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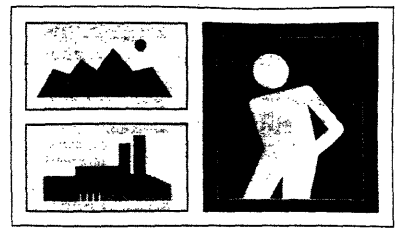

CHAPTER 128

Workers' Compensation

Nicholas A. Ashford

At the turn of the century, pressure began to mount to shift the impact of occupational injury from the worker to the employer and society in general. This pressure came both from increased numbers of successful lawsuits brought by workers against employers for injuries suffered on the job and from increased public awareness that an unfair burden was being placed on workers as the country began a new period of industrialization. The first workers' compensation laws were passed by nine states in 1911, and most of the remaining states quickly followed. At the time these laws were enacted, occupational disease was considered a far less pressing problem than injury. It was not until 1917 that Massachusetts and California became the first states to compensate occupational disease. Unfortunately, it took until 1976 for all 50 states to have some form of occupational disease coverage (1), although that coverage fell far short of addressing most of the serious job-related health problems (2–6).

The primary purpose of a workers' compensation system is to cover the costs of medical care and rehabilitation and to provide compensation for lost wages resulting from workplace illness and injury. The agreement embodied in the state programs is that the employee relinquishes the right to sue an employer for damages in return for fair and timely compensation for occupational injury. To receive compensation, the worker need not prove employer negligence but only that the injury or illness was caused by the job. Most states limit compensation to two-thirds of previous wages and cover all medical costs (2).

Within each state program, three fundamental provisions characterize the operation of the compensation programs: first, all worker claims are handled by the state compensation boards; second, the insurer is entitled to contest permanent disability claims; and third, in any contested case the burden of persuasion is on the worker (7). These provisions establish a one-sided, no-fault system that sometimes operates to the detriment of workers (5,8).

In addition to rapid and fair compensation, workers' compensation programs have two other objectives. One is to internalize the cost of workplace disease and injury so that employers will bear the burden of maintaining hazardous workplaces and have an incentive to improve job safety and health conditions. The other objective is to mitigate the costs to a single employer of a catastrophic financial loss by spreading the risk through an insurance pool. These three goals of the workers' compensation system work somewhat at cross-purposes.

Employers avoid major catastrophic costs through risk spreading, which is accomplished in three ways. The largest firms, which constitute about 1% of employers and 10% to 15% of employees, are self-insured. Risk spreading is accomplished in these firms because of the large number of employees. The smallest firms, constituting 85% of employers and 15% of employees, are class rated. Class rating sets a payroll tax deduction based on industry illness and injury history. The third mechanism used by the remainder of firms, which constitute 14% of employers and about 70% of employees, is experience rating, which is class rating further adjusted to individual experience (9). While these mechanisms promote the goal of risk spreading, they impair attainment of the goal of internalization of injury and illness costs. Since, in most cases, the full cost of disease and injury does not fall on an individual employer, risk spreading, in fact, removes a considerable portion of the incentive to improve job health and safety (2).

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Even if the risk spreading effects of the insurance system did not weaken the employer's impetus to improve job health and safety conditions, little actual incentive exists for an employer to internalize the costs of harm of chronic occupational disease. The employer faces a choice: reduce health hazards today or pay compensation costs 20 to 30 years from now. The cost of capital—the interest-earning capacity of money—makes it economically attractive to avoid compliance costs today, even if higher workers' compensation benefits, measured in nominal terms, might have to be paid decades later. If the costs of workers' compensation were the only incentive an employer faced, the employer would probably profit by postponing preventive measures to improve health and safety.

This chapter reviews some of the inequities arising from variations among state systems and discusses efforts to ameliorate them. General trends and costs of workers' compensation programs, the problems of occupational disease coverage, and alternative mechanisms for compensating occupationally diseased victims are also examined.

INEQUITIES AND STATE VARIATIONS

Prompted by the 1972 study of the National Commission on State Workmen's Compensation Laws, the 1976 Democratic platform promised nationwide minimum standards for workers' compensation programs. The national commission, composed of representatives from labor, industry, and state and federal governments, investigated the status of compensation programs in all 50 states and issued a unanimous report calling for 84 revisions in state systems (10).

Among the problems the commission found were that many employees had no coverage at all; occupational diseases were not covered adequately; there were arbitrary limits on medical and physical rehabilitation services, as well as on the duration or total amount of benefits; there were inadequate cash benefits for temporary, permanent, total, and partial disabilities and for death dependents; coverage of work-related diseases with latency periods was limited by filing restrictions; and in some cases, filing jurisdictions were unclear and provided very different compensation schedules. The commission specified 19 changes that they considered essential. Their report concluded that the states should be given some time to straighten out their programs but that Congress should act by 1975 if all states had not then resolved the most severe problems of workers' compensation.

In the years since the national commission's report, many states have updated, expanded, and improved their programs. These improvements have included expanded coverage to all employees, longer periods for filing claims, full medical benefits for occupational disease, and broader representation of labor's concerns as reflected in the composition of the state compensation boards. While the states' record of compliance with the commission's 19 essential recommendations has clearly shown improvement (an average compliance score of 12.7 out of 19.0 in 1992 compared with 6.8 in 1972), most gains (12.0) had already been achieved by 1980 (11). As of 1988, only some 30 states were in full compliance, and the commission's chairman expressed his continued disappointment, concluding "the quest for adequate workers' compensation benefits is far from over" (12).

In recent years, many states have further increased workers' compensation benefits. Nevertheless, workers' compensation benefits still vary significantly among the states. For instance, in 1995, the maximum state benefits for both temporary total disability and permanent total disability ranged from $817 in Iowa to $253 in Mississippi (13). In 29 jurisdictions, permanent total disability payments were at least 100% of the state's average wage, although in 10 states the payments were no more than 75% of the average wage (13). Although the differences among states in workers' compensation benefits paid to workers have narrowed significantly in recent years (as measured by benefits paid per 100,000 workers), it appears that the primary cause is a substantial reduction in benefits paid by the more generous states rather than an increase in benefits paid by the less generous states (14).

Since 1976, members of Congress have sought to renew the promise of fair and adequate coverage for occupational injury and disease through the imposition of nationwide standards. Characteristically, labor and employers have found themselves on opposite sides of this issue. Labor has vigorously supported nationwide standards as a way to remove the inequities and injustices of the current program, and employers have tended to believe that states can resolve the problems without national interference (9). In the past few years, after escalating costs and inadequate benefits, labor, management, and insurers have all been calling for major reforms (15).

In the past, consensus for a federal solution was reached only after a work-related disease became a pressing problem for industry, and then the solution typically involved the federal government's absorbing most of the compensation costs. The black lung program is a prominent example.

TRENDS AND COSTS IN COVERAGE

Although workers' compensation programs are supposed to provide coverage for all workers, the national commission found that 15% of the 1972 work force was not covered. By 1980 the percentage of uncovered workers declined to around 10% (16). Workers who are not covered include casual workers, some small business

workers, domestic workers, farm workers, self-employed workers, and state and local government workers.

It is estimated that in 1978 there were 7.8 million workers' compensation awards in the following categories:

Medical payments	6 million
Temporary disability benefits	1.3 million
Partial disability benefits	0.42 million
Permanent total disability benefits	2,600
Death benefits	7,800

Although the incidence of occupational injuries and illnesses originally declined after the passage of the Occupational Safety and Health (OSH) Act, from 10.9 cases per 100 workers in 1972 to 7.6 cases per 100 workers in 1983, it has edged up in recent years, to 8.9 cases per 100 workers in 1992 (17). Even more troubling is the fact that, per 100 workers, the rate of injuries involving time lost from work—injuries that are presumptively more severe—has increased by approximately 20% between 1972 and 1992, and the average time lost as a result of these injuries has steadily increased over the period, by approximately 65% in total (6,17).

The fastest growing category of occupational disease, by far, has been musculoskeletal problems resulting from cumulative or repetitive trauma, such as carpal tunnel syndrome (6). Of the 368,000 new cases of occupational disease reported by employers in 1991, some 61% were cumulative or repetitive trauma cases, up from 18% in 1981 (18). In that year, musculoskeletal disorders accounted for 43% of all occupational injuries and illnesses reported by the Bureau of Labor Statistics (18).

Ignoring musculoskeletal disorders, only 5% of occupational diseases are covered by workers' compensation programs (16), and occupational disease accounts for only about 1% of all workers' compensation claims (15).

The costs of workers' compensation have been escalating since the national commission's report and the subsequent state efforts to improve programs. In 1970, total costs were about $4.9 billion; by 1978, costs had escalated to $15.8 billion. This increase was due to inflation in medical costs as well as to improvements in coverage. At the same time that payments were increasing by more than threefold, workers' compensation costs as a percentage of payroll increased by 62%, from 1.11% to 1.80%; 60% of premiums were paid out in compensation, and 40% were used to pay overhead, legal fees, and to provide a cash surplus for insurance carriers (16).

After the mid-1980s workers' compensation insurance costs were driven by rising medical expenses rather than by rising cash benefits for workers (15). From 1990 to 1993 alone, the medical component of workers' compensation benefits increased from 40.9% of total workers' compensation benefits to 50% (6). By 1993, workers' compensation programs cost $57.3 billion, up from $25.1 billion in 1984, and the share of costs paid out in compensation had increased to 73% (19,20). Meanwhile, workers' compensation costs as a percentage of payroll rose to a peak of 2.40% in 1991 and then dipped back slightly to 2.30% in 1993 (20).

Theoretically, workers' compensation payments are intended to provide for two-thirds wage replacement in individual cases. In reality, however, they do not operate this way. Total lost income for occupational disease was estimated to be around $11.4 billion for 1978, and since at most 3% of the $15.8 billion awarded in 1978 was for work-related disease, nearly $11 billion of lost wages was not compensated by workers' compensation programs. If one considers all sources of compensation, only 40% of the earnings lost because of disease is compensated in individual cases, and only 5% of the compensation is provided by workers' compensation programs. The remainder comes from Social Security, welfare, pensions, veterans' benefits, and private insurance.

Work-related *injuries* are covered at a rate of about 60%, the majority of this compensation coming from workers' compensation programs (16). The total compensation from all sources for wages lost from work-related injuries averages around 60%. In 1980, for workers totally disabled by *disease,* the average lifetime compensation in individual cases was $9,700, which is 12.6% of the $77,000 they would normally have expected in adjusted lifetime earnings (16). In very few individual cases does the compensation meet the two-thirds wages goal, and the aggregate figures show an even more dismal picture.

Among the reasons for failure of state programs to cover occupational disease and injury adequately are these:

Payments are subject to low ceilings.
No cost-of-living increases are provided.
Payments for severe permanent disability are lower than those for temporary disability.
There are restrictions on medical care services and total amounts compensated.
Nonpecuniary losses, such as pain and suffering, are never compensated.
Many occupational diseases are not covered at all.
Ten percent of all workers are excluded from coverage.

An additional complicating factor is that compensation is based on the extent of disability as judged by physicians. This arrangement sets up a contest between the worker and employer to find physicians who will provide the most desired judgments.

PROBLEMS IN OCCUPATIONAL DISEASE COVERAGE

The problems are most severe for occupational disease coverage. Workers' compensation programs did not originally cover work-related diseases, and in 1972 only 41

states provided a reasonable range of coverage. Even today, 21 states limit occupational disease coverage to diseases that are peculiar to or characteristic of a worker's occupation, subject to review by the state workers' compensation boards.

Injuries resulting from accidents were the focus of the original workers' compensation systems. The "risk of the accident had to be peculiar to employment or not common to the general public" (21). When the states expanded their coverage to include occupational disease, they often changed the language so that the disease itself and not the risk of the disease was covered. As a result, in many cases, coverage is limited to diseases peculiar to the occupation and ordinary diseases of life are excluded, whatever their cause. This restriction effectively eliminates coverage for much occupationally related disease.

The burden of persuasion for establishing the connection between workplace conditions and disability is also more difficult to meet with occupational disease (8). Illness, particularly cancer and other chronic diseases, often develops many years after exposure and is not usually traceable to exposure in the workplace.

The distinctions between disease and accident compensation are striking. Sixty percent of all disease claims are initially denied, while only 10% of accident claims receive the same treatment (5,8). In addition, there is more than a 1-year average delay in any compensation for disease victims when it is awarded. Furthermore, work-related disease claims are typically burdened by significant litigation costs; legal assistance is required for 77% of all disease claims but only 24% of all injury claims. Compensation also varies; in 1980 survivor death benefits averaged $3,500 for disease victims and $57,500 for injury victims. Finally, workers' compensation claims are contested at an average rate of 60% for respiratory disease, 55% for heart ailments, and only 10% for accidents (5,11). The majority of uncontested compensated disease claims are for minor ailments or problems readily apparent as workplace induced (16).

As stated earlier, ordinary diseases of life are usually excluded from coverage. These include infectious diseases, many heart ailments, and many diseases with a work-related element. Work-related diseases are not generally covered by workers' compensation for several reasons. One reason is that very often occupational diseases have multiple causes, and it is therefore difficult to trace the cause to the workplace. A second reason is that many diseases have a long latency period, which tends to obscure the precise cause of the disease and the exact place of employment where critical exposure occurred. Problems of multiple causation and latency are compounded by statutes of limitations that apply to claims in most states (5). There are, in addition, jurisdictional problems with disease victims who have changed jobs during the period when the disease was developing. Moreover, many states have set minimum exposure requirements; a worker must be exposed for a specific time period before a disease can be attributed to an occupational cause (21). Finally, a major reason that work-related diseases are not covered by workers' compensation is that workers and medical personnel often do not recognize that a disease results from workplace exposure. They therefore neglect to investigate a particular workplace or occupation as a potential source of disease.

Cancer and respiratory tract disease compensation deficiencies continue to be a critical problem today. To obtain compensation for occupationally induced cancer, workers must prove that the disease is work related, and the standard of proof for this demonstration is difficult to meet (8). The courts have accepted some cancers as occupationally induced—mesothelioma caused by asbestos, leukemia caused by benzene, and angiosarcoma of the liver caused by vinyl chloride are three that are increasingly recognized—but other job-related cancers, such as asbestos-induced lung cancer, are less readily accepted, especially if the worker also happens to have been a smoker. In meeting the standard of proof for causation, animal models are not sufficient demonstration that a cancer is occupationally related. Only one of every 79 persons who dies of occupational cancer in the United States receives workers' compensation (8).

Even a nonneoplastic respiratory tract disease such as byssinosis (brown lung) is, for compensation purposes, barely recognized as occupationally related, even though studies of textile workers leave little doubt about the contribution of cotton-dust exposure to byssinosis.

Self-insured employers are subject to the largest losses from successful claims, and they contest at a higher rate than other employers. From the viewpoint of employers the stakes are high: permanent disability from occupational disease accounts for only 5% of the claims but 50% of the costs. To the extent that insurance carriers respond to pressure from employers to keep payouts and, hence, premiums at a minimum, occupational disease will continue to be excluded as much as possible. It is also true that insurance carriers (especially noncompetitive carriers) who operate more or less on a percentage-of-cash-flow basis do face a counterincentive to include occupational disease in order to increase profits. Why, then, is there so much resistance? The answer probably lies in the fact that the occupational disease problem is already large and threatens to become larger (given the history of exposure to harmful substances) and in the great uncertainty involved in setting premium payments for disease. The prospect of large, uncertain payouts in the future would discourage any substantial increase in scheduled payouts for diseases.

In sum, significant scientific, legal, and economic barriers exist to the incorporation of occupational disease into the workers' compensation system. Other avenues to make the victim whole must be pursued, at least as supplements to the currently inadequate state programs.

ALTERNATIVE COVERAGE FOR OCCUPATIONAL DISEASE

There are two additional means by which workers can obtain payments for general occupational disease. In 1980 the Social Security Disability Income Insurance Program provided 53% of the compensation to occupational respiratory disease victims, and it was their major provider of relief (16). Occupational disease costs this program about $2.2 billion annually, and 47% of all disease-afflicted workers received some form of compensation. Although Social Security compensation is low, it is substantially easier to obtain than workers' compensation: 83.6% of all claims are allowed on initial application (16). Nevertheless, workers often do encounter difficulties under the Social Security program, including 5-month delays in payment, restrictions on recency of employment, and 2-year delays in Medicare coverage.

The second means is third-party liability suits brought in the state and federal courts. These are suits brought against manufacturers of harmful substances that an employee uses in the workplace. Workers are generally prevented from suing their employers directly, unless the employer is also the manufacturer. Through this system, workers are able to bring suits against manufacturers or suppliers one step back in the process. Conversely, employers who purchased the harmful substances for use in the workplace may be able to sue manufacturers for the costs of employee compensation.

Although third-party suits are costly for employees, they are appealing because they provide compensation for lost wages, disfigurement, medical and legal expenses, and pain and suffering. On average, the possible awards are much higher than standard workers' compensation claims.

Product liability suits can be brought for three major causes: manufacturing defects, design defects, and inadequate warnings. To receive recovery, a worker must show an injury, a manufacturing or design defect, and a causal link between the two.

A manufacturer can use the following defenses in the negligence suit: contributory negligence, assumption of risk, and misuse of the product. For a suit brought under a breach of warranty, a manufacturer may use the assumption of risk and misuse of the product. However, in such cases, "defendants usually escape liability only when the plaintiff assumes the risk by voluntarily and unreasonably proceeding to encounter a known danger" (21).

At one time, product liability suits were the greatest concern to machine tool manufacturers and were confined to injury claims. Because of the reduction in third-party liability problems that would accompany national standards, machine tool manufacturers are now one of the few industrial groups that support national workers' compensation standards. The use of third-party liability suits in disease claims is well established in the asbestos exposure area and is now being tested in other areas of chemical exposure. The courts have been considering several issues with respect to worker suits: the producer's awareness of effects, the severity of effects, the user's assumption of risk, and the technological feasibility of instructions and warnings. Unfortunately, a number of factors also limit recovery under this system, including statutes of limitation and the expense and time involved in obtaining recovery through private legal action. These suits are most successful where the link between exposure to a harmful substance and occupational disease is acknowledged as a matter of science or medical knowledge. In cases where the link is weak or allegedly complicated by other possible causes, such as smoking or drinking, recovery in the courts meets the same obstacle it does in the workers' compensation system—the problem of causality. Advances in epidemiology, biologic markers (22), and improved diagnoses by physicians are essential to the recognition of occupational disease in both systems.

In addition to the aforementioned programs to provide payment to victims of occupational disease in general, systems may be designed for a specific disease. An example is the black lung compensation system enacted by Congress in 1977. This system operates as a no-fault mechanism to award those suffering from black lung with compensation and medical care in lieu of state workers' compensation benefits. This substance-by-substance approach arises after a problem has reached crisis magnitude, and it relies on a public bailout of the associated industries. While satisfying the social goal of compensating workers, it provides little incentive for prevention of future harm from new hazards.

PROSPECTS FOR THE FUTURE

Compensation for occupational disease will, unfortunately, continue to be a problem that is addressed inadequately by state workers' compensation systems. The Social Security system will probably continue to provide assistance to occupationally diseased workers. In terms of specific diseases, workers' compensation systems will never cover the myriad adverse health effects caused by exposure to chemicals in general. Minimum federal compensation standards would improve the situation for many workers, and private lawsuits may benefit others. However, by and large, since causality remains a difficult problem, most occupational diseases will, sadly, not be paid for by the employer, by the consumer of that employer's products, or by manufacturers of harmful substances (5). Instead, the public and the worker will continue to bear the burden. These considerations are one more reason why a strong federal regulatory effort to limit worker exposure to toxic substances is needed.

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