WORKERS' COMPENSATION AT A CROSSROADS: BACK TO THE FUTURE OR BACK TO THE DRAWING BOARD?

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"Demise of the Grand Bargain" Symposium
September 23, 2016

Outline of Talk

- Overview of the "four-pillared" OSH regime, including how it compares to those in Canada, Europe, Australia, and New Zealand
- Overview of stakeholder incentives – workers, employers, physicians & insurers – including how unique features of OSH regime in the US affect stakeholders' incentives
- Mounting pressures in US workers' comp system
- Research priorities
- Suggested reforms

The Four-Pillared OSH Regime

- Embeds evaluation of WC policy in larger institutional economic context
- Highlights institutional differences between US and other industrialized countries ("comparator countries") that transcend workers' comp, yet affect workers' comp in important ways
- Helps clarify why incentives of workers' comp stakeholders differ from those in other comparator countries, and why some of our problems are so intractable

First Pillar: Free Market Incentives

- Wage-risk premia / "compensating differentials"
- Key assumptions:
  - Full information
  - Negligible transaction costs
  - No borrowing/ liquidity constraints
  - Bargaining power

Free Market Pillar: *US v. Comparator Countries*

- Informational asymmetries about site-level risk:
  - More government-provided, establishment-level info available in US than in many comparator countries (BLS, OSHA, MSHA)
- But much lower union density, esp. in private sector
- Fewer laws giving workers "voice" in OSH matters

Second Pillar: OSH Inspectorate

- State, federal & local agencies that (often) pass regulations, and inspect workplaces to determine adherence to OSH regulations
- Diversity in scope and intensity of activities
- Economic literature distinguishes 2 effects:
  - Specific deterrence
  - General deterrence

Inspectorate Pillar: *US v. Comparator Countries*

- Little info on nitty-gritty operations of OSH inspectorates – makes comparisons difficult!
- However, US OSH standards seem to compare relatively favorably
- Frequency & rigor of conventional inspections also seem to compare reasonably well
- Site-level data on penalties publicly available
- Overall, federal inspectorate seems no less robust than counterparts in many comparator countries, but this conclusion is highly tentative

Third Pillar: Worker's Comp

- *Partial* insurance provided on *no-fault* basis

- Numerous dimensions of variation, such as:
  - Adequacy of benefits
  - Experience rating
  - Share of medical costs in total costs e
  - Insurance market regulation
  - Physicians as gatekeepers
  - Anti-retaliation protection
  - Exclusivity of workers' comp as remedy…..

Workers' Comp Pillar: *US v. Comparator Countries*

- (Much variation *within* US – FECA , between states)
- US system differs from comparators in many ways:
  - Experience rating much more common
  - Higher medical costs
  - More competitive insurance markets
  - Fewer occupational diseases compensated
  - Physicians act more often as gatekeepers in litigation
  - (Relative) inadequacy of benefits
  - Near absence of civil remedies or strong job protection in employment-at-will environment

Fourth Pillar: Social Insurance

- State and federal laws providing *other* types of social insurance to disabled workers
- Medical care:
  - Is it a public entitlement, regardless of work-relatedness of injury/illness? If so, how much of cost do workers bear?
  - If no universal entitlement, how easily can workers access means-tested programs?
- Income replacement
  - Is there paid sick leave?
  - Is there public short- or long-term disability insurance?

Social Insurance Pillar: *US v. Comparator Countries*

- *Public health care:* US is only country in which it does not exist. It is an entitlement in all comparator countries.
- *Public Disability insurance*: US has no federal program except SSDI & SSI, which have relatively restrictive eligibility requirements, and only 51% of US workers have no private disability coverage. Most comparator countries provide much more generous benefits.
- *Paid Sick Leave*: US has no federal entitlement (and even few jurisdictions that mandate it never provide more than 9 days), whereas workers in comparator countries have at least two weeks, and typically much longer

How Differences in OSH Regimes Affect Incentives of Workers' Comp Stakeholders

Worker Incentives

- *Bargaining for risk-wage premia*: depends on availability of info on job risks, union strength, etc.
- *Risk-taking on the job*: depends on cost associated with sustaining an injury v. cost of taking care ["true injury effect" or "risk-taking moral hazard"]
- *Participating in OSH oversight*: depends on union strength & laws/practices giving workers "voice" in OSH matters
- *Filing a claim after an injury*: depends on relative generosity of benefits under WC v. group health, and risks of filing itself ["reporting effect or "claims-reporting moral hazard"]
- *Timing of return to work*: generosity of WC (and other social insurance) benefits compared to wages; "duration effect"

Worker Incentives: *US vs. Comparator countries*

- *US workers probably **less** well equipped to:*
  - *Command wage premiums*
  - *Influence OSH practices after hiring*
- *They also probably have **stronger** incentives to:*
  - *Take care on job*
  - *Return to work after an injury*
  - *Underreport injuries*
- *Overall, US workers' choices may be driven less by full optimization than responses to short-term exigencies that affect capacity to meet basic needs.*

Employer Incentives

- Overall salience of OSH issues depends on share of injury costs that employers are (in theory) supposed to internalize
- Employers' incentives to invest in safety depend on:
  - Direct costs of the improvements
  - Whether the costs will be offset by lower risk-wage premia, enhanced reputation, etc. (free market pillar)
  - Rigor of regulatory oversight (inspectorate pillar)
  - Relative cost of *externalizing* OSH costs (cost shifting)
- Higher medical costs as % of cost per claim, stronger employers' incentives to manage care

Employer Incentives: *US v. Comparator Countries*

- *High cost of workers' comp in US, esp. medical costs, makes the program highly salient*
- *Confluence of trends in US suggest that cost externalization is a (if not the) dominant approach:*
  - *Behavior-based safety / incentive programs targeted by OSH A because tend to encourage underreporting*
  - *Misclassification of employees as independent contractors (more prevalent in industries with high WC costs)*
  - *Aggressive claim management practices, esp. since 1990s, which have contributed to lessened adequacy*
  - *Trends in fee schedules & employer-directed medical care*
  - *Spread of opt-out movement beyond Texas*

Physician Incentives

- Physicians as gatekeepers:
  - Incentives depend on nature and duration of relationship with requesting entity
- Physicians as direct treatment providers:
  - Depends on existence (and relative generosity) of fee schedules
  - In effect, whether physicians can earn more through group health (or other programs) or through WC

Physician Incentives: *US v. Comparator Countries*

- *IME's: very strong incentives to contest work-relatedness of an injury*
- *If WC is less remunerative than group health:*
- *strong incentives not to classify injuries as work-related, or if deemed work-related, to substitute more expensive services or increase utilization.*
- *If WC is more remunerative than group health: strong incentive to classify injuries as work-related.*
- ***In general, two-track system for treating injuries creates myriad forms of moral hazard for doctors.***

Insurer Incentives

- Public vs. private
  - Face different pressures
- Monopolistic vs. competitive
  - Affect whether long-term contracting is feasible
- Many other differences, such as
  - Regulation (or lack thereof) over rates (extent to which dictated by regulation and whether must be approved by WC agency)
  - Availability (or lack thereof) of self-insurance

Insurer Incentives: *US vs. Comparator Countries*

- *Monopolistic insurance systems tend to foster longer-term relationships between insurer and insured (insurer can recoup long-term investments)*
- *For this reason, incentives for insurers to subsidize innovative OSH programs – instead of just utilizing experience rating – would seem to be stronger in monopolistic insurance systems*
- *Dominance of competitive insurance markets in US might help explain fact that insurance-led innovations seemingly less common than in Europe*

Mounting Pressures in US

- Inadequacy of Benefits
- Underreporting / Underclaiming/ Aggressive Claim Screening
- Cost Shifting onto SSDI, SSI, etc.
- Affordable Care Act

Research Priorities

- Examine deregulatory experiments – esp. effects of opt-out on employee welfare
- Explore relevance of behavioral law & economics
- Differentiate (and quantify) contribution of different OSH stakeholders to underreporting
- Examine return-to-work from more comparative (cross-national) & interdisciplinary perspective
- Use FECA as testing ground for innovation

Suggested Reforms

- Comprehensive (systemic) health care reform!
  - Publicly provided health care => integration of OSH & non-OSH medical care, abolition of 2-track system
- More modest reforms to current system:
  - Offset stakeholder incentives to underreport
  - Adopt list of presumptively compensable diseases
  - Connect (in)adequacy of benefits to cost shifting
  - Expand insurance-led programs and innovations besides experience rating, esp. in monopolistic markets
  - Promote better integration & collaboration between different "silos" in OSH system, esp. WC & OSH inspectorate

Main Takeaways

- Idiosyncrasies of US OSH system – including uniquely bifurcated and costly nature of health care system; meagerness of other forms of social insurance; and weak job protections (incl. low union penetration) – create myriad perverse incentives for all key workers' comp stakeholders

- These incentives have combined to create (and perpetuate) many of the pathologies that are crippling the WC system, including benefit inadequacy, under-claiming, and cost shifting

If the demise of the grand bargain is truly a fait accompli, what next?

- **Back to the Future?**
  - Pursue deregulatory models, such as carve-outs and opt-outs?
  - Eliminate exclusive remedy provisions?
- **Back to the Drawing Board?**
  - Follow European model, such as New Zealand or Netherlands?
  - Universal health care?