

# **Adequacy of Earnings Replacement in Workers' Compensation Programs**

## **A Report of the Study Panel on Benefit Adequacy of the Workers' Compensation Steering Committee**

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## Introduction

This study was sponsored by the National Academy of Social Insurance (NASI) under the auspices of its Workers' Compensation Steering Committee. NASI regularly convenes steering committees and study panels charged with conducting research, issuing findings, and, in some cases, making recommendations based on their analyses. Members of these groups are selected for their recognized expertise and with due consideration for the balance of disciplines and perspectives appropriate to the project. Findings and recommendations of the groups are the responsibility of the individual group members, not NASI, its members, or its supporters. In 1998, NASI convened a study panel of its Workers' Compensation Steering Committee (see p. 145 for a list of panel members) to review the earnings replacement benefits under the various state and federal workers' compensation programs for workers injured or made ill by their jobs.

The Benefit Adequacy Study Panel's task was to examine the extent to which workers' compensation wage replacement benefits paid to injured workers replace their lost wages, and to assess the adequacy of wage replacement. Replacement of lost wages is acknowledged as one of the primary objectives of these programs, but it has not been studied extensively until the last few years. Of course, we recognize that benefit adequacy is not the only important issue in workers' compensation policy. Moreover, some states provide certain benefits for reasons other than wage replacement. The fact that this report focuses exclusively on benefit adequacy reflects the overall approach the NASI Workers' Compensation Steering Committee has taken to reviewing the various policy issues in workers' compensation programs.

We also understand that a variety of policy and behavioral factors may influence the extent to which lost earnings are replaced by a workers' compensation program. These include the benefit structure specified by statute, the extent to which systems encourage reduction in the level of losses, and the extent to which procedural and operational characteristics affect workers' recoveries. Examples of these include the cost of obtaining benefits, compromise and release agreements, and

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procedures for terminating benefits. These factors, and many more, interact in complex and sometimes unpredictable ways with wage replacement benefits in a workers' compensation system. In particular, we are not asserting that adequacy of benefits alone would ensure a high-quality workers' compensation system.

Two recent developments have made this inquiry timely: first, a series of changes in workers' compensation statutes through the decade of the 1990s, generally designed to take costs out of the system; and second, a group of empirical studies that promise to provide better information than we have had before about actual replacement of wage losses by workers' compensation systems. Critics of the statutory changes in the 1990s believe that these changes may have significantly undermined the adequacy of workers' compensation benefits (Spieler and Burton 1998). They argue that changes in workers' compensation statutes in the period from 1992 to 1998 reduced the amount and duration of cash benefits, changed the rules on compensability to make recovery more difficult, altered the way disability is assessed, and made other changes that made it more difficult to qualify for benefits.

Supporters of these statutory changes do not agree that they resulted in significant benefit reductions. They argue that in most states benefits increased, and even in the few states that reduced benefits for some types of claims, they often increased them for others. Moreover, supporters argue that the benefit reductions usually were made to bring benefits in line with the norms in other states. Proponents also argue that these changes placed greater emphasis on prevention, increased reliance on objective determinations of disability and compensability, created new tools for preventing and resolving disputes, and eliminated mandates, such as for vocational rehabilitation, that were not cost effective.

Interest in the issue of benefit adequacy was also stimulated by a series of "wage loss" studies conducted in California, Wisconsin, Washington, New Mexico, and Oregon in the last five years. The data and methods used in these studies constitute a significant breakthrough on the comparison group problem. Using electronic administrative records of earnings, it is possible to develop more adequate comparison groups to answer the counterfactual question, "What would injured workers have earned in the absence of their injuries?" In other words, it is now possible to more accurately estimate the lost earnings that workers' compensation benefits are designed to replace.

The NASI Benefit Adequacy Study Panel reviewed the published research literature on benefit adequacy and then formulated an approach to this difficult and contentious issue. During a series of meetings held over a five-year period, the study panel determined that it would be useful to produce a report reviewing what was known, and what was not known, about benefit adequacy in workers' compensation programs. Members of the panel volunteered to prepare draft chapters, which were reviewed and discussed by the entire panel. The draft report was then peer reviewed according to the procedures of the NASI Board of Directors. This book represents the result of that deliberative process.

## **PLAN OF THE PRESENTATION**

The remainder of Chapter 1 consists of a brief overview of workers' compensation programs. Chapter 2 explores alternative meanings of benefit adequacy. What are the conceptual issues involved in assessing benefit adequacy? Do other social models exist for evaluating benefit adequacy? How do the unique features of state workers' compensation programs complicate things when considering benefit adequacy?

Chapter 3 addresses the methodological issues involved in determining benefit adequacy. What data are available to measure benefit adequacy? Why is it so difficult to estimate what injured workers' earnings would have been in the absence of injury? How do the methodological choices influence the outcome of the analysis?

Chapter 4 traces the statutory benefit structure among the state workers' compensation programs over the period 1972–1998 to assess the “intent” of legislators in providing earnings replacement benefits. It compares benefit levels for standard situations among the programs, and also uses the workers' compensation “Model Act, Revised” promulgated by the Council of State Governments in 1974 as a benchmark. The Model Act was designed to provide guidance to state legislatures on good legislative practice in workers' compensation. It incorporated the recommendations of the National Commission on State Workmen's Compensation Laws (NCSWCL 1972).

Chapter 5 describes the recent wage loss results from California, Wisconsin, Washington, New Mexico, and Oregon. These studies are based upon the pre- and postinjury earnings of actual workers. They

employ various techniques to derive a comparison group of noninjured workers that is used to estimate the earnings that the injured workers would have received in the absence of injury. These empirical methods are found to produce the most convincing assessment yet of benefit adequacy in workers' compensation programs.

Finally, Chapter 6 reviews the findings of the study and provides the panel's conclusions on benefit adequacy in workers' compensation programs. An appendix to the chapter presents thoughts on the need for further research.

## **A BRIEF HISTORY OF WORKERS' COMPENSATION PROGRAMS**

Workers' compensation programs provide wage replacement, rehabilitation, and medical benefits to workers with work-related injuries and occupational diseases. They also pay survivor benefits to dependents of workers who die as a result of such injuries. In 2001, benefit payments for workers' compensation totaled \$49.4 billion, or a little more than \$500 per covered worker (Williams, Reno, and Burton 2003).

### **Origins of Workers' Compensation**

Workers' compensation laws did not appear in the United States until the early part of the twentieth century. Prior to the enactment of these laws, the only avenue available for injured workers seeking compensation for a work-related injury was to bring a tort liability lawsuit against their employers. Common law principles established that employers had a duty to not injure their workers, to warn them of risks, and to provide a reasonably safe environment. In practice, securing common law redress for injuries was very difficult. The worker had to establish that the employer was negligent, and even a negligent employer could use three types of defenses that usually precluded a finding of liability:

- 1) *Fellow servant rule*. This held that an employer was not liable for an injury caused by the negligence or carelessness of fellow employees.

- 2) *Contributory negligence*. This held that the employer had no responsibility to the injured worker if the negligence of the employee contributed to the cause of the accident, even if her contribution was minor.
- 3) *Assumption of risk*. Where the employee is considered to implicitly accept all obvious and customary risks of her occupation. Wages were considered to take the increased risk of injury into account.

To the extent that these defenses were persuasive in a court of law, common law remedies were received by relatively few workers.

As the number of accidents rose in the latter part of the nineteenth century, legislative efforts were made to limit employer common law defenses. Such statutes, however, still clung to the common law theory that employers were only responsible for their direct negligence. These “employer liability” laws generally served three purposes (Somers and Somers 1954, p. 21):

- 1) making it illegal for employers and workers to sign contracts relieving the employer of liability for accidents as a condition of employment (27 states by 1908),
- 2) extending the right of suit in death cases (41 states by 1904), and,
- 3) abrogating or modifying common law defenses, usually by eliminating the fellow servant doctrine. These laws generally applied to railroad workers, miners, and other occupations deemed particularly hazardous.

However, these statutes did not appease workers, who continued to fight for expanded responsibility of employers. Employers, too, were dissatisfied with these laws. They faced large legal expenses and a good deal of uncertainty, both financially and in the stability of society at large. Numerous commissions were formed to investigate these issues and generally reached the following conclusions about the employer liability system as it existed at that time (Somers and Somers 1954; Hobbs 1939):

- 1) The system was antiquated, as it was designed in the preindustrial era, when both the organization of production and the types of employment were different.

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- 2) The benefits provided were inadequate, and there was uncertainty as to whether a worker was eligible to receive them.
- 3) The system was wasteful and had high costs to employers.
- 4) There were many delays.
- 5) Rewards were inconsistent.
- 6) There was a lack of prevention, although insurance companies at the time were introducing some preventive measures for certain employers.
- 7) The lack of a good system was creating a public burden.

In searching for a solution to these deficiencies, policymakers looked to Europe for an alternative system (Larson and Larson 2000). As early as the 1830s, Germany had been moving toward a social insurance model, but it came to its fruition under Bismarck in the late 1880s and was adopted in Britain about a decade later. The basic idea of this model was that employers and employees would jointly pay for insurance that would provide benefits for people with disabilities, regardless of the cause.

Unlike in Germany, however, the United States adopted this model only for workplace accidents. So employers alone contributed to insurance costs, but only for injuries resulting from accidents in the workplace. Eventually, workers' compensation coverage was extended to disability due to occupational diseases as well.

Workers' compensation benefits are nontaxable. In the early years of the twentieth century, this was not much of an issue (the federal income tax dates only to 1912), but with federal income taxes, state income taxes, and payroll taxes easily taking one-third of gross earnings today, this is a very significant factor. Most workers' compensation systems today pay wage replacement benefits based on gross wages, although a minority have switched to benefits based on net earnings or after-tax wages in the past decade.

Another important feature of this system was that workers' compensation programs became the "exclusive remedy" for work-related injury and illness. That is, as a tradeoff for receiving no-fault workers' compensation benefits, workers were no longer allowed to sue their employers for damages resulting from negligence in the workplace. By accepting this "historic compromise," workers were guaranteed benefits for work-related injuries and illnesses (putting aside, of course, disputes

about what constituted a work-related condition). Employers had their potential liability limited to the benefits provided under workers' compensation programs, regardless of their culpability for the injury to the worker. Moreover, their exposure to the costs of illnesses and injuries was much more predictable under the workers' compensation plan.

By 1920, all but eight states had a workers' compensation law. The 48th state, Mississippi, enacted its law in 1948. Over the years, through legal interpretation and legislative enactment, workers' compensation statutes have been expanded to include near universal coverage and inclusion of many conditions which were not originally thought to be employment related (including stress, mental disabilities, repetitive strains, and occupational diseases).

### **National Commission on State Workmen's Compensation Laws**

In the United States, there is a heavier reliance on private benefit programs than in other developed countries. Most social insurance programs that do exist are federal, and federal law encourages state adoption of unemployment insurance programs. This is not the case for workers' compensation programs, in part because they began prior to the 1930s, when the U.S. Supreme Court reinterpreted the interstate commerce clause of the Constitution to allow federal regulation of private sector employers (*NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937)). In 1970, Congress established the National Commission on State Workmen's Compensation Laws to "undertake a comprehensive study and evaluation of State workmen's compensation laws in order to determine if such laws provide[d] an adequate, prompt, and equitable system of compensation" (29 USC 676(a)(1)). In addition, the commission was directed to determine if there was a role for federal legislation to improve these programs.

In 1972, the commission made a series of "essential" recommendations, including:

- 1) Workers' compensation should be compulsory rather than elective.
- 2) Employers should not be exempt because of the number of employees or because workers are agricultural employees, government employees, or casual or domestic workers.

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- 3) Full coverage should be provided for work-related diseases.
- 4) The maximum weekly wage benefit should be at least 100 percent of the state's average weekly wage, and cash benefits for temporary total disability should be at least two-thirds of a worker's gross weekly wage.
- 5) Workers' compensation programs should not impose arbitrary limits on the duration or total amount of benefits.
- 6) Workers' compensation programs should provide adequate medical care and rehabilitative services.

Over the decade or so following the commission's report, most states improved their compliance with these (and other) recommendations. However, a biannual U.S. Department of Labor publication that tracks state compliance with the recommendations of the commission indicates that states, on average, only complied with 12.9 of the 19 "essential recommendations" as of January 1, 2002 (U.S. Department of Labor 2002).

### **ATTRIBUTES OF A WORKERS' COMPENSATION PROGRAM**

Receiving workers' compensation benefits for a work-related injury or illness depends on two factors: coverage and compensability. In other words, is the job the worker holds covered by workers' compensation laws, and is the injury or illness considered work-related? If the answers to both of those questions are in the affirmative, then the remaining issue is the amount of benefits to be paid. The answers to all these questions vary depending on the state in which the worker is employed, works, or is injured, and can be quite complex. This section provides a general description of some of the provisions found in workers' compensation programs and some of the issues involved.

#### **Coverage**

Most workers in the United States are employed in jobs that fall under the umbrella of workers' compensation protection. In 2000, that amounted to an estimated 126.6 million persons, or about 97 percent of

all employment (Mont et al. 2002, Table 3). Indeed, coverage is mandatory in every state except for Texas. Even in Texas, 84 percent of workers are covered (Shields and Campbell 2001, p. 1).

However, all states allow for some exceptions. For example, in some states workers in very small firms are excluded. Also, agricultural workers, household workers, employees of charitable or religious organizations, and some units of state and local government are exempt from coverage requirements in certain states. Self-employed persons are also generally not covered in U.S. jurisdictions (see U.S. Department of Labor 2002).

### **Compensability**

Compensability rules define which injuries or illnesses qualify a worker for workers' compensation benefits. Statutes pertaining to compensability, and the administrative procedures and court cases interpreting them, are extremely complex and involve many nuances. An injury or illness is only compensable if it is found to be "work-related" based on certain legal tests. In most states, the work-related requirement for an injury involves four specific tests. There must be 1) a personal injury, 2) by accident, 3) which arises out of employment, and 4) in the course of employment. (See Larson and Larson [2000] for a thorough and authoritative treatment of these issues.)

The "personal injury" requirement has been interpreted in some states to only cover conditions with either a physical cause or a physical consequence, thus excluding many mental illnesses. The "by accident" requirement when construed strictly usually requires that the accident involve a definite time and place and that the cause of the accident be fortuitous. Courts in some states have held that the "by accident" requirement is met if the result is unexpected, not just the event. In most other jurisdictions, special provisions have been enacted to compensate injuries not attributable to a single event and for occupational diseases.

The "arising out of employment" test means that the source of the injury must be related to the job. This test is used to distinguish among three types of risk that may result in an injury to an employee at the workplace: 1) occupational risks, which are universally compensable; 2) personal risks, which are universally noncompensable; and 3) neu-

tral risks, where the cause of the injury is neither distinctly occupational nor distinctly personal, or where the cause is unknown, which may or may not be compensable depending on the legal doctrine used in the particular state and the specific facts of the case.

An example of an occupational risk is a worker injured by a malfunctioning machine. An example of a personal risk is a worker shot by an angry spouse who sneaked into the worksite to vent her rage. An example of a neutral risk is a worker struck by lightning while he sweeps the floor in a convenience store. He will meet the “arising out of employment” test in a state that uses the positional risk doctrine for neutral risks, but probably will not meet the test in a state that relies on the increased risk doctrine for neutral risks.

Of course, not all injuries and diseases are the result of a single cause. Thus, states have had to decide what degree of work contribution is necessary in order for the “arising out of” test to be satisfied. States vary in the degree of work contribution required. For example, state requirements vary from “any causal effect” to requiring that work contribution be “significant” or “substantial” or even the “predominant” cause of the injury or disease.

A related (but not identical) issue is whether or to what degree the employer should be responsible for the total cost of disability when the disability is the result of the combined effects of a preexisting condition and a work injury. The historical general rule was that the employer took the worker as he entered the plant gate. Thus, if a work injury combined with a preexisting condition to produce disability, the employer was responsible for the full workers’ compensation benefit for that disability. However, some states do not believe it is fair to require the employer to pay for the full disability when the work injury was only partly responsible. These states apportion between work and preexisting contributions and reduce the cash benefit accordingly or pay no benefits for injuries where work causation was uncertain or minimal.

The “course of employment” test normally requires that the injury occur on the employer’s premises and during working hours. Thus, an assembly line worker who is injured in an automobile accident on the way to work will not meet the course of employment test. However, a salesperson injured while driving to a client is likely to meet the test. The “course of employment” test is also used to decide whether injuries that result from mixed social and business activities are work related. A

law clerk who is encouraged to participate in an employer-sponsored softball game and injures her hand diving for a fly ball may meet the course of employment test, at least in some states.

Determining whether an illness or disease is work related is even more challenging in other cases. In most states, occupational diseases and back disorders (which, from a medical standpoint, are often the result of disease or normal aging) were evaluated using the four tests for injury compensability. Historically, many occupational diseases could not meet these four tests, particularly the “by accident” test, which was often interpreted as requiring a definite time and an explicit source.

As a result, all workers’ compensation statutes established separate criteria for determining the compensability of diseases. Typically a list of occupational diseases and sources of exposure for these diseases are spelled out in the statute, and if the worker can demonstrate that his or her disease is on this list, the work-relatedness test is met. For a worker who has a condition not on the list, there are legal tests for establishing a work relationship found in most statutes, such as a requirement that the disease be “peculiar to the worker’s occupation.” Thus, a nurse who contracts pneumonia from a patient may qualify for workers’ compensation benefits, while an office worker who contracts pneumonia from a fellow worker may not qualify.

## **Benefit Levels**

Benefit payments for workers’ compensation typically include full compensation for all related medical costs as well as wage replacement benefits designed to replace some portion of lost earnings. Medical benefits typically pay for all reasonable and necessary medical expenses but are only provided for conditions that are related to the injury or illness in question. In approximately 76 percent of workers’ compensation cases, only medical benefits are received (National Council on Compensation Insurance 1998). These “medical-only” cases do not involve compensable amounts of time away from work, and are mostly minor injuries; they account for only 6 percent of all benefits paid.

Payments designed to replace lost wages are more complex and depend on the nature of the disability as well as the jurisdiction. Is it permanent or temporary? Is the disability considered partial or total? Most wage replacement cases in the workers’ compensation system involve

temporary total disability (TTD). To qualify for TTD benefits, workers typically must meet some threshold of lost time from work. This threshold ranges from a minimum of 3 days to a maximum of 7 days among U.S. jurisdictions. After a certain number of days (usually 14 to 21), benefits are paid retroactively for the threshold period.

Usually TTD recipients return to work upon medical recovery and do not receive any permanent disability benefits. Occasionally, they return to work prior to the date of maximum medical improvement (MMI) with a reduced work schedule, or altered responsibilities and at an accompanying lower wage. In these instances, most states provide temporary partial disability (TPD) benefits. Cases classified as temporary disabilities (either total or partial) account for nearly 70 percent of workers' compensation cases where wage replacement benefits are received.

The most difficult and contentious category of benefits is permanent partial disability (PPD) benefits. In these cases, the disability is considered permanent but not severe enough to preclude work. PPD benefits are usually paid to workers who initially receive TTD benefits, but after the date of MMI still have a partial work disability.

There are typically two different types of PPD benefits, scheduled and nonscheduled. Scheduled benefits are for injuries involving specific body parts (such as arms or legs) that are included in a "schedule" in the workers' compensation statute. In most states, physical loss or loss of use of these body parts automatically qualifies the worker for benefits. However, there is no consistency among the states in the amount of benefits awarded for different body parts. Some states provide greater benefits for loss of an arm than a leg, and others are just the reverse.

States also differ in the purpose cited for schedule benefits. Some of those that tie the schedule benefit to the injured worker's average weekly wage characterize the schedule as a form of presumptive wage loss used to facilitate administration of the law. In most states, the schedule is the only permanent partial benefit payable to someone with an injury on the schedule. However, there are a few states in which the schedule benefit is a minimum, and if continuing loss of wages can be shown, additional cash benefits will be paid. In addition, a few states have schedules that do not tie the benefit entitlement to the injured worker's average weekly wage. In those cases, the schedule seems more like a sickness and accident schedule than one designed to compensate for lost earnings.

Nonscheduled benefits are for injuries that are not included in the schedule (such as back injuries). The system for determining benefits in these cases is very complex and varies considerably across jurisdictions (see Barth and Niss [1999] for a thorough treatment). Some states provide benefits based on an impairment rating scheme. The level of impairment, often expressed as a percentage of full functionality or “whole body,” is sometimes translated into a percentage of total disability. This percentage is then used to determine the benefit amount. Some states modify the impairment rating to try and account for loss of earning capacity by adjusting for vocational factors, such as the worker’s education, job experience, and age. Other states employ a system that attempts to compensate workers for actual lost wages. In addition, many states use combinations of these methods that have evolved over the last 90 years.

Although PPD benefits contain the term “permanent,” they do not always last the length of the recipient’s expected working life. Often, PPD benefits are awarded for a set length of time (scheduled benefits nearly always are for a specific number of weeks), and that period can differ within a given state depending on the degree of the disability or other factors. The duration of benefits may also depend upon the worker’s situation. In most jurisdictions, PPD benefits are based on a one-time estimate of what the injured worker’s future loss of earnings will be over the remainder of his or her working life. This estimate by its very nature is fraught with uncertainty.

Most jurisdictions will pay these PPD benefits even if the injured worker does not suffer an earnings loss after the condition has become stable (after MMI). There is much disputation over the specific worker’s circumstances and the resulting workers’ compensation entitlement, and many of these claims end up with compromise settlements. PPD claims account for approximately 28 percent of all cases with wage replacement benefits. Nevertheless, in terms of benefits paid, PPD cases are the most expensive category because more than 63 percent of wage replacement benefits paid are for PPD cases (Mont et al. 2002, Figure 3).

If the disability is severe enough, the worker can receive permanent total disability benefits (PTD). In most states there are some injuries that are presumed to be permanently and totally disabling, such as the loss of two eyes or two arms. In these cases, PTD benefits are paid presumptively. The worker does not have to prove that she is unable to

work. Generally, workers can receive PTD benefits if an illness or injury is deemed significant enough to preclude any gainful employment. But in a few states, PTD benefits are payable if the worker is unable to resume her prior employment, even if employment in another occupation is possible.

Sometimes these determinations take into consideration geographical, educational, and economic factors. An injured person might be able to do some sort of work, but given his education, experience, and the job opportunities where he lives, nonemployment may be the most reasonable outcome. In these instances, PTD benefits can be taken away or reduced if the recipient does return to work. Less than 1 percent of all workers' compensation cases are classified as PTD.

Fatal benefits go to dependent family members of workers whose death is caused by a work-related injury or illness. There are frequently no benefits associated with the deaths of workers who do not have any dependents, although burial expenses may be paid, and usually a "penalty" payment to the workers' compensation administrative entity is assessed. This provides a financial incentive for prevention efforts by the employer. Less than 1 percent of all workers' compensation cases involve fatalities.

Sometimes instead of receiving weekly or monthly wage replacement benefits and fully paid medical care, workers negotiate a settlement (also referred to as a compromise and release agreement) with their employers and/or insurers. Such an agreement is often made in cases where the compensability of an injury is in dispute. Settlements are also common in cases where the parties disagree about the amount of benefits due in the future for an admittedly compensable injury because the amount is subjective, or difficult to ascertain in advance.

The settlement typically provides the worker with a one-time payment that represents the amount agreed to (the compromise) as the worker's recovery. Settlements where compensability is disputed, however, recognize that there is a possibility that the worker may not receive any recovery and therefore are usually more deeply discounted. A settlement generally limits or terminates the employer's liability (the release). Thus, it is a "compromise" agreement that "releases" the employer from liability, or a "compromise and release." The rules governing such settlements vary widely, with some jurisdictions not allowing them at all, some allowing them only under specific circumstances, and

some being fairly free with approval of such agreements. Most states are careful to not approve settlements that make insufficient allocations for future medical expenses, or they allow for the medical part of the settlement to be reopened if need be.

There is another group of settlements that reflect litigation over the degree of disability or the residual work capacity of the injured worker. Such cases revolve around the medical aspects of the case (especially causation) and the implications for the future work capacity of the individual. These disputed cases can involve very expensive and time-consuming litigation within the overall administration of this no-fault insurance system.

## **Insurance**

Employers secure workers' compensation insurance coverage in three ways. They may buy a policy from a private insurance carrier, they may insure with a state fund, or they may self-insure (either individually or as part of a group arrangement). However, all of these options are not available in every state. About 20 states have state funds that compete with private insurance carriers. Five states (North Dakota, Ohio, Washington, West Virginia, and Wyoming) have "exclusive" state funds and do not allow employers to purchase private insurance. The rest of the states rely on private carriers and self-insurance only. Whatever insurance arrangement is used, however, the laws governing coverage, compensability, and the amount of benefits paid are the same within a state.

## **Recent Policy Developments**

Since the National Commission's report in the 1970s, the state workers' compensation programs in the United States have gone through a number of stages, driven by both political and economic forces. The report held out the threat of mandatory national standards if the states did not improve their programs to comply with 19 "essential recommendations." The states did make a significant effort to comply, and through the decade of the 1970s benefits generally were increased and eligibility was expanded.

One example is given by the level of maximum benefits for TTD. The commission recommended that the maximum benefit should be set

to at least 100 percent of the state average weekly wage. When the commission endorsed this goal in 1972, only one state was in compliance. By 1979, 28 states had attained this level (Thomason, Schmidle, and Burton 2001, p. 23). But as benefits improved, employers' costs rose accordingly. Thomason, Schmidle, and Burton (2001) report that employer costs of workers' compensation insurance rose from 1.11 percent of payroll in 1971 to 1.95 percent in 1979, while benefits increased by nearly 16 percent annually.

Many in the business community, including some initial supporters of the essential recommendations, opposed further adoption at this point because the cost impact was greater than they originally anticipated. This was the result of behavioral changes that led to greater utilization combined with continued cost pressures from PPD benefits and the perceived need for improvements in the delivery system and adjudicatory process which the commission did not address.

Employer costs as a percentage of payroll receded from 1980 to 1984, as investment earnings peaked in the insurance industry and the underwriting cycle permitted a return to profitability among workers' compensation insurers. Average employer costs declined from 1.95 percent of payroll in 1979 to 1.66 percent in 1984, and there were relatively few legislated benefit changes.

However, costs began to rise again in the mid 1980s, peaking at 2.16 percent of payroll in 1991 as benefits continued to rise faster than payrolls. Concerns about the rising employer burden of workers' compensation costs and the potential negative impacts on employment growth ushered in what has been termed "the neo-reform era" (Spieler and Burton 1998).

The period from 1992 to 2000 was characterized by a significant reduction in workers' compensation insurance costs for employers, declining from an average 2.16 percent in 1991 to 1.25 percent in 2000 (Thomason, Schmidle, and Burton 2001, Table A.1; Mont et al. 2002, p. 1). Spieler and Burton (1998) identified five causes of this decline:

- 1) reductions in cash benefits,
- 2) changing rules of compensability,
- 3) transformation of the health care aspect of workers' compensation benefits (managed care, etc.),

- 4) the rise of disability management, and
- 5) challenges to exclusivity.

Others disagree with the conclusions of Spieler and Burton and point out that cost declines occurred in states that had not made any of the identified changes. They believe that the decline in workers' compensation costs was more affected by a significant reduction in injury frequency and the rise of disability management programs that occurred in nearly all states, and even in the workers' compensation systems of other developed countries. This decline continued through 2000 in most jurisdictions and has not been satisfactorily explained.

Benefit replacement formulae were not generally changed during this period, although there were a few exceptions. Similarly, benefit maxima were not reduced; most of these are now tied to the state average weekly wage as the commission recommended. However, there were a few states that reduced the maximum number of weeks for TTD, which can affect benefit adequacy for longer duration cases. Business representatives point out that this change occurred in states where a significant number of TTD claims lasted for 18 months or more, a period of time beyond what is commonly considered "temporary." Overall, it would be fair to say that the thrust of workers' compensation amendments during the 1990s was to reduce system costs through a variety of benefit reductions, coverage limits, and administrative efficiencies.

However, according to Spieler and Burton, "The primary target for reform in the 1990s has been permanent partial disability benefits . . ." (p. 219). These benefits, the most difficult and controversial in the workers' compensation programs, are paid to individuals who are able to work but have sustained some permanent impairment. Reductions in the weekly amount of and maximum duration for benefits and changes in the way disability is assessed are two of the many techniques used during this period to reduce the cost of permanent partial disabilities for employers. Of course, changes such as these can have important implications for benefit adequacy.

Insurers point out that changes in the way disability was assessed were done to increase predictability in the determination of PPD, and they maintain that there is no evidence that these changes provided for any less benefit adequacy than the methods of PPD determination they replaced.

## CONCLUSION

The vast majority of workers in the United States are covered by state workers' compensation programs. These state programs differ widely in regard to coverage, compensability, benefit levels, and financing. They also differ in how they are administered and enforced. To fully understand workers' compensation programs and their role in assisting those with work-related injuries and illnesses, it is important to review the programs by comparing and contrasting the experience across states.

This book focuses on the adequacy of wage replacement benefits paid by these programs. It does not examine the medical benefits provided by workers' compensation programs, nor does it address the important issues of coverage or compensability. Thus, it will not analyze the extent to which workers' compensation programs provide benefits to all people who are injured while working or who contract an occupational disease. Rather, it examines the level of benefits provided to those workers who are covered by workers' compensation statutes and have an injury or an illness that meets their state's definition of a compensable condition.

Even within this more limited scope, however, there is much to be discussed. What is meant by benefit adequacy? What are the methodological challenges and analytical advantages of using different measures of benefits? And, finally, what summary judgment can we make about the adequacy of cash benefits in the current state systems? Have legislative enactments of the last decade damaged this important social safety net for working men and women? This book seeks to answer these questions in a balanced and rational manner. We acknowledge that emotions run high when discussing the adequacy of workers' compensation benefits, but we also maintain that facts speak louder than opinions. We have done our best here to present the facts about benefit adequacy.