The Association of Health Risks With Workers’ Compensation Costs

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The purpose of this study was to investigate the association between health risks and workers’ compensation (WC) costs. The 4-year study used Health Risk Appraisal data and focused on 1996-to-1999 WC costs among Xerox Corporation’s long-term employees. High WC costs were related to individual health risks, especially Health Age Index (a measure of controllable risks), smoking, poor physical health, physical inactivity, and life dissatisfaction. WC costs increased with increasing health risk status (low-risk to medium-risk to high-risk). Low-risk employees had the lowest costs. In this population, 85% of WC costs could be attributed to excess risks (medium- or high-risk) or non-participation. Among those with claims, a savings of $1238 per person per year was associated with Health Risk Appraisal participation. Addressing WC costs by focusing on employee health status provides an important additional strategy for health promotion programs. (J Occup Environ Med. 2001;43:534–541)

In 1999, the National Safety Council estimated the total annual cost of occupational injuries at $125 billion: $62.0 billion for wage and productivity losses, $19.9 billion in medical costs, $25.6 billion in administrative expenses, and $16.7 billion in additional employer costs. An estimated $42.4 billion was paid out under workers’ compensation (WC) insurance; the average cost for all claims combined was $10,488 per injured worker. With widespread industry safety programs, the incidence rates for occupational injuries (excluding fatal work-related injuries) have steadily declined from 8.3 cases per 100 workers in 1990 to 6.2 cases per 100 workers in 1998.

In keeping with these national trends, and in an attempt to make significant improvements in quality of life for all US working people, Healthy People 2010 established a goal of further reducing work-related injuries to 4.6 injuries per 100 full-time workers (a 30% improvement over 1997 baseline levels of 6.6 injuries per 100 workers).

Comprehensive initiatives to manage the incidence and costs of occupational injuries often include medical case management (secondary prevention), safety/ergonomic programs, and early return-to-work programs. Cost-containment strategies also used by corporations to control increases in WC costs include utilization review/management programs, risk management programs, and rehabilitation programs for injured workers. These programs focus on injury prevention through worksite review and assess-
ment of worker risk for injury before injuries occur, and management of medical costs, rehabilitation, and return-to-work programs after an injury incident. Most programs show highly favorable cost savings and reductions in the incidence rates for injuries.5–9

The benefits of primary prevention by improving worker strength and/or health have also been investigated.10–13 In one of the earliest studies (1979), Cady et al14 used five measures of fitness and conditioning to classify firefighters into least-fit, middle-fit, and most-fit categories. Their results showed a graded and statistically significant protective effect for added levels of fitness and conditioning for back injuries (least-fit, 7%; middle-fit 3%; and most-fit 1%). It was concluded that physical fitness and conditioning were preventative for back injuries in this population.

Since that study was published, other investigators have considered individual health risks that would predict the incidence of injury, including isometric strength,15 aerobic fitness,16 cardiovascular risks,16 obesity,17 smoking16,17 and psychosocial variables.18–22 Results have varied by health risk. Isometric strength and cardiovascular risks do not effectively predict injury.15,16 Only a few studies have reported an association with obesity, and then only among the most obese.16,17 Although enhanced physical fitness has often been suggested to have a prophylactic effect on injury rate, the type of training required and the critical aspects of fitness are unclear.10,16,23 There is a consistent association between those who smoke and increased injury rates, although the mechanism of this relationship needs further investigation.16,17 Among psychosocial variables, job dissatisfaction, work-related stress, and lack of social support have been associated with higher injury rates. The complex relationship, however, between psychosocial variables and the physical demands of work have made it difficult to reach definitive conclusions about their relative importance to the risk of injury.18–22

Primary prevention programs focused on injury prevention by improvement of worker health/strength are less prevalent, and programs often include multifaceted approaches. In an example of a back injury intervention among county employees, the program consisted of education, training, physical fitness activities, and ergonomic improvements. Savings in medical costs and reduced sick days resulted in a 2.79:1 return-on-investment.24 A health risk appraisal (HRA) assessed the likelihood for back injury with additional questions. After the intervention, there was a significant decrease in the percentage of those employees at high risk for back injury. Overall health status was not reported.

Another company initiated an intensive wellness program with incentives to join fitness centers and participate in education programs and health assessments (HRA). The number of injuries and lost workdays steadily decreased over the 6 years of the program. The HRA was used to track improvements in fitness, nutrition, and cholesterol levels. Calculations of cost savings related to the program yielded a return-on-investment of 2.51:1.25

Health status has been related to medical costs. High-risk individuals have been shown to have higher medical costs than low-risk individuals.26–35 Furthermore, people who change their risk status by improving their lifestyle behaviors have been shown to reduce their costs.36,37 It was of interest to know if these same relationships could also be applied to WC costs.

The purpose of this study was to investigate whether the associations between health risks, as defined from the HRA, and WC costs would be similar to those established for medical care costs. Specifically, the following were examined: (1) effect of individual health risks and overall health status on WC costs, (2) percentage of excess WC costs associated with excess risks/non-participation, and (3) cost savings associated with program participation.

Methods

This project was a 4-year case study (1996 to 1999) of the associations between health risks as measured on the HRA and WC costs and lost injury days among long-term employees at Xerox Corporation. The corporation initiated the Xerox Health Management program in 1978 with the first round of HRAs in 1981. In 1995, a more intensive program was instituted at the Rochester, New York, location, with health risks assessed every 3 years (1995 and 1998). The mission of the Xerox Health Management program is to provide integrated health programs that optimize health and personal productivity. HRA participants received health risk-targeted awareness materials and the opportunity to participate in special, subsidized, on-site lifestyle management programs (eg, weight management, fitness, back care, stress).

Study Population

The study population consisted of 3338 employees who met the following criteria for this 1996 to 1999 study: (1) continuously employed by Xerox Corporation from 1981 to 1999, and (2) selected Blue Choice Health Maintenance Organization as their medical plan. This pilot employee subgroup had been previously selected by the corporation to track short- and long-term health and economic (medical cost) effects of their health promotion program. Demographics from personnel records, including age, gender, and job status (exempt, hourly, non-exempt), characterized those with WC claims during the 4-year period (n = 265) and those without claims (n = 3073).

WC Claims and Lost Injury Days

Data for WC paid claims and days lost from injury from 1996 to 1999
were available from the corporation benefits department. Data for claims and lost injury days were received on a per-claim basis and then aggregated to determine the total WC cost and lost injury days per employee per year. Costs for each year were adjusted to 1999 dollars using published medical inflation rates.38

Lost injury days were converted to a cost measure using an average daily wage per day of $150 (assigned by the corporation benefits department) multiplied by the number of lost days for each employee. A combined outcome measure used in this study summed the total costs from claims and lost days costs for the 4-year period. This approach thus incorporates both direct costs (ie, insurance payments) and indirect costs (ie, lost work time) into the analyses.

HRA

The HRA was originally developed by the Centers for Disease Control/Carter Center and was modified by the University of Michigan Health Management Research Center for the employer. In addition to self-reported age and sex, 15 health risk factors were selected to establish health status36:

- Five lifestyle variables: smoking, physical activity level, alcohol use, drug/medication use, and safety belt use.
- Four psychological variables: perception of physical health, life satisfaction, job satisfaction, and stress.
- Six health/biological variables: blood pressure, cholesterol, relative body weight, serious medical problems, illness absence days, and Health Age Index (a measure of controllable health risks).

High-risk criteria for each of the defined health risks are given in Table 1. Individual health risks for HRA participants were summed, and overall health status was assessed as low-risk (0 to 2 health risks, 50th percentile); medium-risk (3 to 4 health risks, between the 50th and 90th percentiles); and high-risk (5 or more health risks, 90th percentile and above).

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Health Risks and Workers’ Compensation Costs</th>
<th>Musich et al</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High health risk criteria</strong></td>
<td><strong>Selected Measures</strong></td>
<td><strong>High-Risk Criteria</strong></td>
</tr>
<tr>
<td>Lifestyle risks</td>
<td>current cigarette smoker</td>
<td>Current cigarette smoker</td>
</tr>
<tr>
<td>Smoking</td>
<td>less than once per week</td>
<td>Less than once per week</td>
</tr>
<tr>
<td>Physical activity</td>
<td>heavy drinker (&gt;14 drinks/week)</td>
<td>Heavy drinker (&gt;14 drinks/week)</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>use a few times per month or more often</td>
<td>Use a few times per month or more often</td>
</tr>
<tr>
<td>Drug/medication use</td>
<td>use safety belt less than 100% of the time</td>
<td>Use safety belt less than 100% of the time</td>
</tr>
<tr>
<td>Safety belt use</td>
<td>systolic blood pressure greater than 139 mm Hg, or</td>
<td>Systolic blood pressure greater than 139 mm Hg, or</td>
</tr>
<tr>
<td>Health/biological risks</td>
<td>diastolic blood pressure greater than 89 mm Hg, or</td>
<td>diastolic blood pressure greater than 89 mm Hg, or</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>taking blood pressure medication</td>
<td>taking blood pressure medication</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>greater than 239 mg/dL</td>
<td>Greater than 239 mg/dL</td>
</tr>
<tr>
<td>Body weight</td>
<td>20% or more over desirable weight</td>
<td>20% or more over desirable weight</td>
</tr>
<tr>
<td>Medical problems</td>
<td>had problems with heart condition, cancer, diabetes, or bronchitis/emphysema</td>
<td>Had problems with heart condition, cancer, diabetes, or bronchitis/emphysema</td>
</tr>
<tr>
<td>Absent due to illness</td>
<td>≥6 days during past year</td>
<td>≥6 days during past year</td>
</tr>
<tr>
<td>Health Age Index</td>
<td>appraised age minus achievable age (from HRA) &gt;4 years</td>
<td>Appraised age minus achievable age (from HRA) &gt;4 years</td>
</tr>
<tr>
<td>Psychological risks</td>
<td>perception of physical health</td>
<td>fair or poor</td>
</tr>
<tr>
<td>Perception of physical health</td>
<td>personal life satisfaction</td>
<td>partly satisfied or not satisfied</td>
</tr>
<tr>
<td>Personal life satisfaction</td>
<td>job satisfaction</td>
<td>partly satisfied or not satisfied</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>stress</td>
<td>stress-scale score &gt;18</td>
</tr>
<tr>
<td>Stress</td>
<td>overall risk levels</td>
<td>0–2 high risks</td>
</tr>
<tr>
<td>Low</td>
<td>0–2 high risks</td>
<td>0–2 high risks</td>
</tr>
<tr>
<td>Medium</td>
<td>3–4 high risks</td>
<td>3–4 high risks</td>
</tr>
<tr>
<td>High</td>
<td>≥5 high risks</td>
<td>≥5 high risks</td>
</tr>
</tbody>
</table>

Excess WC Costs Related to Excess Health Risks

Total WC costs were calculated for low-risk, medium-risk, and high-risk employees and for non-participants (1998 HRA participants n = 943; non-participants n = 2395). Excess WC costs related to excess health risks and for non-participation were defined as excess WC costs greater than the base cost of the employees having 0 to 2 health risks (low-risk status). The percentage of total costs attributable to excess risks/non-participation was then calculated.

WC Cost Savings Associated With HRA Participation

Participation status during the time period was also investigated for an impact on WC costs. HRA participation status, including the 1995 and 1998 HRAs, was used in defining the following participation groups: two-time HRA participants (n = 515); one-time HRA participants (either
Cost trends among those with claims over the 4-year period were compared for the three participant groups. Total cost savings were then calculated from the differences in the slope lines.

Statistical Testing
Categorical variables were statistically tested using the chi-squared test. Comparisons of continuous variables were tested using the analysis of variance procedure with post-hoc Tukey’s Studentized range test for multilevel comparisons. Because WC costs were highly skewed, a log transformation was performed before statistical testing of cost variables. Slope trends over time were tested using regression analyses testing for significance of independent variable interactions (HRA participation vs time).

Results
During the 1996-to-1999 study period, 265 (7.9%) employees incurred WC claims. Among those with claims, 26% also had lost injury days. Compared with employees without WC claims, employees with claims were more likely to be female, hourly, and younger (53.2 years vs 54.8 years) (Table 2).

WC Costs
The distribution of WC claims and lost injury days (and the summed cost measure) were highly skewed. The median cost for the summed cost measure for the 4 years, shown in Fig. 1, was $527; the mean cost was $8887. The top 10th percentile of employees with costs accounted for 54.4% of the total of WC costs. Reflecting national trends and implementation of a corporate injury policy, the annual percentage of employees with claims steadily declined from 2.7 injuries per 100 workers in 1996 to 2.0 injuries per 100 workers in 1999.

WC Costs by Health Status and by Individual Health Risks
There were 943 HRA participants in 1998 (28.3% participation rate). The individual health risks that were most highly related to high WC costs (summed measure) were Health Age Index greater than 4 years, smoking, poor perception of physical health, low physical activity level, and life dissatisfaction ($P < 0.05$) (Table 3). Although individual risk status and overall risk status as assessed by the 1995 HRA were also tested, the risk-cost relationships were not as strong. Concurrent risk status (1998 HRA) was more highly associated with WC costs (1996 to 1999) than past risk status (1995 HRA) with future costs.

The percentage of employees with WC claims increased with increased risk status (1998 HRA): 4.9% among low-risk, 5.4% among medium-risk, and 8.2% among high-risk employees ($P = 0.26$) (Table 4). Overall, HRA participants had a significantly lower percentage (5.6%) with claims compared with non-participants (8.9%, $P = 0.002$). WC claims, costs associated with lost workdays, and total WC costs increased with increasing risk status. Total WC costs increased from $2178 per person among low-risk employees to $15,162 per person among high-risk employees. Overall, participants had lower total WC costs ($6506) compared with non-participants ($9482, $P < 0.001$). Multilevel post-hoc testing indicated that non-participants’ costs were significantly greater than low-risk ($P < 0.10$) and medium-risk ($P < 0.15$) participants’ costs.

Excess WC Costs Related to Excess Health Risks
Among 1998 HRA participants and non-participants, the total WC costs (claims + lost injury day costs)
were $2,354,044. Low-risk employees had the lowest average cost ($106: $105 claims 1 $0.60 lost injury day costs) compared with medium-risk ($288: $191 claims 1 $97 lost injury day costs), high-risk ($1,241: $729 claims 1 $512 lost day costs), and non-participants ($839: $541 claims 1 $298 lost day costs) (Fig. 2). If those costs above the low-risk baseline cost are defined to be "excess" costs, the total excess WC costs for medium- and high-risk participants and for non-participants would be $2,000,494 (see calculations under Fig. 2). The percentage of total costs associated with excess risks/non-participation is 85%.

To preclude an influential effect from extreme values on our conclusions, the effects of outliers were investigated. There were two extreme observations (one greater than $100,000 and one greater than $200,000). The calculations were repeated removing the most extreme observation (greater than $200,000), and then both observations. Both of these observations were categorized as non-participants, and neither observation was unduly influential in the excess cost conclusions. Thus, no observations were excluded from our calculations.

**WC Cost Savings Associated With HRA Participation**

Among those employees with claims, the slopes of the two HRA participant groups were statistically tested for differences. Because they were not statistically different (P > 0.20), these two groups were combined into one group of HRA participants. The cost trend for this group was then compared with the cost trend for the non-participants. The slope of the cost trend among HRA participants was statistically lower (P < 0.001) than the slope of the cost trend for the non-participants.

**TABLE 3**

Workers' Compensation Costs by Risk Status, 1998 Health Risks

<table>
<thead>
<tr>
<th>Individual Risks, 1998 HRA (n = 943)</th>
<th>WC Claims ($)</th>
<th>Lost Injury Days ($) £</th>
<th>Total WC Costs ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low-Risk</td>
<td>High-Risk</td>
<td>Low-Risk</td>
</tr>
<tr>
<td>Health Age Index</td>
<td>154</td>
<td>2,689 ‡</td>
<td>65</td>
</tr>
<tr>
<td>Smoking</td>
<td>120</td>
<td>1,424 ‡</td>
<td>55</td>
</tr>
<tr>
<td>Physical health</td>
<td>154</td>
<td>865 ‡</td>
<td>53</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>223</td>
<td>531</td>
<td>88</td>
</tr>
<tr>
<td>Physical activity</td>
<td>118</td>
<td>559 ‡</td>
<td>41</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>183</td>
<td>396</td>
<td>41</td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>191</td>
<td>454 ‡</td>
<td>88</td>
</tr>
<tr>
<td>Drug/medication use</td>
<td>236</td>
<td>288</td>
<td>86</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>216</td>
<td>445</td>
<td>118</td>
</tr>
<tr>
<td>Safety belt use</td>
<td>230</td>
<td>291</td>
<td>77</td>
</tr>
<tr>
<td>Stress</td>
<td>202</td>
<td>322</td>
<td>85</td>
</tr>
<tr>
<td>Weight</td>
<td>199</td>
<td>281</td>
<td>82</td>
</tr>
<tr>
<td>Medical problems</td>
<td>250</td>
<td>208</td>
<td>116</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>254</td>
<td>23</td>
<td>126</td>
</tr>
<tr>
<td>Illness days</td>
<td>260</td>
<td>6</td>
<td>130</td>
</tr>
</tbody>
</table>

* WC, workers' compensation; HRA, health risk appraisal.
† Lost injury days cost equals the number of lost days $150 wages per day.
‡ Analysis of variance (log costs), P < 0.05.

**TABLE 4**

Workers' Compensation Costs Associated With Risk Status Among Those With Claims Over the 4-Year Period

<table>
<thead>
<tr>
<th>Risk Level, 1998 HRA</th>
<th>With WC Claims</th>
<th>Lost Injury Days ($) £</th>
<th>Total WC Costs ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (n = 494)</td>
<td>24</td>
<td>2,166</td>
<td>13</td>
</tr>
<tr>
<td>Medium (n = 278)</td>
<td>15</td>
<td>3,540</td>
<td>1,810</td>
</tr>
<tr>
<td>High (n = 171)</td>
<td>14</td>
<td>8,305</td>
<td>6,257</td>
</tr>
<tr>
<td>HRA participants (n = 943)</td>
<td>53</td>
<td>4,335§</td>
<td>2,171†</td>
</tr>
<tr>
<td>HRA non-participants (n = 2395)</td>
<td>212</td>
<td>6,110</td>
<td>3,371</td>
</tr>
</tbody>
</table>

* WC, workers' compensation; HRA, health risk assessment.
† Lost injury days cost equals the number of lost days $150 wages per day.
‡ Chi-squared test, P < 0.002.
§ Analysis of variance, P < 0.001.
† Analysis of variance, P < 0.01.
slopes associated with HRA involvement. Estimation of costs savings from difference in HRA participation among those with claims. 54.4% of total costs. Over the 4-year percentile of costs accounting for was highly skewed, with the top 10th percentiles accounting for 85%. The total excess WC costs for medium-risk employees and for non-participants accounted for 85% of the total costs. Theoretically, if all participants changed to low-risk status and WC costs followed this trend we considered low-risk as the baseline; any risks above this baseline were not statistically different (P < 0.02). The total savings associated with HRA participation among those with claims: 74% received WC without loss of work time. The nature of WC costs was similar to medical care costs, highly skewed with a small number of individuals accounting for a large percentage of the overall costs.

The annual trend for the number of injuries per 100 workers decreased steadily from 2.7 in 1996 to 2.0 in 1999. A Zero-Injury program initiated in 1997 at Xerox perhaps accounted for some of the reduction. The study population is a long-term subgroup of the Xerox employee population, with an average age of over 50 years. A decreasing injury trend may not be surprising in a middle-aged group of employees; the trend was consistent with national trends in WC costs. Xerox Corporation has met and exceeded Healthy People 2010 goals of 4.6 injuries per 100 workers and improved their injury rate by 25.9% during the 4-year period, 1996 to 1999, in this subgroup of employees.

Similar to medical care costs, WC costs are related to individual health risks measured by the HRA, although the specific health risks most highly associated with high medical costs differ from those associated with high WC costs. Unlike the relationship with medical costs, however, concurrent health risk status was more highly associated with WC costs than previous risk status with future costs. The individual risks most highly related to high WC costs included Health Age Index (a difference in appraised age and achievable age from the HRA), smoking, poor physical health, physical inactivity, and life dissatisfaction. Other studies have reported the relationship of higher injuries with the individual health risks of smoking, physical inactivity, and psychosocial variables. In contrast, the individual risks most highly related to high medical costs include absence due to illness, drug/medication use, medical problems, high blood pressure, and poor physical health.

This study is unique in assessing the association of injury claims with risk status: low-risk (0 to 2 risks), medium-risk (3 to 4 risks), and high-risk (5 or more risks). As health risk status increased, the amount of WC costs (claims and lost injury day costs) also increased. The rate of injury occurrence also increased as risk status increased: 4.9% among low-risk employees, 5.4% among medium-risk employees, and 8.2% among high-risk employees. Non-participants, however, had an 8.9% injury rate, which was significantly higher than participants. Although the rates of injury among risk status levels were not statistically different (P = 0.26), the increasing injury trends with increasing risk status were clear. Non-participant rates of injury were significantly greater than participant rates (P < 0.002). The power of these associations for health promotion managers is that WC costs and lost injury days are influenced by specific health behaviors and participation status.

In the assessment of excess WC costs associated with excess risks, we considered low-risk as the baseline; any risks above this baseline level were considered “excess risks.” The total excess WC costs for medium- and high-risk employees and for non-participants accounted for 85% of the total costs. Theoretically, if all participants changed to low-risk status and WC costs followed this change in risk status, this would be the maximum savings. In other unpublished analyses that use medical costs to calculate excess costs associated with excess risks/non-participation, excess costs typically account for about 30% of total costs. This indicates that health risks/behaviors associated with medical costs even more highly influence WC claims and that improving the health of the corporate workforce could result in
substantial savings in WC claims and lost workdays.

Our data indicated that changes in WC costs and lost injury days were also associated with changes in health risk status. This risk–cost relationship has been well documented for medical care costs. The data were not shown here because the number of injury claims among two-time HRA participants (n = 515) was very low (n = 28). Nevertheless, the association was consistent with trends observed with medical costs: as risk status increased from low-risk to high-risk, costs/lost days increased, and as risk status decreased from high-risk to low-risk, costs/lost days decreased.

HRA program participation was associated with a higher annual rate of decrease of WC costs compared with non-participants. The injury incidence rate among participants was also significantly lower compared with that of non-participants. In the Xerox Health Management program, the HRA program serves as a gateway to health awareness materials and lifestyle management (risk reduction) programs; hence the measurement of HRA participation is a surrogate measure that includes the opportunity to participate in other programs. Cost savings associated with program participation amounted to $366,448 for 74 employees, or $1238 per person per year among those with claims over the time period. These results indicate the importance of encouraging employee participation and then measuring participation as an economic outcome measure.

Limitations

The study group is a subgroup of long-term employees selected by Xerox Corporation. The injury trends may not be generalizable to the entire employee population. Given an average age over 50, both the nature of job descriptions and attitudes toward safety may be more conservative than those among younger employees. Thus, the savings associated with low-risk status and program participation may be overstated. Nevertheless, the study reflects the impact on at least one group of employees within the corporation.

The changes in WC costs with changes in health status were not included because of the low injury incidence rate among two-time HRA participants. Documenting the changes in costs relative to changes in health status in a larger employee population would strengthen the benefits of risk reduction and low-risk maintenance. Nevertheless, we showed that low-risk employees have the lowest WC costs.

Implications

The association of health risks with WC costs provides an important strategy for health promotion programs. Risk status does influence WC costs. Program participation status is also associated with cost savings. The strategies that have been used to reduce medical care costs can also be used to reduce WC costs.

References


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**Pigs Can Fly**

The big pig probe has ended. The Federal Aviation Association recently found US Airways not guilty of safety and sanitation violations for allowing an unruly porcine passenger on board an October 17, 2000, Philadelphia-Seattle flight. Passenger Maria Tirotta Andrews said Charlotte, a Vietnamese potbellied porker, whom she claimed weighed 13 pounds, was a service animal—specifically, a “therapeutic companion pet.” The airline approved Charlotte’s boarding, even though at check-in it was obvious that she was a little overweight. Charlotte remained relatively quiet in the first-class cabin until landing. Then the 300-pound pork chop became quite agitated. US Airways filed an incident report with the FAA as a result of passenger complaints. But the FAA Eastern Region office ruled that the airline had not violated any federal regulations or Department of Transportation policy governing service animals.
