THE FUND REPORTER

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NEW NEWSLETTER TO PROVIDE HEALTH, WELFARE AND PENSION COMMENTARY

By DONALD RUBIN, *Editor*

This issue of *The Fund Reporter* launches a publication with the objectives of: helping welfare and pension funds function more effectively by providing articles on fund administration; providing timely information on government actions which will affect the cost of benefits and the functioning of funds; and providing articles on personal health care which will be specially written for reproduction in union, business and trade publications.

These are challenging and uncertain times for everyone in the welfare and pension field. With costs rising relentlessly, funds are faced with two dilemmas: (1) How can health care costs be contained? and (2) How can unions and employers negotiate adequate contributions to cover the inflation in health care costs?

The United States is one of the last major industrial nations without a national public health care system. Health and welfare funds were established to fill the void. They created an insurance mechanism to cover the costs of care for workers in particular unions/industries.

Both labor and management have actively worked to get government to pick up more of the health care burden. They supported the establishment of Medicare and Medicaid. Unions in particular have pushed for a national program to provide hospital and medical care coverage. Many trustees believed that this coverage would eventually be assumed by a national program.

However, at this time there are major efforts being made by government officials representing the present administration and Congress to reduce the benefits provided under Medicare and Medicaid, and to reduce the enforcement of standards of care. In short, there is a move to shift the burden to the private sector, of which welfare funds constitute a large part.

This shift is exemplified by the recent enactment of a provision under TEFRA which requires welfare funds and private employers to cover active employees in the five-year age period of 65-69 years with the same health benefits as for all other workers. Previously, the over-65 employee was covered for primary insurance by Medicare and secondarily by the welfare funds. Under the new law, this will be reversed. Insurance company actuaries have estimated that the cost of providing primary coverage for this age group will be three times the cost of covering members under age 65. While final regulations have not yet been issued, the legislation is effective January 1, 1983; and when the rules are finally determined, it will be retroactive to that date. For many welfare funds with negotiated fixed contribution levels and for funds with a high percentage of employees between 65-69, the legislation will have a disastrous economic impact.

Welfare funds have been plagued over the years by the health care inflation, which continues to rise at two to three times the rate of general inflation, due in large part to government's failure to regulate the private business of medicine and to misconceived incentives which promote the most expensive types of health care. To use an often-quoted example, it is well documented by now that salaried doctors in prepaid group practices perform significantly less surgery and order considerably fewer x-rays and lab tests than their fee-for-service counterparts.

Growing unemployment and the resulting loss of insurance coverage for millions of workers also fuel spiraling health care inflation. Hospitals and doctors increase their charges to offset the income lost due to unemployment, while insurance companies make up their losses by charging those remaining insured higher premiums. Insurance carriers are estimating a two percent per month increase in major medical costs. Many welfare funds have been slapped with increases far beyond this level.

In addition, the Reagan administration is proposing a tax on health insurance premiums paid above a certain amount per covered employee. Pension and welfare contributions have never been taxed in the past. Not only are funds being required to pick up an increased burden of care as the government reduces its responsibility toward workers, but, at the same time, government wants to collect

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Occupational Disease and Injury Checklist

By MARY MILLS

This is a checklist designed for one particular industry. Its purpose is to identify very common categories of hazards and illness and to suggest methods of inquiry for a claim examiner. A claim examiner should become familiar with the work processes in the shops. A hazard identification survey conducted by a union can form the basis of more information about an industry. Readings from special materials can be assembled for your industry from books and publications. Often an informed claims examiner can give a doctor information about exposures that are not covered in a patient's history. Few doctors have training in occupational medicine. Your lawyer and NYCOSH can assist you in finding a doctor knowledgeable in compensation cases and occupational hazards.

Pulmonary, Ears, Eyes, Nose	
asthma, sudden allergies	exposure to chemicals, dust, coated fabric and felt shavings
bronchitis, emphysema	
"pulmonary obstructive disease"	"pulmonary obstructive disease"(a code phrase for all sorts of pulmonary disease)
acute pulmonary edema	acute massive exposure to ammonia, sulfuric acids, mixed chemicals, smoke inhalation.
associated rhinitis, sinisitis	allergies to formaldehyde impregnated cloth, acylonytrile, dyes.
tear duct infections (i.e., conjunctivitis)	dyes, chemicals, rubbed in eyes
deafness—hearing loss	
Skin	
cuts and infected cuts	machine cuts, infections, benzine and chemical bath dermatitis, dyes (black, brown and blue especially contain benzadrine). Check for anemia when benzine is in use.
dermatitis—acne, cysts, rash, etc.	
burns at work	
allergies	
stained skin	face and hand skin stains that won't wash off—check new fabric in shop.
Circulatory	
varicose veins	varicose veins from bench work
Neurological and Mental	
trembling and poor coordination	mercury, all solvents, glues (used in linings), lead compounds used around machines, cutting oil used around machines. Cleaning fluid, spotting fluid (carbon tetrachloride). (Check also for liver disease when these chemicals are in use.)
central nervous system, depression and headaches	
erratic aggressive behavior	
loss of memory	
loss of libido	
constant drunkedness	
neuropathies (carpel tunnel syndrome)	neuropathies—wrist work causes carpel tunnel.
Gastro-Intestinal	
hernias (including hiatus hernia)	lifting (may first feel pains at home)
Lumbar-Skeletal and Sacral	
sprains	machine work requiring bending, pushing, lifting.
pinched nerves	
disc problems	
cervical problems	
Cardiac	
tachycardia (palpitations)	stress, lack of oxygen in atmosphere (CO) ie., loading planks and warehouse docks.
aggravated coronary disease	presence of CO from bad boilers and heating systems, lack of ventilation.
Cancer	
	Formaldehyde, Benzine, Chlorinated Hydrocarbons such as cleaning fluid
Gynecological	
repeated miscarriages	ammonia exposure

DISABILITY INSURANCE REAPPRAISED TO EFFECT SAVINGS IN BENEFITS

By MARY MILLS

Spiraling costs of health care and Reagan administration plans to tax employee benefits as income have pushed unions into difficult bargaining positions. The atmosphere of "give backs" makes health benefit innovations very difficult to propose. Disability benefit programs, statutorally mandated in New York State's private sector, now are burdened by a FICA tax paid by the employer and the worker. Benefits are lower, and the cost of the program is higher.

These developments in disability benefits have prompted administrators to scrutinize benefits plans for savings. One method of saving costs, while strengthening service to members, is to implement a review of disability cases for work-related compensable illnesses and injuries. United Automobile Workers Local 259 maintains a program of this kind in its self-insured fund and estimates that thousands of dollars a year are saved in medical care costs and disability benefits by filing a compensation claim for every member with a hernia or back injury.

One local union with a majority of members employed by the City of New York Health and Hospitals Corporation now has the third-party administrator of its welfare funds scrutinize claims before they are sent to the disability insurance carrier. Members of this local often aggravate back and hernia conditions when lifting patients. They also suffer from varicose veins and often contract hepatitis from patients. All of these illnesses have firm precedents for workers' compensation. Employees who win workers' compensation awards often stand to gain far better benefits than disability can offer them. Besides lost wages (up to $215 a week or 2/3 of pay) claimants can be awarded payments (scheduled awards) for the loss of a body part or loss of full use of a faculty and medical benefits for the treatment of the illness for many years. They also may have a better case for a permanent disability award should they become unable to work long after the initial injury.

Attorney fees are awarded by the Compensation Board after the award is finalized, thus allowing the fund to send workers to excellent attorneys. If workers become permanently disabled, health benefits for injuries continue long after their other health benefits cease. Regardless of the outcome of their case, most workers see this extra effort as a health-related benefit tied to the union's overall concern for better safety and health conditions on the job.

How can an administrator identify compensable claims? How much extra administrative effort is involved? Most administrators are aware of illnesses endemic to their industry, although they may not realize they are compensable. Certain illnesses and injuries should be automatically subject to review (e.g., varicose veins, dermatitis, hernias and back injuries). Even if a person feels a pain while at home, the injury may be caused entirely or partly by work. A questionnaire and detailed protocol for your industry can be obtained from NYCOSH or from consultants trained in occupational health. Your consultants (or union health and safety department) should be available to review suspicious claims.

The administrator or social worker of a fund can interview a member, file claim forms for him or her, and prepare a lien against Workers Compensation so that the member receives disability benefits if the case is contested by the employer's insurance carrier. This initiation and follow-up can strengthen a worker's case and will show the attorney that the union is informed and interested in the resolution. These extra tasks represent very little increase in administrative cost compared to one or two disability and medical claims with, for example, permanent back injury, which in a recurring case often requires repeated hospitalization. Many funds, including city funds, have hired social workers for alcoholism counseling and other services. Their duties can be enlarged without legal objections to this kind of service.

Instituting a screening program falls within the responsibility of the fund administrator to coordinate benefits with other sources of insurance. It also emphasizes the legal obligation of the employer's insurance carrier to cover work-related illnesses and injuries. In addition, it safeguards the deferred income of the worker paid by the employer for health and welfare benefits, not for workplace injuries. Whether your fund is self-insured or not, it pays to follow these actions:

1. Review each disability claim for common occupational illnesses and injuries. 2. Consult NYCOSH or your consultants for review protocols and training in compensation. 3. Develop a firm relationship with one or more attorneys; send your members to them, and monitor problems.

(Editor's Note: Mary Mills, author of the above article and that which appears on page 2, is an account executive with Multiplan, Inc., and former executive director of NYCOSH.)

The Fund Reporter is a publication of the Consumer Commission on the Accreditation of Health Services, which also publishes *Consumer Health Perspectives*. We welcome articles and suggestions for articles relevant to *The Fund Reporter*'s areas of special interest, as well as case histories or experiences which might prove helpful to our readers. *The Fund Reporter* is not copyrighted, so that articles may be reprinted in union and trade newspapers. An advisory board to this publication is being formed. It will consist of benefit fund trustees, administrators, attorneys and consultants.

This publication is sent without charge. Please send the names and addresses of those persons you would like us to add to the mailing list.

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MEDICAL X-RAYS: WHAT THE DOCTOR DOESN'T TELL PATIENTS

Human beings have always lived with radiation exposure from natural background sources. Their exposure to man-made radiation is largely from having medical and dental x-rays. In the U.S. in 1978 there were 278,000,000 x-rays taken. This number has increased around four percent every year since then.

The excessive use of medical and dental x-rays is attributed to the practice of defensive medicine (taking many x-rays and tests as defense against malpractice suits) and reassurance when nothing else will do. Also, uninformed consumers believe frequent x-rays and tests mean quality care.

While it is generally agreed that large doses of radiation exposure can cause cancer and genetic defects, the effects of so-called "low-level" radiation remain hotly disputed by scientists and medical experts. Most of the disagreement centers on whether there is a safe threshold below which no harm from radiation can be said to result. Some experts believe that medical and dental x-rays fall well within the "safe" threshold. Others claim there is no level at which it can be assumed there isn't potential harm.

People concerned with public health recently became interested in limiting citizens' exposure to radiation from medical and dental sources. This concern results partly from the recent estimate by the Bureau of Radiological Health that 30% of all x-rays are "unnecessary."

Certain x-ray procedures are more commonly abused than others. One example is the use of chest x-rays to screen apparently healthy people. While used extensively in past years to detect TB, a procedure known as a Tine test today offers an accurate, non-invasive screening method. Today, screening people for lung cancer makes little sense since most experts agree that by the time anything is apparent on an x-ray, there is little medicine can do. Pre-employment physicals often involve a chest x-ray, although the cautions noted above make this requirement subject to question. Patients entering hospitals are routinely given a chest x-ray no matter what they are admitted for. The Blue Cross Association is critical of such routine x-rays, claiming it has no benefit for medical patients (those not undergoing surgery), is costly and is not without risk.

The skull x-ray is another procedure that studies have shown to be over-utilized. It is one of 17 procedures listed as "questionable" medical practices by the U.S. Congress' Office of Technological Assessment (OTA). They found that 20% of skull x-rays were done for trivial injury, and 34% were done mainly as a defensive measure against malpractice actions. OTA also expressed the opinion that skull x-rays have a limited effect on diagnosis and treatment, since it is underlying brain damage that determines the course of treatment, and this cannot be determined by x-ray.

Here are some suggestions to follow to protect against injudicious use of x-rays:

- Always understand why it is necessary.
- Keep a record of and mention any previous x-ray exams in order to avoid needless repetition.
- Keep a record of the length of x-ray exposures in the past.
- Avoid visits to hospital emergency rooms for minor reasons, since they often order unnecessary tests.
- Have x-rays taken at a hospital or qualified radiologist.
- Determine whether equipment is regularly inspected wherever you have an x-ray taken.
- Request a lead shield to protect parts of the body surrounding the part to be x-rayed.
- Consider whether it would be wise to get a copy of the x-ray taken.

New newsletter to provide health, welfare and pension guidelines *(Continued from page 1)*

more money from funds while providing fewer benefits. What's more, a tax on contributions for benefits discriminates against workers and industries located in areas of high cost medical care such as New York City.

In light of what's happening, union and management trustees must protect the financial integrity of their funds by working to halt the attempts of government to make them bear the burden of the nation's fiscal crisis. In addition, they must evaluate their benefit package and institute savings through cost control techniques.

The Fund Reporter is dedicated to helping achieve these objectives.

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