that requires medical treatment but no claim for cash benefits. In theory, these medical benefits are provided for the particular injury or illness for the duration of the condition, irrespective of whether the individual is working or is totally disabled. In fact, however, in cases involving more serious injuries, medical benefits may be included in cash settlements of claims, and workers may then not have medical coverage for the condition if it persists.

The most common type of claim for cash benefits is for temporary total disability benefits. Often, workers who suffer acute injuries will collect these temporary benefits for a limited period of time and then return to work. Once workers recover from the injury (reach "maximum medical improvement," or MMI) or return to work, they are no longer eligible for temporary total disability benefits. In some states, when workers return to a reduced work schedule, they may receive temporary partial disability benefits.

At the point of MMI or return to work, workers may be eligible for permanent partial disability benefits if they have a permanent impairment or suffer wage loss or loss of earning capacity as a result of the injury. Permanent partial disability (PPD) benefits are theoretically designed to replace earnings lost as a result of the permanent impairment. The expectation is that workers who receive these benefits will
return to work, either at their old job or at a new one. PPD benefits are, in the aggregate, the most expensive (and most controversial) type of benefits in workers’ compensation programs. Despite their expense, however, recent studies suggest that these benefits do not fully replace lost earnings for injured workers (Petersen et al. 1997; Boden and Galizzi 1999; Biddle, Boden, and Reville 2001). Permanent total disability benefits, which on average are the most expensive type of award, are rarely granted.4

Eligibility for Workers’ Compensation Benefits: The Work-Relatedness Test

To be compensable, a claim must relate to an injury or illness that “arises out of” and “in the course of” employment. Eligibility for workers’ compensation benefits is thus tied to the work-relatedness of the health condition or disability. In most states, the employee must meet four legal tests to establish that an injury is work-related and therefore the employee is entitled to benefits:

1) there must be a personal injury, which in some jurisdictions is interpreted to exclude mental illnesses;

2) that results from an accident, which is a test normally involving two elements: the injury must be unexpected or unusual, and the injury must be traceable, within reasonable limits, to a definite time, place, and occasion;

3) that must arise out of employment, which means the source of the injury must be related to the job (a worker shot at work by a neighbor because of a personal quarrel is unlikely to satisfy the arising out of employment test); and

4) that must occur during the course of employment, which normally requires that the injury occur on the employer’s premises and during working hours.

Under the traditional rule, if a worker met these four tests, then he or she was generally entitled to full cash and medical benefits, even if the medical condition was due to multiple causes. There was, in short, generally no effort to apportion causation.
These four tests are relatively easy to apply for injuries resulting from traumatic events, such as fractures or amputations resulting from malfunctioning machinery at work (which normally are compensable) or from automobile accidents (which normally are compensable if they occur as part of the job during paid time, and are generally not compensable if they occur when a worker is driving to or from work). These four tests are also relatively easy to apply to medical conditions resulting from a single cause. For example, an asbestos-exposed worker with a diagnosis of mesothelioma is likely to meet the work-relatedness test for compensation because this rare cancer is almost always associated with exposure to asbestos (although there may be other obstacles to compensability, such as the application of rules governing time limits for the filing of claims).

The tests are more difficult to apply to diseases that occur regularly in everyday life, or that have multiple causation, or that result from long-term exposures at work. Historically, the exclusion of these diseases was often based on the application of the "accident" test. Workers' compensation statutes typically now have special compensability rules for diseases, although often these contain restrictions that are not used for injuries. Occupational diseases remain largely uncompensated today, as a result of a variety of factors: 1) the "accident" test persists in some states; 2) statutes of limitations sometimes require that a claim be filed within a few years of the last exposure, and not all state systems have expanded the time limits to include diseases with long latency periods; 3) "ordinary diseases of life" are still often not compensable, even if the particular individual's disease is occupationally caused; and 4) many occupationally caused diseases are not properly diagnosed by physicians. The result of these factors is that workers' compensation often does not provide benefits for disability associated with chronic diseases that are caused by work.

In addition, there is a growing body of evidence that suggests a significant underreporting of work-related health problems to workers' compensation programs (Biddle et al. 1998; Michaels 1998; Morse et al. 1998; Pransky et al. 1999; Morse, Dillon, and Warren 2000). The underreporting is likely to be a particular problem for older workers, who are most likely to suffer the long-term effects of work exposures.
Key Differences between Workers' Compensation and Other Major Social Insurance Programs

Several aspects of workers' compensation distinguish it from other social insurance programs in the United States. First, as noted in the prior subsection, the injury or illness must be work-related. The question of work-relatedness is a difficult one, particularly when work and nonwork factors contribute to an individual's disability. Individuals whose conditions are deemed work-related by the compensation systems will receive benefits; those whose conditions are not deemed work-related will receive no benefits.

Second, workers' compensation programs emerged in the United States about 1910, when a federal workers' compensation program for private employees would have been unconstitutional. It is therefore a state, rather than a federal, program. More accurately, it consists of over 50 programs: one for each state, plus several federal programs for federal employees, longshore workers, coal miners, and so on. Despite several attempts during the last century, federal standards for the state workers' compensation programs have never been adopted. This means both that eligibility and benefit levels vary significantly among states and that it is difficult to formulate broad conclusions regarding trends without careful study.

Third, workers' compensation provides a variety of cash benefits that do not require total and permanent disability. The duration of a worker's cash or medical benefits may range from days to a lifetime. Unlike other social programs, workers' compensation provides partial benefits that recognize that a worker's earning capacity may be reduced, but not eliminated, by the disability.

Fourth, the financing scheme for workers' compensation includes private insurers and self-insurance, as well as state run funds. Although premium rates are regulated in many states, this is nevertheless primarily a private insurance market, more similar in some respects to the health insurance market than to Social Security or unemployment insurance.

Fifth, claims for workers' compensation benefits involve a substantial amount of litigation in some jurisdictions. Unlike Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claims, employers or their insurance carriers must pay the costs of
claims, and therefore they have a strong incentive to mount a vigorous defense. Litigation tends to focus on issues of compensability, particularly work-relatedness questions, and the extent or duration of permanent disability.

Sixth, these disputed cases can be, and often are, resolved by "compromise and release agreements" that typically involve three elements: a compromise between the worker and the employer concerning the amount of benefits to be paid; the payment of the compromised amount in a lump sum; and the release of the employer from further liability for both cash and medical benefits. The terminology for compromise and release agreements varies among states: examples of alternative terms are "lump-sum settlements" and "wash-outs." It is likely that many workers use these settlements to meet immediate, rather than future, income needs.6

As a result of these differences, workers' compensation functions in a manner that is quite different from federal programs (e.g., Social Security), or state programs that operate with federal financing (e.g., vocational rehabilitation), or even state programs that are funded by payroll taxes and are governed by some federal guidelines (e.g., unemployment insurance).

**Financing and Cost Trends in Workers' Compensation Programs**

Employers are nominally responsible for the cost of workers' compensation, although a substantial portion of the cost is shifted to employees in the form of lower wages. Insurance premiums are paid based on a percentage of payroll. Insurance rates are experience-rated and vary among firms based on the benefits paid by all the firms in the employer's industry and, for larger employers, on the amount of previous benefit payments to the firm's own employees.

In 1998, workers' compensation programs provided $41.7 billion of benefits to workers disabled by work-related injuries and diseases (Mont, Burton, and Reno 2000). Cash benefits accounted for $25.8 billion (62 percent of total benefits) and medical and rehabilitation benefits accounted for $15.9 billion (38 percent). Private carriers paid about 53 percent of these benefits, state and federal funds about 25 percent, and self-insuring employers about 22 percent. Total employers' costs were $52.1 billion in 1998. The $10.4 billion difference between total
benefits and employers’ costs was attributable to various factors, including administrative expenses, profits for carriers, and attorneys’ fees.

Current figures do not give the full picture of the rapidly changing costs and benefits paid by workers’ compensation programs over the past 15 years. In fact, conditions changed rapidly over this period, with benefits paid and employers’ costs increasing rapidly from 1984 to 1991, and then declining rapidly from 1991 to 1998. From 1984 to 1991, workers’ compensation benefits (cash and medical) increased from $19.7 billion to $42.2 billion, or an average annual increase of 11.5 percent. Benefits increased from 1.21 percent of payroll in 1984 to 1.64 percent in 1991. Employers’ workers’ compensation costs also increased during this period, from $25.1 billion in 1984 to $55.2 billion in 1991, an average of 11.9 percent increase per year. This rapid escalation in costs far outpaced payroll growth. As a result, workers’ compensation costs as a percentage of payroll increased rapidly, rising from 1.66 percent in 1984 to 2.16 percent of payroll in 1991.

Throughout the late 1980s and early 1990s, many employers and insurance carriers became concerned, if not alarmed, about these increasing costs of the workers’ compensation program. One result was that employers and carriers supported a series of changes in the program that are examined later in this chapter.

These changes (or “reforms”) were important factors in the trends in the aggregate benefits and costs for the workers’ compensation program after 1991. Benefits paid to workers in current dollars decreased from $42.2 billion in 1991 to $41.7 billion in 1998, which represented a 0.2 percent annual rate of decrease. While benefit payments declined, employment and payroll surged in the 1990s, and so benefits as a percentage of payroll peaked at 1.66 percent of payroll in 1992 and then plummeted to a low of 1.08 percent of payroll in 1998. The multi-year decline in benefits paid relative to payroll is unprecedented in duration and magnitude since at least 1948, when the annual data from the workers’ compensation programs were first published for successive years. Accompanying the slowdown or decline in benefit payments to workers was a similar development for the employers’ costs of workers’ compensation. The costs were $55.2 billion in 1991, increased to $60.8 billion in 1993, and then fell to $52.1 billion in 1998. Because payroll grew rapidly during the period, the employers’
costs as a percentage of payroll plateaued briefly (2.16 percent of payroll in 1991 and 2.17 percent of payroll in 1993) and then spiraled down to 1.35 percent in 1998.

The sources of the rapid increases in workers' compensation benefits and costs between 1984 and 1991 and the stagnation or decline of these aggregate measures of the workers' compensation program during the 1990s are examined in Spieler and Burton (1998) and Thoma-son, Schmidle, and Burton (forthcoming).

SPECIAL CONCERNS OF OLDER WORKERS

There are three relationships that are relevant to our interest in the responsiveness of the workers' compensation program to the concerns of older workers. First, what is the relationship between age and the prevalence of impairments? We use the term impairment to mean "a deviation from normal in a body part or organ system and its functioning" (American Medical Association 1993, p. 1/1). An impairment can result from an injury or an illness and can lead to the inability to perform activities of daily living (American Medical Association 1993, p. 1/1). Second, what is the relationship between age and the prevalence of disability? We use the term disability to mean reduction or "alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment" (American Medical Association 1993, p. 1/2). Our particular concern is work disability. The extent of work disability resulting from an impairment is affected by personal attributes, such as age, education, and job experience, as well as external factors, such as the state of the labor market and the extent of job modifications. Third, what is the relationship between age and the prevalence of workers' compensation benefits? Even if work disability increases with age, the compensability rules for workers' compensation may preclude some of the disabled workers from obtaining benefits.
Age and Impairment

The relationship between age and the prevalence of impairments varies by the source or type of impairment. The frequency of work-related injuries generally declines with age; severity, however, tends to increase with age (Wegman 2000). This pattern is shown in Table 1; the frequency of work injuries is lower for workers in the 45–64 years age category than for younger workers (ages 18–24 and 25–44), while the numbers of restricted-activity days and bed days associated with work injuries are higher for workers in the 45–64 years age category than for younger workers.

While the Table 1 data show that the frequency of work injuries is lower for older workers, the data shown in Table 2 indicate that the number of chronic conditions per 1,000 persons for those 45–64 years old is considerably higher than the rate for persons aged 18–44 for several of the most common conditions, including intervertebral disc disorders, orthopedic impairments of the back, hearing impairment, and heart disease. It is these “border-challenging” conditions that present the most difficult issues regarding work-relatedness for workers’ compensation systems. We explore the historical treatment of one of the most common of these conditions, back injuries, in the following section.

Table 1 Numbers of Episodes of Injuries at Work and Their Consequences per 100 Persons, by Age

<table>
<thead>
<tr>
<th></th>
<th>All ages</th>
<th>18–24 yr.</th>
<th>25–44 yr.</th>
<th>45–64 yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes of persons injured</td>
<td>3.9</td>
<td>5.4*</td>
<td>6.4</td>
<td>1.7*</td>
</tr>
<tr>
<td>Number of restricted-activity days associated with episodes</td>
<td>91.1</td>
<td>45.4*</td>
<td>100.5</td>
<td>142.5</td>
</tr>
<tr>
<td>Number of bed days associated with episodes</td>
<td>21.9</td>
<td>3.1*</td>
<td>24.5</td>
<td>34.6</td>
</tr>
</tbody>
</table>


a Data are for the United States in 1996.

b An asterisk (*) means the “figure does not meet standard of reliability or precision.”
Table 2  Number of Selected\textsuperscript{a} Reported Chronic Conditions per 1,000 Persons, by Age\textsuperscript{b}

<table>
<thead>
<tr>
<th>Type of chronic condition</th>
<th>All ages</th>
<th>18–44 yr.</th>
<th>45–64 yr.</th>
<th>65 yr and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>127.3</td>
<td>50.1</td>
<td>240.1</td>
<td>482.7</td>
</tr>
<tr>
<td>Intervertebral discs</td>
<td>25.4</td>
<td>21.1</td>
<td>62.7</td>
<td>32.2</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>83.4</td>
<td>41.9</td>
<td>131.5</td>
<td>303.4</td>
</tr>
<tr>
<td>Deformity or orthopedic impairment</td>
<td>111.6</td>
<td>122.4</td>
<td>177.8</td>
<td>157.6</td>
</tr>
<tr>
<td>Back</td>
<td>64.0</td>
<td>80.6</td>
<td>102.8</td>
<td>68 7</td>
</tr>
<tr>
<td>Upper extremity</td>
<td>15.8</td>
<td>13.3</td>
<td>29.4</td>
<td>30.9</td>
</tr>
<tr>
<td>Lower extremity</td>
<td>48.0</td>
<td>43.2</td>
<td>82.5</td>
<td>72.6</td>
</tr>
<tr>
<td>Heart disease</td>
<td>78.2</td>
<td>39.3</td>
<td>116.4</td>
<td>268.7</td>
</tr>
<tr>
<td>High blood pressure (hypertension)</td>
<td>107.1</td>
<td>49.6</td>
<td>214.1</td>
<td>363.5</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>53.5</td>
<td>45.4</td>
<td>59.1</td>
<td>63.5</td>
</tr>
<tr>
<td>Asthma</td>
<td>55.2</td>
<td>56.9</td>
<td>48.6</td>
<td>45.5</td>
</tr>
<tr>
<td>Hay fever or allergic rhinitis without asthma</td>
<td>89.8</td>
<td>109.4</td>
<td>104.8</td>
<td>67.7</td>
</tr>
<tr>
<td>Chronic sinusitis</td>
<td>125.5</td>
<td>144.7</td>
<td>174.1</td>
<td>117.1</td>
</tr>
</tbody>
</table>

\textsuperscript{a} All conditions with at least 50 chronic conditions per 1,000 persons are included in this table.

\textsuperscript{b} Data are for the United States in 1996.

**Age and Disability**

The relationship between impairment and disability is complicated because of the multiplicity of factors, including age, education, and experience, that interact with a given impairment to produce work disability. Isolating the effect of age per se on disability is especially complicated because age may be correlated with other factors, notably work experience. Berkowitz (1988) provided a good discussion of the difficulties of capturing the independent effect of age and also provided
an unambiguous conclusion: age is related to disability even after controlling for the other determinants of disability.

The general relationship between age and work disability (not controlling for factors such as experience) is documented by Pransky (2001, Table 4). According to U.S. Census data from 1989, the percentage of persons who report work disability increases steadily with age. Thus, while 7.1 percent of 35- to 44-year-olds report work disability, 10.3 percent of those aged 45–54 and 22.3 percent of those aged 55–64 report they are disabled for work. Burkhauser, Daly, and Houtenville (2001, Table A2) present data from the Current Population Survey which indicate that disability is increasing over time for workers in the same age category. Thus, 6.7 percent of persons aged 35 to 44 reported they were disabled in 1999, up from 5.9 percent of persons in that age category in 1988. Similarly, 10.4 percent of persons aged 45–54 indicated they were disabled in 1999, up from 9.1 percent of persons in that age category in 1988. These and other studies clearly demonstrate a general positive relationship between age and work disability. This association is compounded and partially explained for older workers by the general decrease in labor market mobility associated with advancing age (Hirsch, Macpherson, and Hardy 2000).

Age and Workers’ Compensation

The evidence concerning the relationship between age and the receipt of workers’ compensation benefits is more fragmentary and inconclusive. Biddle, Boden, and Reville (2001, Tables 2, 4, and 7 and Figure 1) have provided evidence that the proportion of workers’ compensation cases paying permanent partial disability benefits increases with age; that earnings losses and injury-related non-employment for workers receiving permanent partial disability benefits increase with age; and that replacement rates (workers’ compensation benefits as a percent of earnings losses) decline with age. Tattrie (2000) has presented some preliminary data suggesting that a young workforce has much lower costs per claim than a middle-aged workforce, but that average costs per claim of older workers are only modestly higher those of 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 the workers' compensation program. In order to better understand the performance of workers' compensation in providing benefits to workers in different age categories, it would be useful to have data showing for various age categories the frequency of workers' compensation claims per 100,000 workers, the average benefits per claim, and the total costs of workers' compensation benefits per 100,000 workers. These data should be disaggregated not only by age but also by the nature of the impairment or medical condition causing the disability. Specifically, the data should distinguish between disability resulting from injuries and disability resulting from the chronic conditions identified in Table 2.

We are not suggesting that the patterns of workers' compensation payments for different age groups should necessarily match the patterns of impairments or work disability for these age groups. Some of the conditions showing an increasing incidence of impairments for older persons in Table 2 may reflect the pure effect of aging. Workers' compensation, with its work-related test, presumably should not have a higher incidence of conditions for older workers that are due solely to aging. Yet, conditions that are substantially aggravated by work may be more prevalent among older workers. These conditions may be of greater concern, particularly in view of the changes in compensability standards (described later) that have occurred in some states. Some of these conditions, notably disorders involving the back, have traditionally met the compensability tests for workers' compensation benefits. If the data indicate that the frequency of compensable back disorders does not increase with age, or if the overall frequency of compensable back or similar disorders is declining, the results will suggest that recent reforms of the eligibility rules for workers' compensation have had a particularly deleterious effect on older workers.
BACKS: CASE STUDY OF A MEDICAL CONDITION WITH A HISTORICAL PROBLEM OF APPLYING THE WORK-RELATED TESTS

Work-relatedness, as we have noted, is the key to eligibility for workers’ compensation benefits. The four legal tests described in the first section of this chapter are particularly difficult to apply to medical conditions resulting from multiple causes. Where impairments are caused by workplace exposures combined with personal lifestyle, aging, or hereditary factors, workers’ compensation systems are confronted with a particularly challenging problem. The chronic impairments that increase with age (see Table 2) are among the conditions that are likely to fall into this category. All of these conditions can be considered “border-challenging” in the sense that they challenge the boundaries of the work-related tests for workers’ compensation. Thus, a workers’ compensation program is likely to have difficulty deciding whether the work-related test is met for a heart attack of a worker who is under job stress, smokes, is 55 years old, and has a family history of heart disease.

The workers’ compensation programs in the various states have developed a variety of refinements to the work-related tests in order to deal with these more complex cases involving medical conditions resulting from exposures over time and/or conditions resulting from multiple causes. Back injuries provide an interesting case study. An examination of the issues pertaining to the compensability of back conditions in workers’ compensation programs is instructive because of the mixed etiology of many back conditions; the relative importance of back cases in the workers’ compensation program (they account for about 40 percent of all benefit payments); and the prevalence of back disorders in older workers. Burton (1992) examined the medical and legal approaches to back disorders.

The Medical Approach

Three sources of back disorders can be distinguished from a medical standpoint. First, there are fractures and dislocations of the back. These conditions are relatively uncommon, although they can be quite
serious. The common causes of fractures and dislocations are traumatic events such as direct blows and falls from heights.

Second, there are sprains and strains of the back. The back is the most frequently affected part of the body; each year nearly 1 out of 30 persons of working age experiences a strain or sprain of the back of sufficient severity to either require medical care or restricted activity. In general, strains and sprains have less serious consequences than fractures and dislocations and are likely to result from less obvious events.

Third, there are diseases of the back, in which damage to the body results from a slowly developing condition rather than from an acute traumatic event. However, the symptoms of many diseases can be precipitated by trauma. Following the approach of Kelsey (1982), diseases can be separated into those involving specific conditions of the back or neck (such as prolapsed discs, degenerated discs, and spondylolisthesis) and those of a more general nature that frequently affect the back (such as osteoarthritis).

Prolapsed intervertebral discs (also known as herniated discs, ruptured discs, or “slipped” discs) are one of the most common sources of disability among the working-age population. At one time, physical trauma was believed to be the only cause of prolapsed discs. However, the accepted medical view now is that, although trauma is sometimes the precipitating event, many prolapsed discs occur without any antecedent trauma, and trauma is seldom the underlying cause.

Two other diseases affecting the back are disc degeneration and spondylolisthesis. A confusing matter for each of these conditions is many people with x-ray evidence of the disease have no symptoms. In addition to the diseases specifically affecting the back, there are other diseases of a general nature that can affect the back, including arthritic disorders.

Burton (1992) made four generalizations about the medical approach to back disorders.

1) Pain in the back and neck are very common problems.

2) In a large portion of cases of low back and neck pain, a definite diagnosis cannot be made. This is partially because the symptoms often are not uniquely associated with a particular disease; partially because x-ray evidence of a disorder often is associated
with no symptoms; and partially because a particular patient may have multiple disorders.

3) The contribution of the workplace to back disorders is difficult to ascertain.

4) The medical view of trauma as a cause varies among the three sources of back disorders. For a fracture or dislocation, a traumatic event normally is readily identifiable as the likely cause. For a strain or sprain, a less significant and therefore less identifiable trauma is the likely cause. For diseases, the role of trauma is much more problematic. Trauma or mechanical stress seems to be a precipitant or perhaps an aggravating factor, rather than the underlying cause for diseases affecting the back. The true culprit often is age, although factors such as hereditary disposition also may be involved.

The Legal Approach

Backs are almost always treated as injuries rather than diseases in workers’ compensation programs. Consequently, the four legal tests for a compensable injury are normally used to decide whether back injuries are work-related. The most difficult legal test for claims involving backs is the accident requirement.

There appears to be little problem with reconciling the medical knowledge concerning fractures and dislocations with the legal approach to these back disorders. There is normally an external traumatic event that causes the back problem, and the application of the accident test is no more difficult than in most workers’ compensation cases. However, fractures and dislocations represent only a small proportion of the back disorders handled by workers’ compensation, so there is little consolation to be derived from this congruence of the medical and legal approaches.

Among back disorders caused by disease, the legal approach makes it easier for herniated discs than for other back disorders to meet the accident test. This is largely because the law relies on an outmoded view of causation in which external trauma is assumed to be the cause of discal herniation. Probably the most serious problem with the legal approach, however, is the implicit assumption that herniated discs can
be differentiated from other sources of back disorders, while medically this is often not possible.

Another aspect of the legal approach to back disorders resulting from diseases (other than herniated discs) is to hold that the accident test is met when unusual exertion is the precipitant of the back disorder but to deny compensation when there is only usual exertion. However, from the medical standpoint (aside from the few cases involving obvious trauma), there is little proof that pattern of use causes lower back disease. In fact, the conclusion that results from this review of the legal rules used to decide which back disorders are work-related (and therefore are compensable) is that these rules have little scientific validity.

While backs are the most important medical condition for which application of the work-related test causes problems, there are similar problems for other medical conditions such as heart disease, stress, and repetitive trauma, for which the etiology can involve a mixture of hereditary, degenerative, and occupational factors. The higher prevalence of these conditions in older workers poses a particular challenge for workers' compensation systems.

**CHANGING RULES IN WORKERS' COMPENSATION: RESPONSES TO THE COST INCREASES OF 1984–1991**

The aggregate costs of workers' compensation, like those of other social insurance programs, are primarily affected by four factors: the number of claims that are filed, the number that are approved for payment, the amount of benefits paid in approved claims, and the amount of administrative and other costs associated with the provision of benefits. Over half of the state legislatures passed major amendments to workers' compensation laws during the period 1989–1997, largely in response to organized political opposition by employers and insurers to escalating costs. During this period of retrenchment, these legislative changes (together with judicial rulings) tightened eligibility rules, lowered the amount of benefits paid on some claims, changed mechanisms and time periods for payment for permanent disabilities, instituted various health care cost containment strategies, and heightened requirements for applicants' burden of proof. This section describes some of
these changes and speculates regarding the likely effects of these changes on older workers.

The specific changes in the availability of benefits vary considerably among states. Moreover, since each state’s program is an interdependent system with its own history of tradeoffs among key provisions, it is important to be careful in making generalizations about trends. It is also important to note that the specific effects of these changes on older workers have not yet been subjected to careful empirical research; data based on age of applicants or beneficiaries are not generally available. It does appear quite likely, however, that many of these changes may particularly restrict the access of older workers to workers’ compensation benefits. The result of these restrictions is therefore likely to be a transfer of disability costs related to occupational morbidity to other social insurance programs or directly to aging workers and their families. This is particularly true for those workers who cannot meet SSDI eligibility requirements because they are only partially disabled, but who are unable to continue to work at their regular or similar wage jobs as a result of their work-related disabilities.

Reducing the Number of Claims in the Workers’ Compensation System

The development of more restrictive rules governing eligibility for benefits has been a prevalent feature of workers’ compensation changes in the 1990s.

Limitations on coverage when the injury involves aggravation of a preexisting condition

Perhaps the most significant development for aging workers is the growing restriction on compensation for disabilities when the worker suffers from a preexisting health condition. This means that a predisposition to an injury or illness may bar a worker from receiving workers’ compensation benefits for an injury or illness caused by current workplace exposures, and that the systems are tightened for those conditions that we have characterized as “border-challenging.”

As noted above, under traditional workers’ compensation theory, compensation did not depend on whether the worker’s condition was caused, in part, by a prior injury or an underlying chronic condition.
Thus, a worker who was aging or who had some preexisting nondisabling condition was not barred from coverage for an injury occurring at work, even if the underlying condition contributed to the occurrence of the injury or to the extent of the resulting disability. Through a variety of legislative and judicial changes, rules governing compensation for preexisting conditions or aggravation have been tightened in many jurisdictions.

Most significantly, 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 major or primary cause of the disability (e.g., Oregon, Florida, South Dakota, and Nevada); excluding from compensability injuries for which current work is merely the triggering factor (Missouri); and requiring that any preexisting condition be aggravated by a discrete accident, rather than chronic work exposures (Idaho). A few of these changes specifically target older workers, or the conditions that are prevalent among older workers. For example, several states now specifically exclude injuries or resulting disabilities or impairments from compensability if they are the effects of "the natural aging process" (e.g., Kentucky, Missouri, and Wyoming), and one state requires proof of a discrete injury if there is an underlying aging-related condition (New Hampshire). These changes are further strengthened both by heightened general evidentiary standards for claimants, including the requirements for "objective medical evidence" (discussed below) and by stricter rules and shorter time limits for reopening prior claims when progression of a condition occurs (e.g., West Virginia, Kentucky, Wyoming, and Idaho). These changes have resulted in the denial of claims involving cumulative trauma disorders, asthma and other respiratory conditions, low back and other musculoskeletal disorders, and so on. 11

In Oregon, the revised rule meant that a steel worker who was predisposed to respiratory illness because of underlying airway irritation disease and who suffered from an occupationally caused lung disease was not entitled to compensation under the state workers' compensation law. 12 Subsequent developments in Oregon show the interesting underbelly of workers' compensation politics and litigation. Because the worker was foreclosed from seeking workers' compensation benefits, he was successful in maintaining a common law tort action against
his employer. The Oregon legislature then responded quickly to employers' concerns about this erosion of the usual workers' compensation bar to civil actions, passing a revised state statute that extends workers' compensation exclusivity "to all injuries and to diseases, symptom complexes or similar conditions" arising out of employment "whether or not they are determined to be compensable under this chapter." Under this provision, workers with occupationally exacerbated conditions are barred from recovering benefits both under the workers' compensation program and in a civil law suit, even if the injury was due to an employer's negligence. Another worker then challenged the new statute as an unconstitutional denial of remedies; in 1997 an Oregon appellate court upheld its constitutionality. As of August 28, 2000, this case was still under consideration by the Oregon Supreme Court. Similar cases are pending in other states, including Idaho.

In addition, second-injury funds (instituted initially to promote the employment of war veterans) historically provided insurance coverage for disability that resulted from the combined effects of a new injury and preexisting conditions. Over the past 20 years, costs associated with second injuries rose, and employers and insurers had little incentive to defend against claims that would be charged to these funds. These funds were generally underfunded, but reformulated accounting principles forced states to recognize the magnitude of future unfunded liabilities. In the 1990s, the private insurance industry led a lobbying campaign for the elimination of the funds. Serious underfunding, when combined with unsubstantiated arguments that disability discrimination laws have made these funds obsolete, resulted in the abolition or severe restriction of second injury funds in a number of states (e.g., Colorado, Utah, Florida, Minnesota, and New Mexico). To the extent that the disability discrimination laws do in fact result in increased hiring of previously injured workers, the elimination of the financial protection offered by second-injury funds means that employers might face increased workers' compensation liability for aggravation of old injuries or chronic conditions. With the abolition of these funds, employers have more incentive both to fight individual claims and to argue in the political arena for reduced workers' compensation coverage for injuries previously compensated by these funds.
Although these changes vary in their scope, they all have the same effect: they limit the liability of workers' compensation systems when a worker brings to his or her current employment an increased level of risk of injury or disability. The likely result may be the exclusion of claims by workers, often older workers, with preexisting chronic musculoskeletal and pulmonary conditions and underlying chronic diseases that predispose them to injury and illness caused by work.

**Procedural and evidentiary changes in claims processing that restrict compensability**

More subtle, but equally restrictive, changes are occurring in the approach to the evaluation of evidence in many state workers' compensation systems. For example, statutory changes in a number of states now require that a claimant prove that his or her injury was both primarily work-related and that the resulting medical condition can be documented by "objective medical" evidence. These heightened requirements appear to be rooted both in a desire to save money and in a distrust of subjective reports of injuries by claimants. A broad requirement for objective evidence excludes from coverage those claims based upon the subjective reports of patients that cannot be substantiated by objective medical testing. Debilitating musculoskeletal injuries involving soft tissue damage and reports of pain and psychological impairment may be excluded from compensation based upon this requirement.

In addition, in some jurisdictions, claimants are being required to meet increasingly strict burdens of proof. In a landmark 1994 case under the federal black lung compensation law, the U.S. Supreme Court threw out the Department of Labor's "true doubt rule" under which the claimant won if the medical evidence offered by the claimant and the coal operator were equal in weight. The court ruled that, due to requirements in the Administrative Procedures Act, claimants must prove their cases by a "preponderance of the evidence." 16 Statutory amendments to some state statutes now require, either in all claims or for specifically delineated ones, that claimants meet this preponderance standard or, for some injuries or diseases, the even more difficult standard of "clear and convincing evidence." Because many compensation programs gave claimants the benefit of the doubt in close or marginal
cases in the past, these changes could prove to be significant, particularly for workers with "border-challenging" claims.

The general tightening of eligibility and compensability standards appears to have a predictable, but difficult to document, effect on the defense of claims. All over the country, claimants and their representatives claim that workers' compensation insurance carriers are more likely to controvert or contest claims and less likely to offer what claimants view as reasonable settlements. The Workers Compensation Research Institute report regarding Massachusetts' experience supports this claim (Gardner, Telles, and Moss 1996). Similarly, a study by physicians at the Mount Sinai Center for Environmental Medicine in New York City found that 81 percent of workers diagnosed in their occupational medicine clinic with occupational cumulative trauma disorders had their claims contested or received no response from the insurance carrier when the claim was filed (Herbert, Janeway, and Schechter 1997). Thus, even in those jurisdictions that nominally compensate for these injuries, many claims go uncompensated. This trend may further magnify the statutory and judicial changes that restrict workers' access to benefits for work-related injuries.

On the other hand, the interpretation of what constitutes objective evidence, an excluded preexisting condition, or the preponderance of the evidence is ultimately up to the courts. Judicial interpretations vary and may not always prove to be as restrictive as the statutory language appears to demand. It is therefore difficult to assess fully the impact of these statutory changes without further study.

**Changes in compensability rules for particular conditions**

As noted above, workers' compensation systems have often failed to compensate occupational diseases. Because of changes in the state laws during the period following the 1972 report of the National Commission on State Workmen's Compensation Laws, claims for conditions involving common physical and mental complaints (such as back or other nonacute musculoskeletal injuries and mental stress) rose in many states. As we have noted, these conditions challenge the boundaries of the traditional work-relatedness test and are often caused by chronic, rather than acute, exposures at work. They sometimes also involve a higher degree of medical ambiguity than do many acute injuries, because they are not easily diagnosed using clearly objective med-
ical tests. In those states in which compensation for these conditions was paid, however, insurers and employers regarded them as a primary cost-driver to the system. Perhaps not surprisingly, these types of conditions became the focus of some attempts to exclude conditions in order to limit aggregate workers' compensation costs.

The two primary areas of exclusion have been psychological injuries and cumulative trauma disorders (CTDs), also known as repetitive stress injuries. In the case of CTDs, 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; or requirements for positive findings on specific diagnostic tests. In the most notorious case, the state supreme court in Virginia ruled that repetitive injury claims, including both carpal tunnel syndrome and noise induced hearing loss, were simply noncompensable under the language of the state workers' compensation statute. In response to the political reaction to these decisions, the Virginia legislature amended the workers' compensation statute to provide nominal, but very narrow, coverage for these conditions. It is important to note, however, that this is not a universal trend. The majority of states do provide some compensation for these conditions; in fact, in 1997, Oklahoma added cumulative trauma to the statutory list of terms denoting compensable injuries.

Stress and other psychological injuries present a more extreme picture. A number of states have made claims for psychological conditions (in the absence of a physical injury) noncompensable. In a much smaller number of states, restrictions on compensation for psychological injury even include those that develop as a result of physical injury and impairment. These restrictions have been designed in a number of ways. Some state laws simply now provide that purely psychological ("mental-mental") claims are noncompensable (e.g., Wyoming, Oklahoma, South Dakota, and West Virginia). A second approach restricts the availability of compensation by imposing heightened standards of causation or increased burdens of proof. A third approach reduces the amount of benefits: in Colorado, benefits for stress or mental injury are now limited to 12 weeks, with a maximum weekly benefit of 50 percent of the state's average weekly wage.
Several states explicitly limit mental-mental claims to situations not involving lawful personnel actions or to situations involving extraordinary or unusual circumstances (e.g., Hawaii, Connecticut, South Carolina, California, Idaho, Missouri, and New York). Psychological reactions to extremely stressful work situations that are not illegal or unusual are therefore noncompensable in these states. Thus, while psychological sequelae from a physical injury remain compensable in most jurisdictions, psychological symptomatology caused by events at work that do not involve physical injury are often no longer compensable.

The motivation for these limitations is clear. Workers' responses to physical and mental stressors at work are subject both to very individualized real responses and to serious measurement problems. The costs are therefore both potentially large and uncertain. The filing of large numbers of claims involving CTDs and stress was a relatively new phenomenon and appeared to be growing quickly in some jurisdictions. By changing the legal rules, claims are made to disappear from the workers' compensation programs. The result is that workers' compensation is eliminated as a primary payer for significant numbers of disabilities that are work-related, thereby externalizing costs from the workers' compensation system.

Restrictions on compensability of permanent total disability cases

Workers' compensation provides benefits for both long and short-term disabilities. The political and economic pressure to reduce costs has also been directed at the actuarially defined "long tail" of workers' compensation claims—those benefits that may continue for years. Benefits for permanent disabilities, including permanent total disability, are the major cost drivers in the system. The assault on these benefits has taken two forms. First, eligibility has been restricted through the mechanisms described above and through a more direct assault on permanent total disability benefits. Second, as described in the next section, payment has been tightened on those claims that are approved.

Permanent total disability (PTD) benefits are generally paid to disabled workers for life. In view of the relatively high cost of a lifetime award, it is not surprising that state legislatures have attempted to reduce these costs. Prior to recent developments, many states had
adopted the "odd-lot" doctrine, which allowed for the consideration of a claimant's age, education and skills in addition to the nature of injury in determining eligibility for benefits. Odd-lot workers were generally older workers with a combination of health impairments and a history of working in manual industries. This is the same population, for example, that may qualify for SSDI benefits under the more lenient provisions for workers who are over 55 years old and have limited education and a long work history in manual labor. Recently, many states have significantly restricted the use of the odd lot doctrine, most adversely affecting older workers. In addition, some states, like Florida, now require a "catastrophic" injury before a worker can be considered for a PTD award. Others have established impairment thresholds requiring the injury to result in a specified and very high level of functional impairment before a worker can be considered for a PTD award. Many states have narrowed the definition of what it means to be permanently and totally disabled by abandoning the claimant's prior work as a reference point. In Minnesota, the injured worker must be incapable of working at any occupation that produces an income; in Colorado, it is inability to earn a wage; in Oregon, a gainful occupation is defined as one that pays the minimum wage.

The results of these eligibility restrictions for PTD benefits have sometimes been startling. For example, in West Virginia, the adoption of a threshold requirement that a claimant have at least 50 percent functional impairment (within the definition in the Guides to the Evaluation of Permanent Impairment [American Medical Association 1993]) resulted in a 97 percent reduction in the rate of permanent total disability awards, from 117 to 5.8 per 100,000 workers in the first two years after enactment (BNA 1997, p. 276). This spurred legislative action in 1999 that relaxed the eligibility threshold to 40 percent functional impairment. The effects of this change have not yet been determined.

**Underfiling of claims and expansion of fraud prosecutions**

State statutes during this period also expanded criminal liability for fraud. Substantial, and perhaps excessive, media attention has been focused on claimants who are viewed as illegally seeking to obtain or extend benefits. Often, these articles assert that large numbers of
claims in workers’ compensation involve fraud, resulting in a broad stigmatization of workers who file for benefits. 22

Of course, the expansion and publicizing of fraud prosecutions of claimants deters intentionally fraudulent claims, but it also may discourage the filing of 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; Pransky et al. 1999; Michaels 1998; Morse et al. 1998; and Morse, Dillon, and Warren 2000). The decision by a worker not to seek benefits is a complex one and has been found to be affected by the severity of the injury, the worker’s level of knowledge about workers’ compensation, and the worker’s own fears regarding how the employer and others will react to the filing of a claim (Morse, Dillon, and Warren 2000). Older workers may have more access to alternative benefits; they are more likely to qualify for SSDI due to the consideration of age in the evaluation process and they are more likely to have vested pension benefits due to duration of employment. 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.

**Reductions in the Amount Paid in Approved Claims**

Reduction in the costs of approved claims is primarily being achieved through reductions in the amount that is paid for permanent disabilities. In general, weekly benefit rates have not been reduced, in large part because most states now provide that maximum weekly benefits automatically increase each year as the state’s average weekly wage increases. 23

**Reductions in payment of permanent partial disability benefits**

A critical difference between workers’ compensation and other social insurance programs is the availability of permanent partial disability benefits, designed to compensate the worker for loss of income resulting from the injury or illness although the worker remains active in the labor market. These benefits, which typically are the largest component of disability benefit costs, 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. First, there have been reductions in the duration or weekly amount of the PPD benefits. For example, in Connecticut, an aggregate 27 percent reduction in PPD benefits was achieved in 1993 by reducing the nominal replacement rate from 80 percent to 75 percent of spendable earnings; by reducing the duration for scheduled injuries (e.g., the number of weeks for loss of a leg was reduced from 238 to 155 weeks); and by reducing the maximum duration of nonscheduled PPD benefits from 780 to 520 weeks. Other states that curtailed the maximum number of weeks of PPD benefits include Massachusetts, Florida, and Maine. The result of these reductions is both to decrease the duration of compensation awards in the more serious cases and to reduce the value of claims when they are settled early in litigation. According to a study by the Workers Compensation Research Institute, these and related changes in Massachusetts drove the average lump sum settlement from $27,040 to $18,860 (Gardner, Telles, and Moss 1996, p. 98).

Second, there was a substantial curtailment of the wage-loss approach to calculation of benefits in the 1990s. Pennsylvania enacted legislation in 1996 that reduced the employer’s responsibilities to offer an actual employment opportunity in order to avoid responsibility for wage-loss benefits. Florida had been viewed as a pioneer in 1979 when it introduced a two-track system for PPD benefits, one track for impairment benefits if the worker experienced an actual physical loss of a body member and another track that could be paid concurrently if the worker had actual earnings losses due to the injury. During the 1980s, the maximum duration for the wage-loss benefits was 525 weeks. In 1990, the maximum duration of the wage-loss benefits was seriously curtailed (which reduced the actuarial valuation of the PPD benefits by 48.4 percent). And in 1994, the impairment benefits track was eliminated, the wage-loss benefits were restricted to a few workers with very serious injuries, and the overall duration for all types of benefits in PPD cases was limited to 401 weeks. The actuarial valuation indicated these 1994 reforms reduced the Florida PPD benefits by another 16.7 percent (NCCI 2000, p. 101).

A third pattern in PPD reform in the 1990s was to move toward benefits that are primarily determined on the basis of the assessment of
the extent of impairment, rather than on the basis of an evaluation of the extent of loss of earning capacity (or loss of actual earnings). The claimed rationale was that the impairment ratings were more objective and thus less prone to litigation. The switch to an impairment-only rating system was often associated with adoption of the AMA's *Guides to the Evaluation of Permanent Impairment* as the tool for assessment of impairment. The *Guides* relies primarily on purportedly objective medical testing but produces inconsistent ratings that may result in devaluation of common disabling injuries for workers. (Spieler et al. 2000) The precise effect of the *Guides*’ ratings has not been studied, but claimants’ advocates assert that the adoption of the impairment-only PPD system is accompanied by reductions in the amount of PPD benefits paid.

**Reductions in benefits based on receipt of other income**

Significantly for older workers, many states now mandate that disability benefits be reduced by other income, most commonly Social Security Old Age benefits, or be terminated when the claimant reaches retirement age or becomes eligible to collect SSOA benefits.24 These offset or termination provisions, which are designed to reduce the cost of workers’ compensation costs for employers, generally make no allowance for the reduction in retirement income resulting from the loss of wages associated with the disability. This means that workers who leave the workforce with reduced old age or pension benefits have their total income further reduced, often dollar for dollar, by the cuts in workers’ compensation payments. These restrictions have been challenged in many states; state courts are split on whether this reduction or termination of workers’ compensation benefits constitutes an unconstitutional age-based classification.25

**Medical Care Cost Containment**

During the 1980s, workers’ compensation health care continued to be paid entirely by the employer and to rely primarily on fee-for-service reimbursement arrangements with medical practitioners. During this same period, general group health insurance adopted and expanded a variety of cost containment strategies. The results of the disparate rules were that medical expenses for comparable conditions were con-
siderably higher in workers' compensation than in the general health care system. Such disparities provided an incentive for providers to classify marginal conditions (such as backs) as work-related in order to receive higher payments.

Since about 1990, because of a perception that workers' compensation was experiencing inordinate rates of increase in health care costs, many states made changes in the health care component of their workers' compensation programs. These included the adoption of "traditional" approaches to limiting health care costs in workers' compensation (e.g., fee schedules, limits on the choice of treating physicians and on the amount or duration of health care); the introduction of managed care networks; and some movement toward "24-hour coverage" which integrated workers' compensation health care with other coverage (Burton 1997, pp. 141-48).26 Most of these changes were designed to reduce the costs of health care delivery in workers' compensation and the cost shifting to workers' compensation 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.

Some of these developments may have particular impact on older workers. For example, many states now restrict employees' choice of physician for both treatment and evaluation of workplace injuries, either directly or through employer-selected managed care networks.27 In these instances, the employer-selected physician may control both treatment and assessment of the worker for continuation of weekly cash benefits. Not surprisingly, organized labor and many workers argue that restrictions on employee choice of providers have an adverse impact on the injured worker, damage the provider-patient relationship, and lead to inferior treatment and premature return to work. This may be especially true for older workers with chronic health conditions, who are required to seek treatment from employer-chosen physicians for health problems with complex etiology.

In addition, there has been considerable concern and political agitation regarding the issue of confidentiality of workers' compensation medical records. Under pressure from employers, some states have explicitly restricted the scope of confidentiality of medical records.
when an employee files for workers’ compensation benefits, including allowing both oral and written communications between the employer or insurer and the employee’s physician without a release by the employee (e.g., West Virginia) and requiring the release of all medical information relating to arguably relevant preexisting conditions (e.g., Nevada).

The effects of expansion of communication among third parties about a worker’s health status have not been studied. It is however reasonable to speculate that broad elimination of medical confidentiality may have several effects. On the one hand, providing the health care provider and employer with better information may promote appropriate disability management and return to work. On the other hand, this erosion of confidentiality may discourage some workers from filing for workers’ compensation benefits, particularly those with chronic health conditions who prefer not to reveal their health status to their employers. This last group of workers is likely to include an overrepresentation of older workers.

Rise of Disability Management and Return-to-Work Programs

Like the interest in expanding return to work for SSDI/SSI recipients, there has been a significant shift to a focus on disability management and “return-to-work” programs in workers’ compensation. In the past, whether a disabled worker would return to his or her old job, or to any job at all, was solely within the discretion of employers and was not viewed as the concern of workers’ compensation programs. In contrast, work participation by disabled workers is now actively encouraged.

Disability management can accomplish two critical goals: it can save costs by decreasing both the length of time a worker is out of work and the higher permanent disability rating that is thought to result from longer absence from work, and it can improve quality of life for workers by increasing successful postinjury work participation. Clearly, employers and insurers are economically motivated to decrease workers’ compensation liability by encouraging—or forcing—employees to return to work. Light duty programs are often designed specifically to bring workers back to work, often at temporary job assignments, after initial recovery from an occupational injury. In general, employers and
insurers believe that earlier return to work will limit both the duration of temporary benefits and any psychological “overlay” which may result in increased permanent disability.

Not surprisingly, the strong economic motivation for insurers and employers to focus on rapid return to work makes many labor union officials and injured workers' groups wary of these developments. In many states, an offer of a job, even before the worker has reached maximum medical improvement after an injury, will lead to termination of temporary total disability benefits; in states that measure permanent disability based upon wage loss or loss of earning capacity, the job offer may limit permanent disability benefits as well. Not all states require that the job offered be an appropriate one that the worker can perform. Workers and their unions have charged that injured workers are asked to resume duties they are not yet physically capable of performing.

Legal changes have both supported and reflected this shift toward disability management. Some of these changes are internal to workers' compensation statutes: expanding rehabilitation opportunities, making retaliation for filing workers' compensation claims actionable, and establishing both incentives and requirements for returning an injured worker to work. Other legal developments, outside of the workers' compensation laws, have both encouraged and reinforced these trends. Most importantly, the Americans with Disabilities Act (ADA), state disability discrimination laws, and the Family and Medical Leave Act now regulate employers' treatment of injured workers. Workers with disabilities caused by work-related injuries and diseases are within the potential class of employees who receive the protection of these new laws. The ADA clearly supports the return-to-work concepts now espoused in workers’ compensation. However, the overall effectiveness of the ADA in promoting employment of occupationally injured workers is currently in doubt (Acemoglu and Angrist 1998; American Bar Association, Commission on Mental and Physical Disabilities 1998 and 2000; Colker 1999; DeLeire 1997).

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 worklife through appropriate workplace accommodations, it will tend to expand both work earnings and retirement income levels. On the other hand,
to the extent that it results in reductions in 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.

EFFECTS OF WORKERS’ COMPENSATION DEVELOPMENTS ON OLDER WORKERS AND OTHER SOCIAL INSURANCE PROGRAMS

The foregoing summary suggests that several factors must be considered when analyzing the adequacy of workers’ compensation programs for older workers. First, workers’ compensation has never provided compensation for all occupationally induced disabilities, nor has workers’ compensation fully replaced lost wages when a worker is eligible for benefits. Workers’ compensation is most adequate, from the standpoint of both eligibility and benefit rates, 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.

Second, under recent workers’ compensation developments in some states, the likelihood that workers with chronic impairments will replace their lost wages through workers’ compensation appears to be shrinking. The reductions are due to changes in eligibility rules, changes in the approach to permanent disability, and reductions in benefits on receipt of other old age benefits.

Third, the combined effect of the various changes in compensability of conditions will have their greatest impact on conditions that are most medically ambiguous. Musculoskeletal conditions resulting from the wearing down of a worker’s body and chronic diseases such as hearing loss, arthritis, respiratory ailments, and heart disease are all more prevalent in older workers. These conditions involve questions regarding causation; all are subject to challenge based on tightened evidentiary standards; many cannot be clearly diagnosed and evaluated using “objective” medical tests; and several have been the specific target of tightened eligibility standards. Aging workers are overrepre-
sent among people with chronic disabilities and diseases that are partially work-induced. Restrictions on compensation are therefore likely to affect older workers more adversely.

Fourth, aging workers face barriers in the labor market when they lose their jobs. The job mobility of all disabled workers is also limited. It is certainly likely that aging workers with disabilities face even greater barriers. Erosion of medical confidentiality, increases in stigmatization of workers who file for benefits, and generalized concern about labor market mobility may all act to increase the reluctance of aging workers to file claims for workers’ compensation benefits, particularly if other benefits are available to cover their medical costs.

Fifth, the decline of long-tailed indemnity benefits means that workers’ compensation is unlikely to be a useful source for wage and pension replacement for aging workers in the coming period. This problem is exacerbated by the practice of compromise and release, which allows for lump-sum, non-annuity payments to workers in order to end the adjudication of a claim.

Sixth, reductions in the availability of permanent disability benefits (both through eligibility and duration/amount restrictions) result in a loss of replacement income for injured workers. To the extent that this affects workers who may be eligible for SSDI or SSI, the federal programs become the primary payers for these disabilities.

Seventh, state legislatures and those who lobby for restrictions in 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). This means that there is little attention paid in the states to the effects of these legislative changes on other, primarily federal, benefit programs.

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 poverty 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. This latter goal is reflected in various program design elements: relatively high maximum weekly benefits, provision of partial disability benefits for people who continue to work, a benefit structure designed to replace a substantial pro-
portion of lost earnings, and so on. Currently, we are concerned that workers’ compensation may be increasingly failing to meet both goals. Because of changes in compensability standards, workers suffering from occupationally induced morbidity may not meet the work-relatedness tests to qualify for benefits, and in a number of jurisdictions, permanent disability benefits—designed to cushion the economic impact of injuries for workers—have been significantly reduced.

As a result, workers may be less likely to be able to retain their economic status in the face of work-caused disabilities. To some extent, other programs will fill the gap. But many workers who are not totally disabled will face reductions in income that are not compensated. To the extent that workers’ compensation reduces the availability of benefits to workers who cannot qualify for SSDI or other benefits, the costs associated with these disabilities are transferred to the workers (and their families). The reductions in benefits after disabled workers reach the age of 65 may mean that levels of poverty for these workers will grow, since workers’ compensation benefits will no longer compensate for the reductions in pension and SSOA benefits that were caused by the reduced lifetime earnings resulting from workplace injuries.

In addition, although conclusive evidence is not available, there are some data that suggest workers turn to SSDI for income support when workers’ compensation benefits are unavailable. The proportion of workers with occupationally caused disabilities may therefore rise in the DI program. This means that the SSA expectation that workers whose disability is occupationally caused will find benefits elsewhere may be increasingly misplaced. Similarly, the growing restrictions on both compensability and medical care are likely to transfer health care costs from workers’ compensation to Medicare (if the worker qualifies for SSDI) or to Medicaid (if the worker is impoverished or does not qualify for Medicare). From the standpoint of injured workers, the effect of this is mixed. On the one hand, SSDI benefits tend to be lower and the disability eligibility requirements have historically been stricter than in workers’ compensation programs. On the other, applicants for DI benefits are unlikely to face equivalent resistance from employers or carriers to their claims, and once eligibility for SSDI benefits has been established, the benefits are more secure and the health care provided is
more comprehensive than that available through workers' compensation.

Costs are also likely to be shifted from workers' compensation to employment-based insurance programs offered by employers. This includes short- and long-term disability and general health plans. Since the premium costs of these programs tend to be sensitive to specific employer experience, this may then encourage large employers to expand the integration of benefit and disability plans, including workers' compensation, in order to gain control over the firm's total expenditures on disability.

CONCLUSION

In summary, the recent decline in workers' compensation costs and benefits in part reflects a decline in the adequacy and availability of these benefits. In particular, workers in the second half of their work lives are likely to be adversely affected by these declines. Although workers' compensation will continue to provide adequate compensation for acute short-term injuries, the availability of benefits for permanent disabilities, particularly those associated with aging, appears to be declining in many states. This trend is likely to shift additional economic burdens to other social and private insurance systems. To the extent that other social insurance programs fail to provide replacement of a substantial proportion of earnings lost due to partial disability, these costs are being transferred to workers and their families.

Notes

We appreciate the assistance of several persons who provided comments or other assistance during the preparation of this chapter: Keith Bateman, Leslie Boden, Ann Clayton, Alan Ducatman, Donald Elisburg, H. Allan Hunt, William Johnson, Barbara Markiewicz, and Greg Wagner. We absolve them of responsibility for any remaining errors of fact or analysis.

1. A more extensive description of the program and additional references can be found in Spieler and Burton (1998).
2. We use the term\textit{border-challenging} for these often chronic conditions with complex etiology, in the sense that these conditions are on the border of the traditional definitions of compensable conditions.

3. Three exceptions to the general rule are the following: 1) the doctrine of the “odd-lot” worker (which considers age as a component of evaluation of eligibility for permanent total disability benefits); 2) the reduction or termination of cash benefits when a worker receives Social Security Old Age benefits, reaches a particular age (usually 65), or is eligible for a pension or other benefits; and 3) the use of age adjustments to the ratings assigned to particular impairments (e.g., respiratory diseases and hearing loss). The first two of these exceptions are discussed in the fourth section of this chapter.

4. Countrywide data indicate there are 6,837 workers' compensation cases per 100,000 workers, of which only 7 per 100,000 workers involve permanent total disability benefits (NCCI 2000, Exhibit XII). The average total benefits per case (including cash and medical benefits) for all workers' compensation cases are $5,244, while the average total benefits for permanent total disability cases are $513,284 (NCCI 2000, Exhibit XI).

5. The Workers Compensation Research Institute (WCRI) has published a series of administrative inventories of state workers' compensation programs. One of the measures of litigiousness used in these studies is requests for workers' compensation agency intervention to resolve contested cases involving cash (or indemnity) benefits. Ballantyne and Shiman (1997, p. 75) summarized the results for 11 states the WCRI has recently studied. The low end of the range was from North Carolina, where 9 percent of indemnity claims involved a hearing request; similar results were found for Wisconsin (10 percent). States where litigation (as measured by agency intervention to resolve disputes) was most extensive were Washington (40 percent of state-fund indemnity claims involved a protest filing), Missouri (43 percent of indemnity claims involved at least one meeting at the agency), New Jersey (35 to 55 percent of indemnity claims involve one or more claim petition filings), and Illinois (68 percent of indemnity claims involved agency intervention).

6. Thomason and Burton (1993) surveyed the limited literature on the use of compromise and release agreements. One of their conclusions (p. S12) is that the evidence "suggests that claimants who settle for lump sum awards are in a more precarious financial position after their injury compared to claimants who do not settle."

7. The data in Table 2 are inconsistent with the following statement in Bernard (1997, p. B-2): "The prevalence of MSDs [musculoskeletal disorders] increases as people enter their working years. By the age of 35, most people have had their first episode of back pain . . . Once in their working years (ages 25 to 65), however, the prevalence is relatively consistent . . ."

8. Pransky (2000) provides additional evidence (in his Table 2) of "the dramatic age-related increase in prevalence of selected chronic diseases and the number of persons with . . . any limitations in ability to do usual life activities."
9. The relationship is particularly elusive because of the general underreporting of work-related health problems (discussed earlier) that are likely to be especially prevalent among older workers.


11. In Idaho, for example, the Supreme Court has upheld denial of benefits in the following types of claims where there was a preexisting condition: carpal tunnel syndrome (Reyes v. Kit Manufacturing Co. [Id. 1998], Nelson v. Ponsness-Warren IDGAS Enterprises, 879 P.2d 592 [Id. 1994]), asthma (Combes v. State of Idaho, ISIF, 942 P.2d 554 [Id. 1997], second appeal pending, Idaho Supreme Court No. 25407); lumbar back pain (Demain v. Bruce McLaughlin Logging, 979 P.2d 655 [Id. 1999]); and flexor tenosynovitis secondary to underlying diabetes (Nycum v. Triangle Dairy, 712 P.2d 559 [Id. 1985]).

12. Errand v. Cascade Steel Rolling Mills, Inc., 888 P.2d 544 (Or. 1995). The compensation bureau had denied him workers' compensation benefits because "his work was not the 'major cause' of his condition and, thus, he did not suffer 'compensable injury' within meaning of exclusivity provision."

13. 1996 Oregon Rev. Statutes, Title 51, Section 656.018.


17. See, for example, some of the cases decided by the Oregon appellate courts under the more restrictive standards that were adopted by the legislature: Conner v. B&S Logging, 957 P.2d 159 (Or. App. 1998); Beverly Enterprises v. Michl, 945 P.2d 658 (Or. App. 1997); SAIF Corp. v. Williamson, 882 P.2d 621 (Or. App. 1994) (a finding of impairment may be based on a physically verifiable impairment or on the physician's evaluation of the worker's description of the pain that she is experiencing.)


19. It is important to note the following. First, PTD awards have always been relatively infrequent in workers' compensation programs (see note 4). These data may, however, be somewhat misleading, since the frequent practice of settling claims (termed compromise and release agreements or lump sum settlements) often means that awards for significant disabilities are classified as permanent partial disability benefits, even when the workers' medical and economic conditions could justify permanent total disability awards. Second, although the majority of states provide for lifetime weekly benefits, some states set a maximum period of eligibility for PTD benefits even before the recent legislative changes in these types of benefits.
20. According to §608 of the 1997 Social Security Handbook (13th ed.), two special provisions may establish disability for persons who are unable to perform any of their past relevant work.

A. A finding of disability may be made where the individual:
1. Has long-time work experience (35 years or more) limited to arduous, unskilled, physical labor; and
2. Has little education; and
3. Has a significant impairment that prevents performance of the previous kind of work; and
4. Has not demonstrated ability to do lighter work.

B. A finding of disability may also be made where the individual:
1. Has no past relevant work; and
2. Is of advanced age (55 years or older); and
3. Has less than a high school education; and
4. Has an impairment that is more than "not severe" (see §606).

However, considering age, education, and work experience, a younger or better educated worker, or one who has transferable skills to work that could be performed despite the impairment(s), might not be considered disabled. Although advancing age may affect a person’s capacity to work in competition with others, unemployment due primarily to age (i.e., employers may not wish to hire older workers) does not show inability to engage in substantial gainful activity by reason of a medical impairment.

21. The rate of PTD awards in West Virginia prior to the 1995 legislative amendments far exceeded the national average of 7 per 100,000 (NCCI 2000, Exhibit XII). The rate of PTD awards after the changes was below this national average. As discussed in note 19, these data can be somewhat misleading (Spieler 1995).

22. Burton and Thomason (1993) provided a dispassionate critique of a series of articles in the New York Times that alleged there was a “vast amount of fraud” in the workers’ compensation system.

23 In January 1990, 32 of 51 jurisdictions (including the District of Columbia) had maximum weekly benefits for temporary total disability that were at least 100 percent of the jurisdiction’s average weekly wage; by January 1998, 34 jurisdictions met this standard. Again, this is not a universal development. Connecticut and Massachusetts cut the nominal replacement rate for temporary total disability benefits, and several states (including Minnesota, New Hampshire, and Texas) reduced the maximum number of weeks of temporary total disability benefits (usually to a limit of 104 weeks).

24. There are specific federal rules regarding offsets between SSDI and state workers’ compensation systems for workers who are below the age of SSOA eligibility (see 20 C.F.R. 404.408). In general, with the exception of some states that were “grandfathered,” SSDI benefits are reduced based upon receipt of total benefits that exceed caps on income established in the Social Security Act. This is different from these new offset provisions, which generally provide for an automatic dollar for dollar reduction in workers’ compensation benefits after the worker
becomes SSOA eligible, or which simply terminate workers' compensation benefits at age 65 without regard to the total income the retiree is receiving.

25 Cases that have held that these provisions are unconstitutional include *Golden v. Westark Community College*, 969 S.W.2d 154 (Ark. 1998); *State of West Virginia ex rel. Boan v. Richardson*, 482 S.E.2d 162 (W.Va. 1996); and *Industrial Claim Appeals Office v. Romero*, 912 P.2d 62 (Colo. 1996). Cases that have upheld these provisions include *Sasso v. Ram Property Management*, 431 So.2d 204 (Fla.Dist.Ct.App. 1983), aff'd, 452 So.2d 932 (Fla.1984); *Tobin's Case*, 675 N.E.2d 781 (Mass. 1997); and *Vogel v. Wells Fargo Guard Services*, 937 S.W.2d 856 (Tenn. 1996).

26 For a more complete discussion of medical care cost containment in workers' compensation, see Dembe (1998) and Spieler and Burton (1998).

27 A survey by the Workers Compensation Research Institute indicated that, as of 1998, workers' compensation programs in 14 states gave employees an unrestricted initial choice of the treating provider, a number that has been cut in half in the last decade (Tanabe 1998, p. 41). Four jurisdictions required employees to select from an insurer's or employer's list of providers, and 12 required the employee to choose from within a managed care organization if one exists. The employer selects the initial treating provider in 17 states. Four other states have choice rules that vary by circumstances.


29 Mont, Burton, and Reno (2000, p. 25) speculate that

the opposite trends in workers' compensation and Social Security benefits during many years since the mid 1970s raise the question of whether adjustments in one program increases demands placed on the other, and vice versa. The substitutability of DI and workers' compensation for workers with severe, long-term disabilities that are, at least arguably, work-related, or might be exacerbated by the demands of work, has received little attention by researchers and is not well understood.

References


