RESPONDING TO PRO PUBLICA

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[Author's Note: In 2015, Pro Publica published a series of reports critical of the nation's workers' compensation system. Those accounts were misrepresentative of the workers' compensation system and drew conclusions, based on either a misunderstanding of certain information or tarring with a broad brush based on several specific cases involving understandably sympathetic claimants who were clearly experiencing difficulties. At base, its criticism reflects long-standing policy disputes some have with the workers' compensation system extending back over 25 years. That is not to denigrate those points of view but to explain and to lend context to their arguments. That is what this narrative seeks to do, in a manner that is thoughtful, not inflammatory, and can serve as a basis for further debate about these policy differences.]

Abstract

ProPublica's criticisms of the state workers' compensation system over the past year are rooted in policy arguments extending back at least 25 years if not longer, to the 1972 report of the National Commission on State Workmen's Compensation Laws. The underlying argument concerns public policy differences surrounding the design of the benefit delivery system and the nature of "justice" owed the injured worker. Any consideration of the public policy at issue must be informed by best practices inherent in the management of disability and understanding that the system requires affordability for employers, *who pay one hundred percent of the costs*. There is always friction in balancing these multiple and sometimes conflicting interests; it is what makes workers' compensation the complex social insurance system it is.

ProPublica ignores context and history in its mischaracterization of law changes enacted in the late 1980s and early 1990s when the nation's workers' compensation system faced a financial crisis caused by excessive costs and inadequate rates. Many of these changes ProPublica mislabels as "benefit cuts" -- the most biased and misleading aspect of its work. Most of the legislative changes that ProPublica labels benefit reductions are, in fact, administrative changes which are neutral or benign to injured workers. Examples of these are: enacting or strengthening fee schedules, requiring the use of the AMA *Guides to the Evaluation of Permanent Impairment*, and modifying rules on self-insurance. Other law changes designated as "take-aways" can be regarded by more objective observers as reasonable and tested reforms designed to restore balance, eliminate unnecessary costs, protect injured workers from potentially unnecessary and dangerous medical treatment, and preserve the ability to continue providing workers' compensation benefits.

The report makes no effort to provide context for any of the reforms, nor to explain the policy justifications for implementing these reforms. The benefit cuts decried by the authors were motivated by employers who felt the system unfairly saddled them

with unsustainable costs and deterioration of the business climate relative to other jurisdictions.

ProPublica claims, erroneously, that so-called “benefit cuts” and compensation impediments have shifted costs from the workers’ compensation system to public programs, such as SSDI and Medicare. Studies and contrary analysis show these claims to be incorrect, yet ProPublica fails to take cognizance of them.

ProPublica claims that states are “cutting benefits” in a “race to the bottom.” States are all independent governing – and economic – units. They do “compete” on a broad array of social and economic policies, and the cost of workers’ compensation is a significant economic metric that may require attention from state officials. But as a practical matter, few of them are willing to alter their workers' compensation programs by taking an axe to protections for their constituents who are injured on the job in order to make workers' compensation coverage less costly. To the contrary, state officials responsible for public policy on workers' compensation have recognized that they need to act responsibly to preserve and maintain essential protections for their workforce by addressing specific problem areas rather than focusing on reducing benefit levels.

Those contending states are “racing to the bottom” really want is federal supervision of state workers’ compensation programs, a step that would not only eliminate the ability of states to act in accordance with their own judgments, of their economies and workforces, but would risks freezing states’ ability to act expeditiously and effectively without approval (explicit or implicit) from the federal government, miring the states in endless disputes with the federal government over the state’s authority.

In urging federal benefit standards, ProPublica completely mischaracterizes the historic relationship between state workers’ compensation and federal authority. They claim that “Congress *allows* each state to determine its own benefits . . .” [emphasis added]. This implies that somehow Congress should be *expected* to impose its will on state workers’ compensation programs. To infer that it is only through Congressional forbearance that for 100 years state workers’ compensation programs have existed independently of federal supervision says much about the mindset of ProPublica’s critique. Indeed, it is the ability of states to act relatively quickly – and not through Congressional forbearance -- that is the hallmark of the state-based workers’ compensation system.

Rather than “racing to the bottom,” it is far more accurate to say that the nation’s workers’ compensation system reflects the best of the federal system. States are able to calibrate policies that are aligned with their own economies and to adjust those policies relatively quickly when necessary. The federal system has often been described as 50 state laboratories, and that is an accurate description of the workers’ compensation system. None of the workers' compensation policy initiatives evolving over the past quarter of a century were directed by the federal government. All flowed from state legislatures, grappling with complex (and often conflicting) policy challenges, crafted to maintain balance in a social insurance program critical to the welfare of that

state's workers and employers and, ultimately, its economy. States are able to experiment, and continue doing so today. If a policy proves to be mistaken, that mistake is not a national mistake and can be corrected in due course. No state workers' compensation program is perfect. However, for the vast numbers of injured workers, it works as intended. Workers who get injured recover and return to productive lives. But, they never generate headlines.

All workers' compensation systems, like other social insurance programs, are imperfect, and there are times when good intentions still do not produce a positive result. Other social programs -- SSDI, Medicare, Veterans Benefits, and Medicaid -- are well known to have many controversial features and critics. One common problem with the above systems is that funding them from taxpayer revenues creates huge problems. ProPublica could find fertile ground in these programs for its future stories. They also could explore issues within workers' compensation that drive unnecessary costs and wasteful practices, such as physician dispensing of drugs, including harmful opioids, and unnecessary dispute that add friction costs to the workers' compensation system with little to no benefit for injured workers.

Rather than "journalism by horror story," a fairer approach would have explored the underlying policy differences that inform workers' compensation debates and present a balanced discussion of those issues. It is unfortunate ProPublica could not see, or chose to ignore, the positive contribution workers' compensation makes daily to our social insurance safety net. It's an opportunity missed.

Last year, ProPublica and National Public Radio (NPR) issued a critical report of the nation's workers' compensation system. The report, released March 4, 2015, is entitled "*The Demolition of Workers' Comp.*" It asserts that "Over the past decade states have slashed workers' compensation benefits, denying injured workers help when they needed it most, and shifted the costs of workplace accidents to taxpayers." Reportedly, their survey covered over 30 states over a 12-year period (2002-2014). They concluded that the majority of states enacted cuts in workers' compensation benefits or erected impediments to injured workers receiving benefits.

ProPublica/NPR was not balanced with their coverage. Their report mischaracterizes and distorts changes states have made to their state systems. The report cites heart-rending accounts of two seriously injured workers who, based on the information reported, were treated quite poorly by the workers' compensation system. We do not dismiss them nor do we minimize the real suffering these individuals have endured from their injuries. If they were common, workers' compensation would face a serious problem and would be widely attacked in state legislatures. However, these cases are aberrational and present only one side of the story. The authors attempt to use these hand-picked cases to discredit the entire workers' compensation system. Since the initial release, ProPublica has published numerous follow-up reports, all of which also distort, or at least exhibit an uninformed understanding of, the workers'

compensation system. This article will present a balanced, alternative view of the system.

To prove their assertion of "slashed" state benefits, the authors' offer a visual representation of their characterization of changes in state laws. The states listed on the chart embedded in ProPublica's March 4 electronic document release represent a simplistic and often misleading account of the law changes to individual state systems in the arbitrarily selected time period, 2002-2014. Instead of starting with a clean slate in 2002 (the first year reforms are analyzed), the chart makes unwarranted and inconsistently applied value judgments about the starting point of each state through use of color shadings. Unfortunately, their evaluation was done without an indication of which pre-2002 factors contributed to those judgments. As a result, more than 30 states *began* the period studied color coded with some pink or red shading in order to create a significant visual and conceptual bias against the perceived fairness of state workers' compensation systems. A good example is Indiana, which starts in 2002 with a shade of red (without any explanation) that remains constant through 2013. Admittedly, Indiana has been recognized by experts as having low benefits, but their laws have been like this well before 2002, consistent with its relatively lower cost of living and business environment. Hence, the color code should have been white, signifying no change. Another inherent visual bias is the fact that, once an alleged benefit reduction is noted in a given year, the negative shading remains in place until the next reform, which might be years down the line or never. These practices do readers a disservice by literally coloring their perceptions instead of focusing on the substance of the reforms.

Another anomaly is Illinois, which is listed as a state that "stayed the same." Yet, click on Illinois, and it pops up green, as a state that raised benefits. This is inconsistent with ProPublica's supporting narrative which includes changes that should place it among the "benefit cut" states, colored salmon-red. Yes, it did raise benefits – in 2005, a decade ago! -- but Illinois subsequently adopted many changes that ProPublica criticizes in other states, such as adopting a medical fee schedule, "limiting workers' ability to choose their own doctors," "raising the burden of proof on workers' claims," "capping wage loss benefits for workers who return to work at a lower salary at age 67 or 5 years after the injury, whichever comes later," "limited compensation for carpal tunnel syndrome caused by repetitive stress," and "required new American Medical Association guidelines be used for determining disability awards, which studies show significantly lowers ratings used for compensation." Yet, Illinois is described as "stayed the same" or "raised benefits" during the study period. This is only one example of their reasoning.

It is ProPublica's mischaracterization of law changes that constitutes the most biased and misleading aspect of its work. Most of the legislative changes that ProPublica labels benefit reductions are, in fact, administrative changes which are neutral or benign to injured workers. Examples of these are: enacting or strengthening fee schedules, requiring the use of the AMA *Guides to the Evaluation of Permanent Impairment*, and modifying rules on self-insurance. Other law changes designated as

"take-aways" can be regarded by more objective observers as reasonable and tested reforms designed to restore balance, eliminate unnecessary costs, protect injured workers from potentially unnecessary and dangerous medical treatment, and preserve the ability to continue providing workers' compensation benefits.

The report makes no effort to provide context for any of the reforms. The benefit cuts decried by the authors were motivated by employers who felt the system unfairly saddled them with unsustainable costs and deterioration of the business climate relative to other jurisdictions.

The tone of ProPublica/NPR's report represents an offensive by those with serious policy differences with the workers' compensation system, a policy argument extending back at least 25 years. In that sense, the criticism is nothing new. It is serious and requiring a response, but a response that lends context to the policy changes to which ProPublica takes exception. The underlying argument concerns public policy differences surrounding the design of the benefit delivery system and the nature of "justice" owed the injured worker. Any consideration of the public policy at issue must be informed by best practices inherent in the management of disability and understanding that the system requires affordability for employers, *who pay one hundred percent of the costs*. There is always friction in balancing these multiple and sometimes conflicting interests; it is what makes workers' compensation the complex social insurance system it is.

The present attack on state laws is rooted in the 1972 report of the National Commission on State Workmen's Compensation Laws. This Presidential Commission, created as part of the Occupational Safety & Health Act of 1970, was tasked with examining the nation's workers' compensation laws. The Commission made 84 recommendations, 19 of which it deemed to be "essential," and it called on the states to immediately amend their laws to incorporate the 19 "essential" recommendations. The Commission also stated that failure to meet this goal in just a couple of years should justify Congress enacting federal standards for state workers' compensation laws. Bills to establish federal standards were introduced immediately, and hearings continued for the rest of the decade, but no bill was approved by either Senate or House committees of jurisdiction. In the interim, states responded, at a varying pace, to implement many of the so-called "essential recommendations." States did so because there was a broad consensus, including within the employer community, that workers' compensation laws and basic benefit levels needed to be improved.

Contrary to ProPublica's criticisms, many of the Commission's "essential" recommendations were adopted and remain an accepted part of state law today, including lifetime medical treatment and more generous wage replacement benefits, the maxima of which are indexed annually to increases in the state's average weekly wage in most states. A 2004 report by the U.S. Department of Labor looked at state compliance with the 19 essential recommendations. They found: "The possible total score is 988, or 19 recommendations multiplied by 52 jurisdictions for which data were available. The current total of 667.25 represents 67.54% of the possible total."[1] It is

worth noting that even if the states had achieved a perfect score in complying with the 19 essential recommendations it would have only a miniscule effect on the criticisms cited by ProPublica. None of the 19 recommendations touches on causation or admissibility of claims – the authors' main indictment of state law trends. None specified how appropriate and necessary medical care should be defined, which is the basis for doleful cases reported in the study.

The Commission recognized that the affordability of workers' compensation would be impacted by its recommendations to expand coverage and increase benefits and that controls were also necessary to maintain affordability for employers. Yet, by its own admission, the Commission left important work undone on these controls, on which there was no agreement. As a result, the benefit expansions proved to be far more costly than estimated. Of special relevance is that the Commission failed to address how benefits should be determined for permanent partial disability (PPD). Why? Because determining fair and administratively workable PPD compensation is one of the most intractable problems in workers' compensation, and has been so from the advent of state workers' compensation.

Fortunately less than one-tenth of one percent of all claims result in permanent total disability, as most permanent impairments are partial in nature, and most injuries do not result in any permanent impairment. But, this was a critical omission, because most of the expense of any state workers' compensation system is associated with claims for PPD. There never has been a consensus in the long history of the workers' compensation system over how PPD benefits should be determined, whether based principally on physical impairment or on notions of lost wage earning capacity or other tests. The design of a state's PPD system has significant implications for policies underlying disability management, including limiting unnecessary medical treatment, promoting return-to-work, and reducing friction costs caused by dispute and litigation. Even today there is a huge range of academic and public policy analysis that disagrees on the best PPD compensation scheme.

By the late 1980s, many state workers' compensation systems faced a financial crisis. Costs had exploded, insurance rates necessary to finance this ever-more-costly system remained inadequate, and benefits in many cases were unpredictable, making the program nearly uninsurable. The result was a withdrawal of insurers from voluntary insurance markets (complete withdrawal from a state or vastly tightened underwriting) and a consequent ballooning of involuntary coverage ("residual markets"). Employers sought coverage through state-authorized assigned risk pools or state funds -- state-sponsored insurers required by law to accept all risks. For assigned risk pools, the same insurers who provided coverage in the voluntary market were also responsible for any financial losses in these residual market pools, where rates were even more inadequate than in the voluntary market. A few states experienced an insurance death spiral, with the effective evaporation of any voluntary market. The residual market deficit

[1]See Glenn Whittington, U.S. Department of Labor, covering laws in effect January 2004, found at; http://workerscompresources.com/wp-content/uploads/2012/11/DOL-Jan-2004-Entire-Compliance-Matrix.pdf

in 1989 in Texas alone was half a billion dollars. Insurers were required to pay that deficit in an assessment before writing another dollar of coverage in the voluntary market. This assessment drove the largest workers' compensation insurer in the state into insolvency. Insurer insolvency was a nationwide problem. This sad episode in the history of workers' compensation was the result of well-meaning impulses -- and a blind eye by state governments to the fiscal and benefit delivery consequences of their largesse.

Employers and insurers worked with state legislatures and governors – Republican and Democratic -- to financially rebalance their state systems, reducing costs by addressing the systemic cost-drivers and deregulating insurance pricing. This undertaking was difficult, and many changes were controversial. Among the controversies was how to pay for years of unfunded benefits. Reforms were challenged in many states as unconstitutional, but by the mid-1990s, they ultimately were upheld in all states.

The backlash is still felt today from this era of an intensive but successful effort to save the nation's workers' compensation system. Polices adopted then, many of them extended in the years since, are the foundation for ProPublica's criticism of the workers' compensation system. Despite charges to the contrary, these changes did not involve benefit "cuts," at least in the majority of states and for the majority of injured workers. Surely no one then receiving a benefit ever had that benefit reduced. Benefit maxima in a few states, all in the northeast, *were* reduced, but to the level prevailing throughout the rest of the country (100 percent of the state average weekly wage), while in other states cost saving reforms allowed increases in the maximum benefit. In 1991, Massachusetts reduced its indemnity benefit from two-thirds of a worker's average weekly wage to 60 percent, as part of a comprehensive reform to reduce costs and improve insurability. That reform was contentious, but the reduction to 60 percent, which was agreed to by organized labor, reflected that tax-free workers' compensation benefits in Massachusetts effectively replaced a larger percentage of pre-injury net pay in this high-tax jurisdiction. Other common state law adjustments addressed the maximum duration of TTD and the coverage for some subjective injuries. Lawmakers were persuaded that some claiming behaviors needed to be controlled.

Objections then and now concern a disagreement over policies adopted to carry out other objectives of the workers' compensation system – to improve medical treatment, promote return-to-work, reduce dispute and litigation, and retain overall affordability. What are these policies?

Using impairment as a proxy for disability: There has been a general trend over the past 25 years to adopt permanent partial disability systems based on more objective criteria of disability by using physical impairment as a baseline. This trend began in the late-1980s and early 1990s, as states grappled with the unsustainable costs of their workers' compensation systems. In this respect, they picked up where the National Commission left off, in its inability to address how permanent partial disability should be compensated. This approach supplants the more subjective methodology of lost wage

earning capacity typical among the states. Estimating future wage loss caused by a work injury is inherently speculative, expensive and highly variable, leading to dispute and litigation. Although a determination of lost earning capacity may provide a benefit that is theoretically more tailored to a specific worker, it is a reasonable and responsible policy decision to replace it with an approach that is socially balanced, more predictable and less costly and subjective; an approach that allows calculation of the benefits without the expensive litigation and delay, and significant "friction costs," inherent in a more subjective construct. The analogy is that of buying a suit – a custom-made suit from a tailor fits each individual perfectly but is very expensive, whereas a suit off the rack is much less expensive but fits most people reasonably well, and more people can afford to buy suits. To extend the analogy, an impairment formula may allow a significantly less costly compensation system as a whole at a given benefit level.

Typically, an impairment-based approach employs the use of an impairment guide, usually the American Medical Association *Guides to the Evaluation of Permanent Impairment ("*AMA *Guides")*, of which the 6th edition is the most recent. The AMA *Guides* are used in all but four or five states, and their virtual universality and completeness make them a useful tool in evaluating anatomical impairment on a more uniform basis. Some states have used the *Guides*' rating as a baseline for determining PPD and in paying benefits. There is controversy over this approach because the AMA itself has discouraged their use for purposes other than simply measuring physical impairment, but states have the inherent authority to make a policy decision on how the *Guides* are deployed.

The objection to the AMA *Guides* among some workers' compensation practitioners is at its core an objection to using physical impairment as a proxy measuring the degree of disability in evaluating and ascertaining permanency, from which a benefit is determined. Furthermore, ProPublica's criticism of the 6th *Edition* is inaccurate, based on studies by the AMA itself that have shown little aggregate difference between average rating between the 6th and 5th editions. In fact, the *6th Edition* allows ratings for conditions that were not ratable in earlier editions. Specifically there now are ratings available for conditions largely based on symptoms with limited objective clinical findings. Ratings are now allowed for tendonitis, epicondylitis, muscular low back or neck pain and migraine headache. All these conditions result in ratings of a maximum of one to three percent. As a result, there may be an increase in the number of ratings at the very low end of the rating spectrum. In response to ProPublica's assertion that studies have shown the 6th *Edition* reduces benefits, the only study of which I am aware was roundly criticized by the AMA for its "significant conceptual and methodological flaws . . . "[2]

The use of impairment as a proxy for disability is inherent in states' use of disability schedules, applicable to the loss, or loss of use, of limbs and anatomical systems. In a follow-up report (*How Much is Your Arm Worth? Depends on Where You Work*, March 5, 2015) ProPublica cites the wide variation among the states in benefits payable through disability schedules as a "disparity [that] grimly illustrates the

[2] *AMA Guides Newsletter*, Rondinelli, et. al, Nov/Dec. 2012, p. 6.

geographic lottery that governs compensation for workplace injuries in America. Congress allows each state to determine its own benefits, with no federal minimums, so workers who live across state lines from each other can experience entirely different outcomes for identical injuries."

Since the advent of workers' compensation, most states have used a statutory schedule of benefits for permanent loss or loss of use of various extremities. A schedule is an impairment-based formula, and workers with injuries listed on the schedule are compensated based on a percentage of the statutory level even when there is no subsequent loss of earnings. In this sense, at least initially, they were meant to be a rough proxy for expected income loss from the injury and were also intended to make it easy to calculate the amount of compensation due for common permanent injuries. Ease of administration and certainty of outcome were the controlling factors.

Although ProPublica cites interstate disparities of scheduled awards as another illustration of the inequities of the state-based workers' compensation system, a state's injury schedule is but one aspect of a comprehensive disability system that is a matrix of interwoven policies affecting the ability to effectively manage disability. ProPublica would have been more balanced by also discussing the higher costs associated with unscheduled PPD than its narrative focusing on "inequities" surrounding scheduled PPD. Unscheduled PPD can drive medical costs, dispute, litigation, and delay return to work. All this increases cost to insurers and causes disruption in the lives and economic fortunes of disabled workers.

Still, policymakers should be concerned that significant multi-state disparities in scheduled awards can generate public criticism that, whether misrepresentative or not, can impugn the credibility of this critically important social insurance system. States could be well-served taking a fresh look at their schedules to assure they are reasonable and consistent with similar cost environments in their region.

Some states have agreed with critics that schedules may produce inconsistent levels of benefits for people with similar degrees of disability. Instead, they have repealed their schedules in favor of a system measuring impairment to the "whole person," which is less arbitrary and more consistent than the scheduled injury approach. Other states that have schedules allow payment of benefits in excess of the scheduled amount when an injured worker can show that the degree of disability is greater than the schedule assumes, in some cases paying the scheduled amount as an additional benefit on top of benefits for unscheduled PPD. Some states also pay for permanent total disability (PTD) on top of a scheduled PPD award. So, there are circumstances in a number of states where what is paid as a scheduled permanency benefit is not exclusive.

Finally, ProPublica mischaracterizes the historic relationship between state workers' compensation and federal authority. They claim that "Congress *allows* each state to determine its own benefits . . ." [emphasis added]. This implies that somehow Congress should be *expected* to impose its will on state workers' compensation

programs. To infer that it is only through Congressional forbearance that for 100 years state workers' compensation programs have existed independently of federal supervision says much about the mindset of ProPublica's critique. Indeed, it is the ability of states to act relatively quickly – and not through Congressional forbearance -- that is the hallmark of the state-based workers' compensation system.

Enhancing authority to provide high quality medical treatment by providing treatment through medical networks: The objective is to ensure better medical care, improve coordination of medical treatment, eliminate unnecessary care, and reduce the level of dispute over treatment. A minority of states allows injured workers wide latitude in choosing their physician, and a growing majority of states places some reasonable limits on that choice. Typically, state laws restricting worker choice permit workers to select a treating physician from a panel or from a network provided by the employer or its insurer and, in this respect, workers' compensation emulates the group health system. A growing body of research has shown beneficial results from enhanced employer/insurer authority, with the same worker medical outcomes, but with improved return to work and generally lower costs overall. ProPublica's criticism of this improvement echoes that of some injured worker representatives who would rather direct the injured worker to a physician of their own choosing ("doctor shopping").

Establishing medical fee schedules: All but five states now use fee schedules as a benchmark control of unit pricing of medical services. Many fee schedules reimburse based on a multiple of the Medicare rate. Fee schedules are another tool in the disability management toolbox. They alone are not a silver bullet, but when used in conjunction with treatment guidelines and other utilization controls, they can be an effective means of reining in escalating medical costs. ProPublica erroneously equates adoption of medical fee schedules as "benefit cuts" or impediments to receiving benefits. This characterization is inaccurate. Theoretically, that claim might have some merit if a fee schedule were set so low that it impeded access to medical treatment. However, in the almost 25 years of medical fee schedules, there has not been a single instance of a state experiencing a systemic access-to-care problem. That does not mean that states have not raised their fee schedules based on reports that providers were requiring higher reimbursements to treat injured workers, as was the case in Florida several years ago. However, paying more than a fee schedule permits, in order to secure appropriate care, shows that a market will respond, even where a fee schedule may be perceived as too low, to ensure a fee schedule does not operate as a barrier to workers receiving necessary treatment. Fee schedules cap reimbursements in the absence of an agreement to pay otherwise, more or less.

Finally, this is not only the experience of insurers but of workers' compensation agencies themselves, many of which are required by law to monitor access.

Establishing evidence-based treatment guidelines: Several states have adopted evidence-based treatment guidelines to better define the parameters of acceptable medical treatment. Workers' compensation obligates employers to provide all medical treatment "reasonable and necessary" to heal the worker and enable return to work as

expeditiously as possible. Under workers' compensation, treatment is covered without arbitrary dollar and/or duration limits commonly found in group health plans and is provided at no cost to the worker – there are no demand-side controls prevalent in group health. Therefore, workers' compensation has an embedded demand side bias in favor of more medical treatment. On the supply side, workers' compensation is a more generous payer than group health, and much more generous than Medicare and Medicaid. For this reason, providers have a financial incentive to engage in treatments that would otherwise be limited by non-workers' compensation payers, thus necessitating a greater reliance on regulatory controls to avoid unnecessary treatment (and cost).

> Evidence-based medicine focuses upon the need for health care providers to rely upon a critical appraisal of available scientific evidence rather than clinical opinion or anecdotal reports in reaching decisions regarding diagnosis, treatment, causation, and other aspects of health care decision–making. This mandates that information regarding health outcomes in study populations or experimental groups be extracted from the medical literature, after which it can be analyzed, synthesized, and applied to the care of individual patients or used as the basis for guidelines.[3]

Evidence-based medicine also has been described as the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients," which required "integrating individual clinical expertise with the best available clinical evidence from systematic research."[4]

Simply put, treatment based on evidence-based medicine is using the highest quality medicine for treating injured workers. When combined with appropriate tools governing utilization review and incorporated into an adjudicatory mechanism that is deferential to treatment within the guidelines, the use of evidence-based medicine can not only deliver higher quality medical treatment but also avoids unnecessary treatment that is wasteful, costly, and may be dangerous (e.g., over-prescription of opioids). [5]

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[3]Genovese; IMX Medical Management; Statement, Feb. 6, 2006.

[4]Genovese, quoting Sackett (Sackett DL, Rosenberg WMC, Muir Gray JA, Richardson WS; "Evidence based medicine: what it is and what it isn't"; BMJ 1996;312:71-2.).

[5]The California Workers' Compensation Institute cites illustrations discovered in its study sample of 2014 Independent Medical Review (IMR) cases where the process affirmatively prevented inappropriate and potentially harmful treatment:

> "Example 1:
> The physician proposed administering Propofol to a patient during an epidural injection because they get "anxious." Propofol is typically used during major surgeries or ventilator placement.
>
> "Example 2:
> The proposal was to fuse every vertebra from the pelvis to the middle back (7-levels) in a 76-year old patient. The request was denied because there was no documentation of a

Critics of evidence-based medicine and utilization review fear necessary care is denied to injured workers. An extensive analysis of recent and far-reaching reforms of the California system has shown this concern to be false. In fact, in an overwhelming percentage of cases (over 95%) medical treatment is provided as requested. California's approach adds another step to treatment review, called Independent Medical Review (IMR), in which workers' treatment is reviewed by the same professionals who are tasked with reviewing group health claims. Decisions are accorded wide deference, and appeals to the Workers' Compensation Appeals Board (WCAB) are limited. This approach allows medical professionals to make medical treatment decisions, with greater weight given to medical professionals reviewing appeals of medical treatment. What adversaries really object to is an approach that limits the ability of lawyers and judges to second guess medical professionals' decisions. More on California follows below.

Independent Medical Examinations (IMEs)

The same thread runs through ProPublica's critical commentary about "IMEs" – independent medical exams. Purportedly they are being abused by employers to deny appropriate medical treatment. This claim is misleading, surely to the extent it reflects a systemic practice. Furthermore, IMEs are criticized as lacking medical validity because they may be done without examining the worker-patient. That claim is also misleading, if not incorrect.

What Pro Publica characterizes pejoratively as "IMEs" really describes multiple types of review, depending on the purpose. Generally, there are three levels. The most

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lesion, neural compromise, or limitations due to radiating leg pain, no evidence of prior conservative treatment, and no clinical findings supporting the procedure.

"Example 3:
One IMR determination letter addressed requests for Oxycodone and Ambien prescriptions, a left knee MRI, and an MRI of the right shoulder. The IMR physician took issue with each of these requests:

- The treating physician had requested a higher dose of Oxycodone even though the patient had been on opioids since 2012 and there was documented addiction;
- Ambien was requested even though there was documentation that when the patient had taken it in the past it was ineffective; and
- Shoulder and knee MRIs were requested even though there was no evidence of shoulder or knee pain or other symptoms.

"Had the UR/IMR process not been in place, this patient, who had already been subjected to multiple failed back surgeries and become addicted to opioids would have been prescribed even higher dosages of Oxycodone, combined with ineffective sedatives, and been subjected to unnecessary scans of areas where there was no evidence of a serious underlying condition requiring treatment." *Independent Medical Review Outcomes in California Workers' Compensation*; CWCI Research Update; April 2015; pp. 21-22].

intensive level is a true independent medical exam, which generally involves a physical exam. The least intensive level is utilization review; the second level is a comprehensive records review. Neither of these last two involves – nor should reasonably be expected to involve -- an additional physical examination of the patient, except in extraordinary circumstances.

A. Levels of Medical Treatment Review

(1) Independent Medical Examination (Level One)

True IMEs should always involve a hands-on examination of a patient. They are used for a variety of reasons, including but not limited to:

- Evaluation of current status of an injured worker with regard to fitness to work or recovery from injury;
- Assessment of impairment level for determination of permanent partial disability;
- Evaluation of a patient regarding the need for a specific medical procedure or service (e.g., spine surgery, ongoing physical therapy or chiropractic treatment); and
- Evaluation of possible pre-existing conditions, for apportionment or second injury fund qualification.

So, regardless of how the review is labeled, a *bona fide* “IME” normally is a physical examination of the patient.

(2) Comprehensive Records Review (Level Two)

In this instance a reviewing physician (independent from the employer/insurer and usually a specialist) is asked to review the “entire” (or at least a substantial portion of the) clinical record on a claim. This review is usually requested by the carrier when a more comprehensive assessment of a claim is desired. The issue could be with regard to causation, apportionment or some other claim-related reason. Other reasons could be to assess earlier response to treatment, drug history or other historical questions regarding the claim. Rarely are records reviewed after the death of an injured worker. A hands-on examination is not performed. This type of review is used much less often than an IME.

(3) Utilization Review (Level Three)

Utilization review (UR), as defined by the Institute of Medicine (IOM), is "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision." These techniques are accepted as a necessary part of the group health system and are equally if not more important for workers' compensation cost management because, as noted above, there

is no patient cost sharing as used to help manage group health costs. States and workers' compensation payors have strived to provide a fair, fast, efficient and medically efficacious system to conduct reviews of workers' compensation claims, including an appeals mechanism via independent medical review to reconsider a UR determination when the injured worker challenges a determination modifying or denying proposed treatment.

Peer review is a usual part of utilization review when a carrier cannot immediately approve a requested medical service, usually because the requested service is outside of treatment guidelines or meets some state specific review criteria, (e.g., all in-patient hospital requests). In such cases, the carrier sends the medical service request and supporting medical documentation to a medically qualified physician reviewer. The peer reviews the medical documentation provided and then contacts the requesting provider in an effort to better understand the request and attempt to reach agreement with the treating provider regarding the treatment course for the patient. The outcomes are approval as requested, negotiated or partial approval, or denial of the requested medical service.

The contention that UR and appeals from UR determinations are objectionable because reviews normally are conducted without a further physical exam is misplaced. By the time treatment is referred for UR, the injured worker has had a physical exam at least once, probably multiple times, and perhaps as well had a chance to change physicians. The issue at UR is whether past or future treatment is consistent with established guidelines and, if not, whether there is a medically sound basis for deviating from them. As such, the review, and appeal, if any, generally does not require any further physical examination. In addition, this form of review is consistent with almost all group health managed care programs.

B. IME's and California's Practice

Subsequent to its initial two reports, ProPublica published several follow-up releases, two of which reprise its previous criticism of the California system for a final Independent Medical Review (IMR) process that it says does not entail an examination of the patient. In one of these reports, ProPublica states:

> The 2012 law removed judges from the handling of medical disputes and put them in the hands of independent medical reviewers — outside doctors hired by a state contractor who make decisions based on records but never examine injured workers.[6]

While its characterization is literally correct, it is misleading in suggesting that injured workers disputing their treatment are unable to have a physical examination.

[6] ProPublica, *California Announces Audit of Insurance Company That Took Away Home Health Aide*, March 16, 2015).

Under California's Workers' Compensation Act, there are multiple reviews of medical determinations, depending on the stage of review and the circumstances. There are different procedures depending on whether the injured worker or insurer is the party disputing medical treatment, or whether the dispute is over medical treatment or other issues (e.g., whether the injured worker's condition is permanent and stationary for purposes of determining permanent disability benefits, the need for future medical treatment, temporary disability status, existence and extent of permanent disability, and ability to return to work). Nevertheless, in most of those circumstances, the injured worker has an opportunity for a review based on a physical examination. With respect to treatment, the injured worker had opportunity for multiple exams prior to submission of the treatment recommendation to UR, and it is medically appropriate for further review of treatment to be based on medical records, so that the decision on the course of treatment can be expedited.

Although the UR review is typically a records review, the reviewer can request an additional examination or test (Rule 9792.9.1(f)(1)(B)). The reviewer can also request a specialized consultation and review of medical information by an expert reviewer (Rule 9792.9.1(f)(1)(C)). UR determinations, based on the Medical Treatment Utilization Schedule (MTUS), are intended to reflect principles of evidence-based medicine, to ensure workers receive the most effective treatment. That is a far different picture than ProPublica paints.

California's workers' compensation IMR – which is similar in form and function to the Texas Workers' Compensation System -- is another layer of medical review beyond the UR review, giving an injured worker – and only the injured worker (or the requesting physician, or a representative on the injured worker's behalf) -- the right to contest a UR determination through a supplemental review by medical professionals instead of workers' compensation judges. This final (IMR) review, which ProPublica finds so objectionable, because it does not entail another examination of the injured worker, is nearly identical to the process used by the California Department of Managed Care for group health claims in California, and on which the 2012 reforms were modeled.

ProPublica also finds California's IMR process objectionable, because there is a limited right to appeal an IMR determination to the Workers' Compensation Appeals Board. In this, ProPublica's complaints echo those of the California injured worker bar, which has sought to undermine the 2012 reforms by preserving a role for lawyers and judges to second-guess medical decisions. However, it makes more sense – and results in more consistent medical outcomes -- to have qualified physicians making this medical treatment determination quickly and professionally instead of relying on a slow and costly appeal to judges who have no medical expertise. Extensive research last year by the California Workers' Compensation Institute found that adding yet another exam during the IMR process would not result in improved outcomes: The overwhelming percentage of treatment is approved. But doing so would lead to more disputes needing to be resolved by judges, not medical professionals, with unjustified added costs and more delays – the very problems California's policymakers are striving to prevent with the 2012 reforms.

California's treatment review process was further validated with CWCI's April 27, 2015, release of its updated analysis of treatment review rules implemented with the 2012 reform law.[7]

Strengthening compensability rules: In response to judicial interpretations that expanded workers' compensation compensability to cover health conditions that may have little or no demonstrable work causation, several states have clarified the standard for compensability by requiring that the work injury be the "major contributing cause" or the "predominant cause" or "a substantial cause" of the injury or the aggravation of a pre-existing injury. ProPublica characterizes such reforms as a benefit cut (or impediment to awarding benefits). That, too, is an inaccurate characterization and ignores that historically, workers' compensation covered a much narrower range of injuries. Most claims were from traumatic injuries; covering disease or medical conditions would have never crossed the minds of most people. The rapid rise in repetitive motion injuries, for example, has occurred only over the past 25 years. So too is occupational disease coverage broader now than years ago. Thus, relative to a period of even 25 years ago, refining what is compensable in the workers' compensation system is not a "cut." If anything, it is recognition that the nexus between work and injury has become weaker, thus more subject to dispute and litigation. Also driving both dispute and compensability is an in aging workforce with increasing co-morbidities.

The point is this: workers' compensation is not intended to cover medical treatment and wage loss for non-occupational conditions. There are other benefit programs, private and public, intended to fill these gaps, whether employer-funded health insurance, Medicare or public disability insurance programs – both federal and state. The policy underlying compensability changes recognizes a need to require a stronger nexus between the injury and work, where it is inherently more difficult to establish a causal relationship with work because of the nature of the injury (or disease). Those objecting to higher standards of compensability have a more fundamental disagreement with the purpose of workers' compensation and its practices over the past 100 years.

Oregon was the first state to adopt compensability rules to make sure workers' compensation was not responsible for disability unless it resulted from work. These rules were included in its 1990 reforms, also agreed to by organized labor, which required work to be the "major contributing cause" of the injury (or aggravation). The

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[7] See California Workers' Compensation Institute Bulletin 15-04; April 24, 2015; p. 1:
"[A] new CWCI analysis of IMR [Independent Medical Review] decisions from 2014 finds that 91 percent of physician-level UR modifications or denials of treatment reviewed by an IMR physician were upheld, while 9 percent were overturned. The finding suggests that UR and IMR not only work to assure that the care rendered to injured workers is appropriate, but also provide a needed check against prescription drugs, diagnostic tests, surgeries and other procedures that do not meet evidence based medicine standards and that could delay an injured workers' recovery or lead to further impairment or disability."

Oregon Supreme Court held the standard obviated the exclusive remedy defense, requiring the legislature to redraft the law. That change was also successfully challenged, on constitutional grounds, so that for over the past 15 years there has been a residual tort right for employees whose injuries allegedly caused by work were denied coverage under the Workers' Compensation Act because they failed to satisfy the compensability standard. However, there never has been an avalanche of tort claims, suggesting these, indeed, are injures with a weak causal connection to work and vindicating the merit of this policy change.

At least a dozen states have followed Oregon's lead, including California in 1993, for mental-mental claims, which are claims without a physical component, where purely mental injury is based on purely mental stimuli. Such claims are extremely hard to adjudicate: often there is no specific time or event causing the stress and no objective evidence of psychological injury. In response to a surge of such claims, and after finding that they were rife with abuse, California imposed a "predominant cause" standard on mental-mental claims. In the over-20 years this has been the law, there has not been a successful challenge, either based on the exclusive remedy or constitutionality. This does not mean there is not a downside risk to adjusting the statutory compensability standard. Taking this step places stress on the exclusive remedy and/or raises constitutional issues. However, as noted above, the policy basis for strengthening compensability is sound, to limit employers' exposure for injuries and conditions that have little if any relationship to work, in light of the significant financial exposure employers undertake in covering workers' compensation injuries on a no-fault basis, with benefits covering lost wages and lifetime medical coverage at no cost to the worker.

Another means of addressing injuries with weak or inconclusive workplace causation is through higher evidentiary standards, adopted by a number of states. One example is Virginia's Workers' Compensation Act which includes an "ordinary diseases of life" statute that requires "clear and convincing evidence" to link such an injury with work.

Limiting duration of temporary total disability (TTD): The National Commission recommended against duration limits on TTD benefits, relying instead on a determination that the injured worker has reached permanency (maximum medical improvement or "MMI)." Although conceptually sound, in practice, this approach has often-entailed egregious delays in, and litigation involving, termination of TTD. This is because of features of a state's workers' compensation system that reduce incentives to return-to-work or encourage the consumption of greater medical services. A permanent partial disability design may effectively reward more medical treatment, to justify a higher PPD award. Weak employer-insurer ability to direct medical care may dis-incent treating physicians to release the worker to return to work, more so in a weak economy when there might not be a job to return to. Some states – so-called "wage-loss" states – do not use degree of impairment in a permanency determination or even make a finding of permanent impairment in any degree, instead basing eligibility for continued wage loss benefits on lost wages alone. These wage-loss states (e.g., Pennsylvania,

Michigan, North Carolina, Louisiana), also have strict tests for terminating TTD that impose burdensome job-availability mandates on employers that are unable to bring a worker back. Alternative-job availability requirements often morph into mandates that employers find an alternative job. That, too, can result in egregious delays, and also layers on additional costs for extensive vocational rehabilitation consultations and training.

Finally, even where the treating physician may release the worker to work, many states do not permit the employer or its insurer to terminate TTD without a formal on-the-record hearing before the workers' compensation agency, another procedural hurdle that can add months of unnecessary TTD payments.

Faced with this difficult landscape, a cap is a reasonable, if imperfect, approach. It is imperfect, because duration caps may also drive litigation, as the cap nears.

There are 24 jurisdictions (including the District of Columbia) with TTD duration caps. The caps range from 104 weeks to 700 weeks (New Mexico) but typically are 400 to 500 weeks. Such limits are sufficiently long that they are not routinely triggered.[8] Furthermore, even upon reaching a TTD duration limit, the option to stop benefits is generally not an all-or-nothing decision. If after all this time the worker still is not at MMI and still does not have the physical capacity to return to work, some states appropriately permit a petition to the agency for a renewed duration of several weeks, or a finding of temporary partial disability (TPD) can be entered, during which the worker receives a portion of the TTD benefit, typically based on two-thirds of the difference between current earning capacity and pre-injury earning capacity. Thus, a duration cap is not a benefit cut. It is rather a means – though imperfect -- of incenting a determination of the ability to return to work and of permanency.

Repealing second injury funds: ProPublica characterizes the abolition of second injury funds as among the steps taken that purportedly cut benefits. This contention is baseless. Second injury funds were first established following World War II, with "handicapped" veterans returning to the workplace. They were intended to incent an employer to hire visibly disabled people by limiting the employer's liability if such an individual were injured again. In such cases, the employer would be responsible for paying only the benefits attributable to that portion of the combined pre-existing and workplace disability that would have been due if there had been no prior disability. The balance of the benefits payable for the combined disability was still payable, just not funded by the employer. Instead, these benefits were financed by issuing an assessment against *all* employers (or their insurers), with the amount of assessment limited only to the projected annual payout from the fund rather than the incurred loss.

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[8] See NCCI Research Brief, *Workers Compensation Temporary Total Disability Indemnity Benefit Duration – 2013 Update*, August 2013. Average country-wide TTD duration is 120 days, ranging from 60 days (Wisconsin) to 192 days (Louisiana). Of the four wage-loss states noted above, three are among those with the highest TTD duration. See exhibit 8, p. 17.

Although second injury funds were well-intended, in the subsequent half-century it became clear that they do not work. There is no demonstrable evidence that in practice employment decisions are motivated by the knowledge that the employer's direct liability is thus limited. In fact, the employer usually learns of the prior disability only after the second injury occurred. As a result, the second injury fund serves to cost-shift a portion of the benefits away from the employer responsible for the injury. This cost shift deviates from the principle that an employer's costs of work injuries should be internalized so that compensation for work injuries is reflected in the price of producing the employer's goods and services.

As workers' compensation costs exploded, the opportunity to avoid claims costs by discovering a "first" injury after the second injury occurs led to the accumulation of enormous unfunded liabilities. In some cases second injury funds literally ran out of money and could not pay current obligations. Second injury funds create administrative costs and foster dispute, while promoting attorney involvement. They also are unfair to smaller employers, who are required to finance second injury funds through assessments although they rarely have any claims because of their size. Thus a few employers enjoy an effective subsidization of their losses, because they can "get back" in second injury fund "relief" more than they pay in annual assessments.

Over the past 25 years, 19 states and the District of Columbia have abolished their second injury funds.[9] This action has had no effect on an injured worker's benefits. All benefits are now paid directly (through the insurance policy) and not in part through a fund financed by all employers. Repeal of second injury funds has had a positive effect on reducing dispute and attorney involvement. Nor has there ever been evidence in states with repealed second injury funds that workers faced employment discrimination or denial of benefits as a consequence.

In fact, for the past quarter century, the Americans With Disabilities Act (ADA) has given employees a more direct, and thus certain, protection in case of employment discrimination against disabled workers, because the ADA prohibits certain improper inquiries about the existence or nature of a disability prior to an employment offer. Even following an offer of employment, when such an inquiry would not violate the ADA, a second injury fund gives an employer the incentive to inquire about a preexisting disability. This is so, because some states require an employer to be aware of a preexisting injury in order to qualify for second injury fund coverage of a subsequent injury (as noted above, the rationale for having a fund mechanism to pay part of the benefits). Even without a prior knowledge requirement, a second injury fund gives an employer at time of injury a powerful incentive to inquire into an injured worker's medical history in order to discover a qualifying preexisting injury and spread the losses to other employers. Therefore, second injury funds can give an unscrupulous employer a

[9]Alabama, Arkansas, Colorado, Connecticut, Florida, Georgia, Kansas, Kentucky, Maine, Minnesota, Nebraska, New Mexico, New York, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia. During this period two states reversed their repeal: Oklahoma (2000) and this year, Louisiana, repealing a 2015 sunset.

pretext to inquire into preexisting disabilities. Thus, in a perverse way, second injury funds may operate to discriminate against those with disabilities.

If second injury funds really were essential and their demise resulted in denial of benefits to injured workers, we would have known years ago.

Offsetting workers' compensation benefits for employer-funded retirement benefits and Social Security retirement benefits: A number of states over the past 25 years have incorporated a means for recognizing that after retirement a workers' compensation injured worker is losing wages because of retirement and no longer because of the work injury. States have used different approaches to achieve this policy result, such as offsetting workers' compensation disability benefits for employer-funded retirement benefits and/or Social Security Old Age & Survivors' Benefits, phasing out workers' compensation benefits over time, or terminating workers' compensation benefits at a specific age (e.g., age 65). This policy also reflects a principle that employers should not be paying for duplicative benefits – for a work injury *and* for retirement.

Those objecting to offsetting (or eliminating) workers' compensation benefits at retirement argue (as does ProPublica) that workers (especially younger workers) who are disabled years before reaching their peak earning years will earn less over time and therefore eventually receive less in Social Security benefits and other retirement income. This contention may be theoretically valid for the small subset of workers who are permanently and totally disabled. The frequency of injuries resulting in permanent total disabilities is low (about 2.4 per 100,000 workers), and thus few workers are permanently totally disabled, making them rare compared to those with permanent partial disabilities or those who return to work with no permanency.[10] Furthermore, although wage loss soon after the injury can be closely linked to the workplace, the longer a worker remains out of work, the more tenuous is the link between the injury and resultant wage loss. After five years from date of injury, how much of a worker's wage loss is due to the injury and how much is due to other unrelated factors, such as the economy, other non-work related health problems, or poor job performance?

Actual wage loss due to a serious injury that would impair a worker's wages and benefits over decades is speculative at best. For this reason, as well as recognizing the essential purpose of workers' compensation – to replace a portion of wages lost while in the workforce on a no-fault basis in an economically efficient way that addresses the vast majority of workers injured on the job – it is entirely appropriate to offset or eliminate workers' compensation benefits once a worker is of the age to be retired.

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[10] Countrywide average (CW) of 37 states and District of Columbia, as reported by the National Council on Compensation Insurance (NCCI) Annual Statistical Bulletin 2015 (5th Report). Including 9 states with independent rating bureaus, frequency ranged from zero or statistically zero in 4 states to 15 in Montana (an outlier), with no other state above 6.7 (Minnesota) and only 8 states at 4 or higher. In contrast, the CW of permanent partial claims is 375, of temporary total claims, 585, and medical-only claims, 3,109. 5th Report reflects most mature data available, covering policy years extending back to 2007-2008.

ProPublica levels other charges against the state workers' compensation system that do not stand up to closer scrutiny: (1) "Benefit cuts" are causing a cost-shift to SSDI and other public assistance; and (2) States are cutting benefits in a "race to the bottom." Neither is accurate.

Are "Benefit Cuts" to Workers' Compensation Programs Causing a Cost-Shift to SSDI and Other Public Assistance?

ProPublica states that reductions in workers' compensation benefits have pushed workers onto public assistance programs. According to ProPublica:

> All the while, employers have found someone else to foot the bill for workplace accidents: American taxpayers, who shell out tens of billions of dollars a year through Social Security Disability Insurance, Medicare and Medicaid for lost wages and medical costs not covered by workers' comp.

It has been for many years an argument made by Professor John Burton, who was Executive Director of the National Commission on State Workmen's Compensation Laws which issued its report in 1972. Professor Burton has long objected to policies states adopted in the 1990s to rebalance their systems, bringing several back from the precipice of financial collapse. He also argues that benefit changes beginning in 2000 have led to cost-shifting to SSDI, but his underlying objections are to policy choices states have made with which he disagrees.

He is inaccurate on multiple grounds, and ProPublica's one-sided reporting does a disservice in not recognizing alternative analysis, let alone crediting the correct explanation.

Workers' compensation is designed to internalize the costs of work injury and illness as a cost of doing business, so that such costs will be reflected in prices paid by consumers for goods and services. Proponents see it as a more equitable and efficient means of providing compensation than tort liability, the system that workers' compensation replaced. As noted above, internalizing the cost of work injury gives employers incentive to prevent injury and mitigate any resulting disability by returning workers to employment as quickly as possible. It also promotes equitable distribution of job injury costs. Sweeping in coverage for non-occupational health conditions broadens employers' financial responsibility for the health of their workers but weakens the nexus between a worker's condition and the role of the workplace. Improved worker health might improve some workers' compensation outcomes, notably in reducing the contribution of co-morbidities in driving workers' compensation costs, but at another "cost" – that of externalizing workplace costs and thereby distorting the positive incentives built into the workers' compensation system, including that of maintaining a safe workplace. As noted above ("Strengthening Compensability Rules," page 13), over many years, workers' compensation compensability was expanded, generally by judicial decision, to cover an array of health conditions that can be, but may not be, caused by work. State legislatures have acted legitimately and appropriately to incorporate

reasonable and responsible compensability standards that help distinguish occupational from non-occupational health conditions. -

The growth in our welfare, Medicaid, Medicare, and SSDI programs is not caused by cutbacks in workers' compensation compensability. According to the Congressional Budget Office and the Chief Actuary of the Social Security Administration, the main drivers of growing SSDI rolls are the aging workforce, the increase in women participating in the workforce, and SSDI program eligibility changes.

The issue is not whether injured workers receiving workers' compensation ever qualify for SSDI and Medicare/Medicaid. There has been for decades an offset for either workers' compensation or SSDI in all states. Nor is there any doubt that some receiving workers' compensation benefits subsequently receive SSDI. Rather the issue is whether there are *systemic* reasons for significant numbers of workers ending up on SSDI *because of the exhaustion of their workers' compensation benefits due to alleged "benefit cuts" in the 1990s or thereafter*. To this claim, the analysis says no. In 2010, the National Bureau of Economic Research ("NBER") explored this premise, concluding:

> *In this paper, we start by showing how at the national level, total spending on two of the largest social insurance programs, WC and DI were moving in opposite directions during the 1990s. WC and DI are two major programs that pay for costs associated with ill health, aside from traditional forms of private and public medical insurance. This negative relationship between the WC and DI trends has prompted speculations as to whether there was an increase in reliance on DI (a federal program) as a direct result of tightening of state WC programs. We show that the movement in opposite directions of the aggregate national trend does not hold once one looks within states, the level at which a causal story could be told. A causal relationship may still exist where WC tightening leads to a growth in DI rolls, despite no correlation being found in the magnitude of the two programs over time at the state level. Thus, we next test whether WC policy changes that reduce the generosity of the program have a causal effect on WC (first) and DI outcomes (subsequently) at the state level. We find no statistically significant evidence in the overwhelming majority of our tests; there are a few cases of statistically significant results of relatively small magnitudes, but since this could arise due to pure chance when running many regressions, on net, our results suggest that it is unlikely that substitution between these programs is present and contributing substantially to the decline in employment of working-age individuals with disabilities.*
>
> *We acknowledge that at the micro level, for certain individuals at the margin, it is still possible that changes in WC generosity may affect DI applications.* ***However, we argue that our approach answers the relevant policy question that the decline in WC outcomes observed in the national trends during the 1990s is not a significant factor in***

the increase in DI receipt and the fall in employment rates among working aged people with disabilities during the same period.[11]

Also casting doubt on the cost-shifting argument, Gregory Krohm, former Executive Director of the International Association of Accident Boards & Commissions, (IAIABC) termed as "implausible" that "law changes in workers' compensation coverage or benefits are a significant factor in the rapid rise in SSDI beneficiaries or payments, particularly during the period 2000-2010 . . . . Since formulating my testimony in 2010, the evidence has mounted against blaming workers' compensation for the woes of the SSDI program."[12]

First, he notes that SSDI's incidence rate dropped significantly "when state workers' compensation laws were being restricted. Then, beginning in 2000, the incidence rate sharply rose." Indeed, based on the 2010 OASDI Trustees Report, SSDI incidence waxed and waned over past decades, sharply rising through half of the 1970s, then plummeting through the early 1980s, then rising again and falling off through the late decade, then rising sharply from the 1980s to the early 1990s. During this period of supposed "benefit cuts" and a cost-shifting from workers' compensation to SSDI, the rate fell again, until 2000. Dr. Krohm notes that among 16 "leading determinants" of SSDI incidence, the Office of the Actuary for Social Security does not mention workers' compensation among them.[13]

Dr. Krohm also disputes Dr. Burton's use of cash benefits as a percentage of covered wages as evidence of the impact of state law changes: Cost is a function of injury rates and average benefits paid, and consistently declining frequency "goes a long way in explaining the welcome decline in cost." Furthermore, improved disability management "is a plausible cause for the drop in cases paying permanent partial disability benefits" that Dr. Burton cites in his research.

Furthermore, there are "many states with extremely high percentage of SSDI injured workers that also have relatively high workers' compensation benefits. The opposite is found with some states having relatively low benefits . . . [and] as crude as it is, I would argue that this is a more appropriate measure of the relationship between the two social insurance programs than annual changes in aggregates for the whole U.S." As noted, the 2010 NBER report systematically looked at this issue at the state level

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[11] *The Effect of State Workers' Compensation Program Changes on the Use of Federal Social Security Disability Insurance*; McInerney, Simon; Working Paper 15895, April 2010; pp 32-33; footnotes omitted; **emphasis added**.

[12] IAIABC Journal, Vol. 49, No. 1 (2012), see generally pp. 67-78. This article updated testimony before the U.S. House Committee on Education & Labor (2010) by Dr. Krohm, Professor John Burton, and Douglas Holmes, President of UWC-Strategic Services for Unemployment & Workers' Compensation.

[13] The most recent published analysis of the Chief Actuary once again fails to mention workers' compensation as a driving force in rising DI benefits. See: Testimony to the Senate Committee on Finance, "The Foreseen Trend in the Cost of Disability Insurance Benefits," Stephen C. Goss, Chief Actuary, Social Security Administration, July 24, 2014.

and found that there is no correlation between workers' compensation benefits and SSDI enrollments.

Dr. Krohm also disputes Dr. Burton's research methodology in which the impact of state law "restrictions" was inferred by a method "that seems unreliable." Instead, Dr. Krohm examined specific state law changes, concluding "states have rarely changed any feature of workers' compensation that would lead to a worsening of conditions for SSDI." He also disagreed with Dr. Burton's assertion that PPD changes restricting duration have led to SSDI cost-shifting, countering that those with PPD rather than permanent, totally disabling conditions are not as likely to meet SSDI's test of not being able to engage in any "gainful employment." It is also plausible that, if it could actually be shown that workers' compensation beneficiaries with PPD awards are qualifying for SSDI, that would say more about the relaxed eligibility qualifications for SSDI than it would about the design of workers' compensation systems, especially with PPD ratings in the lower-to-moderate range.

Dr. Krohm concludes with his objection to Dr. Burton's call for federal standards, noting that "notwithstanding this negative trend [in control of state legislatures post-2010] from a labor perspective, one must consider the overall positive and well-balanced nature of workers' compensation benefits. Few states have actually reduced benefits levels for accepted claims. Rather, in recent years several states have restricted the nature of compensable claims . . . The justification for these restrictions is that the disability being claimed is not the primary responsibility of the employer and should not be included under workers' compensation."

ProPublica's broad and unsubstantiated assertion that "benefit cuts" have led to cost-shifting to public programs further diminishes the credibility of its reporting. Had it actually studied the issue from a balanced perspective, rather than accepting uncritically a well-critiqued narrative holding to the contrary, it would have taken cognizance of the scholarship on the other side of the issue. Serious people with extensive experience with workers' compensation have thought and written about this issue, and come to a different conclusion.

Are States "Cutting Benefits" in a "Race to the Bottom"?

The policies discussed in this analysis reflect a commitment to improve outcomes for injured workers within a framework that employers can reasonably afford. The state-based workers' compensation system is dynamic. Hundreds of bills are introduced and countless other regulatory actions are taken annually, as states continually adjust the many internal moving parts of a workers' compensation "machine." Case law also continues to shape both results and expectations, in expansive or more restrictive interpretation of the statute. ProPublica again quotes with approval Professor John Burton. Dr. Burton stated that "I think we're in a pretty vicious period right now of racing to the bottom." The so-called "race to the bottom" is the pejorative used by those who object to policies adopted by this state-based social insurance system or, at least one not controlled or otherwise supervised by the federal government. Simply put, Dr.

Burton is incorrect. States are all independent governing – and economic – units. They do "compete" on a broad array of social and economic policies, and the cost of workers' compensation is a significant economic metric that may require attention from state officials. But as a practical matter, few of them are willing to alter their workers' compensation programs by taking an axe to protections for their constituents who are injured on the job in order to make workers' compensation coverage less costly. To the contrary, state officials responsible for public policy on workers' compensation have recognized that they need to act responsibly to preserve and maintain essential protections for their workforce by addressing specific problem areas rather than focusing on reducing benefit levels.

What those characterizing this "competition" as a "race to the bottom" really want is to take decisional authority away from states and put it in Washington, D.C., by having the federal government judge the relative equities of the state systems and impose inflexible minimum benefit standards on workers' compensation programs, as Congress threatened in the wake of the National Commission's report in 1972. That approach risks freezing states' ability to act expeditiously and effectively without approval (explicit or implicit) from the federal government and mire the states in endless disputes with the federal government over the state's authority. The workers' compensation system could never have recovered as quickly or as fully from the financial crisis 25 years ago, assuming it recovered at all, if the actions states needed to take to rebalance their systems were hamstrung by federal oversight.

In contrast to the states' record of pragmatic responses to changing circumstances, there is a record of policy mismanagement, and outright failure in connection with federally managed disability programs. The three federal workers' compensation programs are a case in point. The federal Longshore & Harbor Workers' Compensation Act has not been amended since 1984. The Federal Employees' Compensation Act has not been amended since 1974. The Black Lung Benefits Act, intended to be "temporary" when enacted in 1969, has cost tens of billions of dollars, to taxpayers, the coal industry, and insurers. In addition, the Social Security Disability Insurance program is technically insolvent, i.e. its future incurred obligations are greater than the assets and projected income that the program has to pay these benefits. The DI trust fund is projected to be exhausted next year. In light of the abysmal record managing *existing* federal responsibilities, it would be a tragedy for everyone to give the federal government authority over state workers' compensation programs. Had Congress enacted federal workers' compensation benefit standards years ago, as Dr. Burton and others have long-recommended, it is certain states could not have acted as swiftly and decisively as they did 25 years ago to stem the billions of dollars in workers' compensation losses that produced a national workers' compensation financial crisis, severely stressing many state systems, imposing rapidly escalating costs on employers, and driving some insurers into insolvency. With federal standards – in reality, federal oversight – there would have been a national workers' compensation insolvency crisis two and a half decades ago. Instead of Governors and legislatures acting when faced with a crisis, they would have needed to look to Congress to act. We know how that would have turned out.

Rather than “racing to the bottom,” it is far more accurate to say that the nation’s workers’ compensation system reflects the best of the federal system. States are able to calibrate policies that are aligned with their own economies and to adjust those policies relatively quickly when necessary. The federal system has often been described as 50 state laboratories, and that is an accurate description of the workers’ compensation system. None of the workers' compensation policy initiatives evolving over the past quarter of a century were directed by the federal government. All flowed from state legislatures, grappling with complex (and often conflicting) policy challenges, crafted to maintain balance in a social insurance program critical to the welfare of that state’s workers and employers and, ultimately, its economy. States are able to experiment, and continue doing so today. If a policy proves to be mistaken, that mistake is not a national mistake and can be corrected in due course. No state workers’ compensation program is perfect. However, for the vast numbers of injured workers, it works as intended. Workers who get injured recover and return to productive lives. But, they never generate headlines.

Conclusion: ProPublica has attracted considerable attention to its workers' compensation reports. But most of the criticisms ProPublica voices are misplaced and reflect policy disagreements of those with a different view of what the workers’ compensation system should be. All workers' compensation systems, like other social insurance programs, are imperfect, and there are times when good intentions still do not produce a positive result. Other social programs -- SSDI, Medicare, Veterans Benefits, and Medicaid -- are well known to have many controversial features and critics. One common problem with the above systems is that funding them from taxpayer revenues creates huge problems. ProPublica could find fertile ground in these programs for its future stories. They also could explore issues within workers’ compensation that drive unnecessary costs and wasteful practices, such as physician dispensing of drugs, including harmful opioids, and unnecessary dispute that add friction costs to the workers’ compensation system with little to no benefit for injured workers.

The culture within workers’ compensation, as this author has seen it for over 25 years, is dedicated to making it work – for workers who suffer serious injury and employers who pay for the cost of those injuries. Rather than “journalism by horror story,” a fairer approach would have explored the underlying policy differences that inform workers’ compensation debates and present a balanced discussion of those issues. It is unfortunate ProPublica could not see, or chose to ignore, the positive contribution workers’ compensation makes daily to our social insurance safety net. It’s an opportunity missed.

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