North Dakota Legislative Council Interim Industry, Business, and Labor Committee
Committee Meeting March 6, 2008

Presentation of Dean J. Haas

Chairman Berg, and Members of the Committee:

Thank you for inviting me to appear before the Committee. My name is Dean Haas, and I'm appearing in my personal capacity, and not as a representative of the Attorney General, where I am currently employed. I've an abiding interest in the North Dakota Workers Compensation system, having spent 12 years as its Counsel, and another 5 years in private practice representing injured workers. I've written two law review articles about workers compensation, the second of which received considerable media coverage from the Fargo Forum. *See* Falling Down on the Job: Worker's Compensation Shifts from a No-Fault to a Worker-Fault Paradigm, 79 N.D. Law Rev. 203 (2003).

Rather than provide an abstract overview or criticism, today I'll point out the most significant topics that I believe warrant the attention of the next legislature.

I. Hearings decisions should be separated from the Insurance Function

First, as I wrote in my law review article, I continue to believe that the Adjudicative Function (deciding claims) should be separated from the Insurance Function of the Agency. Most states accomplish this by setting up an oversight agency that regulates all workers compensation insurers (including state funds). This oversight agency decides contested cases, and has its own hearing officers (who are thus completely independent of the insurance fund that pays the benefits). My law review article proposes creating a separate oversight agency independent of WSI; the current initiated measure accomplishes a separation of the adjudicatory function from the insurance function by requiring WSI to use the Office of Administrative Hearings, and making their decisions final (meaning that if WSI doesn't agree, the agency can't simply reverse the decision as they now are able to do, but will have to appeal to the courts and show that OAH's decision isn't reasonable).[1] If the initiated measure fails, I recommend that the legislature itself enact some kind of reform to separate the hearings process from the insurance function.

To illustrate this issue, imagine that you've filed a claim with your property insurer under the same kind of dispute process that govern workers compensation in this state. In that case, your property insurer will examine your claim, and make a decision. Suppose the

[1] N.D.C.C. § 28-32-46 provides the grounds for reversal of an agency decision. The Courts apply an extremely deferential standard of review, stated as whether a reasoning mind could have reasonably arrived at the decision. See *Victor v. Workforce Safety and Insurance*, 2006 ND 68 ¶ 13, 711 N.W.2d 188.

insurer decides that your claim is not covered because the damages are due to a flood, and your policy excludes flood coverage. You claim that the damages are due to storm (wind) rather than simply a flood. If the rules that pertain to deciding WSI disputes govern, the hearing would be decided by a hearing officer of your insurer's choice, and if the insurer didn't like the recommended decision, the insurer could simply reverse it. Your appeal to the courts would be limited to whether the decision was reasonable; a minimal standard that your insurer can probably meet—just as WSI is able to do. Or, suppose you claim damages to your home from a fire, and your insurer hires an expert—likely someone who commonly testifies for it—who opines that the fire is arson, and excluded. You may hire an expert stating that the fire was electrical, but under rules that govern WSI appeals, the hearing officer—again, hired by the insurer—might decide to give more weight to 'the defense expert.' Under the kind of rules that govern WSI decisions, you wouldn't get a jury trial on the issue, but would have to appeal the decision to the courts and show that a reasoning mind could not have made the decision—a tough standard. (Courts are loath to reverse agency decisions that were decided on a factual basis by a battle of experts). This is why it is important that the hearings officers be independent of the insurer, and the decision not be subject to reversal by the insurer.

II. Long-term Disability Benefits are generally unavailable for Injured Workers

WSI frequently boasts that its benefits generously compare to other states. This is true for injured workers whose disability doesn't last longer than a couple of years. But for the long-term injured, North Dakota's disability benefits are dismal, having been cut back by the legislature over several sessions. And it is the long-term disabled that are so upset—legitimately so—by the workers compensation system in this state. A leading actuary, Actuarial & Technical Solutions, Inc., in September published their *2007 Workers Compensation State Rankings*, on average statutory benefit provisions, and they concluded:

> *Average Statutory Benefit Provisions.* The study also compares the statutory provisions underlying the workers' compensation benefit delivery system in each of the states. An average statutory cost per case (excluding medical benefits) is calculated for each state. For both the 2006 and 2007 studies, North Dakota was ranked first with the lowest statutory benefits, and Nevada was ranked last with the highest statutory benefits. See: http://law.lexisnexis.com/blogs/Insurance/2007-Workers'-Compensation-State-Rankings-Now-Available

How has this happened? First, the interplay of N.D.C.C. § 65-01-02(25) and N.D.C.C. § 65-01-02(29) significantly limit availability of disability beyond two years. N.D.C.C. § 65-01-02(25) defines "permanent total disability," onerously, that it includes only those with:

a. Total and permanent loss of sight in both eyes;

b. Loss of both legs or loss of both feet at or above the ankle;
c. Loss of both arms or of both hands at or above the wrist
d. Loss of any two members [arms or legs as described above];
e. Permanent and complete paralysis of both legs or both arms or of one leg and one arm;
f. Third degree burns that cover at least forty percent of the body and require grafting;
g. A medically documented traumatic brain injury affecting cognitive and mental function which renders an employee unable to provide self-care and requires supervision or assistance with a majority of the activities of daily living.

Any person not meeting this very limited definition isn't permanently disabled, and under N.D.C.C. § 65-01-02(29) is merely temporarily totally disabled, and limited to two years (104 weeks) of temporary total disability.

After total disability benefits end at 2 years, the worker is shunted to partial disability status. But partial disability benefits are also capped: at five years of benefits. See N.D.C.C. § 65-05-10(2). Partial disability benefits are calculated by establishing an "earnings capacity," which may be established by an expert in vocational placement regarding the injured workers' capacity to earn in the statewide job pool. N.D.C.C. § 65-05-10(3). Partial disability benefits are two-thirds of the difference between pre-injury wage, and the artificially contrived earnings capacity. N.D.C.C. § 65-05-10. In practice, a vocational expert determines an earnings capacity by identifying a variety of one-size-fits-all light-duty low-skilled jobs that are usually available in this state.[2] Although the rehabilitation experts normally conclude that the injured worker retains earning capacity, many workers—especially those with limited educational backgrounds and a history of heavy work—never return to work. After five years of reduced partial disability benefits, these workers are left to their own devices.

Admittedly, determining whether a worker is totally disabled and how long it lasts (especially those with high school educations and a history of only heavy work) is the most difficult issue in workers compensation. Yet, limiting compensation in cases of permanent total or permanent partial disability (as opposed to little change in shorter term temporary total benefits) clearly shifts the costs of 'reform' to injured workers with more serious disabilities.

Workers whose disability benefits are discontinued because of a work release by a doctor, but subsequently find that their disability has recurred and worsened find obstacles to reinstatement. N.D.C.C. § 65-05-08(1), provides that if after disability benefits are discontinued, they cannot be reinstated unless the worker proves that:

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[2] *See* 79 N.D. Law Rev. 203 at 261, 265.

a. The employee has sustained a significant change in the compensable medical condition;

b. The employee has sustained an actual wage loss caused by the significant change in the compensable medical condition; and

c. The employee has not retired or voluntarily withdrawn from the job market....

In *Gronfur v. North Dakota Workers Compensation Fund*, 2003 ND 42 ¶ 9-14, 658 N.W.2d 337, the Court held that the injured worker must necessarily first demonstrate that he was earning wages from employment to show actual wage loss. In other words, any worker who had never been able to return to work—not uncommon—can't qualify for reinstatement of disability benefits even if the worker's condition requires surgery and results in an undisputed acute period of total disability during recuperation, and a eventually a significantly more restrictive work release (work restrictions—e.g., to light or sedentary work).

Similarly, N.D.C.C. § 65-05-35 creates a closed claim presumption, wherein any claim where no payment has been made for a period of four years is presumed closed. While the concept does make sense, the problem is that the statute is so stringent, requiring the injured worker show that the work injury is "the sole cause of the current symptoms." N.D.C.C. § 65-05-35(2). The problem is that causation is notoriously difficult to untangle. "Putatively, almost every injury could, with sufficient scrutiny, be linked to some preexisting weakness or susceptibility." *Balliet v. N.D. Workmen's Comp. Bureau*, 297 N.W.2d 791, 794 (N.D. 1980). It's a very rare case indeed that a worker will be able to show that the injury is "the sole cause" of the work restrictions. WSI may call for a physician to opine that one reason for the work restriction is the preexisting condition, even if it had been asymptomatic—and even his weight will he held against him. And the individual may have unrelated work restrictions (e.g., blindness), which might not be taken into account.

I recommend that the legislature consider amending N.D.C.C. §§ 65-01-02(25) and 65-01-02(29) eliminating the cap of 2 years of permanent total disability benefits, and eliminating the 5 year cap on partial disability established by N.D.C.C. § 65-05-10(2). The legislature should consider amending N.D.C.C. § 65-05-08(1)(b), substituting the term "a loss of earning capacity" for the term "an actual wage loss." The legislature should consider amending N.D.C.C. § 65-05-35(2), substituting "a significant cause" for "the sole cause."

III. The term compensable injury is narrowly drawn.

To receive workers compensation, the worker must prove a "compensable injury" under N.D.C.C. § 65-01-02(10). The definition reflects a "reform" standard meaning "injury by accident arising out of and in the course of hazardous employment which must be

established by medical evidence supported by objective medical findings." *Id.* The purpose may be to cull out those who suffer only from pain, or more likely, to discover malingering. The term is excessively narrow in several respects: for example, subsection (a)(3) has eliminated compensation for heart attack (requiring proof that work stress is at least 50% of the cause, and induced by unusual stress); subsection (a)(6) has nearly eliminated compensation for mental injury caused by a physical injury at work (requiring proof that the physical injury is at least 50% of the cause, and only if the mental condition didn't pre-exist the work injury (e.g., how would you prove that your depression is "at least 50% related" to your chronic pain syndrome, and note that if you had ever been prone to depression, you almost certainly can't meet the test); and subsection (b)(10) has completely eliminated compensability for any mental injury caused by a mental stimulus.

But most importantly, WSI has narrowly interpreted N.D.C.C. § 65-01-02(10)(b)(7)&(9), frequently claiming that the worker's injury is attributable to a pre-existing condition (and that the employment did not substantially accelerate the injury's progression, or worsen its severity); or that the worker's symptoms are due to a latent or asymptomatic degenerative condition simply triggered or made active by a work injury. This denial of compensation may occur in any case where the body has some pre-existing defect: say degenerative disc disease, or spinal stenosis, or spondylolisthesis. In many of these cases, the worker may not even know he is afflicted, but radiographic evidence may show that the condition had been there prior to the injury, and, according to the doctor, the degenerative condition itself looks the same now on a repeat test (x-ray, MRI).[3] A summary from my law review article states it thus:

> If, for example, an independent medical evaluation (IME) states that a worker's fall from a ladder merely triggered symptoms in degenerative disc disease but did not alter the course of the disease, one must ask what is being measured. The IME opinion will almost certainly rest on the fact that the condition itself, as measured radiographically by narrowing of the disc space, did not show any change after the fall. Yet, the worker's life might be utterly shattered. If the fall triggers symptoms that require medical attention and result in disability, the worker certainly suffers a significant worsening in the severity of his or her condition. The answer should be that we look to the effect of the fall on the worker's health, life, his need for medical attention, and disability, not on whether the fall altered the appearance of an MRI.

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[3] *See Geck v. N.D. Workers Comp. Bureau*, 1998 ND 158, 583 N.W.2d 621. In *Geck*, the court remanded the case so the Bureau could consider whether a fall at work had "triggered" a worsening of her preexisting arthritis of the knee. 583 N.W.2d at ¶ 9. Prior to the fall, her condition had been asymptomatic. *Id.* The majority found the distinction between worsening the "condition itself" and the symptoms to be without significance. *Id.* at ¶ 10.

70 N.D. Law Rev. at 238.

I recommend that the legislature consider amending N.D.C.C. § 65-01-02(10)(b)(7). The statute should provide that the relevant measurement is the *effect of the injury*, not whether the pre-existing condition changes its appearance on an MRI. For example, subsection 7 could be amended to read that non-compensable injuries include: "Injuries attributable to a preexisting injury, disease, or other condition, including when the employment acts as a trigger to produce symptoms in the preexisting injury, disease, or other condition unless the employment substantially accelerates its progression or substantially worsens its severity, as measured by the changes in symptoms, need for medical attention and disability."

IV. Give more weight to the treating doctor.

Medical opinions are essential to most of the decisions in workers compensation matters: including an opinion whether the injury or disease is work-related, the nature of the medical care, the extent of the permanent impairment and disability (work restrictions). WSI frequently utilizes 'defense-minded' doctors to perform 'Independent Medical Evaluations' (IME's), to contradict the opinion of the treating doctor. Admittedly, treating doctors may become prone to patient advocacy, and a second opinion warranted. But the opposite result—hiring an expert to provide an adverse opinion to counter what appears to be standard medical opinion—is the more pernicious. When I began work at the State Fund, it was more common to solicit actual treating physicians to conduct the IME's. It seems that currently there is little stomach among treating doctors to subject themselves to doing this service. If this reluctance is not overcome, I recommend that the legislature consider enacting a 'burden shifting' mechanism to give the opinion of the treating physician more weight—as exists in social security disability cases.[4]

[4] "In considering a claim for disability benefits, greater weight should be given to the findings of a treating physician than to a physician who has examined the claimant as a consultant." *Adorno v. Shalala*, 40 F.3d 43, 47 (3d Cir. 1994).