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Workers' Compensation Reform

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Workers' compensation exists as part of the social safety net of programs, both mandatory and voluntary, that protect large numbers of workers from unemployment and disability and provide social service needs. Workers' compensation laws require that medical expenses and loss-of-earnings replacement costs are paid for injuries and illnesses caused by work. Workers' compensation medical care is beset by the same issues as in general health care: effectiveness of managed care and free choice of physician, chronic care treatment, costs of pharmacy benefits and technology, and the aging of the US population. Workers' compensation medical care makes up less than 5% of all medical care,¹ but for those injured on the job, it often becomes their primary relationship with the health care system.

Disparities in Coverage, Care, and Compensation

Workers' compensation systems, which are administered by each state, poorly serve the needs of many injured workers and are unpopular with many employers and health care providers.² Although most states have similar approaches to providing workers' compensation benefits, in covering most workers, and in paying for all necessary medical care, each state system is unique and varied in its case adjudication process, its levels of benefits, its allowance of choice of primary treating physician and treatment modalities, and its regulation of insurance companies and self-insured employers. States differ, often dramatically, on the level and scope of permanent disability and other benefits, coverage of mental health conditions resulting from work, and insurance and claims administration regulation (e.g., the maximum burial allowance in Mississippi is \$2,000, compared with \$6,000 in Michigan and up to \$15,000 in Minnesota).³

In most states, workers' compensation benefits are administered through private, profit-oriented insurers. In 23 states, a state fund exists to provide coverage and administration in competition with private insurers; in 4 states, a state-run fund is the exclusive provider of mandatory insurance.⁴ Purchase of insurance coverage by employers is commonly handled like a commodity, with premium cost being the primary consideration and prevention and claims services being undervalued. In those states with competitive private insurance, the shifting of coverage between carriers is counterproductive to public health; no consistent or long-term effort is directed at injury and disease prevention. Premium levels often fluctuate because of macroeconomic changes rather than because of an individual employer's attention to and success in reducing injury and illness. Workers' compensation, on average, covers only 27% of the \$170 billion estimated annual cost of occupational injuries, illnesses, and fatalities.⁵

Mistrust, denied claims, stigmatization, payment delays, and refusals to pay benefits are common experiences for many workers who must deal with the system.⁶ Coverage by the system is made especially difficult for contingent, migrant, and undocumented workers.⁷ Many undocumented workers fear sanction under immigration laws if they exercise their workers' compensation rights.⁸ In many states, compensation

laws restrict coverage from agricultural employees or home care and domestic household workers or remove coverage from some by labeling workers as “independent contractors” responsible for their own disability coverage.⁸ Workers’ compensation fails to fully compensate many occupational injuries and fails to cover most illnesses, including fatalities.^{9,10} Even when workers’ applications are successful, workers’ compensation payments often replace only a small portion of their lost earnings.¹¹ After workers’ compensation wage payments expire, injured workers, on average, never achieve the earning potential that they had before injury.¹²

Workers’ compensation systems typically cover both injuries and illnesses, but they are more successful at providing care and benefits in cases of acute injury than in cases of illness, especially illnesses caused over time, or cumulative injuries. Statutory sections typically do not try to distinguish the meaning of accident and instead use the occurrence of injury on the job as determinative.). Determination of work-relatedness is more difficult in illness cases, in particular those illnesses with latency periods or those caused by cumulative exposures. In the competitive private insurance systems, where coverage over time may be provided by several companies, there may be controversy about degrees of responsibility among different parties.

Experts estimate that only 1 of 20 occupational disease victims receive workers’ compensation benefits.¹³ For occupational cancer, it is less than 1 in 100.² Ten times as many severely disabled occupational disease victims receive Social Security Disability Insurance (SSDI) or early retirement benefits as receive workers’ compensation benefits.¹⁴ This situation is perpetuated by systematic employer and physician underreporting of occupational injuries and illnesses to the Occupational Safety and Health Administration and the Bureau of Labor Statistics.^{15–18} Access to coverage in occupational disease claims also meets major obstacles, because although research has linked toxic exposures to diseases, epidemiological evidence is denied, has been suppressed, or is considered insufficient by the workers’ compensation claim adjudicator.^{13,19}

The Federal Employees’ Compensation Act (FECA)²⁰ program provides loss-of-earnings benefits and payments for medical treatment to federal civilian employees. Disability benefits under FECA are greater than those in the state workers’ compensation programs. Although federal civilian employees represent only 2.1% of all workers eligible for workers’ compensation benefits, federal programs account for 6.0% of the benefits paid.²¹ For equity and efficiency, workers in the United States, whether employed in the private or public sector, should be afforded a workers’ compensation system with uniform benefits and controls.

Reform Efforts

Several reforms for the workers’ compensation system have been proposed over the years, but none have resulted in fundamental change. The Report of the National Commission on State Workers’ Compensation Laws concluded in 1972 that workers’ compensation laws in general were neither adequate nor equitable.²¹ The commission raised the possibility that the medical component of workers’ compensation could be assigned to an expanded Medicare or national health insurance program. The commission also considered the possibility that disability cases could be assigned to the SSDI system.²² The commission and subsequent policy debates challenged states to improve their systems or face mandatory minimum standards imposed by federal law. In 1980, the US Department of Labor proposed 3 major alternatives for improving compensation benefits for occupational diseases: strengthening and restructuring the workers’ compensation system, building onto the existing SSDI program, and developing programs for compensation for exposures on a substance-by-substance basis.¹³ All 3 reform proposals were instituted in varying degrees but with only limited success.^{23–25}

Reforms in Asia and Europe have demonstrated that fundamental change is possible in workers’ compensation. New Zealand has had a comprehensive accident insurance system since 1974. The New Zealand system provides for compensation for all victims of injury by accident, regardless of the cause. Emphasis is placed on accident prevention and, when necessary, on the rehabilitation of injured people. Public hospitals provide medical treatment, and the system offers timely compensation to injured workers.²⁵ Some European social security systems provide universal coverage for disability.²⁶ Wage replacement schemes consist of social insurance covering the loss of earnings caused by age,

unemployment, temporary sickness, or permanent disability.²⁷

In North America, many Canadian provincial systems operate nonprofit workers' compensation programs that emphasize injury and illness prevention incentives and focus public attention on the nature and scope of the problem, as well as the tragedy of the many preventable injuries. (See for example, programs of WorkSafe Saskatchewan and WorkSafeBC. Available at www.worksafesask.ca and www2.worksafebc.com/Safety/Home.asp.) Calls for reform in the United States have outlined a program of change consistent with reforms in other countries. In 1986, the AFL–CIO called for the integration of the medical portion of workers' compensation into the overall health care system.²⁸ Moreover, it supported punitive liability imposed on those who knowingly cause disability, industrywide shared liability for disability caused without knowledge, and societywide shared responsibility for disability whose cause cannot be identified. Labor representatives favored an integrated approach to disability compensation such as exists in The Netherlands and favored a return to the tort system, because it provided an additional remedy for dispute resolution in occupational diseases.²⁹

Experts proposed the integration of workers' compensation health care into a national health service system. Moreover, some experts favor supplemental tort liability when damage from work has occurred because of employer negligence or serious wrongdoing.³⁰ Some experts observed that the United States may not need 2 separate systems for paying benefits to the disabled and suggest combining SSDI with workers' compensation into 1 program.³¹ A system of taxing by industry sector, similar to the Black Lung Trust Fund, has been suggested.¹⁷ Others emphasized the need to replace the existing array of fragmented workers' compensation programs with a comprehensive plan of compensation for disability and premature death.³² Many workers' compensation experts favor the removal of physicians as gatekeepers for disability benefits and an end to the exclusive remedy provision of workers' compensation.³³ Some observers note that unless there are both civil and criminal penalties, employers will often continue to find it more cost-effective to allow the negligence that kills and maims workers.^{34,35}

American Public Health Association Policy

The American Public Health Association (APHA) has a long history of supporting measures to improve workers' compensation for occupational injury and disease and to create publicly funded occupational health and safety programs. APHA policy calls for increased research on work-related illness and reporting methods.^{36–40}

Recommendations

APHA supports the following elements of a workers' compensation reform proposal:

1. The workers' compensation system should put prevention of injury and illness and rehabilitation of those unable to return to work after injury and illness as its foremost goals.
2. The current fragmented workers' compensation system should be replaced by a national program with uniform coverage of health care and adequate loss-of-earnings benefits for all occupational injuries and illnesses.
3. The system should be a more comprehensive, no-fault compensation system based on disability, not impairment, such as exists in The Netherlands, where all employees are covered by a compulsory government administered plan that insures against loss of earnings from long-term disability resulting from any occupational injury or disease.
4. The system should include a national standard of coverage for all workers, including all federal and state government workers. Individual state exemptions for seasonal agricultural workers, home care workers, domestic workers, part-time workers, contractors, immigrant workers, employees of small companies and all other special categories should be removed.
5. The system should be integrated in a seamless manner with SSDI; benefits should be provided for all permanent injuries and illnesses.

6. Health care for injured workers should be provided by a national health care system independent of industry involvement and insurance industry control; health care providers should be removed from the responsibility of determining eligibility for benefits.
7. The system must have mandatory root cause investigation requirements for all occupational injuries and illnesses.
8. The system must have money set aside for training of occupational health and safety professionals, preventive initiatives based on root injury and illness analyses, worker health and safety training, and mandatory reporting by health professionals.
9. The system should provide assistance, incentives, and training in job modification and appropriate return to work.
10. Where appropriate, tort and criminal liability for negligence should be permitted for those who knowingly or recklessly cause disability.
11. A national medical and statistical database should be established to document worker injuries, worker illnesses, worker toxic exposures, and resultant diseases. A national database would lay the groundwork for research into the causes and consequences of occupational illnesses and lead to improved diagnosis, treatment, prognosis, and ultimately, prevention of occupational diseases. There should be a comprehensive and universal reporting system for all occupational injuries and illnesses.

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