Workers' Compensation and the Prevention of Occupational Disease

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After some 17 years of experience in addressing the issue of occupational disease prevention and its relationship to the OSHA regulatory system, it can safely be concluded that regulation alone cannot adequately address or resolve the problem. Indeed, the sheer number and extent of workplace toxic exposures are such that OSHA regulation alone is simply inadequate to effectively reduce exposures to the point where disease can be prevented. Even if the policy difficulties of setting effective OSHA standards on the thousands of toxic substances in the workplace could be overcome, which is highly doubtful, the necessary enforcement and compliance mechanisms to implement the standards are not available. In these times of staggering budget deficits it is unrealistic to expect any Administration or Congress to make the kinds of budgetary commitments required to field an army of compliance officers and attendant legal, technical, and other personnel necessary for effective enforcement and implementation.

This is not to suggest, however, that the regulatory approach should be abandoned, for it is the front-line defense in reducing toxic exposures. Neither is it suggested that the current regulatory system cannot and should not be improved. Indeed, after nearly 8 years of summary neglect by the Reagan Administration, the OSHA/NIOSH regulatory regime is in shambles and in desperate need of rebuilding and restructuring. It needs more effective policy direction as well as an increased commitment of resources. Moreover, the Occupational Safety and Health Act itself probably needs to be revisited and undoubtedly changed to take into account all that has been learned about workplace health and safety since it was enacted in 1970. Even a casual survey of the technical, scientific, medical, economic, legal, and policy factors that have surfaced since passage of the Act inevitably leads to the conclusion that the statute should be reviewed and changed where necessary to take into consideration the experience of the last 17 years. Many of the assumptions on which the Act was initially based either are not valid today or do not fit the realities of the 1990s. I believe that it is time to review and reevaluate those assumptions and modernize the statute as necessary.

However, even if major positive changes can be made in the OSHA regulatory scheme, at least two additional policy tools need to be created to effectively deal with occupational disease prevention. The first is occupational disease risk notification, medical monitoring, and health promotion. Workers who have already been exposed to high levels of toxic substances and who are at high risk of latent occupational diseases need a federal program to identify, notify, and counsel them so as to either prevent the disease from occurring in the first place or diagnose it early enough for successful treatment. The regulatory system alone cannot help these workers, because it is predicated on prospective protection.

Because these previously exposed workers are already at high risk and may currently be carrying the latent disease "time bomb" in their bodies, it does them little good to confront a future workplace where the regulatory system has resulted in lower exposures. Although reduced exposures can have a positive effect in reducing the cumulative risk burden, what these high risk workers really need is the scientific and medical information necessary to protect themselves from disease through medical surveillance and health promotion. What is needed is the program mandated by the High Risk Occupational Disease Notification and Prevention Act of 1987 which has passed the U.S. House of Representatives and is currently pending before the U.S. Senate. The positive aspects of such a program are recognized not only by the labor movement and the public health community, but also by major segments of the business community such as the chemical, electronics, paint and coatings, and parts of the insurance and asbestos industries, all of whom are actively supporting passage of the legislation.

The second policy tool required as a critical supplement to the OSHA regulatory system is basic workers' compensation reform that allocates the total costs of occupational disease where it rightfully belongs—on the production of goods and services. For a whole host of reasons, some of which are outlined herein, employers, through the workers' compensation system, have not had to bear the costs of occupational disease and therefore have had no economic incentive to clean-up the workplace and reduce or eliminate toxic exposures. For all practical purposes the workers' compensation system simply does not compensate for occupational disease and never has.

Currently, the workers' compensation system compensates less than 10% of all occupational disease cases and most of these are relatively minor illnesses such as dermatitis. Of the 10% involving serious diseases, nearly all that are ultimately compensated must first be litigated over the basic question of compensability.

As originally conceived in the early 1900s, workers' compensation was to be a "no-fault" insurance program by which employers assumed financial responsibility for injuries to workers due to "personal injury by accident arising out of and in the course of employment." The idea was to move away from the legal problems of attempting to determine negligence and to simply provide certain benefits to workers and their families to overcome the economic hardships of work-related injuries and death. For the most part, the system was designed to compensate for traumatic injuries and death resulting from workplace accidents. Occupational disease, which theoretically is covered by workers' compensation programs, has, however, been effectively excluded from the system.

Part of the problem is that a number of state workers' compensation laws include what have been called "artificial barriers" to occupational disease compensation. These barriers include requirements that a compensable disease be "peculiar" to the workplace, or not an "ordinary disease of life;" or to be compensable a disease must first be listed on a specific schedule of diseases; or not be an infectious disease; or that disease claims must be filed within a restricted time period from the time of exposure rather than the onset of disease.[1]

Most of these artificial barriers have little or no relation to modern medical science which has concluded that most occupational diseases are multicausal in nature and have relatively long latency periods from the time of initial exposure to the actual manifestation of disease. Some asbestos-related diseases, for example, have latency periods as long as 25–30 years.

Even more basic than the artificial barriers, however, is what I have termed the "iron rule" of workers' compensation which I believe is the single, most

important legal factor barring compensation for occupational diseases.[2] As just indicated, the original no-fault concept was predicated on the qualifying notion that a worker must demonstrate that his injury/illness/death was due to a "personal injury by accident arising out of and in the course of employment." Although the "personal injury by accident" test has largely been removed from most state and federal compensation laws, the iron rule of workers' compensation remains "arising out of and in the course of employment."

For the most part, the "arising out of and in the course of employment" test has required the demonstration of a direct cause and effect relation between the injury/illness/death and the job before a worker can qualify for benefits. In most cases of traumatic injury or death, the cause and effect relation is clear; a worker loses a hand in a stamping machine, falls from a scaffold, or is killed in a grain elevator explosion. In each case the injury or death clearly arose out of and in the course of employment, and the worker is awarded workers' compensation benefits no matter who was at fault.

The matter becomes much more complicated, however, when the iron rule is juxtaposed against serious occupational diseases. For many of these diseases, such as work-related cancers, it is often difficult, if not impossible, to determine a specific cause and then link it specifically to a particular workplace exposure or set of exposures. Unlike traumatic injuries that are direct and immediate, many occupational diseases have long latency periods and are often multicausal in nature; therefore, it is often impossible to link a specific toxic exposure to a specific industrial substance and prove that it was the sole determining cause of the disease exclusive of any other factor or factors. As a result, most occupational diseases cannot meet the direct causal test and therefore fail the "arising out of and in the course of employment" requirement.

Over the years, the artificial barriers and the iron rule have combined to effectively deny workers access to benefits under workers' compensation, even when they are aware of the relation between toxic workplace exposures and their disease, which in many cases they are not.

This lack of information is another major obstacle to occupational disease compensation. Indeed, the overwhelming number of occupational disease cases never enter the workers' compensation system. In the first place, many workers are simply ignorant of the toxic exposure-disease relationship and therefore die believing that their lung, bladder, or brain cancer was an "act of God" or just plain bad luck. Moreover, even when they are aware of the linkage, workers do not have access to all the information they might need to make a case, especially the highly technical data on the toxicity of the substance, its known health effects, or their past exposure levels. Very often they do not even know the true chemical name of the substance to which they were exposed.

Although some of this information gap should be overcome through the recent OSHA Hazard Communication Standard as well as the High-Risk Notification legislation should it become law, progress under the best of circumstances will be slow. However, even with all the available data and information, workers are still confronted with worker compensation laws that make it difficult, if not impossible, to successfully pursue a workers' compensation claim. As stated earlier, nearly all workers' compensation claims for occupational disease must first be litigated over the basic question of compensability.

The first hurdle, of course, is the presence of artificial barriers included in many state laws. Thus, for example, if the worker has lung cancer—which is an "ordinary disease of life"—he has no claim in those states that bar compensation for such diseases no matter how much data he can muster to demonstrate a link

between the workplace and lung cancer. If the state has overly restrictive time limitations on filing disease claims, which a number of states do, then the worker is disqualified if his latent disease does not become manifest until after the filing deadline. In those states that bar compensation for infectious diseases, any health care worker that contracted AIDS because of contact with infected blood would be unable to qualify for compensation.

Even without the artificial barriers to compensation, which some states are beginning to eliminate, the iron rule of "arising out of and in the course of employment" remains the key issue. Because the multicausal nature of most occupational diseases makes it very difficult to prove an exclusive workplace cause and effect relationship, the burden of proof on the worker becomes overwhelming.

As a result, most lawyers are reluctant to accept workers' compensation disease cases on a contingency basis, because they get paid only if they win the case. Workers, therefore, are left with the unenviable option of paying a lawyer on a retainer to persue a claim that under the best of circumstances is difficult to win. This, plus the fact that most workers' compensation benefits are traditionally low and inadequate, places the worker in a very disadvantageous position. Indeed, most workers, given all these hurdles, simply do not bother with the workers' compensation option, thereby relieving the employer of any costs.

Rather than pursuing the workers' compensation route, many, if not most, diseased workers have turned to the public welfare system for a measure of economic relief, most notably the Social Security system including Social Security Disability, Supplemental Security Income, Medicaid, and Medicare. The House Committee on Education and Labor recently estimated that the cost of occupational disease to the Social Security system alone is some $5.4 billion annually. To this must be added another $1.7 to $4.3 billion in annual wage loss and other medical costs.[3] Thus, without counting such additional public costs as lost tax revenues, the direct costs of occupational disease to the federal government and workers are about $7.1 to $9.7 billion a year, which is nothing more than a direct public subsidy to American industry.

More recently, workers have begun turning to another source, the tort system, in an effort to obtain a measure of economic justice. Although the workers' compensation laws have traditionally barred workers from suing their employers for workplace injuries and illnesses by application of the so-called "exclusive remedy rule," workers have always been able to sue third parties who may have contributed to the injury or illness. More often than not, these "third parties" are product manufacturers who introduce a product into the workplace that caused or contributed to the harm. Most such product liability suits have been aimed at the manufacturer of industrial equipment that causes traumatic injuries or death, but recently workers have been successfully pursuing toxic torts directed at the manufacturer of toxic chemicals and other hazardous substances. Perhaps the most dramatic and successful toxic torts have involved asbestos and asbestos-related diseases, but as more becomes known of the relation between other toxic chemicals and diseases, these too are becoming the focus of work-related toxic torts.

For well over 15 years, ever since the report of the National Commission on State Workmens' Compensation Laws concluded that workers' compensation was "generally inadequate and inequitable," the labor movement has been seeking federal reform of workers' compensation.[4] Although a number of reform bills have been introduced in the United States Congress over this period, none has ever gone beyond the public hearing stage. Although the reform issue remains very complicated, involving a host of economic, legal, medical, scientific, and

public policy questions, the bottom line involves three basic and fundamental reforms: increased benefits, elimination of artificial barriers to disease compensation, and expansion of the iron rule of compensation, especially for occupational disease claims.

Traditionally, workers' compensation has provided three types of benefits: weekly wage replacement, medical care, and rehabilitation benefits. Of these, the weekly wage replacement benefits are by far the largest cost item and therefore present the greatest problem in terms of reform. Although workers' compensation is supposed to replace two thirds of an injured worker's weekly wage, every state has placed a maximum cap on what a worker can collect, which in most cases does not approximate the two-third level. Indeed, on average the weekly wage replacement benefits have traditionally been inadequate to meet the economic requirements of injured workers and their families. Moreover, wide disparities exist in the maximum benefits workers are entitled to, from a high of $1,108 a week in Alaska to a low of $140 a week in Mississippi, not including Puerto Rico which pays a weekly maximum of $31. At the beginning of 1987, 37 states (including the District of Columbia and Puerto Rico) paid maximum weekly benefits of less than $350 and only eight states paid over $400 a week.

To put all this into some perspective, at $350 a week, a totally disabled worker with a family to support can only collect $18,200 a year. In 14 states, the maximum benefit is $250 or less, or $13,000 a year, and of these 14 states, six pay a maximum of $200 a week or less, which is $10,400 a year. In Mississippi, a totally disabled worker can collect a maximum of $7,280 a year for himself and his family whether he needs it or not, and in Puerto Rico he can collect $1,612.[5]

There is simply no question that in the overwhelming number of cases, weekly wage replacement benefits are far too low to afford injured workers and their families anything approaching economic security or equity. Thus, we believe that at a minimum there should be a national standard that requires all states to pay wage replacement benefits at two thirds of the worker's weekly wage subject to a maximum of 200% of the average national weekly wage in manufacturing which last year was about $692 a week or $36,000 a year. This, of course, would apply only to the highest paid workers in the country. For the lowest paid, no matter what their actual weekly wage, we believe that economic justice demands a minimum payment of 50% of the average national weekly wage, which would be about $173 a week or about $9,000 a year. Most workers, of course, would fall somewhere in between.

In terms of artificial barriers to occupational disease compensation, the reform issue is simple. These barriers, which have little relation to modern medical science, need to be eliminated. It makes no sense to deny benefits to workers because their lung cancer, for example, is an "ordinary disease of life" whether or not it is related to the workplace. At a minimum, workers exposed to carcinogens that have been linked to lung and other common cancers should have the opportunity to demonstrate the linkage and be paid benefits if the relation can be proved. The same is true for other work-related diseases. The test should be work-relatedness, not some arbitrary determination that may or may not be related to the workplace.

With respect to reforming the iron rule of compensation, what is required is an expansion of the concept of "arising out of and in the course of employment." Rather than requiring workers to prove a direct cause and effect relation between exposure and disease, which is very difficult if not impossible, the test should be a demonstration of whether the exposure was a contributing "factor" to the disease. Thus, the question should not be "did the workplace *cause* the disease" but

rather "was the workplace a *factor in causing* the disease." In other words, rather than applying the Newtonian concepts of cause and effect to occupational disease compensation, what the modern industrial situation requires is the adoption of factor analysis for compensation purposes.

There is nothing new in the approach. As a matter of fact, it was incorporated into the first two workers' compensation reform bills introduced by then Senators Jacob Javits (R.-N.Y.) and Harrison Williams (D.-N.J.) in 1973 and 1975. The 1973 bill proposed to expand the iron rule by providing that "an injury (illness) shall be deemed to have arisen out or in the course of employment if *work-related factors were a contributing cause* of the injury (illness)." Although somewhat different, the 1975 bill held that "an injury (illness) shall be deemed to have arisen out of and in the course of employment if *work-related factors were a significant cause* of the injury (illness)."[6] Under either approach, all a worker would have to prove was that he was, in fact, exposed to the toxic substance, that the substance in question had been scientifically linked to the disease, and that the cumulative exposure was a contributing or significant factor in causing the disease.

To make this factor analysis concept fully operational, any reform must also include certain presumptions concerning exposure and disease. Working with Drs. Irving Selikoff, Philip Landrigan, and William Nicholson of Mt. Sinai Medical Center in New York, we have developed a set of worker population-based presumptions for occupational disease that can be characterized as the "30% rule."

Essentially the 30% rule states that a compensable occupational disease is one in which, through the use of epidemiologic and clinical studies, it can be demonstrated that a given worker population exposed to the substance in question exhibits at least a 30% increased incidence of the disease compared to a nonexposed population. In other words, when it can be scientifically shown that an exposed population of workers has a disease rate 30% greater than that of a nonexposed population, the disease in question would be deemed to be work related. The individual worker with the disease in question would then have to prove that he was a part of the exposed population and that his individual exposure was sufficient to have been a factor in causing his disease.[7]

To finally complete the reform of the iron rule, a third ingredient must be added to the factor analysis and 30% rule, which is a set of time-based exposure presumptions. In this respect, we believe any reform should include a formula that links a presumption of disease to a defined period of individual exposure. Thus, for example, using Selikoff's data for asbestos, it might be that a worker, depending on his job, would have to have had at least 5 years of asbestos exposure in a chemical plant in order to qualify for a presumption of lung cancer, or 15 years of exposure for a presumption of asbestos-related cancer of the larynx.[8] Each time-based exposure presumption for a specific disease could be established by regulations promulgated by the Department of Labor.

Should the traditional iron rule governing workers' compensation be reformed to include factor analysis, the 30% rule, and time-based exposure presumptions, it would dramatically expand what heretofore has been a very limited workers' compensation approach to occupational disease. Indeed, if properly formulated and institutionalized, such an expansion would go far in finally providing social and economic justice to the tens of thousands of occupational disease victims who have been effectively excluded from the workers' compensation system.

Moreover, by increasing workers' compensation benefits and eliminating the artificial barriers to occupational disease compensation, such reforms, by placing the entire burden on the production process to pay for occupational disease

compensation, would provide a powerful economic incentive to employers to reduce exposures and clean-up the workplace. As it is now, employers for all practical purposes are paying little or nothing for occupational disease and, in fact, are being subsidized by the public welfare system and workers themselves. The only current incentive for employers is the OSHA regulatory program which, after 17 years, has only been able to produce a relatively small handful of health standards governing some 20–25 toxic substances. In addition, at least for the last 8 years, the enforcement of these standards has been nearly nonexistent. I believe that without a properly reformed workers' compensation system that bears the full economic burden for work-related diseases, the ultimate prevention of these diseases will largely remain an unmet public goal.

NOTES AND REFERENCES

1. The artificial barriers to occupational compensation were first raised as a reform issue by Senator Harrison Williams when he introduced his 1975 Workers Compensation reform bill. They were also identified and analyzed in the *Report of the Interdepartmental Workers Compensation Task Force*, U.S. Department of Labor, 1977.
2. MALLINO, D. L. 1979. Policy Dimensions of Workers Compensation. A report prepared for the United Steelworkers of America and published as part of the "Hearings of the National Workers Compensation Standards Act of 1978," U.S. Senate, Committee on Labor and Human Resources, March–April, pp. 483–573.
3. U.S. House of Representatives, Committee on Education and Labor, Report on the High Risk Occupational Disease Notification and Prevention Act of 1987, pp. 7–8.
4. National Commission on State Workmens' Compensation Laws, Report of the National Commission on State Workmens' Compensation Laws, U.S. Department of Labor, 1972.
5. These data were compiled from annual AFL-CIO analysis of workers' compensation and unemployment insurance state laws. See AFL-CIO, "Workers Compensation and Unemployment Insurance Under State Laws January 1, 1987."
6. U.S. Senate, S. 2008 (1973) and S. 2018 (1975).
7. The 30% rule was incorporated into the "Occupational Disease Compensation Act of 1985" (H.R. 3090), introduced by Representative Pat Williams (D.-Montana), Section 15(b)(7).
8. The time-based presumptions were also incorporated into H.R. 3090, along with specific presumptions based on the Selikoff *et al.* data. See H.R. 3090, Section 6(c).