
DRAFT Commentary on August 30 Draft: "Workers' Compensation at a Crossroads: Back to the Future or Back to the Drawing Board?"

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Alison Morantz's paper, "Workers' Compensation at a Crossroads: Back to the Future or Back to the Drawing Board?" 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.

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.

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. Among these supposed misaligned incentives, I note, is a concern that experience rating is not a particularly effective incentive to prevent claims and actually "incentivizes companies to underreport injuries" (page 23).

This results in a critique of the U.S. system, focusing on what the author perceives as the inadequacies of what has come to be called the Grand Bargain. Workers' compensation in the U.S., the author concludes, inexorably shifts costs away from the employer onto the worker and government social insurance programs.

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

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 explains 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, that it suppresses claims rather than eliminates them. I note the most exhaustive paper the author cited 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. That 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.[1]

The author devoted considerable space discussing the lack of incentive-based rating schemes outside of experience rating. I would like to have seen some acknowledgment 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 schedule rating, with the explicit intent to reward employers that implement programs that make the workplace safer prospectively.

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."[2] The paper 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. A work injury requires no out-of-pocket expenses, and the injured person will receive compensation while they recover. Both confer economic advantages not available in health insurance.
- A medical professional has in many cases an incentive to classify an injury as work-related since, as the author notes, "medical care is generally even more expensive in the U.S. workers' compensation system than under group health plans." (page 25). In their function as gatekeeper to workers' compensation benefits, the doctor often must choose between allowing themselves to be compensated more richly than doctors anywhere else on earth or to classify the claim as workers' compensation and earn a bit more.

I was surprised the author failed to catalog these and other incentives that invite overreporting of injuries or exorbitant billing for treatment. For example, there is evidence that Accountable Care Organizations (ACOs) created by the Affordable Care Act will drive claims into the workers' compensation system, as doctors look for ways to generate revenue beyond the ACO's per patient capitation.[3]

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[1] Alan Clayton, *The Prevention of Occupational Injuries and Illness: The Role of Economic Incentives, Working Paper 5.* NATIONAL RESEARCH CENTRE FOR OHS REGULATION (2002), https://digitalcollections.anu.edu.au/handle/1885/41128 (last visited Sept. 03, 2016).

[2] *Schedule Rating Plan*, North Carolina Rate Bureau, http://www.ncrb.org/Portals/0/ncrb/workers%20comp%20services/forms/Schedule%20Rating%20Plan%208-09.pdf (accessed Sept. 5, 2016).

[3] James Lynch, *WCRI Looks at Impact of Affordable Care Act on Workers Comp*, Terms + Conditions, March 9, 2015, http://www.iii.org/insuranceindustryblog/?p=3978 (accessed Sept. 5, 2016).

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. Knee arthroscopies in New Jersey cost $4,954, or 266 percent more than their counterparts across the Hudson.[4]

Workers' compensation regulators in Illinois and California restricted payments for 5 milligram and 10 milligram doses of a particular muscle relaxant, and doctors responded by prescribing 7.5 milligram doses. The new dosage cost considerably more but provide no additional medical benefit. However, the new dosage did increase revenues and profits for doctors and pharmaceutical companies.[5]

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 don't 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 aren't 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 million of its surplus in gold coins sold by a politically connected coin dealer. Property/casualty companies rarely invest in such a volatile, illiquid fashion. 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.[6]

Political vulnerability also often translates into inadequate rates. Examples of this include the Michigan Catastrophic Claims Association, which reinsures all Michigan auto drivers for no-fault claims exceeding, at this writing, $545,000. Consistent underpricing has left the insurer with a surplus of negative $690 million, and that does not include a $16.9 billion discounting of reserves to present value via an accounting treatment that no viable U.S. auto insurer has available to it.[7] Without the discount, the insurer would show a $17 billion deficit on its balance sheet.

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

[4] Lynch, *WCRI Conference Highlights*, Terms + Conditions, March 16, 2016, http://www.iii.org/insuranceindustryblog/?p=4384 (accessed Sept. 5, 2016).
[5] Richard A. Victor, *Physician Dispensing in Workers' Compensation*, Workers Compensation Institute, Oct. 15, 2015, http://www.wci360.com/news/article/physician-dispensing-in-workers-compensation (accessed Sept. 5, 2016).
[6] The various scandals that ensued are encapsulated at a web page, *State of Turmoil: The Coingate Scandal*, The Toledo Blade http://www.toledoblade.com/coingate (accessed Sept. 5, 2016).
[7] 2015 Annual Statement of the Michigan Catastrophic Claims Association, pages 3 and 14.3. http://www.michigancatastrophic.com/Portals/71/Annual_Statement_June_30_2015.pdf (accessed Sept. 5, 2016).

Sandy in 2012 leave it $23 billion in debt to Congress, with no practical means of ever repaying.[8] Congress attempted to implement actuarial pricing across the board in 2014, but after a public outcry the attempt was halted within six months.[9]

Mispricing itself creates perverse incentives for policyholders. Michigan drivers might seek to restructure their unique auto insurance program were its costs accurately reflected in rates. 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 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.

It is worth noting that the average cost per indemnity claim has grown 23 percent faster than wages since 1995. Medical claim severity per lost time claim has grown 55 percent faster than medical inflation over the same period. Medical costs have increased so markedly that they now constitute 58 percent of workers' compensation costs, up from 43 percent in 1981.[10]

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 59 percent for private industry, faster than wages (34 percent) and benefits overall (46 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.[11]

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[8] Jared T. Brown, *Introduction to FEMA's National Flood Insurance Program*, Congressional Research Service, Aug. 16, 2016, http://www.fas.org/sgp/crs/homesec/R44593.pdf (accessed Sept. 5, 2016).

[9] *Flood Insurance*, Insurance Information Institute, August 2016 http://www.iii.org/issue-update/flood-insurance (accessed Sept. 5, 2016).

[10] 2016 State of the Line Guide, National Council of Compensation Insurers, 2016. https://www.ncci.com/Articles/Documents/II_AIS-2016-SOL-Guide.pdf (Accessed Sept. 5, 2016).

[11] 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 runup 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.