2025 Bill No. 2181
Testimony before the Senate Industry & Business Committee
Presented by Tim Wahlin, Workforce Safety and Insurance
January 21, 2025

Mr. Chairman and Members of the Committee: My name is Tim Wahlin, Chief of Injury Services for Workforce Safety & Insurance (WSI). I am here today to provide testimony regarding Senate Bill No. 2181. The WSI Board voted unanimously to not support this bill. Within the deliberation of the bill, the Board expressed support for additional study and exploration of the subject, but it opposed the approach the bill employs and expressed apprehension about making such a profound change to our workers' compensation system with so little formal study and professional input.

Senate Bill 2181 amends the definition of "compensable injury" to, for the first time, include mental injuries from mental stimuli, making these non-physical injuries a compensable condition. Significant alterations to our workers' compensation system have the potential to be disruptive and can be costly. As a result, caution and discretion are important.

There are a number of areas in the bill that WSI submits should be considered and addressed. I will identify each within the respective bill sections.

SECTION 1:

Explicit clarity is required when defining compensable conditions, especially in an area that poses significant financial impacts. If clarity is lacking, it is generally provided through litigation which can be slow and expensive. Most importantly, lack of clarity jeopardizes the prompt and accurate adjudication of benefits due our injured employees. We urge further clarification at lines 13-17 on page 2, as it appears a typographical error exists. Perhaps the term "condition" at line 14 should be replaced with "work related incident." If this is not a typographical error, WSI is uncertain of the intent of the sentence.

Likewise, the term "mental injury" on line 18 and again on line 27 on page 2, should more specifically be "posttraumatic stress disorder." This would help to eliminate any possible confusion with other mental conditions that may preexist the post traumatic stress disorder or with which the posttraumatic stress disorder is to be compared.

Beginning at line 15 on page 2, the bill defines and uses the term "unusual stress." It defines the term as "stress of a greater dimension than the day-to-day emotional strain and tension experienced by similarly situated employees." A different definition of the term "unusual stress" already exists in NDCC 65-01-02(11)(a)(3) which coincidentally begins on line 23 of page 1 of the bill. There "unusual stress" is defined as "stress greater than the highest level of stress normally experienced or anticipated in that position or line of work." This definition is established, and litigation has clarified its meaning. Consequently, it would be WSI's preferred definition.

Next, the bill requires the post traumatic stress disorder be diagnosed by a psychiatrist or psychologist and meet the criteria in the "Diagnostic and Statistical Manual of Mental Disorders", American psychiatric association, (5th edition, text revision 2022) (hereafter DSM). To assist in your understanding, I have attached to this testimony an excerpt of the relevant portion taken from the National Institute's of Health website within its National Library of Medicine. The DSM requires eight diagnostic criteria that must be met. The first is exposure to an actual or threatened death, serious injury, or sexual violence. It must be directly experienced, witnessed in person, or

involve a close family member or friend, and must have been violent or accidental. And under the proposed language of this bill, been experienced in a work-related capacity.

The bill provides the disorder may not preexist the event. And it must be determined with reasonable medical certainty to be at least fifty percent of the cause as compared with all other contributing causes combined.

The second portion of subsection seven places WSI in a role in which it has never been. Sub part (b) makes posttraumatic stress disorder compensable in the event it arises from an employment action taken in bad faith. With this inclusion, it places WSI claims adjusters in the position of judging the motivations of employment actions in order to determine compensability. WSI is currently unequipped for these determinations. Claims adjusters do not have the requisite human resource expertise and would presumably need to build those skillsets in order to handle these claims.

This role would also undermine relationships built over years of interaction between the claims adjusters and the employers they assist. Currently, claims adjusters handle employer defined caseloads. The intention of this is so a claims adjuster can get to know an employer, learn their work practices, and coordinate any possible return to work issues. The goal is to establish rapport and positive relationships in order to assist with claims handling. That could easily be sacrificed if an adjuster is required to investigate motives surrounding an employer's human resource actions.

In 2015, the Legislative Assembly considered two bills establishing PTSD coverage for first responders. In those bills, personnel matters were specifically excluded from coverage. The relevant language was as follows:

> The posttraumatic stress disorder may not have resulted from an event or series of events that are incidental to normal employer and employee relations, including a personnel action by the employer such as a disciplinary action, work evaluation, transfer, promotion, demotion, salary review, or termination.

This language would eliminate WSI's concern of evaluating personnel matters in PTSD claims and is the preferred language to use.

SECTION 2:

This section repeats verbatim the terms of Section 1 which is necessary because of how the Century Code is arranged and how effective dates are reflected in the definition section.

SECTION 3:

This section apparently establishes caps on the duration of disability to thirty-two weeks and two claims per lifetime. It does not establish any caps on medical benefits which will run as long as the PTSD is active and requires medical care. Note that there appears to be a typographical error at line 5 on page 7. If the term "or" is correct, WSI is uncertain whether the two claims may result in sixty–four weeks of disability, or cumulatively thirty-two weeks. Clarification of this is necessary.

In addition, at Subsection (F.) of the attached DSM guidelines, post traumatic stress disorder may only be diagnosed if the "duration of the disturbance (Criteria B, C, D and E) is more than 1 month." The question then arises: Does disability begin at the point of diagnosis or is it to become retroactive up to thirty days from the point of diagnosis?

SECTION 4:

This act would apply for injuries sustained on or after August 1, 2025.

SECTION 5:

This act will expire or sunset without further legislative action on July 31, 2029.

Fiscal Impact:

Because this legislation has no precursor for comparison within North Dakota, there is insufficient data to comprehensively evaluate the impacts. However, using other jurisdictions as a guide, our actuaries anticipate that,

> "If passed in its present form, the legislation will act to increase both rates and reserves. For certain classes of business such as law enforcement, paid firefighters, and first responders, WSI anticipates that the rate increases could be significant."

Most employees in these classes are employed by governmental bodies so any rate increases will flow through to those tax structures.

We have seen PTSD legislation pass in Minnesota and the impacts have been significant.

This concludes my testimony. I am happy to answer any questions you may have.

DDSM Exhibit:

Link to exhibit source: Diagnostic Criteria for PTSD

Exhibit 1.3-4 DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

    1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
    2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
    3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
    4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
    5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

    1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

    2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

    1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).

    2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

    3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

    4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

    5. Markedly diminished interest or participation in significant activities.

    6. Feelings of detachment or estrangement from others.

    7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

    1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.

    2. Reckless or self-destructive behavior.

    3. Hypervigilance.

    4. Exaggerated startle response.

    5. Problems with concentration.

    6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.