The American workforce has grown older over the last two decades, and people above the age of 55 will soon represent more than a quarter of all US workers. The aging of the workforce carries with it the potential for higher workers’ compensation expenses for employers, driven by more costly injuries and illnesses and longer recovery times for injured workers.

In light of these demographic realities, employers can take several steps to limit their risk. Forward-looking strategies that combine integrated wellness programs, job design, and ergonomics can help employers maintain a healthy, productive workforce, and reduce workers’ compensation costs.

US WORKERS GROWING OLDER

In 1992, the median age of the civilian labor force in the US — people 16 and up who are working or looking for work — was 37.1, according to the US Bureau of Labor Statistics (BLS). Since then, the median age steadily increased to 41.9 in 2012, and is projected to reach 42.6 in 2022 (see FIGURE 1).

How an employer defines an “older” employee is often open for debate. Some employers may limit the definition to employees over a given threshold — 45, 55, or 65 — while others may consider the aging process to begin at 35 or even earlier. Regardless, employees above any of these thresholds make up an ever-greater share of the workforce (see FIGURE 2).

Some of the growth among older employees appears to be driven by the economic downturn as many people are now working beyond the once typical retirement age of 65. Other workers have reentered the workforce after retirement; the civilian labor force participation rate has steadily increased for all segments of the population above 55, especially for people 65 and older.
FIGURE 1
MEDIAN AGE OF THE US LABOR FORCE

FIGURE 2
PERCENTAGE OF CIVILIAN LABOR FORCE, BY AGE
HIGHER WORKERS’ COMPENSATION COSTS

For employers, the good news is that older workers seem to be no more prone to work injuries than younger ones. A 2011 report by the National Council on Compensation Insurance (NCCI) found that the frequency of workplace injuries and illnesses has declined since the mid-1990s for all age groups. And while in 1994 there was a sizable difference between the injury frequency of younger employees (age 20 to 24) and older workers (age 55 to 64), that gap had largely disappeared by 2009.

But when older employees are injured on the job, the costs to employers can be much higher than when younger workers are injured. NCCI analysis of data from 1996 to 2007 shows that lost-time claims with temporary payments to 45- to 64-year-old employees cost 56% more than similar claims to 20- to 34-year-old employees.

In addition to higher wages for experienced employees, much of this additional cost can be attributed to the presence of comorbidities that are more likely to develop in older workers. Obesity, for example, is more common among people 40 and older (see FIGURE 3). Individuals between the ages of 40 and 59 are also three times as likely — compared with 20- to 39-year-olds — to have metabolic syndrome, a combination of abdominal obesity, high cholesterol, elevated blood pressure, and insulin resistance that can put individuals at an increased risk of developing cardiovascular diseases and diabetes.

These comorbidities can be costly. A 2012 NCCI study found that medical costs for claims with a comorbidity diagnosis were roughly double those of otherwise comparable claims. Obesity and other conditions can also increase the risk of injury in the workplace and extend recovery times.

Older workers are often valued by employers because of their knowledge, skill, and productivity. If experienced employees are absent from work for extended periods of time — or retire as a result of injury — the resulting shortfall in qualified workers can be troubling, especially for a number of technical industries that are already under stress from economic and demographic shifts. For example, a 2013 report from the National Academy of Sciences noted that energy and mining companies will face challenges in replacing baby boomers who are expected to retire over the next several years. And a 2013 report from the NTAR Leadership Center at Rutgers University identified a similar concern for health care organizations as experienced physicians and nurses retire and demand for medical care grows. (For a closer look at another factor that may impact workers’ compensation, read our recent Marsh Risk Management Research briefing, Health Care Reform and Workers’ Compensation Programs.)

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FIGURE 3

PREVALENCE OF OBESITY AMONG ADULTS AGED 20 AND OVER (2011–2012)

Source: US Centers for Disease Control and Prevention

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Adults 20 And Over</td>
<td>34.9%</td>
</tr>
<tr>
<td>20 To 39</td>
<td>30.3%</td>
</tr>
<tr>
<td>40 To 59</td>
<td>39.5%</td>
</tr>
<tr>
<td>60 And Older</td>
<td>35.4%</td>
</tr>
</tbody>
</table>
Organizations are using a number of strategies to address these concerns, including wellness programs that encourage workers to take charge of their weight management and fitness level. Integrated wellness programs that break down silos between safety and health and employee wellness initiatives can benefit both workers and employers.

There is no one-size-fits-all approach to wellness initiatives. But successful programs can include a range of activities, from employee communications and health risk assessments to biometric screenings and targeted intervention programs for certain employee groups. Onsite gyms, personal trainers, sleep studies, vision exams, and physical therapists can produce benefits before and after an injury, while onsite cafeterias may present an opportunity to introduce nutrition programs.

Combining occupational safety and health and wellness programs may increase program participation, acceptance, and effectiveness. According to the Health Enhancement Research Organization (HERO) Employee Health Management Best Practice Scorecard’s 2012 Annual Report, developed in collaboration with Mercer, organizations can drive positive outcomes in wellness programs by:

- Including spouses in key program components.
- Promoting all wellness activities under a single brand name.
- Having formal, written strategic plans with financial objectives.
- Encouraging active participation by senior leadership.

As they are introduced, wellness programs should consider the concept of the “whole worker” on a 24-hour basis. Ultimately, the goal of such programs is to promote healthy behavior by employees of all ages at all times — not just at the worksite during typical work hours. Not only can a healthy workforce translate into fewer injuries, but injured employees who are otherwise healthy generally recover more quickly than unfit workers.

In the long run, these strategies are proving to be cost-effective. For every dollar spent on wellness programs, employers can reduce medical costs by $3.27 and absentee day costs by $2.73, according to a Harvard University analysis. This average return on investment suggests that the wider adoption of such programs could prove beneficial for budgets and productivity as well as health outcomes. Examples of return on investment include:

- A global manufacturer of trucks, buses, and engines reduced its injury frequency rate by 81% over a nine-year period after introducing an integrated health initiative. The company also reduced the number of “controllable absences” due to workplace injuries and illnesses by 48%.
- After merging wellness with occupational health and safety programs, a metal processing company reduced injuries by 65% and the number of workers’ compensation claims from lost work days by 64% over a five-year period.
Whether in an industrial or office setting, employers should design work environments that limit repetition and force and avoid postural stress on joints or body parts. When defining demands of various job tasks, organizations should take into account several factors that are particularly important for older employees, such as:

- Visual elements, including contrast, color, lighting, and transitions between bright and dark environments.
- Physical demands, including static postures.
- Mental demands, including fatigue and concentration.

Employers can address these concerns in several ways. For example, well-marked curbs and lighting at transitions in floor surfaces, which may be more difficult for older workers to see, can reduce slips and falls. Well-lit transitions at manufacturing, retail, and construction work spaces can reduce collisions in warehouses and other environments where heavy machinery may be in use. Technology or automation — for example, handling aids — can help to minimize the force demands of lifting tasks in health care and other industries.

Physical risk assessment: Instead of written job descriptions, employers should perform thorough assessments of the physical risks involved and develop observation-based descriptions of each job. This can allow organizations to identify specific job requirements and match employees with appropriate tasks. Post-offer employment testing (POET) — through which prospective employees mimic job functions — can allow employers to objectively match individual capabilities with job demands. Such testing has been used successfully by companies in several industries; for example, airlines typically use POET programs when hiring ramp agents and baggage handlers.

A well-designed POET program incorporates efforts to minimize physical demands by modifying tasks, where feasible, to maximize the population capable of safely performing the work. This testing can also help employers address the risks related to aging longtime employees by allowing injured workers or those returning from non-occupational disability leave to be matched with appropriate tasks, and supporting evidence-based return-to-work decisions.

Kinesthetic training: One of the least expensive strategies available to employers is the retooling of traditional safe body mechanics training. Research has shown that most US workers learn kinesthetically — by moving their bodies. Crucial to kinesthetic training is that workers feel improvements and gain confidence in their strength by adjusting their posture or position. The most receptive employees to this type of training are often older workers who have already experienced work-related trauma.

NCCI research indicates that older workers generally tend to have more rotator cuff and knee injuries than younger workers (see Figure 4), and some tasks specific to particular industries or job functions could lead to a higher frequency of such injuries. As a result, some organizations have identified physical engineering improvements to reduce shoulder and knee injuries, which often require a more complex mix of treatments, a greater number of treatments, and a longer time to heal — especially when accompanied by a comorbidity.

Program development: To develop an effective kinesthetic ergonomic program, an employer should first analyze loss data and identify high-risk tasks that drive claims costs. This should be followed by an extensive onsite interview, conducted by a certified ergonomist, of employees, their
MANAGING THE EFFECTS OF AN AGING WORKFORCE

While demographic shifts leading to an older workforce may be unavoidable, employers can address the potential effects on their workers’ compensation programs. Addressing employee behavior on a 24-hour basis through integrated wellness programs can lead to healthier workers with fewer comorbidities, while ergonomic adjustments can reduce the physical demands of job tasks. Combined, these efforts can contribute to a lower frequency and severity of injury and illness, and better position workers to quickly recover from injury — a win for both employers and employees.

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FIGURE 4  TOP 10 CLAIM DIAGNOSES FOR LOST-TIME CLAIMS WITH TEMPORARY PAYMENTS THAT CLOSED WITHIN 24 MONTHS OF DATE OF INJURY, ACCIDENT YEARS 1996-2007
Source: NCCI

<table>
<thead>
<tr>
<th>AGES 20-34</th>
<th>AGES 45-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Sprain lumbar region</td>
<td>Sprain rotator cuff</td>
</tr>
<tr>
<td>2 Lower leg injury, not otherwise specified</td>
<td>Unilateral inguinal hernia</td>
</tr>
<tr>
<td>3 Sprain of ankle, not otherwise specified</td>
<td>Carpal tunnel syndrome</td>
</tr>
<tr>
<td>4 Unilateral inguinal hernia</td>
<td>Tear medial cartilage/meniscus of knee</td>
</tr>
<tr>
<td>5 Cervicalgia</td>
<td>Lower leg injury, not otherwise specified</td>
</tr>
<tr>
<td>6 Lumbar disc displacement</td>
<td>Sprain lumbar region</td>
</tr>
<tr>
<td>7 Carpal tunnel syndrome</td>
<td>Cervicalgia</td>
</tr>
<tr>
<td>8 Lumbago</td>
<td>Rotator cuff syndrome, unspecified</td>
</tr>
<tr>
<td>9 Sprain lumbosacral</td>
<td>Lumbar disc displacement</td>
</tr>
<tr>
<td>10 Sprain of neck</td>
<td>Lumbosacral neuritis, not otherwise specified</td>
</tr>
</tbody>
</table>
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Marsh’s Workers’ Compensation Center of Excellence helps our clients gain a competitive advantage by leveraging an integrated approach to workers’ compensation programs to drive down total cost of risk. While controlling workers’ compensation costs is a priority for most organizations, many treat risk management, workplace safety, and claims administration as isolated functions, limiting their value and effectiveness. Our Workers’ Compensation COE differentiates Marsh by seamlessly delivering the full spectrum of our offerings: optimal program design and placement, advanced analytics and modeling, pre- and post-loss consulting strategies, and claims management and advocacy.

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