

National Developments in Workers' Compensation: Nullifying the Grand Bargain?

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I. INTRODUCTION

This article examines the origins of workers' compensation in the U.S., including the Grand Bargain between workers and employers that included several principles or tenets that benefited one or both parties. The article then discusses recent national developments subverting these principles and threatening the future of the program.

II. ORIGINS OF WORKERS' COMPENSATION IN THE U.S.

Workers' compensation is the oldest social insurance program in the United States. Many of the program's current features reflect its historical origins. These features include the incorporation of the workers' compensation principles from the Grand Bargain in all workers' compensation statutes and the dominant role of the states in determining the provision of the benefits provided to injured workers.

Prior to the enactment of workers' compensation statutes, a worker had to bring a negligence suit against the employer in order receive payment for a work-related injury. A negligence suit is a form of tort or civil remedy, for which the legal doctrines developed over time in decisions made by judges under common law. Injured workers were often unsuccessful in tort suits, not only because the worker had to prove that the employer was negligent, but because the courts had established several legal defenses – known as the “unholy trinity” -- that a negligent employer could use to avoid liability. One such defense was the fellow servant rule, which precluded an injured worker from suing the employer when the worker was injured by the negligence of another worker. In contrast, an employer was liable for damage to a stranger (such as a customer) caused by the negligence of an employee.¹

In many jurisdictions, the first effort to deal with the deficiencies of the common-law approach to workplace injuries was the enactment of statutes - known as employer liability acts – which removed or limited the employers' use of defenses such as contributory negligence. However, the employee's success in a suit still required the demonstration that the injury resulted from the employer's negligence, which often was impossible. A study cited by Somers and Somers (1954, 24), indicated that in 32.5 percent of 604 cases the survivors or workers who died in workplace accidents before 1911 received no compensation under employers' liability laws in New York, Pennsylvania, and Minnesota. In another 47.8 percent of the cases, the award was \$500 or less.

Despite this record of meager recoveries under the common law or employer liability acts, a study by Posner (1972) found that between 1875 and 1905 there was a tremendous growth in litigation over workplace injuries and that employees were increasingly recovering damages in negligence suits. The negligence suit approach was like a lottery, where employees usually recovered minuscule or no awards – which workers did

not like – but where employers were increasing losing and paying large awards - which employers did not like.

Workers' compensation was designed to overcome some of the deficiencies of the negligence suit approach and of employer liability acts. Workers' compensation has been referred to as “The Grand Bargain” between workers and employers.

For workers, there were two advantageous tenets or principles of workers' compensation: (1) *No Negligence Test*: Workers' compensation is a no-fault system, which means that to receive benefits, a worker does not need to demonstrate the employer is negligent, and (2) *No Special Defenses*: The employer cannot use the special defenses, such as contributory negligence, to avoid liability. Because of these features, the employee only has to prove the injury is “work-related” to qualify for benefits (although there are legal tests that are obstacles to meeting the work-related requirement in many cases).

For employers, there are also two advantageous tenets or principles of workers' compensation. (1) *Truncated Liability*: The benefits provided by workers' compensation statutes are significantly less than the potential damages in a tort suit. There are no recoveries for pain and suffering or for punitive damages in workers' compensation. In addition, “the immunity not only bars tort actions by injured employees but also derivative claims for loss of consortium and wrongful death” (Dobbs, Hayden and Bublick 2016, 918-19). Medical benefits were also limited or nonexistent in the original workers' compensation statutes.² Cash benefits were significantly less in workers' compensation than the full replacement of lost wages possible in a tort suit.³ (2) *Exclusive Remedy*: Workers' compensation benefits are the employer's only liability to the employee for the workplace injury. The exclusive remedy aspect of workers' compensation means that employees cannot bring tort suits against their employers (subject to some limited exceptions).

There were also two tenets or principles of workers' compensation that were supposed to be valuable to both workers and employers. (1) *Simplified Determination of the Extent*

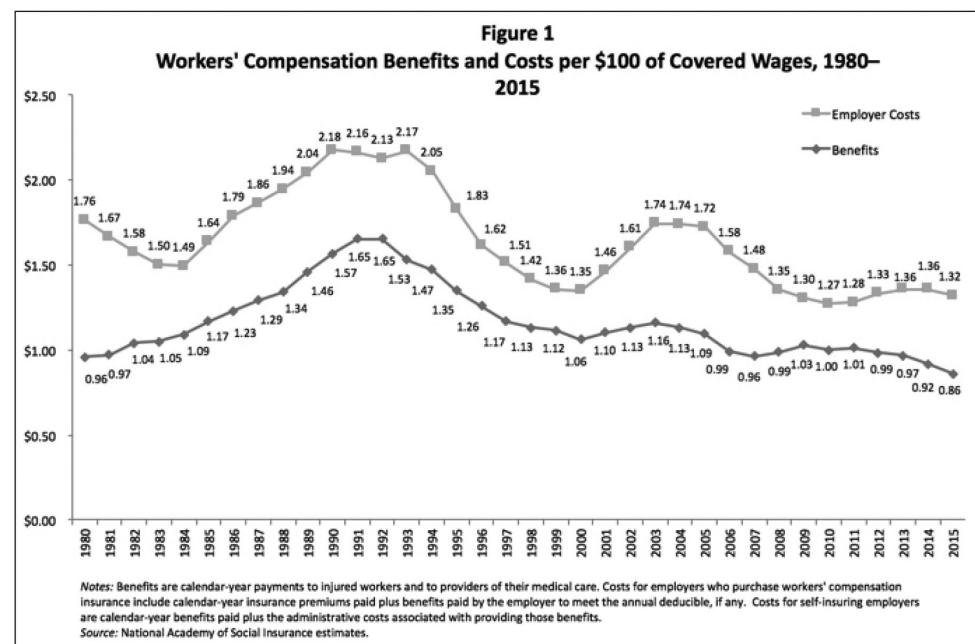


of Liability: Workers' compensation laws prescribe cash benefits by formulas, including weekly benefits that are a specified percentage of pre-injury earnings and durations of benefits for permanent impairments that are specified in the statutes. The statutory specificity of benefits was intended to reduce the litigation, delays, and uncertainty associated with tort suits. (2) *Specialized Dispute Resolution:* Workers' compensation statutes in most states removed workplace injuries from the general court system and established workers' compensation agencies and industrial commissions that were given the primary responsibility for resolving disputes between workers and employers. Reformers felt this delivery system would also reduce the delays, uncertainties, and inconsistencies of the court system (Berkowitz and Berkowitz 1985, 161-163).

For many members of the labor, employer, and insurer communities, workers' compensation rather than tort suits became the preferred remedy for work-related injuries or fatalities. The features of the statutes that were enacted in the early 20th Century are still basically present in current programs: a worker is eligible for benefits without having to prove that the employer is negligent; workers' compensation benefits are the exclusive remedy against the employer; benefits are largely prescribed by formulas and (for many serious injuries) by fixed durations; and workers' compensation agencies largely administer the program.

The legal context of the early 20th century also affected the level of government where workers' compensation programs were enacted. At that time, the U.S. Supreme Court interpreted the commerce clause of the Constitution in a narrow fashion, which limited the ability of Congress to regulate activities not directly involved in interstate commerce. The federal government was able to enact a workers' compensation program for its own employees.⁴ However, most workers in the private sector as well as state and local government employees could not be regulated by the federal government, and therefore, of necessity, most of the initial workers' compensation laws were enacted by the states.

New York was the first state to enact a comprehensive workers' compensation statute in 1910. However, the act was held



invalid in March 1911 by the New York Court of Appeals in *Ives v. South Buffalo Ry. Co.*, 201 N.Y. 271 (1911) because it conflicted with the due process provisions of the state constitution and of the Fourteenth Amendment. Subsequently, the New York state constitution was amended to allow a mandatory workers' compensation law and the state enacted a new workers' compensation law in 1913 that was found constitutional by the New York Court of Appeals and ultimately by the U.S. Supreme Court in *New York Central Railroad Co. v. White*, 243 U.S. 188 (1917).

The first workers' compensation laws to withstand constitutional challenges were enacted in 1911, first by Washington and Kansas,⁵ followed by New Jersey and then by Wisconsin.⁶ By 1920, all but five states had enacted workers' compensation statutes. Many of these early laws were elective for employers to avoid constitutional challenges that doomed the 1910 New York law.

III. RECENT DEVELOPMENTS IN BENEFITS AND COSTS

Workers' compensation programs have varied over time in the benefits paid to workers and the costs for employers. Figure 1 provides data from the National Academy of Social Insurance (NASI) of benefits and costs for all state and federal workers' compensation programs (McLaren and Baldwin 2017, Figure 1). Benefits per \$100 of covered wages increased from 1980 (the earliest year

with comparable data) to the early 1990s, declined rapidly during the 1990s, and then declined slowly from 2000 until 2015. Benefits were \$0.86 per \$100 of covered payroll in 2015, the lowest figure since the series began in 1980.

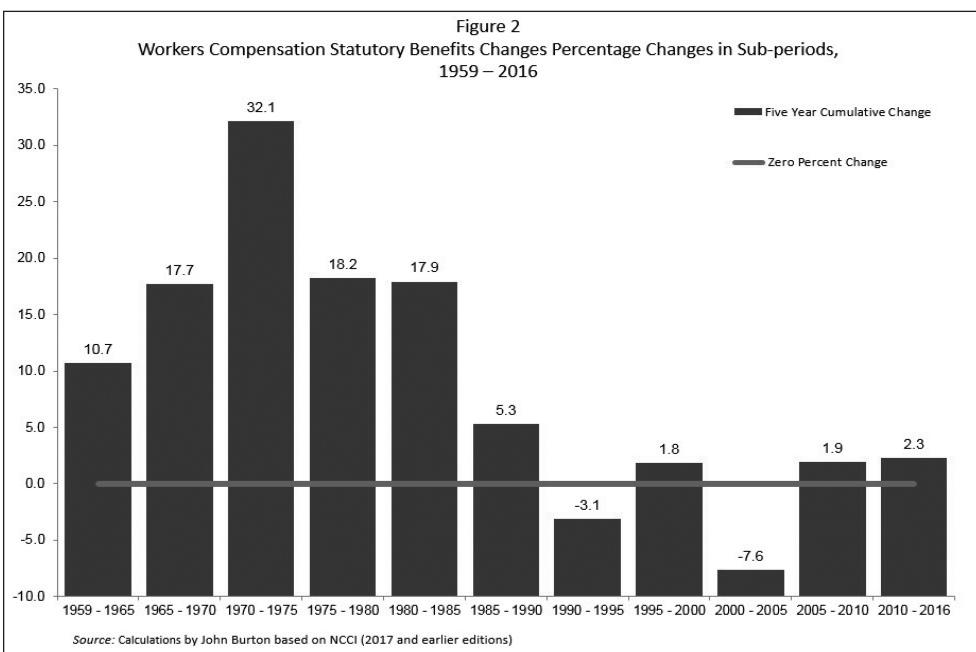
The costs of workers' compensation for employers fluctuated very roughly in tandem with benefits between 1980 and 2015.⁷ Costs declined from 1980 to the mid-1980s, then increased until the early 1990s, followed by steep declines in the balance of the 1990s, followed by increases for several years in the early 2000s. Then there were declines until 2012, and followed by modest increases in most recent years. Costs were \$1.32 per \$100 of covered payroll in 2015, near the low point for the period since 1980.

IV. SOURCES OF DECLINE IN BENEFITS AND COSTS IN WORKERS' COMPENSATION SINCE 1990

This section examines several sources of the decline in benefits and costs in the workers' compensation programs since 1990. One overall theme: some of the program changes have been held unconstitutional in some states.

A. Reductions in Statutory Benefits

The changes in benefits and costs per \$100 of covered wages since 1980 are explained in part by the changes in state workers' compensation statutes. The National Council on Compensation Insurance (NCCI) provides advisory rate-making and statistical services for the



workers' compensation programs in 36 states (including the District of Columbia) (NCCI 2017, 7). The NCCI publishes an *Annual Statistical Bulletin* (ASB), which includes data on these 36 states plus data from all other states except those with exclusive state funds. The NCCI publishes state and countrywide data on adjustments in premium level due to several factors, including benefit change, which "refers to adjustments in premium level to account for benefit changes adopted by the various state legislatures, as well as medical fee and hospital rate changes (NCCI 2017, Exhibit 1)." The changes in statutory benefits by decades indicate a drastic change beginning in the 1990s, as shown in Figure 2.

- **The 1960s.** Statutory benefits increased by more than 28 percent.
- **The 1970s.** Statutory benefits increased by more than 50 percent.
- **The 1980s.** Statutory benefits increase varied over the decade: up 18 percent in the first five years but only 5 percent in the last five years.
- **The 1990s.** For the first time since at least the 1950s, statutory benefits declined during the decade, although the decline was only one percent.
- **The 2000s.** Statutory benefits declined over five percent during the decade.
- **The 2010s.** Statutory benefits increased two percent through 2016.

Much of the decline in statutory benefits after 1990 was caused by

changing compensability rules which made it more difficult for injured workers to qualify for workers' compensation benefits, a development discussed in Subsection B. There were, aslo, some states that reduced cash benefits for some workers who qualified for those benefits. An example is the limits on the duration of temporary total disability (TTD) benefits found in 24 states as of 2016, including at least six states that limited the duration of TTD benefits to 104 weeks (Baldwin and McLaren 2016, Appendix C).⁸ What is the fate of workers who are still totally disabled after 104 weeks in states with that limit on benefits?

Westphal v. City of St. Petersburg, 194 So. 3d. 311 (Fla. 2016) was decided by the Supreme Court of Florida. The case involved a gap in the system of cash benefits for workers with serious injuries. Section 440.15(2)(a), which was enacted in 2009, cut off disability benefits for a totally disabled worker after 104 weeks or sooner if the worker reached the date of maximum medical improvement (MMI) before 104 weeks. The statute also provides that permanent total disability benefits cannot be awarded until the worker reaches the date of MMI. Westphal was still totally disabled after 104 weeks but had not yet reached the date of MMI and so the statute required all total disability benefits to cease.

The Florida Supreme Court concluded "that the 104-week limitation on temporary total disability benefits results in a statutory gap in benefits in violation of the

constitutional right of access to courts." Of particular interest, the Court found that Section 440.15(2)(a) was unconstitutional because it created "a system of redress that no longer functions as a reasonable alternative to tort litigation." Arguably this would have led the Court to find that Westphal was entitled to bring a tort suit against the City of St. Petersburg. Instead, the Court provided an alternative remedy.

Florida law has long held that, when the legislature approves unconstitutional statutory language and simultaneously repeals its predecessor, then the judicial act of striking the new statutory language automatically revives the predecessor unless it, too, would be unconstitutional." *B.H. v. State*, 645 So. 987, 995 (Fla. 1994). We therefore conclude that the proper remedy is the revival of the pre-1994 statute that provided for a limitation of 260 weeks of temporary disability benefits. . . The provision of 260 weeks of temporary total disability benefits amounts to two and a half times more benefits – five years of eligibility rather than only two – and thus avoids the constitutional infirmity created by the current statutory gap as applied to Westphal.

B. Constricted Compensability

Spieler and Burton (2012, 498-503) provided this analysis of the constriction of compensability in state workers' compensation programs:

[T]here are three common barriers to compensability: complexity in the proof of causation; difficulty in proving impairment and disability; and procedural roadblocks that may relate to these two substantive areas but also may exist simply as part of the program's approach to adjudication of claims. . .

PROOF OF CAUSATION

. . . The litigation over causation generally focuses on the following issues:

- **Aggravation of preexisting conditions:** In many instances, workers have preexisting health conditions or predispositions for particular health problems. The historical view in workers' compensation was that employers took

employees as they found them. Aggravation of preexisting conditions would therefore have been compensable. The inquiry focused on whether the workplace contributed, or contributed significantly, to the condition. This often led to litigation, as workers' compensation programs drew boundaries around what constituted adequate contribution from work, responding to defense of claims by employers and insurers. But in the 1990s, several states moved more aggressively to limit compensation for conditions with complex causation.

Second injury funds historically provided some coverage for disabilities that resulted from the combined effects of current employment and past disabilities. Initially designed to encourage the employment of war veterans, these funds became the source of benefits for a wide range of conditions. Often, employers, insurers and workers' representatives all gained by 'dumping' claims into funds which were not vigorously defended. The costs within these funds rose, while new accounting principles forced states to recognize the potential long term liabilities in the funds – and no one was interested in providing the necessary financing. This led to the elimination or significant restrictions on the range of injuries covered by these funds in a number of states – resulting in limitations on the availability of benefits to workers who were forced to prove causation within the usual system.

In addition, state courts and legislatures moved to restrict compensation for injuries involving aggravation of preexisting conditions in a number of ways: excluding injuries or disabilities if they are the effects of "the natural aging process"; requiring that work be the "major" or "predominant" cause or the "major contributing factor" of any disability; excluding injuries for which current work is merely the triggering factor; or requiring proof of a discrete injury

if there is an underlying aging-related factor. Contributing to this in some jurisdictions are stricter rules and shorter time limits for reopening prior claims when progression occurs.

The results are, not surprisingly, denials of claims. This may be particularly troubling for aging workers, a growing proportion of the workforce. But it also affects large numbers of other workers with preexisting conditions who are exposed at work to conditions that injure or disable them. . . .

- *"Gray area" cases:* Many arguably work-related health conditions fall into "gray" areas, leading often to litigation, delays, battling experts and confusion for the claimant. They are in a gray area because they involve exposures over time, preexisting dispositions, overlap with conditions that occur outside work, or they are conditions that are difficult to measure and diagnosis relies on self-reports from workers. Often recovery periods for these conditions are either uncertain or the condition may result in long term disability. Gradual onset health conditions, particularly those in which the health condition is likely caused by both work and non-work factors, often meet with resistance when workers file for benefits. There is ambiguity as to whether some of these conditions are injuries or diseases, so that workers' compensation agencies struggle with how to manage them under the differing statutory provisions for injuries and disease; sometimes, mere classification as a disease can lead to denials of compensability. Common conditions that often fall into this gray area include repetitive motion injuries, including carpal tunnel, other musculoskeletal injuries, hearing loss, lung diseases such as asthma or chronic obstructive pulmonary disease (COPD), stress disorders

unrelated to physical harm, and heart attacks. We discuss back injuries separately in the next subsection. The workers' compensation adjudicatory systems have always had difficulty determining how to address these conditions, leading to extensive litigation – and confusion for the worker.

Starting in the 1990s, in part as a response to rising concerns about the costs of workers' compensation programs, several states enacted legislative changes that were designed to specifically limit the availability of benefits in these gray areas. For example, many states excluded availability of benefits for stress claims, following what was viewed as an explosion of these claims in California. Fifteen states simply made all of these claims noncompensable unless accompanied by physical injury. Colorado limited benefits to twelve weeks with a reduced maximum weekly benefit. Other states excluded stress claims related to personnel actions, or limited them to situations involving extraordinary or unusual circumstances. Sometimes, the burden of proof required for these claims was raised, requiring that employment be the predominant cause of injury or that claims be proved by a preponderance of evidence.

In another example, some states have created barriers to compensation for repetitive motion injuries. In a worst case example, the Virginia supreme court ruled that cumulative trauma disorders were not "as a matter of law" compensable under the workers' compensation act. *Steinrich Group v. Jemmett*, 467 S.E.2d 795 (Va. 1996). The state legislature responded by providing nominal, but very narrow, coverage for these conditions. It must be noted, however, that most states do provide coverage for cumulative trauma disorders, though other barriers may make it challenging for workers to obtain benefits. . . .

PROVING IMPAIRMENT OR DISABILITY: THE ISSUE OF MEDICAL EVIDENCE

It is the role of physicians in

many cases to provide the causal link between work and the health condition, as well as to provide proof that the worker is suffering from a condition that requires medical treatment or absence from work. As states have raised the level of proof required for claims, they have also moved away from accepting lay testimony as adequate proof.

There has always been tension between legal and medical definitions, and there has always been some discomfort, even among doctors who are sympathetic to injured workers, regarding the nature of proof that is needed by injured workers in contested claims. But the problem has become worse in recent years.

These changes are sometimes subtle and difficult to track. For example:

- There has been a move away from relying on a worker's own physician in complex cases, looking instead to experts who are less familiar with the worker's history. This development parallels the shift in many states away from allowing workers free selection of physicians for treatment of their work-related conditions. Some states now require proof of the physician's expertise before a doctor's testimony can be admitted, further delaying the adjudication of a claim. The application of the technical standards for expert testimony (referred to by lawyers as the "Daubert" standard after the U.S. Supreme Court case of *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993)) seems to be spreading; this is particularly ironic, since these standards were developed for complex civil litigation, and the workers' compensation systems were originally intended to be easy for workers to navigate.
 - Politically appointed medical boards, whose membership is often a reflection of politics and the members' ideology, are now sometimes used to screen
- cases, particularly occupational disease or gray area cases, on issues of compensability.
- There has also been a movement to require 'objective medical evidence' to establish the existence of a medical condition, resulting in exclusion of claims. This might, for example, include mental health conditions or complaints involving pain, including severe pain. There are also conditions that do have objective tests, but in which the medical literature suggests that the objective tests fail to identify some, sometimes a large number, of people suffering from the condition; that is, the test may be valid for some of the people identified, but it is inadequate to identify everyone with the disorder.
 - There also appears to us to be a growing tendency to reject testimony that might be cautious or in which the physician states possibilities rather than offering definitive opinions, or suggests a workplace "could" or "might" have caused the condition.

This entire area is further complicated by the widespread adoption of the American Medical Association *Guides to the Evaluation of Permanent Impairment*, now in its Sixth Edition (Rondell, 2008). The *AMA Guides* provide a measure of impairment, with chapters on each organ system, a mechanism for determining the degree of impairment for each organ system (stated in percentage of loss), and then a conversion from loss in the organ system to a whole person impairment. Many of the chapters base their analyses of the extent of loss on objective medical tests. The impairment ratings themselves have never been validated (Spieler et al., 2000) and are unlikely to be subject to validation. Although the use of the *AMA Guides* appears predominantly in the assessment of permanent impairment – a subject that is outside the scope of this paper – we believe

that it may also have insidious effects on the way in which many physicians view common occupational injuries, thereby affecting the way in which experts will approach the claims of injured workers.

PROCEDURAL HURDLES

The process by which claims are considered can be opaque and confusing to claimants. This seems to be a universally reported phenomenon, across states, irrespective of the apparent generosity of benefit levels. At both the initial, relatively informal level (when insurers and employers have considerable control over outcome) and later during adjudication when there is a 'neutral' fact finder, there are a wide array of barriers to compensability.

We mentioned above the problem of the application of statutes of limitation to occupational diseases with long latency periods. More recently, and most importantly, the standards for proof of claims have been raised in many jurisdictions, and these standards can determine the outcome. For example, many jurisdictions have moved away from an approach to evidence that applied a relatively liberal standard, allowing claimants to prevail if the evidence was essentially equal on all sides. Now, quite a few states require a claimant to prove the case by "clear and convincing" evidence (e.g. Alabama) or by a preponderance of the evidence. In the federal system, the U.S. Supreme Court eliminated the Department of Labor's "true doubt rule," which had allowed claimants to win claims if the evidence was roughly equal on both sides of a black lung case. Instead, the court applied the standards of the federal Administrative Procedures Act, which requires that cases be proved by a "preponderance of the evidence." *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). In one truly bizarre twist, workers with brain injuries in Virginia have had difficulty obtaining benefits due to a provision in the law that requires that there be a witness or that the claimant be able to recall the incident. In one

now notorious case reported by the *Roanoke Times*, Zurich North America reportedly terminated the benefits of a severely brain damaged worker who had fallen at a residential site where he was working alone, installing a satellite TV dish. (Casey, 2010)

The significance of this shift cannot be overstated. When combined with requirements for objective medical evidence, these higher standards of proof lead to denial of claims that are arguably in any of the gray areas described above. In occupational disease claims in which the only proof is based upon population-based studies, it is virtually impossible to meet the higher standard. When combined with the raised expectations regarding medical testimony, the ability of claimants to prevail in many cases involving common disorders is dramatically affected.

Studies indicate that restrictions in the availability of benefits, described more fully in Part II, have a negative effect on the availability of compensation for work-related injuries and illnesses. Thomason and Burton (2001) looked at a series of amendments to the Oregon workers' compensation statute between 1987 and 1995 that constricted eligibility rules. They estimated that by 1996 these changes reduced the number of claims by 12 to 28 percent and the benefits for workers (and costs to employers) by 20 to 25 percent below what the amounts would have

been if the laws had not been enacted. Boden and Ruser (2003) found that compensability restrictions accounted for 7.0 to 9.4 percent of the decline in injuries reported to the BLS involving days away from work in 1991-1997 when examining all states. In states passing these reforms, they accounted for 12.2 to 23.7 percent of the decline.

Guo and Burton (2010) identified several factors that help explain the decline in cash benefits in many states during the 1990s. They constructed a measure for the benefit allowance stringency (the BAS variable), which looked at the proportion of injuries reported by employers to OSHA that resulted in workers' compensation claims, and found that the proportion declined between 1985 and 1999 as state workers' compensation programs became more stringent because of administrative practices, rules, or decisions by state agencies or courts. They also found that a portion of the decline in cash benefits was due to statutory changes in state compensability rules that involved tightening of eligibility standards, as shown in Figure 3. Together, changes in the BAS variable, in the compensability index, and in the declining share of workers' compensation cases that resulted in permanent partial disability benefits explained more of the decline of cash benefits paid by workers' compensation programs during the 1990s than did the decline in the BLS injury rate.

Although the decline in WC benefits shown in Figure 1 examined by Spieler and Burton (2012) and Guo and Burton (2010) began in the early 1990s, the rate of constriction in coverage and benefits may have accelerated in the last ten years. Grabell and Berkes (2015a) report that "Since 2003, legislators in 33 states have passed workers' compensation laws that reduce benefits or make it more difficult for those with certain injuries and diseases to qualify for them."

C. The Dual Denial Doctrine

As discussed in more detail in Section II, prior to the enactment of workers' compensation statutes, workers had the right to bring negligence (tort) suits against their employers for work-related injuries. Negligent employers had several special defenses (such as contributory negligence), but employees were increasing successful in the negligence suits in the early 20th century. For this and other reasons, states began to pass workers' compensation laws around 1910. These laws had provisions of benefit to workers: they were no-fault laws (the employer is liable for workers' compensation benefits even if the employer is not negligent, and the employer can no longer use the special defenses). These laws also had features of value to employers: workers' compensation statutes provide cash benefits that are less than the potential recovery under tort suits. And workers' compensation is the exclusive remedy of the employee against the employer, which means that the employee cannot bring a tort suit against the employer (even if the employer is negligent).

Given these historical features of the workers' compensation program, a current issue is: Can a workers' compensation statute both (1) make it impossible for a worker to qualify for workers' compensation benefits and (2) preclude the worker from bringing a tort suit by stating that workers' compensation is the exclusive remedy for a workplace injury? In essence, can there be a dual denial doctrine that precludes both



workers' compensation and tort remedies?

Larson and Robinson (2016, § 100.02) state that "Exclusiveness clauses have consistently been held to be constitutional under the equal protection and due process clauses of both federal and state constitutions. Attacks based on specific state constitutional provisions, such as those creating a right of action for wrongful death, have fared no better."

This is an overstatement. To be sure, there have been unsuccessful constitutional challenges, such as *Shamrock Coal Co. v. Maricle*, 5 S.W.3d 130 (Ky. 1999). The Kentucky legislature amended the law to eliminate workers' compensation benefits for workers who had less than a 20 percent respiratory impairment as a result of black lung disease. The employer subsequently laid off nineteen workers who would have been entitled to workers' compensation benefits under the prior law but who were not entitled to benefits because of the new impairment threshold. The Kentucky Supreme Court in a 4-3 decision held that the employer could rely on the exclusive remedy provision even though the workers had no remedy.

But there are contrary examples (albeit rare). An example is *Automated Conveyor Sys. v. Hill*, 362 Ark. 215 (2005), in which the Arkansas Supreme Court held that disallowing a tort suit for injuries not expressly covered by the workers' compensation act "is not in line with its stated purpose and, in addition, would contravene ... the Arkansas Constitution." The dual denial doctrine also appears to be clearly unconstitutional in Montana. Based on an extended review of cases, such as *Stratemeyer v. Lincoln County (Stratemeyer II)*, 276 Mont. 67, 915 P.2d 175 (1996), McClure (2000 at 13) concluded that "Montana allows an employee whose injury is not compensable under the worker's [sic] compensation laws to file a tort action for recovery." These decisions indicate that a workers' compensation statute incorporating the dual denial doctrine may violate a state's constitution.⁹

And then there is (or was) Oregon. The Oregon legislature passed legislation in 1993 denying workers' compensation benefits unless the worker could prove that work exposure was the major contributing cause (MCC) of an occupational disease. A worker who experienced a work-related disease that did not meet the MCC requirement was denied workers'

compensation benefits. The Oregon Supreme Court, in *Errand v. Cascade Steel Rolling Mills, Inc.*, 888 P.2d 544 (Or. 1995), relying on a statutory interpretation of the Oregon workers' compensation law, held that exclusive remedy provision did not preclude the worker from bringing a tort suit against the employer. In response to *Errand*, the Oregon legislature amended the workers' compensation statute in 1995 to provide that workers' compensation was the exclusive remedy for work-related injuries and diseases, even if the condition was not compensable under workers' compensation because the work exposure was not the major contributing cause. In essence, the Oregon legislature said: when we say dual denial for diseases for which the workplace is not the MCC, we mean it. In *Smothers v. Gresham Transfer, Inc.*, 23 P.3d 333 (2001), the Oregon Supreme Court responded by holding that the Oregon constitution did not allow the legislature to eliminate both the workers' compensation remedy and a tort remedy when the employment is not the major contributing cause of the condition.

But wait! With a 15 year lag, the Supreme Court of Oregon overruled *Smother*s in *Horton v. Or. Health & Sci. Univ.*, 359 Ore. 128 (2016). The *Smother*s decision involved an interpretation of the remedy clause in the 1857 Oregon Constitution, which the Oregon Supreme Court has now reinterpreted. (Justice delayed is Justice honed?) But what does this mean? In response to the *Smother*s decision, in 2001 the Oregon legislature enacted a statute (ORS 656.019) that indicates "An injured worker may pursue a civil negligence action for a work-related injury that has been determined to be not compensable because the worker has failed to establish that a work-related incident was the major contributing cause of a worker's injury . . ." Will the Oregon legislature now repeal the 2001 statute so the "spirit" of the *Horton* decision can be honored?

The challenge to the dual denial of both workers' compensation and tort remedies does not depend on a constitutional issue. A Pennsylvania Supreme Court decision, *Tooley v. AK Steel Corp.*, 81 A.3d 851 (Pa. 2013), considered the statute of repose, which requires a disease to manifest within 300 weeks of the last exposure to the source of the disease.¹⁰ Two workers, Tooley and Landis, were exposed to asbestos and developed

mesothelioma, but their last exposures were 1,300 and 780 weeks before the manifestation of their diseases. Because the claims did not meet the 300 week manifestation rule, they did not qualify for workers' compensation benefits.

As a result, the workers' brought tort actions against their employers, who invoked the exclusivity provision of the Pennsylvania workers' compensation act. The lower courts dismissed the cases, but the Supreme Court reversed the decision based on statutory construction:

It is inconceivable that the Legislature, in enacting a statute specifically designed to benefit employees, intended to leave a certain class of employees who had suffered the most serious of work-related injuries without any redress under the Act or at common law.

By basing the decision on the statutory construction of the Pennsylvania workers' compensation law, the Supreme Court avoided having to deal with constitutional challenges to the dual denial doctrine that were raised in the case.

The essence of this discussion? There is a significant risk that the adoption of a workers' compensation statute relying on the dual denial doctrine will result in challenges to the exclusive remedy provision that will make employers susceptible to tort suits for work injuries that are no longer eligible for workers' compensation benefits. In the absence of successful court challenges to the dual denial doctrine, exclusive remedy has swelled from a principle protecting an employer from a tort suit when the injured worker receives workers' compensation benefits to a principle that protects an employer from a tort suit even when the employee injured at work receives no benefits.

D. The Four-Bites-at-the-Apple

Doctrine: Apportioning by Cause

How should workers' compensation benefits be determined for a permanent disability (loss of earning capacity or actual loss of earnings) that involves a current work-related injury (or disease) that overlaps a pre-existing work-related or non-work-related injury (or disease). The basic issue is: how should the rating for the permanent disability be apportioned among the multiple injuries? Two factual patterns can be distinguished:

- (1) A worker has a pre-existing medical

condition due to a congenital problem (such as a back disorder) that has limited his actual earnings by 20 percent and the worker experiences a work-injury that (in combination with the congenital problem) reduces his earnings capacity by 50 percent. Usually the worker will only receive benefits for the 30 percent incremental loss of his earning capacity. A previous impairment that caused a loss of actual earnings (disability) will reduce the workers' compensation benefits for a subsequent injury to the same body member.

(2) A worker has a pre-existing medical condition due to a congenital problem (such as a back disorder) that did not previously limit her actual earnings and the worker experiences a work-injury that (in combination with the congenital problem) reduces her earnings capacity by 50 percent. Assume the evidence indicates that if the worker did not have the pre-existing medical condition, the work-related injury would have reduced her earning capacity by only 20 percent. Question: how much of the loss of earning capacity of the worker is the responsibility of the employer? The "traditional" workers' compensation answer to this question is: "The employer takes the worker with all her preexisting conditions" (Dobbs, Hayden, and Bublick 2016, 916). This maxim can be translated into a specific answer: the employer is responsible for the entire amount of her 50 percent loss of earnings capacity. A previous impairment that did not cause a loss of actual earnings will not reduce the workers' compensation benefits for a subsequent injury involving the same body member.

Larson and Robinson (2016) restate these principles:

Several states have been confronted with the temptation to dispose of the troublesome dual-causation problem by resorting to apportionment, and most have succeeded in resisting the temptation. . . The crucial distinction, then, is between apportioning disability and apportioning cause. The former is possible in the minority of states having apportionment statutes; the latter is never possible. (§52.06[4][d])

Apart from special statute, apportionable "disability" does not include a prior nondisabling defect or disease that contributes

to the end result. Nothing is better established in compensation law that the result that, when industrial injury precipitates disability from a latent prior condition, such as heart disease, cancer, back weakness and the like, the entire disability is compensable, and except in states having special statutes on aggravation of disease, no attempt is made to weigh the relative contribution of the accident and the preexisting condition to the final disability or death. Apportionment does not apply in such cases, nor in any case if the prior condition was not a disability in the compensation sense. (§90.04[1])

There is, however, a footnote to the phrase "except in states having special statute on aggravation of disease" that refers to the 2004 amendments to California Labor Codes section 4664. Permanent disability is now apportioned on the basis of causation, with employer's liability limited to the 'percent of permanent disability directly caused by the [work-related] injury. Allocation of permanent disability based on causation was upheld in *Brodie v. Workers' Compensation Appeals Bd.*, 156 P.3d 1100 (2007), which indicates that California changed the traditional approach to apportionment and now will deal with factual pattern (2) by only awarding the worker for a 20 percent loss of earning capacity.

The California Court of Appeal recently decided *City of Jackson v. Workers' Compensation Appeals Board*, 11 Cal. App. 5th 109 (Cal. Dist. Ct. App. 2017) and expanded the apportionment holding in *Brodie*. Rice was a police officer who sustained a work-related cumulative injury during a period ending in April 2009. Prior to that date he had worked full time. Before undergoing neck surgery, Rice was examined by a Qualified Medical Examiner (QME), Dr. Blair. Based on an X-ray showing degenerative disc disease, Dr. Blair apportioned the causes to (1) work for the City – 25% (2) prior work activities – 25% (3) personal activities, including recreational activities – 25%, and (4) personal history, including "heritability and genetics" and a history of smoking. – 25%. After the operation, Dr. Blair changed the allocations among the four causes because of three recent publications that supported "genomics as

a significant causative factor in cervical spine disability." The resulting allocations were (1) 17% (2) 17% (3) 17%, and (4) 49%. The ALJ found "City had carried its burden of showing apportionment as to 49 percent attributable to genetic factors. The Appeals Board "ordered the matter returned to the trial level for an unapportioned award of permanent disability." The Board reasoned that "finding causation on applicant's genetics' opens the door to apportionment of disability to impermissible immutable factors." The Court of Appeal annulled the Board's opinion and decision and remanded the matter to the Board with instructions "to deny reconsideration" of the ALJ's decision. The Court held that apportionment may be properly based on genetics/hereditability under the 2004 California statute and that Dr. Blair properly apportioned disability. The *City of Jackson* decision is provocative because the original and revised apportionment allocations by Dr. Blair were based in part on studies of multiple patients and not solely on evidence about the relevance of some of these factors for Rice. It will be interesting to see whether the decision is appealed to the California Supreme Court and/or the legislature responds by amending the 2004 statute.

The traditional view that the employer is responsible for all the consequences of a new work-related injury that interacts with prior medical conditions to produce a permanent disability rating that is greater than the rating that the new injury would have produced by itself, so long as the prior medical conditions had not resulted in disability (loss of actual earnings) has also been rejected in a recent decision in Colorado, *Hutchison v. Industrial Claim Appeals Office*, ____ .P.3d ____ 2017 Colo. App. 79. The claimant's job required him to spend half his work time over a 25-year period on his knees on concrete floors. The Independent Medical Examiner (IME) concluded that Hutchison's work had likely aggravated his arthritic knees, but that other factors – including that the claimant was overweight – had contributed to the extent of the resulting disability. The ALJ adopted the IME's recommendations and found that only one-third of the disability was work-related and therefore the employer was only responsible for one-third of the medical and cash benefits.

THE RECENT APPORTIONMENT DECISIONS IN A BROADER CONTEXT

The recent developments in California and Colorado indicate a break from the traditional understanding of the circumstances when apportionment can be used to reduce workers' compensation benefits. While this is disturbing by itself, I suggest that apportionment based on causation factors that had not yet manifested themselves in disability (loss of earning capacity or loss of actual earnings) should be viewed in a larger context.

Adoption of the California and Colorado approach will result in four steps that reduce potential recovery by employees of damages resulting from work-related injuries and diseases.

- First, as discussed in Section II, the benefits provided by workers' compensation are less than the potential damages in a tort suits, because *inter alia* there are no recoveries for pain and suffering or for punitive damages.
 - Second, even within the types of benefits provided by workers' compensation, the extent of recovery considered adequate in workers' compensation statutes is less than the recoveries possible in tort suits. For example, while a tort suit might replace all the wage losses from an injury caused by a negligent tortfeasor, the National Commission on State Workmen's Compensation Laws (National Commission 1972, Chapter 3) indicated that for most types of disabilities benefits were adequate if they replaced at least 66 2/3 percent of wages lost because of the workplace injury. Subsequently, the National Academy of Social Insurance concluded that adequate permanent partial disability (PPD) benefits required replacement of two-thirds of lost wages (Hunt 2004).
 - Third, wage-loss studies in several jurisdictions provide evidence that workers' compensation PPD benefits replace considerably less than the two-thirds of lost wages.¹¹ The most comprehensive review of wage loss studies found that workers who received PPD benefits had replacement rates (total
- cash benefits divided by ten-year earnings losses due to work-related injuries) ranging from 30 to 46 percent in the five states included in the study (Boden, Reville, and Biddle 2005, Table 3.4). For example, PPD benefits replaced 37 percent of the wage losses for California workers injured in 1994. The authors concluded (at 60) that for many groups of workers in the five states, "replacement rates do not approach the two-thirds benchmark for adequacy."
- Fourth, the new approach to apportionment in California will reduce PPD benefits that are already inadequate after the previous three steps. A study of the effects of the new approach to apportionment in California (Neuhauser 2008, 170) found that 9.9 percent of permanent disability claims in the sample had some portion of the PPD awards apportioned to non-work-related causes and that in those cases involving apportionment on average approximately 40 percent of the award was attributed to non-industrial causes.

For most persons, there is probably a positive reaction to the general principle that damages should be allocated (or apportioned) to the party responsible for his or her share of the damages. That principle may make sense in tort suits, where the starting point is a panoply of damages, even though the apportionment rules are complex (See Dobbs, Hayden, and Bublick 2016, Chapter 25). But in workers' compensation, where apportionment for cause is the fourth step reducing the recovery for injured workers, the principle is inappropriate and misguided. In addition, as discussed in Section III, one of features of the Grand Bargain that established workers' compensation in the U.S. was Simplified Determination of the Extent of Disability. This feature was supposed to be valuable to both workers and employers. However, apportionment of disability among the causes of the disability adds complexity and uncertainty to the dispute resolution process. While some employers may pay lower benefits, the main beneficiaries are likely to be a bevy of expert witnesses who

offer competing views of how to cut the Gordian knot of causation – for fees that will increase the costs of resolving cases for both workers and employers.¹²

E. Limits on Worker Representation

Shakespeare famously said: "The first thing we do, let's kill all the lawyers." William Shakespeare, *King Henry VI, Part II*. Or should we at least starve them out of workers' compensation? The Florida Supreme Court to the Rescue! In *Castellanos v. Next Door Co.*, 192 So. 3d 431, 432 (Fla. 2016), the court concluded "that the mandatory fee schedule in section 440.34, which creates an irrebuttable presumption that precludes any consideration of whether the fee award is reasonable to compensate the attorney, is unconstitutional under both the Florida and United States Constitutions as a violation of due process." Section 440.34 of the Florida statutes was adopted in 2009 and included a fee schedule for applicants' attorneys that allowed Castellanos' attorney a fee of \$1.53 per hour for 107.2 hours of work, an amount of time that had been determined by the Judge of Compensation Claims to be "reasonable and necessary" in handling this complex case. The Court noted that 2003 legislation had amended the attorney's fee schedule to limit applicants' attorneys' fees, and that in *Murray v. Mariner Health*, 994 So. 2d 1051 (Fla. 2008) the Court had upheld the 2003 legislation because it permitted a claimant to receive a reasonable attorney's fee even when that amount exceeded the statutory attorney's fee schedule. Following the *Murray* decision, in 2009 "the Legislature removed any ambiguity as to its intent by removing the word "reasonable" in relation to applicants' attorneys' fees and thus removed any discretion "to award the fee award in cases where the sliding scale based on benefits obtained results in either a clearly inadequate or a clearly excessive fee." The Court found that such a restriction on determining attorneys' fees was a violation of due process. The Court's remedy for the lack of due process in the 2009 legislation is particularly interesting:

Accordingly, our holding that the conclusive fee schedule in section 440.34 is unconstitutional operates to revive the statute's immediate predecessor. This is the statute addresses by this court in *Murray*.

where we construed the statute to provide for a "reasonable" award of attorney's fees.

F. Opt-In Laws, Opt-Out Laws, and Related Topics

Some of the most contentious and complicated issues in workers' compensation concern the relationships among (1) workers' compensation programs; (2) disability plans established by employers that provide benefits for workplace injuries and that replace workers' compensation programs; (3) the exclusive remedy provision that protects employers from tort suits; (4) the Employee Retirement Income Security Act (ERISA); and (5) mandatory employment arbitration agreements. My discussion of these topics is brief; more comprehensive discussions are Torrey (2016) and Duff (2017).

(1) Opt-In Laws

Texas is the sole example of a state with an opt-in law, as it has been for at least the last fifty years. In the absence of an affirmative action to elect coverage, an employer is not covered by the state workers' compensation law. The employer who does not elect coverage can be sued by an injured worker in a tort suit and the employer cannot use the special defenses discussed in Section II. Some employers not covered by workers' compensation establish disability plans that provide benefits to workers injured at the workplace. There are no standards for benefits or coverage of the disability plans mandated by state or federal law.

(2) Opt-Out Laws That Maintain the Exclusive Remedy Provision

States can enact laws opt-out laws, which require the employer to provide workers' compensation benefits unless the employer elects not to provide coverage. One of the most notable workers' compensation decisions in recent years, *Vasquez v. Dillard's, Inc.*, 381 P.3d 768 (Okla. 2016) involved the Oklahoma Employee Injury Benefit Act (also known as the Opt-Out Act), which allowed a qualified employer to opt out of the workers' compensation act, to establish its own disability plan (which did not need to include the same benefits as the workers' compensation act), to at least arguably treat the disability plan as covered by ERISA and thus avoid state oversight of

the plan, and to retain immunity from tort suits. Dillard's opted out and established a disability plan that *inter alia* excluded many injuries and diseases from its plan covered by the Oklahoma workers' compensation law, provided compensation only if the injury report is filed before the end of a worker's shift, and provided that any dispute would be decided by an appeals panel composed of company-selected individuals. The Oklahoma Supreme Court found the Opt-Out Act unconstitutional based on the state constitution's ban on special laws because the Act created unequal and disparate treatment of some injured workers (such as Vasquez) who were subject to employer disability plans compared to the treatment of other workers who were covered by the workers' compensation law.

Torrey (2016, 43) provided this trenchant analysis of the decision:

With *Vasquez*, the progress of opt-out laws has been slowed, but proponents of the laws have promised further promotion of such schemes. Meanwhile, a principal observer (Duff 2017) believes that the Oklahoma enactment is "a harbinger of things [that is, radical efforts to escape workers' compensation] to come."

(3) Opt-Out Laws That Do Not Include the Exclusive Remedy Provision

The "principal observer" referred to by Torrey is Michael Duff, who subsequently observed (Duff 2017):

The current discussion appears to center on the revival of opt-out without an exclusive remedy provision. That, of course, would simply mark a return to the predominant workers' compensation model from 1911 to 1917. Most systems were "elective." Employers were permitted to decline participation, but in event of declination were liable in negligence and unable to avail themselves of the affirmative defenses – contributory negligence, assumption of the risk, and the fellow servant rule. . . .

One still is at a loss to know what "opt-out without exclusive remedy" means. If it means merely that employers have the choice not to participate in workers' compensation without a state attempting to dictate the details of ERISA-governed plans, that will return us to 1911. Why might employers be willing to do this? . . .

Opt-out without exclusive remedy in this sense could avoid many of the state constitutional problems that plagued the Oklahoma model, particularly if both employers and employees were able to elect participation (no exclusive remedy). As a matter of *state* law, that would leave employees with the historical common law remedy for injury. Whether this would be good for employees in the long run is a separate question. While it is true that many states have significantly weakened, or eliminated, the affirmative defenses that originally led to the Grand Bargain, it is also true that *prima facie* cases are not easy to establish (especially the nature of the employer's duty of care) and court-based litigation is a long and expensive process.

(4) The Employee Retirement Income Security Act (ERISA)

If Duff is correct that enactment of opt-out laws that do not include an exclusive remedy provision will return to the workers' compensation model prior to 1917, then a central tenet of the Grand Bargain – Specialized Dispute Resolution in workers' compensation agencies or industrial commissions rather than the general court system – will be scuttled. Another unattractive approach would be a variant of the Oklahoma opt-out statute that allows to opt out of workers' compensation and establish disability plans designed by the employer for which disputes over the application are controlled by a dispute resolution system chosen by the employer. The opt-out variant invalidated by the Oklahoma Supreme Court arguably protected the employer from challenges to the application of the disability plan by arguing that the plan was covered by the Employee Retirement Income Security Act (ERISA) and thus challenges to the plan could only be pursued in Federal Courts under limited circumstances, such as violation of a fiduciary duty. While the *Vasquez* decision essentially rejected the argument that the disability plan established by Dillard's was an ERISA plan, Duff (2017) is skeptical: "With all due respect to the Oklahoma Supreme Court, I continue to think that it never properly had jurisdiction in the case." If Duff's view is correct, then subsequent challenges to state jurisdiction over disability plans established under

Opt-in Laws based on federal preemption under ERISA will be successful.

(5) Mandatory Employment Arbitration Agreements

Duffy has also expressed concern that employers will utilize the Federal Arbitration Act to require employees as a condition of their employment to sign agreements requiring the use of arbitration procedures established by the employer to resolve any disputes over their disability plans. Duffy (2017) indicates that "Employers going bare in Texas can compel their employees to sign arbitration "agreements" as a condition of employment, and the evidence has become very clear how poorly employees do in such a regime." Colvin (2017) documented the rapid spread of mandatory employment arbitration agreements, which now cover 56.2 percent of all nonunion private-sector employees. These agreements bar employees "access for all types of legal claims, including those based on Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Family and Medical Leave Act, and the Fair Labor Standards Act." As

discussed by Colvin (2017), a source of the expansion of mandatory arbitration agreements is a series of Supreme Court decisions beginning with *Gilmer v. Interstate/Johnson Lane*, 500 U.S. 20 (1991). Duff argues that employers could expand the coverage of mandatory arbitration agreements to disputes involving workers' compensation, while Torrey disagrees. If Duff is correct, the future of workers' compensation will be fundamentally altered.¹⁵

V. THE FUNDAMENTAL CAUSE OF THE DECLINE OF BENEFITS AND COSTS

Although workers' compensation statutory benefits were increasing in the 1960s (as discussed in Section IV.A.), benefits and coverage were criticized in the period. One result is that when the Occupational Safety and Health Act (OSHAAct) of 1970 was enacted, the National Commission on State Workmen's Compensation Laws (National Commission) was created and directed to determine if state workers' compensation laws "provide an adequate, prompt, and equitable system of compensation for

injury or death arising out of in the course of employment."

The National Commission, whose 18 members included three representing Cabinet members and 15 appointed by the Nixon White House, issued a unanimous report in 1972. The *Report of the National Commission* documented serious deficiencies with state workers' compensation statutes: for example, "the maximum weekly benefit for temporary total benefits in more than half of the states" did not reach the 1971 national poverty level for a non-farm family of four (\$79.56 a week) (National Commission 1972, 61). The report also reported that in most states the maximum weekly benefits for temporary total disability benefits relative to the state's average weekly wage were lower in 1972 than they had been in 1940 (National Commission 1972, Table 3.6).

The conclusion of the National Commission (1972, 25) was that "State workmen's compensation laws are in general neither adequate nor equitable." Of greater relevance to an understanding of current workers' compensation programs is the National Commission's



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analysis of a major source of the deficiencies of state programs (1972, 124-25):

Competition among States.

The economic system of the United States encourages the forces of efficiency and mobility. These forces tend to drive employers to locate where the environment offers the best prospects for profit. At the same time, many of the programs which governments use to regulate industrialization are designed and applied by States rather than the Federal government. Any State which seeks to regulate the by-products of industrialization, such as work accidents, invariably must tax or charge employers to cover the expenses of such regulations. This combination of mobility and regulation poses a dilemma for policymakers in State governments. Each State is forced to consider carefully how it regulates its domestic enterprises because relative restrictive or costly regulation may precipitate the departure of the employers to be regulated or deter the entry of new enterprises.

Can a State have a modern workers' compensation program without driving employers away? Our analysis of the cost of workmen's compensation has convinced us that no State should hesitate to adopt a modern workmen's compensation program. . . .

While the facts dictate that no State should hesitate to improve its workmen's compensation program for fear of losing employers, unfortunately this appears to be an area where emotions too often triumph over facts. . . . whenever a State legislature contemplates an improvement in workers' compensation which will increase insurance costs, the legislators likely will hear claims from some employers that the increase in costs will force a business exodus. It will be virtually impossible for the legislators to know how genuine are these claims. To add to the confusion, certain States have abetted the illusion of the runaway employer by advertising the low costs of workmen's compensation in their jurisdictions.

When the sum of these inhibiting factors is considered, it seems likely

that many States have been dissuaded from reform of their workmen's compensation programs because of the specter of the vanishing employer, even if that apparition is a product of fancy not fact. A few states have achieved genuine reform, but most suffer with inadequate laws because of the drag of laws of competing States.

The deterioration of state workers' compensation laws by the perceived threat of run-away employers is the major challenge for the program today in my opinion. There appears to be an accelerating movement to reduce benefits, tighten compensability rules, or allow employers to opt-out of the program.

VI. SOLUTIONS TO THE CURRENT CHALLENGES TO WORKERS' COMPENSATION

A. Federal Standards?

The National Commission made 84 recommendations for improving state workers' compensation programs. Of particular relevance to developing a strategy to deal with the deleterious effect of competition among states were the designation of 19 of these recommendations as essential and a recommendation (National Commission 1972, 127) that "compliance of the States should be evaluated on July 1, 1975, and, if necessary, Congress with no further delay in the effective date should guarantee compliance." There were no dissents to this recommendation for federal standards among the 18 members of the National Commission.

Federal standards for workers' compensation have not been enacted. The threat of federal intervention probably explains the surge in improvements in workers' compensation statutes in the 1970s discussed in Section IV.A. With the change in the national political environment since 1980, the threat of federal standards diminished as a threat in the 1980s and disappeared in subsequent decades.

Indeed, it is almost inconceivable that Congress would enact federal standards for the state workers' compensation program. Moreover, I do not think that federal standards are adequate to deal with the current threats to the state system (Burton 2015a).

The only currently feasible expansion of Federal involvement in state workers'

compensation programs involves the rules requiring offsets between workers' compensation and Social Security Disability Insurance (SSDI) benefits when a disabled worker qualifies for both programs. In 35 states federal law reduces SSDI benefits when the combined total of workers' compensation and SSDI benefits exceeds 80 percent of the worker's earnings prior to disability. However, in 15 states with "reverse-offset" provisions, the workers' compensation benefits are reduced to meet the 80 percent limit. Burton and Guo (2016) recommended that the reverse-offset provision should be eliminated and the President's proposed budget for FY 2018 eliminates the reverse-offset provision for the 15 states. One reason that Congress may be sympathetic to this recommendation is that the Trust Fund for the Disability Insurance program is in dire straits.

B. A federal workers' compensation statute?

A federal workers' compensation program to replace state programs (i.e. federalization of the workers' compensation program) is even more unlikely to be enacted than federal standards. To invoke the analytical term commonly used in New Jersey:

C. Absorption of Workers' Compensation into Existing Federal Programs? Workers' Compensation Cash Benefits Absorbed by Social Security Disability Insurance?

Another possible outcome for workers' compensation is that the responsibility for providing cash benefits to workers disabled by work-related injuries and diseases could be taken over by the SSDI programs, which already provides cash benefits to workers disabled from any cause. The SSDI program pays more than four times as much in cash benefits to disabled workers and their dependents as does the workers' compensation program and so the whale could probably swallow the walrus (McLaren and Baldwin 2017, 1, 52). One advantage of such a merger is the resources currently devoted by the workers' compensation program to deciding whether injuries or diseases are work-related could be reduced or perhaps even eliminated. However, the SSDI program currently only provides benefits

for permanent and total disability, while 61 percent of all workers' compensation claims involve temporary disability and 56 percent of workers' compensation benefits are paid for permanent partial disability (PPD) (McLaren and Baldwin 2017, Figure 4). Of particular concern are PPD benefits, which are even more complex and litigious than current DI benefits, and so an SSDI program that absorbed the workers' compensation program would have to develop a much more elaborate delivery system to provide both temporary and permanent as well as with total and partial disability benefits.

As a practical matter, the folding of workers' compensation cash benefits into the SSDI program seems highly unlikely – not only because of the issues raised above but because of political considerations. Workers' compensation benefits are largely provided by private insurance carriers and the program is largely administered by state employees whose replacement by federal employees would not be universally acclaimed. So unless the new SSDI program, which absorbed workers' compensation, had a major role for private carriers and was largely administered by the states, the notion of a grand disability program seems doomed.

Another potential drawback of an SSDI program that absorbed workers' compensation concerns the manner of financing the new program. The SSDI program is financed by a portion of the FICA tax that is paid by both workers and employers and that does not vary among these contributors, while the workers' compensation premium is paid solely by employers and is experience rated so that employers pay more or less depending on their industry and their own prior history of benefit payments. The historical rationale for experience rating is that the procedure promotes workplace safety and, although there is disagreement among scholars about whether experience rating actually improves workplace safety (Burton 2015b), nonetheless the absence of experience rating in the SSDI program will be of concern to some supporters of workers' compensation if the SSDI and workers' compensation programs are combined. Of course, the "obvious" solution is to experience rate the SSDI program, which has long been advocated by some (Burton and Berkowitz 1971, 351) and which has recently been proposed as a partial solution to

the current SSDI financial problems (Burkhauser and Daly 2011, 110-13). Burton and Guo (2016) made three proposals for reform of the SSA program and in particular the relationship between workers' compensation and SSDI. Our most significant proposal is that the SSDI program should use experience rating to determine employer's contributions to the program. We think that experience rating – which has been used with general success in workers' compensation for over 100 years – would improve the outcomes for workers in the SSDI program and would decrease the incentives for employers to shift costs from workers' compensation to SSDI.

WORKERS' COMPENSATION MEDICAL BENEFITS ABSORBED BY THE ACA?

The relationship between the workers' compensation health care system and the Affordable Care Act¹⁴ (ACA) health care system for non-work-related injuries and diseases is murky at best. Gruber (2014) suggested that because more workers will have health insurance there will less need for them to rely on workers' compensation if they are injured, which should lower the costs of workers' compensation. On the other hand, he recognized that effect could be offset by changes in the health care plans offered by employers for non-work-related medical conditions, such as high-deductible plans, provider networks with limited choices of providers, and caps on reimbursements for medical care providers. These changes could encourage workers and providers to shift marginal cases into the workers' compensation health care system unless workers' compensation quickly adjusts its own health care system. If these adjustment do not occur, then health care costs in workers' compensation could increase, which is reminiscent of what happened to workers' compensation health care costs in the 1980s when managed care in other parts of the health care system preceded changes in the workers' compensation program.

This raises the question of whether there should be separate health care systems for employees if their injuries or diseases are work-related or if their injuries or diseases are caused by other conditions. Is such a dual system of health care beneficial for workers, carriers, and employers? Carriers and employers

expressed concerns about the unitary health care system included in the Clinton health care proposal because they feared that loss of control over health care would jeopardize their chances to quickly heal workers and return them to work, and the resulting lags would lead to higher payments of cash benefits. However, as discussed by Mustard and Sinclair (2005), Ontario has a health care system that essentially uses the same health care delivery system to treat all sources of disability for workers and the costs of both the medical care and the overall costs of the workers' compensation program in Ontario appeared to be lower than in most U.S. jurisdictions.

VII. THE FUTURE OF WORKERS' COMPENSATION

I suggested earlier that the current threat to the state workers' compensation system is a race to the bottom among states. As a byproduct of this competition, several tenets of the Grand Bargain that have guided the workers' compensation program for more than a century have been violated. Unfortunately, I do not think that any of the solutions to this threat I just discussed – such as Federal standards – will be enacted.

Does this mean the entire state workers' compensation system will eventually collapse into a black hole? Or will the state system survive largely in its current constellation, with some states maintaining adequate benefits, broad coverage of workers, and expansive compensability rules, while other states plunge into the abyss? One problem is that states that try to maintain decent programs will increasingly find their workers' compensation costs under attack as other states pass them by on the way to the bottom.

In my view, the state workers' compensation system is in its most dire situation in at least the last half-century.

But lest you take my prediction too seriously, allow me to close with two examples of bad prognostications. In 1986, I co-authored a chapter on the recent moderation in workers' compensation costs in which we predicted that the decline in workers' compensation costs in the early 1980s was likely to persist for many years (Burton, Hunt, and Krueger 1986). Alas, by the time the chapter was published, workers' compensation costs had already started a rapid increase in

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costs that persisted for the rest of the decade. I tried to retract our chapter, but it was too late to head off the dissemination of the unduly optimistic forecast.

And for those who are disturbed by my doleful assessment about the future of workers' compensation, it is worth remembering that the premier study of workers' compensation published more than a half-century ago (Somers and Somers 1954) concluded with a chapter entitled "Workmen's Compensation at the Crossroads." The thrust of the chapter was that the problems of the program threatened its future unless fundamental changes were made. The program's name may have changed and the problems are different from those of concern in 1954. But the experience of the intervening years suggests that the fundamental attributes of workers' compensation – a system confined to work-related injuries that provides limited benefits on a no-fault basis – are hard to successfully challenge and may be immutable.

And so, let us not be too pessimistic about the future of workers' compensation.¹⁵ Indeed, I look forward to participating in the 125th Anniversary of the first state workers' compensation programs. 

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ENDNOTES

1. The other common law doctrines, which were part of the "unholy trinity" that severely limited the ability of workers to recover from their employers for workplace injuries in tort suits, were the contributory negligent doctrine and the assumption of risk doctrine (Willborn et al. 2017: 891-92). The contributory negligence doctrine precluded the employee from any recovery if he or she were negligent, even if the employer was the primary negligent party. The assumption of risk doctrine barred recovery for the worker who was injured by the ordinary risks of employment as well as the extraordinary risks of employment if the worker knew of them or might reasonably have been expected to know of them.
 2. "Several states made no provision at all for medical benefits. Where provided they were limited in duration or amount or both." (Brodie 1963, 61).
 3. "In general, compensation laws limited indemnity benefits to maximum total amounts, even for permanent disability benefits. Cash benefits were usually stated as a percent of wages at the time of injury, 50 percent being the most common, although a few acts provided for about two-thirds of wages, subject to statutory maximum compensation ranging from \$10 weekly in several states up to \$15." Brodie 1963, 61).
 4. The federal government was also able to enact an employers' liability act for railroad workers, since railroads were directly engaged in interstate commerce.
 5. Somers and Somers (1954, note 27): "Kansas and Washington had the first enactment dates, March 14, 1911."
 6. As noted by McLaren and Baldwin (2017, note 2): "The New Jersey law was enacted on April 3, 1911, signed by Governor Woodrow Wilson on April 4, and took effect on July 4, 1911 (Calderone 2011). The Wisconsin law was enacted and took effect on May 3, 1911 (Krohm 2011)."
 7. The costs include premiums paid by employers, the costs of workers' compensation for self-insuring employers, and premiums paid by workers in Washington state.
 8. Some of the limits on the duration of temporary total disability (TTD) benefits were included in state workers' compensation laws before the 1990s, such as the 400-week limit for TTD benefits in New Jersey.
 9. State workers' compensation statutes incorporating the dual denial doctrine may also violate the U.S. Constitution. See Willborn et al. (2017, 920).
 10. This discussion of Tooley is largely based on Torrey (2014).
 11. Wage-loss studies rely on data from large samples of injured workers who received PPD and compares their permanent disability ratings, the workers' compensation benefits received by the workers, and the workers' actual losses of wages resulting from the workplace injuries. The replacement rate is the amount of cash benefits received by the workers divided by the actual losses of wages.
 12. I use "Gordian Knot" to describe an intricate problem, especially an insoluble problem.
 13. The widespread use of mandatory employment arbitration agreements is reminiscent of the use of the yellow-dog contract, which according to Wikipedia (2017) "is an agreement between an employer and an employee in which the employee agrees, as a condition of employment, not to be a member of a labor union. In the United States, such contracts were, until the 1930s, widely used by employers to prevent the formation of unions . . . In 1932, yellow-dog contracts were outlawed in the United States under the Norris-LaGuardia Act." It may take legislative action to limit the use of mandatory employment arbitration agreements. Alas, given the current political environment, the modern-day equivalents of Norris and LaGuardia are unlikely to emerge.
 14. The Patient Protection and Affordable Care Act (PPACA) is commonly called the Affordable Care Act (ACA) or Obamacare.
 15. Mild depression is acceptable.
- Pelis re occab es aut untur, con concesis isitati consequam, suntectae sit que comni et moluptaqui se maion consecutiis volorum autam adit molo tote ma ped quid estrum qui sam, quas alignis eum que coreius andeles sitataese maximus id et occur aut qui voluptiut ex eos pedis ad quos natuas peressit verferspe non riberis, con commolupta dolupta aruntia nimus modi re dolectur?
- Optur? Quia eos est di vel in et quunt omnistiae. Epeles alic odiit quae conseit orerore preptiatquas am, sequamenis quas dolesqueiae. Pel int.
- Tempore puditia quatibusam sus autat venis estia