

COVID-19 Vaccine Injury Claims

Wisconsin Worker's Compensation | Wisconsin Department of Health Services

Acknowledgment

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Executive Summary

The roll-out and subsequent rapid uptake of the COVID-19 vaccine led to employers and government agencies considering workplace vaccine requirements. Other than civil liberty concerns, workers were also concerned about the safety of the vaccine given its emergency use status. In order to estimate the impact COVID-19 vaccine injuries had on the workforce, this analysis examines Wisconsin worker's compensation claim data for COVID-19 vaccine injuries. Claim data were compared with population estimates, immunization numbers, and reported adverse side effects of the working age population. Additionally, claim data were described by industry, occupation, claim outcomes, and payments.

We identified a total of 104 claims for COVID-19 vaccine injuries. The demographic composition of claimants differed from that of the working age population and vaccinated individuals with higher rates between the ages of 46 to 65, females, and Black or African Americans. Rates were lower for ages 16-25 and those who were White. The majority of claimants worked in health care industries and occupations with education and administrative positions standing out as well. Although several claims were paid out over an extended period of time and some reported severe side effects, all claim payments were temporary, indicating a return to the workforce. The results of this report demonstrate the rarity of COVID-19 vaccine injuries among the working age population and supports a limited negative impact on the Wisconsin workforce.

1 Introduction

The introduction of COVID-19 vaccines was hailed as a boon for public health as well as a key to protecting workers and bringing them safely back to the worksite. Once vaccines became available, the federal government and many companies pursued universal workplace vaccination as a goal. At the same time, such efforts were hampered by both civil libertarian objections and concerns by both the public and some experts about the potential for adverse vaccine effects from the new vaccines. Adverse vaccine effects and injuries can range from mild (for example, soreness at the injection site, mild cold, or flu symptoms) to severe (for example, severe shoulder injuries, blood clots, myocarditis) or even fatal.

Efforts to administer vaccinations in the workplace or make vaccination a requirement for employment introduced Worker's Compensation (WC) as a potential data source for monitoring adverse reactions to COVID-19 vaccinations in working age adults. Employer vaccine requirements would give vaccine-injured workers the option of claiming worker's compensation for any lost time or medical expenses stemming from such injuries or reactions.

In this report, we review Wisconsin's WC data during December 2020 to December 2021 to characterize reported COVID-19 vaccine injuries among Wisconsin's working age population and determine the number of claims filed by vaccine-injured workers.

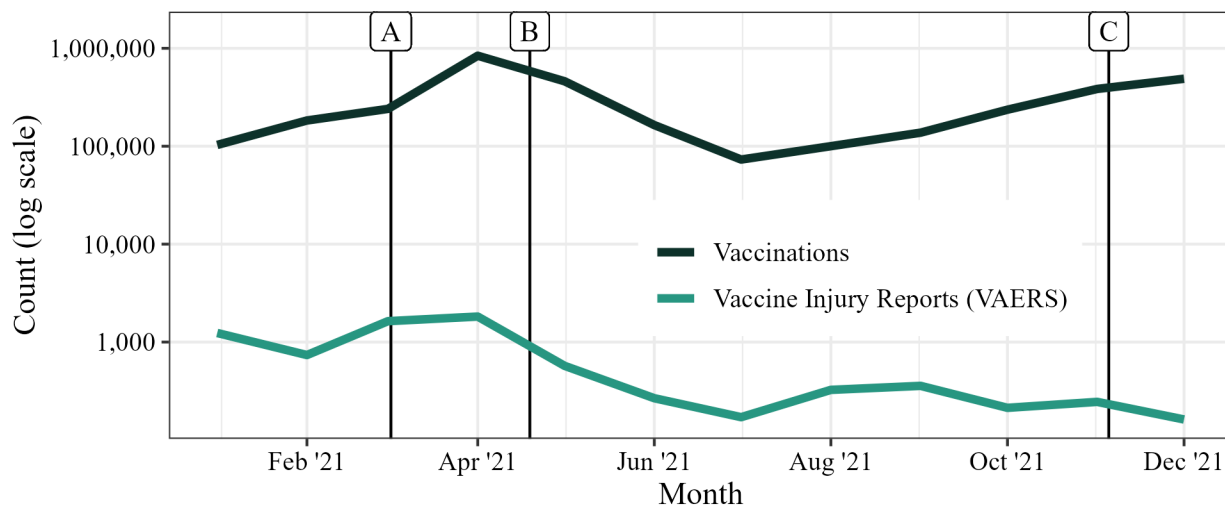
1.1 Timeline of COVID-19 vaccine availability

The first COVID-19 vaccine emergency use authorization (EUA) was issued by the U.S. Food and Drug Administration (FDA), the [Pfizer-BioNTech \(Pfizer\) 2-dose series](#), on December 11, 2020, and the first doses were administered to health care workers in Wisconsin on [December 15, 2020](#). This was followed by EUAs for vaccines from [Moderna](#) and [Johnson & Johnson/Janssen](#) on December 18, 2020, and February 27, 2021, respectively. Vaccine distribution in Wisconsin initially prioritized [persons working in high-risk health care settings](#), and by January 25, 2021, [emergency personnel](#) and those at [high risk of severe infection](#)¹ were also eligible. On March 1, 2021, Wisconsin expanded vaccine eligibility to include [teachers, school staff, and child care workers](#); and by April 5, 2021, [all persons age 16 and older](#) were eligible, making the vaccines available for the entire working age population. From December 15, 2020, to December 31, 2021, 88.4% (n = 2,418,497) of the working age population (age 16–64) in Wisconsin received at least one vaccination² (Figure 1). Of all vaccinations given during this period, 0.2% (n = 8,219) resulted in a vaccine injury report to Centers for Disease Control and Prevention's (CDC) [Vaccine Adverse Event Reporting System \(VAERS\)](#), which collects any reported health problems occurring within a specified time period following vaccination **regardless of severity or causation**.

¹ Adults over 65 and persons in assisted living facilities.

² 2020 ACS 5-year estimates used for denominator.

Figure 1: Monthly COVID-19 vaccination counts and vaccine injury reports, age 16–64, Wisconsin, January 2021–December 2021.



- A) March 2, 2021: Rollout expanded to include education workers
 B) April 19, 2021: Rollout expanded to include all working age persons
 C) November 5, 2021: OSHA ETS released

1.2 Vaccinations and the workplace

On November 5, 2021, the Occupational Safety and Health Administration (OSHA) released an [emergency temporary standard \(ETS\)](#) which required all employees at private workplaces with at least 100 workers be vaccinated or undergo weekly testing and masking. Although the ETS was challenged and [withdrawn](#) on January 26, 2022, a [rule issued by the Centers for Medicare and Medicaid Services \(CMS\)](#) requiring vaccinations for workers in health care settings remained in place. In Wisconsin, it is unclear how many employers implemented vaccine mandates on their own as [legal considerations](#) and [vaccine hesitancy](#) among workers may have complicated employers' views of instituting vaccine requirements.

In the absence of mandates, establishing work-relatedness for vaccine injuries is difficult; claims for compensation to vaccine-injured workers (indemnity or medical) from WC do not meet the [compensability requirements](#) applied to other work-related injuries. The Health Resources and Services Administration (HRSA) provides compensation for vaccine injuries, including those caused by the COVID-19 vaccine, through the [Countermeasures Injury Compensation Program \(CICP\)](#) for serious physical injuries³ and death. As of May 1, 2022, 5,036 [claims for COVID-19 vaccine injuries](#) were filed with CICP nationally. However, 97.8% (n = 4,923) of those claims were denied compensation because they did not meet the [standard of proof](#).⁴ In addition, HRSA [specifies](#) that "CICP is the payer of last resort and can only reimburse or pay for medical services

³ Any injury that warranted hospitalization or resulted in disability

⁴ Must be the direct result of COVID-19 vaccine administration

or items or lost employment income that are not covered by other third-party payers, such as Worker's Compensation."

Therefore, injured workers must file a vaccine injury claim with WC before CICP.

Vaccine injuries are relatively new to WC⁵ and little is known about the circumstances and characteristics of those filing claims. This report provides a high-level summary of COVID-19 vaccine injury claims filed with WC, including claimant demographics, industry and occupation claim rates, claim outcomes, payments,⁶ and lost work time.

⁵ Injury codes for vaccine injuries were added by [Workers Compensation Insurance Organizations \(WCIO\)](#) February 23, 2021

⁶ Monetary impact of COVID-19 vaccine injury claims on CICP is not publicly available

2 Methods

2.1 Data sources

WC claim data were obtained through a data use agreement with the [Wisconsin Department of Workforce Development \(DWD\)](#). These data include basic claimant information⁷ and details about the claim itself.⁸ Claimants were matched with the [Wisconsin Immunization Registry \(WIR\)](#) in order to learn more about the vaccination event,⁹ claimant demographics, and COVID-19 vaccination history. Industry and occupation estimates were obtained from the [American Community Survey \(ACS\) 2020 5-year data](#). Publicly available data containing Wisconsin vaccine injury reports (self or physician reported) from HHS was acquired through VAERS.

2.2 Vaccine injury claim identification

Only indemnity claims for injuries that occurred during December 15, 2020, through December 31, 2021, were included. Claims that were ineligible for lost work time may still have been eligible for medical cost compensation, but Wisconsin's administrative data does not contain information on medical costs or medical-only claims. COVID-19 vaccine injury claims were defined as all claims that met the definition for a COVID-19-related claim¹⁰ and (1) had a detailed claim information (DCI) nature code of 38 (adverse reaction to a vaccination or inoculation) and cause codes of either 82 (Absorption, Ingestion, or Inhalation) or 83 (Pandemic); or (2) contained relevant injury description terms ("vaccine," "vax," "immune," "shot"). Injury descriptions for all claims meeting these criteria were checked manually (Figure 2). All vaccine injury claims were included in this analysis irrespective of severity or causality. This means that the severity of injuries may be broad¹¹ and may not be directly caused by the vaccine itself but rather by poor injection practice or some other external factor that coincided with the vaccination event.

⁷ Details (some demographics and employment information) about the injured person

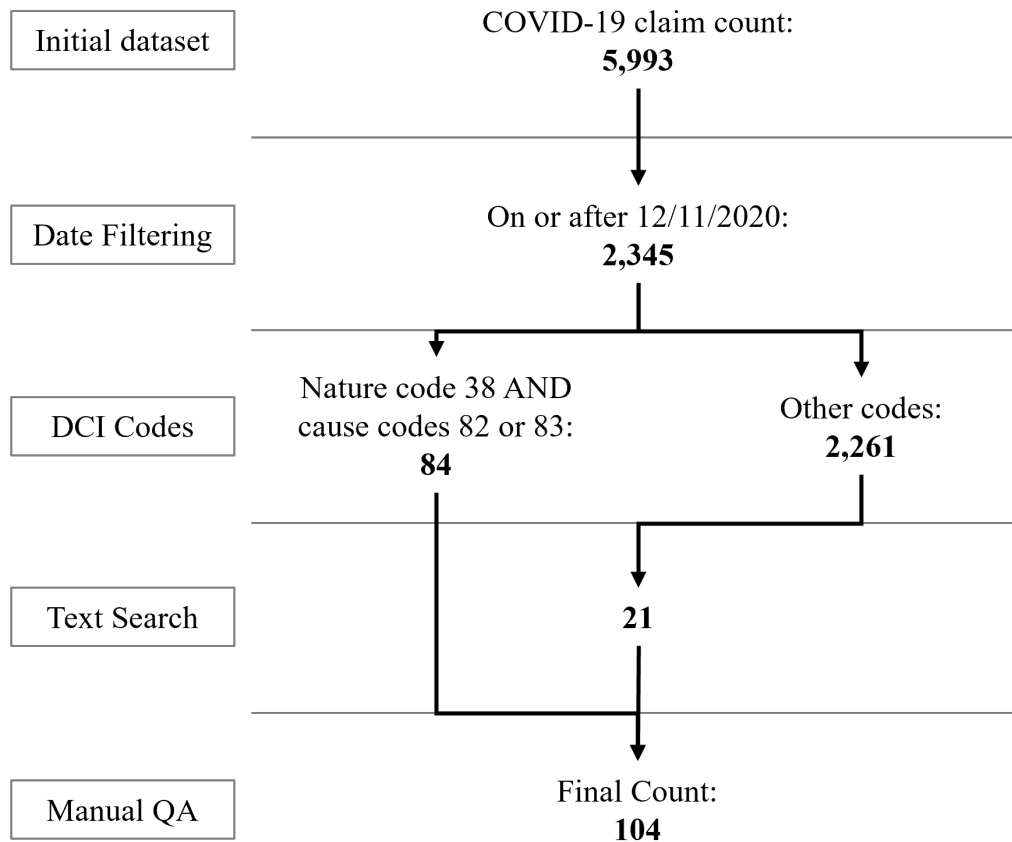
⁸ DCI codes, injury description, payment information, etc.

⁹ Vaccine type, date, dose, etc.

¹⁰ See [Modji et al 2022](#), figure 1; includes all claims resulting from the COVID-19 pandemic, including lost time from quarantine, isolation, and vaccine injuries.

¹¹ Common (e.g., fever, redness at injection site, etc.) and uncommon (e.g., shoulder injuries, severe allergic reactions, etc.) side effects are not explicitly differentiated in WC. See [CDC: Possible Side Effects After Getting a COVID-19 Vaccine](#).

Figure 2: COVID-19 vaccine injury WC claim identification flow chart, Wisconsin, December 15, 2020–December 31, 2021.



Detailed Claim Information (DCI) Codes:

38 – Adverse reaction to a vaccination or inoculation

82 – Absorption, Ingestion or Inhalation

83 – Pandemic

2.3 Claim rates and claimant demographics

Claim rates were calculated per 100,000 working-age residents (using ACS data) and per 100,000 vaccines administered (using WIR data). VAERS is a passive reporting system and as such, should not be used for population estimates for adverse events; it was included in this study for descriptive comparison with WC. ACS, WIR, and VAERS data were limited to working age persons (age 16–64).

For demographic analyses, claims were stratified by age, gender, race, and ethnicity (where available)¹² and presented as a proportion of all vaccine injury claims. The demographic distribution of claims was then compared to the distribution of the same demographic categories in the working-age population (ACS data), the vaccinated population (WIR), and vaccine-injured

¹² Race and ethnicity not available for VAERS data

persons (including non-claimants) from VAERS. Proportional ratios were calculated by dividing the WC proportion for each group by the corresponding proportion in each of the three population groups:

$$\frac{\text{WC proportion}}{\text{Denominator proportion}}$$

To identify demographic differences between claimants and each of the comparison groups, the ratio of a given demographic subpopulation for claimants vs. each comparison group (ACS, WIR, VAERS) was calculated. Two-proportion z-tests between claimants and each comparison group were then employed to identify statistically significant differences.

2.4 Injury information

Counts and proportions were calculated by DCI part of body codes. Part of body codes broadly indicate the part of the claimant's body that was involved in the injury but provide limited insight into the severity or cause of the injury. DCI nature and cause codes partially address this question, but do not provide any details about severity or symptoms and were not used in descriptive analyses.

Some symptom and injury severity data were gathered from manual review of injury descriptions for paid claims and part of body codes. Claims with injury descriptions that only included [common side effects](#) (for example, pain, swelling, and redness at the injection site; flu-like symptoms) were categorized as "Minor," while those with injury descriptions or part of body codes including [rare or severe injuries](#) (for example, hospitalization, severe allergic reactions, swelling or numbness in legs, or cardiac symptoms) were categorized as "Severe."

2.5 Industry and occupation rate calculation

Worker's Compensation data allows for stratification by claimants' industry and occupation. Claim submission rates were calculated by 2-digit and 3-digit North American Industry Classification System (NAICS) and Standard Occupation Classification (SOC) codes using the 2020 5-year ACS estimates. Confidence intervals (95%) were calculated for all industries and occupations with 10 or more claims.

2.6 Claim outcomes

Claim resolution status included three categories: denied, accepted, or ineligible for lost work time. Denied claims were eligible for consideration but determined not to be compensable. Accepted claims were considered compensable and paid. Claims for three or fewer days of lost work time were considered ineligible and excluded from the paid claim description.

The number of accepted claims and the total amount of the associated claim payments were described overall and across time. Lost work time payment data was presented in terms of the number of days of Total Temporary Disability (TTD), Total Partial Disability (TPD), or salary payments associated with accepted claims only.

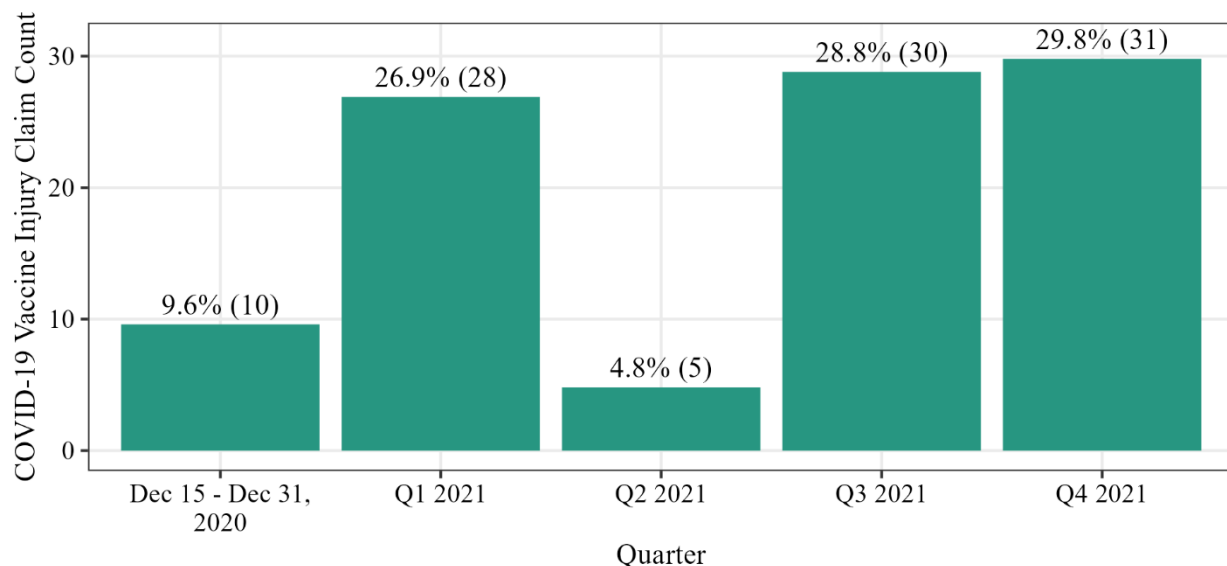
3 Results

3.1 Overview and demographics

COVID-19 vaccine injuries (n=104) made up 0.2% of all claims and 1.7% of all COVID-19 claims for injuries during December 15, 2020–December 31, 2021. The vaccine injury claim rate was 4 per 100,000 vaccinations administered to working-age adults. The relative infrequency of such claims could reflect low injury incidence, low injury severity, lack of compensability, or other factors beyond the scope of the current analysis.

In 2021, 4.8% of vaccine injury claims occurred in the second quarter while the other quarters ranged from 26.9% to 29.8% (Figure 3). This may have coincided with a drop in vaccinations around the same time (Figure 1).

Figure 3: Quarterly proportions of COVID-19 vaccine injury claims, Wisconsin, December 15, 2020–December 31, 2021.



Notes: The first bar on the left only represents the last 16 days of 2020 while the others represent each quarter of 2021.

The ages of WC COVID-19 vaccine injury claimants ranged from 21 to 67 years with a median of 46. Age group distributions appeared similar for ages 26–45 and 56–64. However, WC had a higher proportion of claimants aged 46–55 than the other data sources and lower proportions in ages 16–25 (Table 1, *p-value* < 0.05). More than four out of five claimants were female. The WC gender distribution was significantly different than the other data sources (*p-value* < 0.05) with male proportions one-fourth to half that of the other data sources (Table 1). The low proportion of males in these data, relative to their share of both the working age population and vaccinated adults, are consistent with the [gender distribution of all vaccine injury reports among adults in VAERS](#) and [widely noted gendered reporting patterns](#). Additionally, the gender

distribution is likely also a result of the gendered distribution of health care workers, who comprise the majority of claimants.

Table 1: Comparison of age and gender distribution of ACS, WIR, VAERS, and WC COVID-19 vaccine injuries, Wisconsin, December 15, 2020–December 31, 2021.

Working-age population (ACS), n = 2,736,795			Vaccinations (WIR), n = 3,411,563		Vaccine injuries (VAERS), n = 8,219		Vaccine injury claims (WC), n = 104
Age	% (n)	WC Ratio	% (n)	WC Ratio	% (n)	WC Ratio	% (n)
16–25	17.6 (481,716)	0.27	15.2 (520,234)	0.32	14.5 (1,188)	0.33	4.8 (5)
26–35	22.0 (603,031)	0.65	17.5 (597,816)	0.82	19.4 (1,596)	0.74	14.4 (15)
36–45	20.8 (569,663)	1.15	19.5 (666,500)	1.23	23.1 (1,896)	1.04	24.0 (25)
46–55	22.2 (607,797)	1.64	21.3 (725,053)	1.71	22.1 (1,813)	1.65	36.5 (38)
56–64	17.3 (474,588)	1.17	26.4 (901,960)	0.77	21.0 (1,726)	0.96	20.2 (21)
Gender							
Male	51.9 (1,420,820)	0.26	46.5 (1,586,669)	0.29	26.6 (2,189)	0.51	13.5 (14)
Female	48.1 (1,315,975)	1.76	53.1 (1,812,828)	1.59	72.8 (5,986)	1.16	84.6 (88)
Unknown	N/A	N/A	0.4 (12,066)	4.75	0.5 (44)	3.8	1.9 (2)

*Notes: WC proportions shown in **bold** are significantly different than proportions in other data (p -value < 0.05). ACS, WIR, and VAERS data were limited to working age persons (16–64). There were two WC COVID-19 vaccine injury claims from claimants older than 64 (65 and 67). WC Ratio = WC Proportion/Population Proportion.*

The proportions across data sources were not significantly different for race categories except for ‘Black or African-American’ and ‘White.’ WC proportions for these two groups were significantly different than the other data sources with ‘White’ individuals filing claims half as often and ‘Black or African-American’ individuals filing claims more than twice as often as would be anticipated given population data (Table 2, p -value < 0.05). WC data also revealed significantly different proportions in relation to ethnicity with ‘Not Hispanic or Latino’ individuals filing claims less often than would be anticipated given population data (p -value < 0.05). However, it is important to note that 33.7% (n = 33) of WC COVID-19 vaccine injury claimants did not successfully match with WIR and two that did match were missing race and ethnicity information. This means that more than one third of WC injury claims did not include race or ethnicity data for comparisons (Table 2).

Table 2: Race and ethnicity distribution of ACS (2020 only), WIR, and WC COVID-19 vaccine injuries, Wisconsin, December 15, 2020–December 31, 2021.

	Working-age population (ACS), n = 2,736,795		Vaccinations (WIR), n = 3,411,563		Vaccine injury claims (WC), n = 104
	% (n)	WC Ratio	% (n)	WC Ratio	% (n)
White	86.9 (2,378,465)	0.5	81.6 (2,784,639)	0.53	43.3 (45)
Black or African-American	4.9 (133,438)	2.35	4.5 (155,032)	2.56	11.5 (12)
Asian	2.9 (80,600)	1.66	3.9 (132,726)	1.23	4.8 (5)
American Indian or Alaska Native	0.6 (17,783)	0	1 (35,645)	0	0 (0)
Other Race	4.6 (126,509)	1.46	5.5 (188,573)	1.22	6.7 (7)
Unknown	N/A	N/A	3.4 (114,948)	9.91	33.7 (35)
Not Hispanic or Latino	93.6 (2,560,293)	0.66	90.3 (3,081,556)	0.68	61.5 (64)
Hispanic or Latino	6.4 (176,502)	0.75	6.3 (216,136)	0.76	4.8 (5)
Unknown	N/A	N/A	3.3 (113,871)	10.21	33.7 (35)

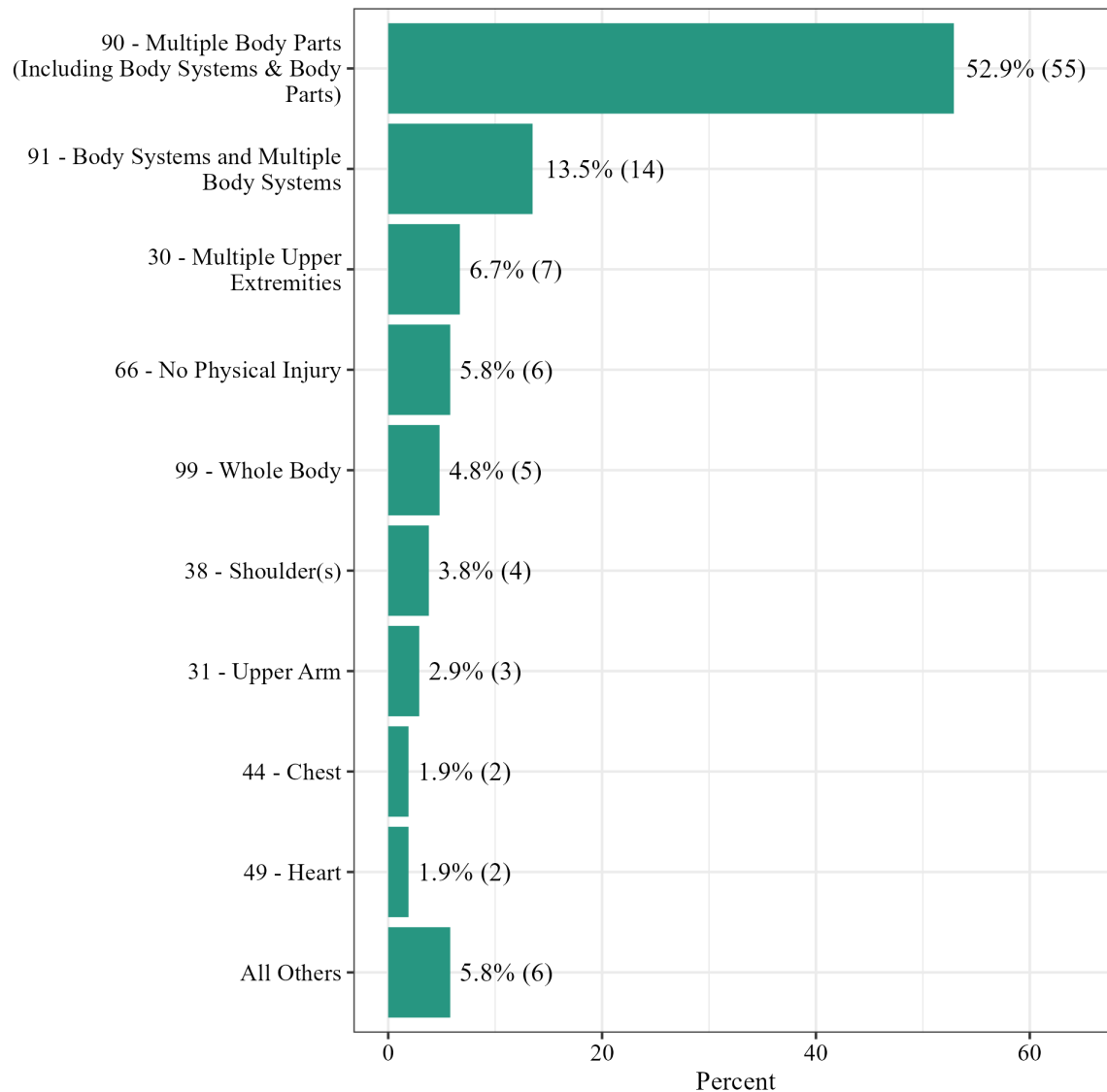
*Notes: WC proportions shown in **bold** are significantly different than proportions in other data (p -value < 0.05). Race and ethnicity unavailable for VAERS. ‘Other Race’ includes those with multiple races. WC Ratio = WC Proportion/Population Proportion.*

3.2 Part of body injury codes

The most common DCI part of injury code was ‘Multiple Body Parts (Including Body Systems & Body Parts)’ at 52.9% (n = 55) (Figure 4). Detailed part of injury codes were not gathered in the WC data. The appearance of ‘Shoulder(s)’ and ‘Upper Arm’ injuries may indicate transient local pain, inflammation, or shoulder injuries related to vaccine administration (SIRVA), which are well documented in literature¹³ (but uncommon) and not unique to the COVID-19 vaccine.

¹³ [SIRVA in VICP: www.sciencedirect.com/science/article/pii/S0264410X19315579](https://www.sciencedirect.com/science/article/pii/S0264410X19315579)

Figure 4: COVID-19 vaccine injury WC claim DCI part of injury code distribution, Wisconsin, December 15, 2020–December 31, 2021.



Notes: 'All Others' includes 'Eye(s),' 'Soft Tissue,' 'Multiple Neck,' 'Internal Organs,' 'Lower Leg,' and 'Lungs.'

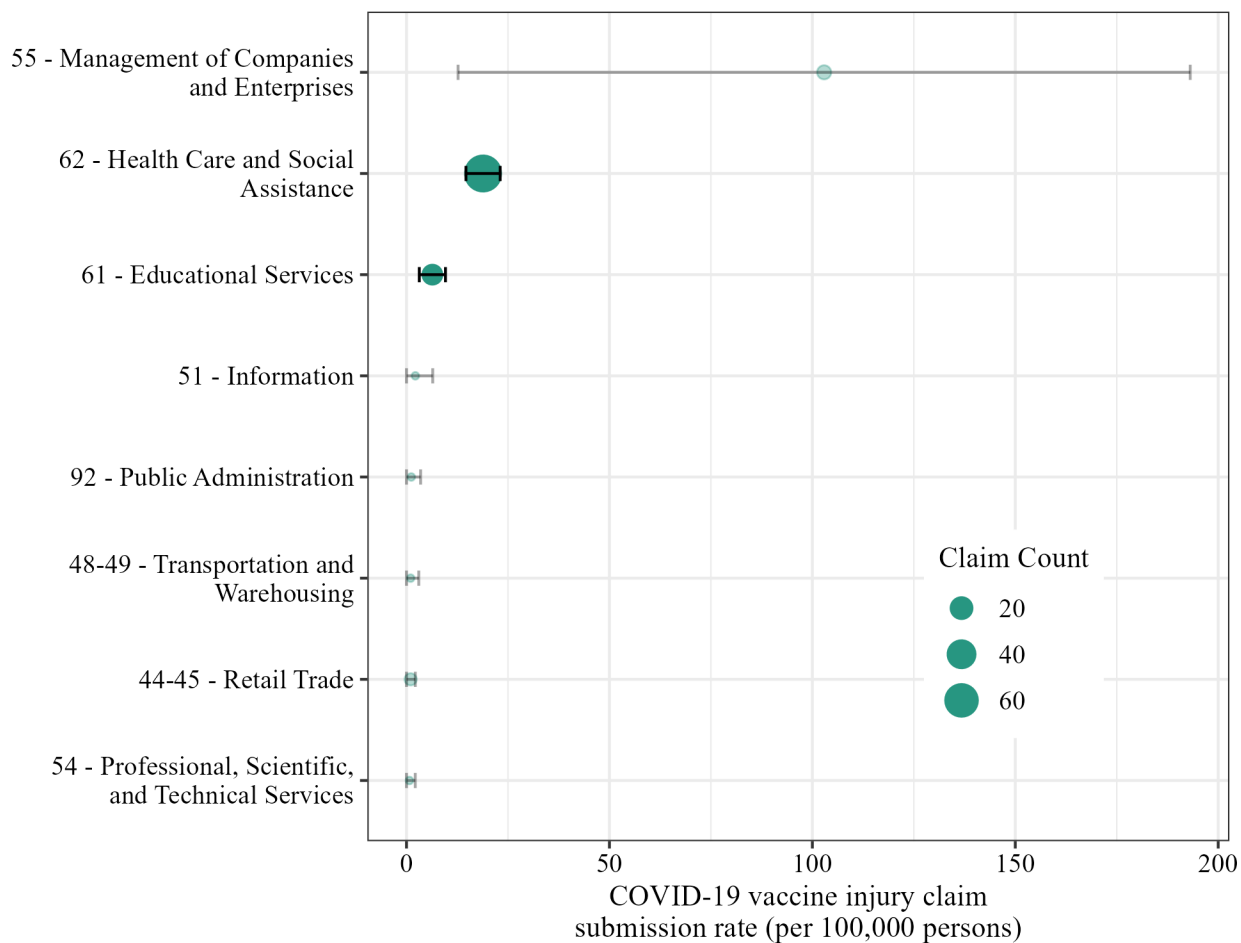
3.3 Industry and occupation rates

3.3.1 Industry (NAICS)

While claims were filed across eight broad industry groups, only two—'Health Care and Social Assistance' (n = 77) and 'Educational Services' (n = 15)—had 10 or more claims, which was used here as the threshold for presentation of rates. Their COVID-19 vaccine injury claim rates were 19 and 7 per 100,000 persons, respectively. The other six groups are included in Figure 5 but faded to denote the small number of claims and highly unstable rates. 'Management of

Companies and Enterprises' (n=5) had a high but unstable rate at 103 claims per 100,000 persons (Figure 5).

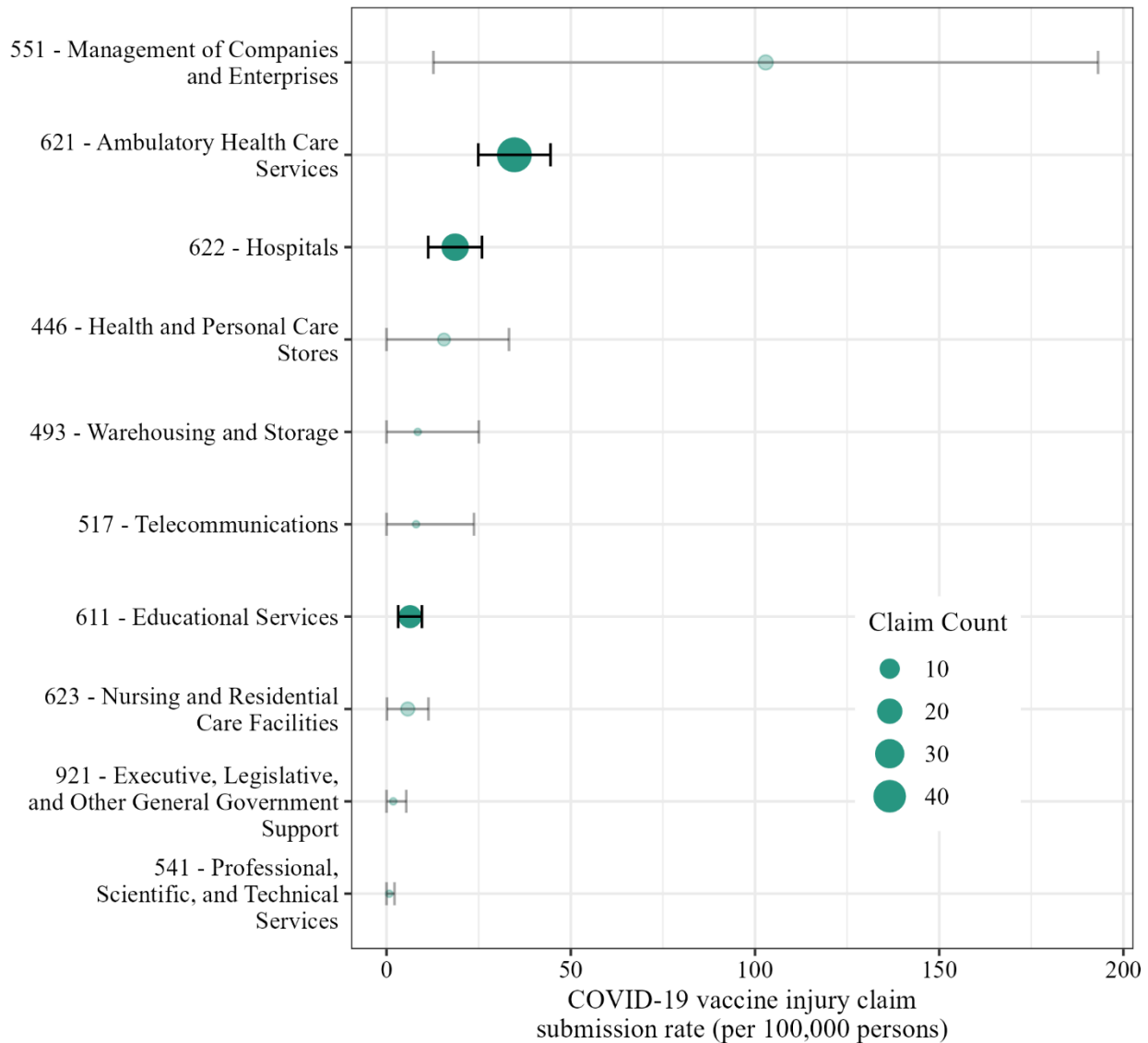
Figure 5: Major (2-digit) NAICS industries by COVID-19 vaccine injury WC claim rate (per 100,000 persons), Wisconsin, December 15, 2020–December 31, 2021.



Notes: Due to unstable rates, industries with 10 or fewer claims are faded.

Health care and educational sectors had the highest stable rates among minor industry groupings with 'Ambulatory Health Care Services' at the top (35 claims per 100,000 persons). Again, 'Management of Companies and Enterprises' stood out with the highest rate at 103 claims per 100,000 persons, however, this estimate was not reliable given the small number of claims (Figure 6). This is broadly consistent with higher COVID-19 claims overall for these sectors.

Figure 6: Minor (3-digit) NAICS industries by COVID-19 vaccine injury WC claim rate (per 100,000 persons), Wisconsin, December 15, 2020–December 31, 2021.

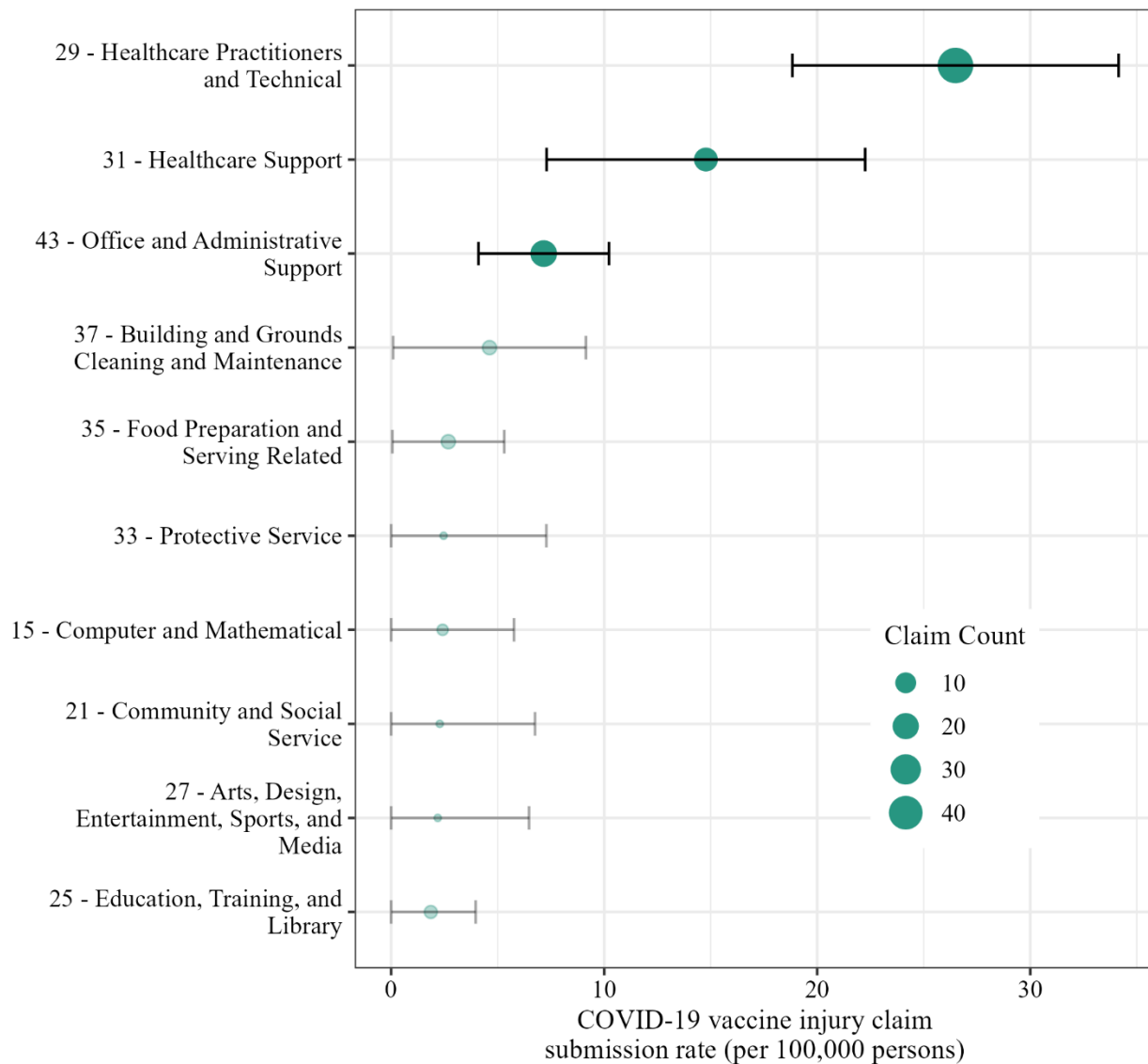


Note: Due to unstable rates, industries with 10 or fewer claims are faded.

3.3.2 Occupation (SOC)

The occupations with the highest stable claim rates were ‘Healthcare Practitioners and Technical,’ ‘Healthcare Support,’ and ‘Office and Administrative Support’ with 35, 23, and 11 claims per 100,000 persons respectively (Figure 7).

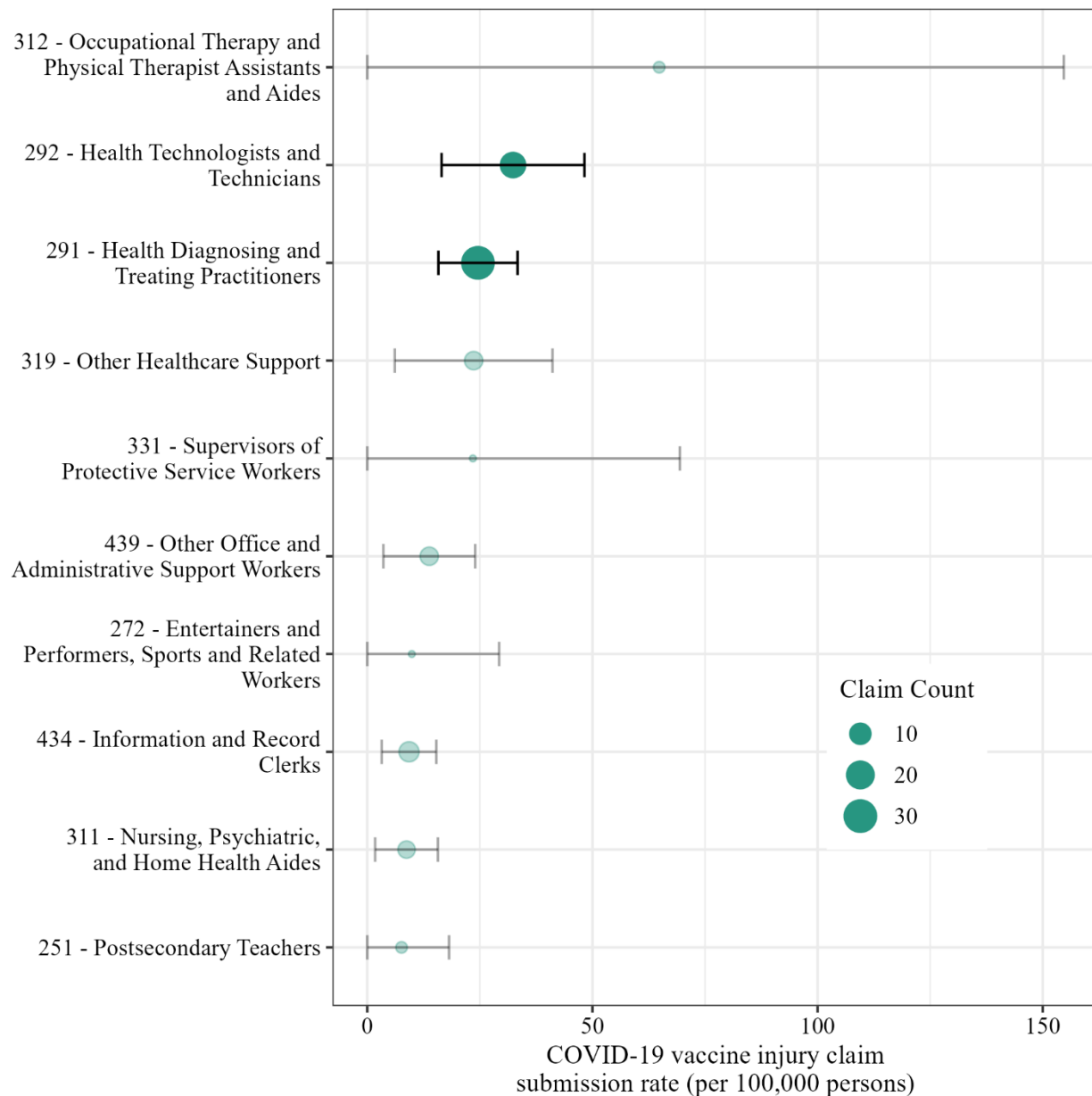
Figure 7: Top 10 major (2-digit) SOC occupations by COVID-19 vaccine injury WC claim rate (per 100,000 persons), Wisconsin, December 15, 2020–December 31, 2021.



Note: Due to the unreliability of the estimates, occupations with 10 or fewer claims are faded.

‘Health Technologists and Technicians’ and ‘Health Diagnosing and Treating Practitioners’ had the highest stable rates among minor-level occupations at 32.4 and 24.6 claims per 100,000 persons, respectively. Notably, 70% (n = 21) of ‘Health Diagnosing and Treating Practitioners’ claims were registered nurses. ‘Occupational Therapy and Physical Therapist Assistants and Aides’ stood out as well with 65 claims per 100,000 persons however, this estimate was not reliable given the small number of claims (Figure 8).

Figure 8: Top 10 minor (3-digit) SOC occupations by COVID-19 vaccine injury WC claim rate (per 100,000 persons), Wisconsin, December 15, 2020–December 31, 2021.



Notes: Due to the unreliability of the estimates, occupations with 10 or fewer claims are faded.

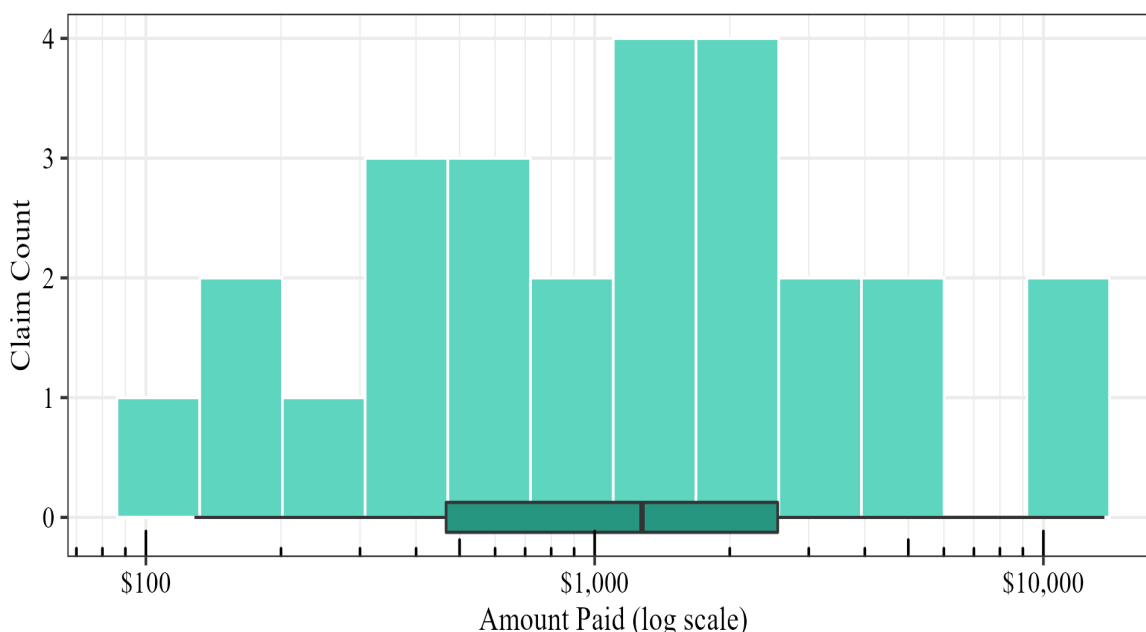
3.4 Paid claim description

The majority (72.1%) of WC COVID-19 vaccine injury claims were denied while 23.1% (n = 26) were paid out.

In total, \$58,892.27 was paid out for vaccine injury claims with a median payment of \$1,274.04 and a range of \$128.31 to \$13,675.00. The two highest paid claims were two to three times higher than the third highest paid claim, skewing payment data to the right (Figure 9). All three

claimants worked in a health care sector and two were practitioners. The highest paid claimant fell under ‘First-Line Supervisors of Office and Administrative Support Workers.’

Figure 9: COVID-19 vaccine injury WC claim payment distribution (log), Wisconsin, December 15, 2020–December 31, 2021.



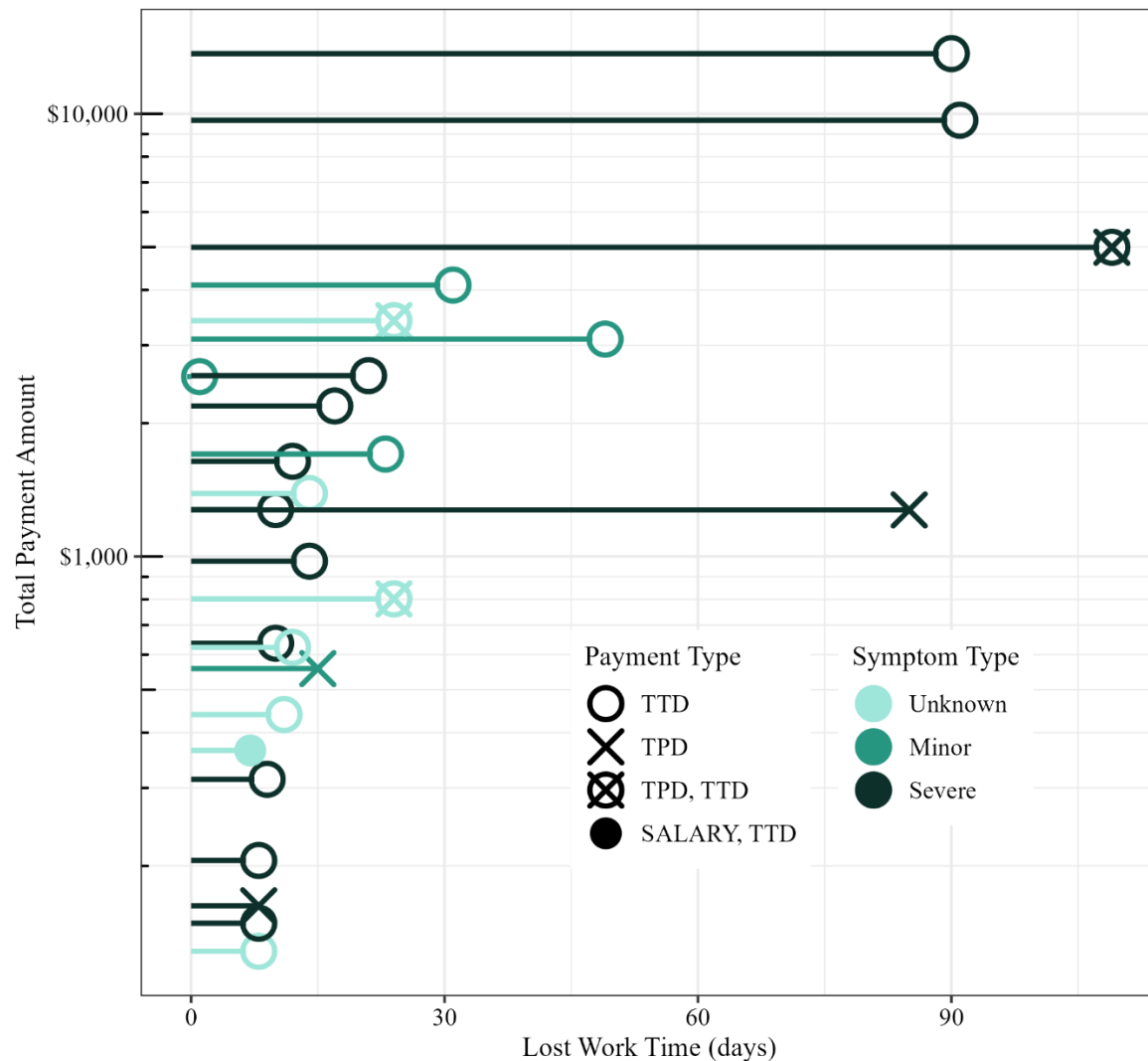
Note: Claims with claim status NL (No lost time) were excluded as they did not qualify for compensation.

The number of days of lost time per paid claim ranged from one to 109 with a median of 14 days. The majority of paid claims (53.8%) had 14 or fewer days of lost time. The most common payment type was ‘Temporary Total Disability’ (TTD) with 88.5% (n = 23) of paid claims having TTD payment or a combination of TTD and some other payment type (for claims with multiple payment periods) (Figure 10).

Of the 12 claims with more than two weeks of lost time, all were female between the ages of 21 and 60. Of the eight claims with race and ethnicity information, five were ‘White,’ two ‘Asian,’ one ‘Other Race,’ and all identified as ‘Non-Hispanic or Latino.’ All worked in health care settings, and 10 held health care occupations (for example, nurse, medical assistant, optician, etc.). The other two were a food server and building cleaning worker.

After manual review of injury descriptions of the 26 paid claims, 11 reported severe or uncommon symptoms (for example, heart problems or allergic reactions, etc.). Of those with severe symptoms, two indicated being hospitalized, both of which were TTD and had fewer than 14 days of lost time. Additionally, six claims had more than 14 days of lost time and reported severe symptoms. The remaining 17 claims either had minor symptoms (n = 6 claims; for example, flu-like symptoms, arm pain or swelling, etc.) or no symptoms reported in the injury description (n = 7 claims) (Figure 10).

Figure 10: WC COVID-19 vaccine injury paid claims with lost work time, Wisconsin, December 15, 2020–December 31, 2021.



4 Discussion

WC COVID-19 vaccine injury indemnity claims appear to be rare considering the volume of vaccines administered in Wisconsin, with about 4 claims per 100,000 vaccination events. Vaccine injury claims also make up a small proportion of WC claims at only 0.2% of all claims.

Paid COVID-19 vaccine injury claims with more than two weeks of lost time ($n = 12$) accounted for 11.5% of all vaccine injury claims, 0.5% of all COVID-19 related claims, and 0.04% of all WC claims filed during the study period. Of the 10 claims with more than two weeks of lost time that reported symptom information, 6 reported severe symptoms, accounting for 5.8% of all COVID-19 vaccine injury claims, 0.3% of all COVID-19 related claims, and less than 0.01% of all WC claims filed during the study period. In contrast, 89 COVID-19 claims reported more than two weeks of lost time, accounting for 3.8% of all COVID-19 claims and 0.3% of all claims filed during the study period.

Demographic and employment patterns of claims broadly aligned with other COVID-19 claims, with higher claim rates in those who identified as ‘Black or African-American’ and in those employed in healthcare, although those employed in administrative positions (healthcare and non-healthcare) stood out as well. The fact that vaccine injury claims were driven by those in healthcare is unsurprising as this is the only field that had an active [vaccine mandate](#) during the study period. A large volume of vaccination events, plus the fact that the mandate implied compensability, would predictably yield a higher vaccine injury claim rate than non-healthcare occupations and industries.

A small number of claims do appear to have caused significant disruption for a few workers, with four claims for over 85 days of lost time and up to \$10,000 in indemnity payments. Additionally, 11 workers reported severe symptoms and reactions to the COVID-19 vaccinations, with two leading to hospitalization. However, with a median payment of \$1,274.04 and most paid claims (53.8%) with two weeks or less of lost time, vaccine injury claims do not appear to have caused a large disruption to workers overall. The large number of denials and short indemnity periods may indicate low severity of injuries for most claimants. Furthermore, most claim payments were for TTD, indicating a short period away from work, followed by a full recovery and return to normal work.

Limitations

This report provides a detailed snapshot of vaccine injuries as reported by Wisconsin residents to administrative data systems (WC and VAERS). Vaccine injuries that were not reported by Wisconsin residents would not be accounted for in this report. As noted above, WC claims depend on factors beyond the injury itself (for example, a worker’s knowledge of WC and willingness to file a claim) and may therefore be assumed to under-count any type of work-related illness or injury, including vaccine injuries.

Although VAERS does include some mandatory reporting, it is a passive system and not comprehensive. Additionally, since VAERS accepts reports from individuals and clinicians,

there is a wide range of variability in adverse events reported or not reported (depending on general public knowledge of the system). Furthermore, an adverse event report in VAERS alone cannot be used to establish causation. Several other systems exist to monitor vaccine safety including the Vaccine Safety Datalink (VSD) and Clinical Immunization Safety Assessment (CISA). However, neither of these datasets were as readily available for public use as VAERS which, was sufficient for this report.

Notably, race and ethnicity data were missing for about one-third of vaccine injuries due to the lack of matching records in WIR despite mandatory vaccinator reporting. This may be due to WIR records being locked by patients, making them unavailable for this study.

It is possible that some injuries resulted from concurrent flu vaccination. Upon further review, none of the 104 vaccine injury claimants filed claims for flu vaccine injuries during the time period in question. WIR records for flu vaccinations were not examined.

Conclusions

In this report we summarized Wisconsin's WC data during December 2020 to December 2021 to characterize reported COVID-19 vaccine injuries among Wisconsin's working-age population. Wisconsin's WC data highlighted the few disabling effects these types of claims had on the workforce. Demographic distributions were consistent with those of COVID-19 illness claims, demonstrating disparities in some populations. Those few claims that were considered severe indicated successful recovery outcomes. This report shows how the [CDC assertion of the rarity of COVID-19 vaccine adverse effects](#) relative to the volume of vaccine doses administered to the population is also consistent with the workforce population.