ECONOMIC INCENTIVES IN WORKERS' COMPENSATION: A HOLISTIC, INTERNATIONAL PERSPECTIVE

COMMENT*

James Lynch†

Alison Morantz's article, *Economic Incentives in Workers' Compensation: A Holistic, International Perspective* takes an interesting, unique approach to understanding workplace safety, the benefits received by those injured at work and how well the U.S. workers' compensation system fulfills its role.

The author undertakes a daunting bit of research to try to compare the adequacy of the American program to those of Canada, Europe, and Australasia. It is a difficult task, in part because the U.S. system spends far more than its counterparts on medical expenses, as the author documents.[1]

The author addresses the problem by zooming out, examining workers' compensation as one of four pillars that monitor workplace safety and compensate workers, alongside the free market, government inspectors and social insurance programs. All of the countries examined address these issues, some better than others in the author's view.[2]

Along the way the author looks at the incentives of the key players in the system—workers, employers, doctors and insurers. Many of these incentives, the author asserts, inadvertently align to discourage the reporting of injuries.[3] Among these supposed misaligned incentives, I note, is a concern that experience rating is not a particularly effective

---

* This is a comment written in response to Alison Morantz et al., *Economic Incentives in Workers' Compensation: A Holistic International Perspective*, 69 RUTGERS U. L. REV. 1015 (2017), for the Volume related to the Conference on "The Demise of the Grand Bargain: Compensation for Injured Workers in the 21st Century" at Rutgers Law School, Camden, NJ, September 23, 2016.

† FCAS, MAAA; Chief Actuary, Insurance Information Institute

1. Alison Morantz et al., *Economic Incentives in Workers' Compensation: A Holistic International Perspective*, 69 RUTGERS U. L. REV. 1015, 1040–41 (2017).
2. *Id.* at 1031–52.
3. *Id.* at 1025–31.

incentive to prevent claims and actually "incentivizes companies to underreport injuries."[4]

This results in a critique of the U.S. system, focusing on what the author suggests could lead to a breakdown of what has come to be called the Grand Bargain. Workers' compensation in the United States, the author concludes, inexorably shifts costs away from the employer onto the worker and government social insurance programs.[5]

The paper ends with some ideas for further research and reform.[6]

The author is to be commended for taking such a broad approach and attempting to adapt the lessons other nations have learned about workers' compensation insurance.

As chief actuary at the Insurance Information Institute, a not-for-profit organization that increases public understanding of insurance—what it is and how it works—I bring a unique perspective. My work allows me to closely observe many insurance markets, not just workers' compensation. As a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries, I often approach insurance issues from an actuarial point of view—in this instance, the role of appropriate pricing in telling a policyholder what their risk profile is.

As such I enjoyed reviewing the research suggesting that experience rating is ineffective and that it suppresses claims rather than eliminates them. I note the most exhaustive paper the author cited (that of Alan Clayton) is not so much an empirical study but a recitation of logic similar to what Professor Morantz performs: in essence, saying that a decrease in claims is not necessarily a decrease in injuries. The paper acknowledges that research is ambivalent on the matter. Still, author Clayton acknowledges the benefits of experience rating in rehabilitation and return-to-work, a finding that by itself is a demonstration of the practice's merit.[7]

The author devoted considerable space discussing the lack of incentive-based rating schemes outside of experience rating. I would like to have seen greater discussion of schedule rating: the practice of crediting or debiting an insured based upon a physical condition of the workplace, where data has shown that said condition results in fewer claims, or smaller ones. Insurance companies have long employed

---

4. *Id.* at 1040.

5. *Id.* at 1065–66.

6. *See id.* at 1075–78.

7. Alan Clayton, *The Prevention of Occupational Injuries and Illness: The Role of Economic Incentives* 16–25 (Nat'l Research Ctr. for OHS Regulation, Working Paper No. 5, 2002), https://openresearch-repository.anu.edu.au/bitstream/1885/41128/3/working_paper_5.pdf (last visited Nov. 11, 2017).

schedule rating, with the explicit intent to reward employers that implement programs that make the workplace safer prospectively.

The Pennsylvania Compensation Rating Bureau describes schedule rating as the process by which premium may be adjusted "to reflect defined characteristics of the risk which, in the sole judgment of the underwriting carrier, are not adequately reflected in prior experience of the insured risk."[8] The rating bureau instructs insurers how the adjustment is calculated.[9] In the Pennsylvania plan, the adjustment is step 40 in the 74-step process of calculating a rate.[10]

Schedule rating is ubiquitous. North Carolina's rating bureau, for example, has a simple plan that offers discounts for characteristics such as "return-to-work programs," "safety devices and equipment," "commitment to workplace safety," and "safety committee organization and effectiveness."[11] Insurers, rating bureaus, and regulators measure and monitor the impact of schedule rating on the premium charged.[12]

Professor Morantz's article would have benefited, I think, had it shown how schedule rating is either different from or inadequate beside the schemes the author envisions.

The author also detailed a great many economic incentives among doctors, employers, workers and others. I think the work would have been enhanced with the inclusion of a few other incentives:

- Given an injury, the injured or ill person has an incentive to claim the malady is work related. Suffering a work injury, the patient incurs no out-of-pocket expenses, and the injured person will receive compensation while they recover. Both confer economic advantages not available in health insurance.
- There is evidence that Accountable Care Organizations (ACOs) created by the Affordable Care Act will drive claims

8. PA. COMP. RATING BUREAU, *Schedule Rating*, DCRB.COM, http://www.dcrb.com/pcrb/pricing_programs/p_schedule.htm (last visited Nov. 11, 2017).

9. *Id.*

10. PENNSYLVANIA WORKERS COMPENSATION STATISTICAL PLAN MANUAL: PREMIUM CALCULATION ALGORITHM 2 (Pennsylvania Compensation Rating Bureau 2006), http://www.pcrb.com/pcrb/filings/c349/C349_Algorithm_StatPlan.pdf.

11. N.C. RATE BUREAU, SCHEDULE RATING PLAN 1–2 (2009), http://www.ncrb.org/Portals/0/ncrb/workers%20comp%20services/forms/Schedule%20Rating%20Plan%208-09.pdf.

12. *See* KATHY ANTONELLO, NAT'L COUNCIL ON COMP. INS., STATE OF THE LINE REPORT 21 (2017) https://www.ncci.com/Articles/Documents/II_AIS-2017-SOL-Presentation.pdf.

> into the workers' compensation system, as doctors look for ways to generate revenue beyond the ACO's per patient capitation.[13]

I was surprised the author failed to catalog these and other incentives that invite overreporting of injuries or exorbitant billing for treatment.

Much of the current research and legislation regarding U.S. workers' compensation involves finding ways to reduce incentives that drive costs higher with no discernable benefit to the worker. For example, some New York doctors book surgery in New Jersey in what looks like an attempt to dodge their own state's fee schedules.[14] Knee arthroscopies in New Jersey cost $4,954, or 266% more than their counterparts across the Hudson.[15]

Workers' compensation regulators in Illinois and California restricted payments for five-milligram and ten-milligram doses of a particular muscle relaxant, and doctors responded by prescribing 7.5 milligram doses.[16] The new dosage costs considerably more but provides no additional medical benefit.[17] However, the new dosage did increase revenues and profits for doctors and pharmaceutical companies.[18]

It is important, I believe, to have as complete a picture as possible of incentives when seeking policy solutions. An inadequate catalogue of incentives is an invitation for the nefarious to abuse the uncatalogued.

While the author focuses on the incentives (primarily economic) that most actors face, they do not appear to discuss the incentives faced by monopolistic workers' compensation insurers. It is often difficult to divine these incentives, because monopolistic carriers are quasi-governmental in nature. They are not driven to maximize profit.

That does not mean such carriers automatically operate altruistically. They are vulnerable to political pressures, and those pressures can take interesting forms. The near monopoly that is the Ohio Bureau of Workers Compensation (insuring approximately two-thirds of all employees in the state), for example, in 2005 invested $50

---

13. James Lynch, *WCRI Looks at Impact of Affordable Care Act on Workers Comp*, TERMS + CONDITIONS: INS. INDUSTRY BLOG (Mar. 9, 2015), http://www.iii.org/insurance industryblog/?p=3978.

14. *See, e.g.*, James Lynch, *WCRI Conference Highlights*, INS. INFO. INST.: TERMS + CONDITIONS: INS. INDUSTRY BLOG (Mar. 16, 2016), http://www.iii.org/insuranceindustryblog/?p=4384.

15. *Id.*

16. Richard A. Victor, *Physician Dispensing in Workers' Compensation*, WORKERS' COMPENSATION INST. (Oct. 15, 2015), http://www.wci360.com/news/article/physician-dispensing-in-workers-compensation.

17. *See id.*

18. *Id.*

million of its surplus in gold coins sold by a politically connected coin dealer.[19] Property/casualty companies rarely invest in such a volatile, illiquid fashion.[20] In the ensuing scandal, Ohio's governor was found guilty of violating ethics laws, and the bureau fired all of its money managers and began to invest more prudently.[21]

Political vulnerability also often translates into inadequate rates as legislators find it politically expedient to keep rates low rather than distress voters. Examples of this abound throughout the insurance world. For example, the Michigan Catastrophic Claims Association reinsures all Michigan auto drivers for no-fault claims exceeding, at the time of this writing, $545,000.[22] Consistent underpricing left the insurer with a surplus of negative $1.7 billion in 2016, and that did not include a $18.5 billion discounting of reserves to present value via an accounting treatment that no viable U.S. auto insurer has available to it.[23] Without the discount, the insurer would show a $20.2 billion deficit on its balance sheet.[24]

The federal government's National Flood Insurance Program has also been unable to charge actuarially sound rates to many of its riskiest customers. Losses from Hurricane Katrina in 2005 and superstorm Sandy in 2012 left it with more than $20 billion in debt to the U.S. Treasury, with no practical means of ever repaying.[25] Congress attempted to implement actuarial pricing across the board in 2014, but after a public outcry the attempt was halted within six months.[26]

Mispricing itself creates perverse incentives for policyholders. Michigan drivers might seek to restructure their unique auto insurance

19. The various scandals that ensued are encapsulated at a web page, *State of Turmoil: The Coingate Scandal*, TOLEDO BLADE, http://www.toledoblade.com/coingate (last visited Nov. 11, 2017).

20. *See id.*

21. *Id.*

22. JC Reindl, *How Michigan Got – and Kept – No-Fault Auto Insurance*, DETROIT FREE PRESS (May 6, 2017, 11:04 PM), http://www.freep.com/story/news/local/michigan/2017/05/06/michigan-nofault-insurance-history-detroit/100301828/.

23. *See* MICH. CATASTROPHIC CLAIMS ASS'N, ANNUAL STATEMENT FOR THE PERIOD ENDING JUNE 30, 2016, at 3, 14.3 (2016), www.michigancatastrophic.com/Portals/71/Annual%20Statement%20FYE%2006302016%20Final.pdf.

24. *See id.*

25. DIANE P. HORN & JARED T. BROWN, CONG. RESEARCH SERV., R44593, INTRODUCTION TO THE NATIONAL FLOOD INSURANCE PROGRAM (NFIP) 24 (2017), http://www.fas.org/sgp/crs/homesec/R44593.pdf.

26. *See Background On: Flood Insurance*, INS. INFO. INST. (Oct. 3, 2016), http://www.iii.org/issue-update/flood-insurance.

program were its costs accurately reflected in rates.[27] People living in low-lying areas might redesign their residences or move to higher ground if their flood premiums accurately reflected the risk being borne.

These particular monopolistic entities do not write workers' compensation insurance, but they are classic examples of how political considerations often outweigh actuarial considerations when the government holds the underwriting pen.

None of this is meant to imply that monopolistic insurers are incapable of developing and implementing a robust insurance program. I think it does mean that monopolistic insurers are prey to unique incentives and these incentives are both hard to discern and difficult to resolve. Any attempt to rely on monopolistic insurers for testing or implementing reform should carefully consider how these incentives are likely to operate.

The author also discusses research that indicates that the U.S. workers' compensation system fails to compensate injured workers fully and that many costs are shifted onto government social programs that are far less adequate than programs in other countries.[28]

It is worth noting that the average cost per indemnity claim has grown twenty-three percent faster than wages since 1995.[29] Medical claim severity per lost time claim has grown fifty-five percent faster than medical inflation over the same period.[30] Medical costs have increased so markedly that they now constitute fifty-eight percent of workers' compensation costs, up from forty-three percent in 1981.[31]

Workers' compensation is not the only area in which medical costs are spilling onto employers' expense statements. Between Q1 2004 and Q1 2016, health insurance costs per hour for private firms rose fifty-nine percent for private industry, faster than wages (thirty-four percent) and benefits overall (forty-six percent). A back-of-the envelope calculation indicates that had health insurance costs per hour risen only as fast as wages, the savings would have afforded a tripling of indemnity benefits.[32]

---

27. *See* Reindl, *supra* note 22.

28. *See* Morantz et al., *supra* note 1, at 1065–66.

29. NAT'L COUNCIL ON COMP. INS., 2016 STATE OF THE LINE GUIDE 39 (2016), https://www.ncci.com/Articles/Documents/II_AIS-2016-SOL-Guide.pdf.

30. *Id.* at 46.

31. *Id.* at 44.

32. These are the author's calculations based upon data extracted from Bureau of Labor Statistics databases at http://www.bls.gov/data/. The relevant time series are taken from Employer Cost for Employee Compensation surveys with the following Series IDs: CMU2150000000000D (health insurance), CMU2270000000000D (workers' compensation), CMU2030000000000D (benefits) and CMU2020000000000D (wages).

Employers struggle to manage benefit costs, and employee health costs have proved the most vexing. Any proposal to make workers' compensation more responsive must contemplate how to control medical inflation, whose remarkable run-up is now in its sixth decade.

This issue also affects the ability of the social service sector to respond to all injuries, both in the cost of supplying medical services and in the loss of funds to pay for medicine instead of other services.

Any Grand Bargain solutions must contemplate controlling health expenses, not just in workers' compensation but in the health care system overall.