2020 Worker's Compensation Institute
November 18, 2020
Index

ICLEF Electronic Publications

Feature Release 4.1
August 2020

To get the most out of your *ICLEF Electronic Publication,* download this material to your PC and use Adobe Acrobat® to open the document. The most current version of the Adobe® software may be found and installed by clicking on one of the following links for either the free Adobe Acrobat Reader® or the full retail version of Adobe Acrobat®.

Feature list:

1. **Searchable** – All ICLEF Electronic Publications are word searchable. To begin your search, click on the "spyglass" icon at the top of the page while using the Adobe® software.
1. **Bookmarks** – Once the publication is opened using the Adobe Acrobat® software a list of bookmarks will be found in a column located on the left side of the page. Click on a bookmark to advance to that place in the document.
2. **Hypertext Links** – All of the hypertext links provided by our authors are active in the document. Simply click on them to navigate to the information.
3. **Book Index** – We are adding an INDEX at the beginning of each of our publications. The INDEX provides "jump links" to the portion of the publication you wish to review. Simply left click on a topic / listing within the INDEX page(s) to go to that topic within the materials. To return to the INDEX page either select the "INDEX" bookmark from the top left column or right-click with the mouse within the publication and select the words "*Previous View*" to return to the spot within the INDEX page where you began your search.

Please feel free to contact ICLEF with additional suggestions on ways we may further improve our electronic publications. Thank you.

Indiana Continuing Legal Education Forum (ICLEF)
230 East Ohio Street, Suite 300
Indianapolis, Indiana 46204
Ph: 317-637-9102 // Fax: 317-633-8780 // email: iclef@iclef.org
URL: https://iclef.org

WORKER'S COMPENSATION INSTITUTE

November 18, 2020

www.ICLEF.org

DISCLAIMER

The information and procedures set forth in this practice manual are subject to constant change and therefore should serve only as a foundation for further investigation and study of the current law and procedures related to the subject matter covered herein. Further, the forms contained within this manual are samples only and were designed for use in a particular situation involving parties which had certain needs which these documents met. All information, procedures and forms contained herein should be very carefully reviewed and should serve only as a guide for use in specific situations.

The Indiana Continuing Legal Education Forum and contributing authors hereby disclaim any and all responsibility or liability, which may be asserted or claimed arising from or claimed to have arisen from reliance upon the procedures and information or utilization of the forms set forth in this manual, by the attorney or non-attorney.

Attendance of ICLEF presentations does not qualify a registrant as an expert or specialist in any discipline of the practice of law. The ICLEF logo is a registered trademark and use of the trademark without ICLEF's express written permission is prohibited. ICLEF does not certify its registrants as specialists or expert practitioners of law. ICLEF is an equal opportunity provider of continuing legal education that does not discriminate on the basis of gender, race, age, creed, handicap, color or national origin. ICLEF reserves the right to refuse to admit any person or to eject any person, whose conduct is perceived to be physically or emotionally threatening, disruptive or disrespectful of ICLEF registrants, faculty or staff.

INDIANA CONTINUING LEGAL EDUCATION FORUM

OFFICERS

TERESA L. TODD
President

LYNNETTE GRAY
Vice President

HON. ANDREW R. BLOCH
Secretary

SARAH L. BLAKE
Treasurer

ALAN M. HUX
Appointed Member

LINDA K. MEIER
Appointed Member

DIRECTORS

James H. Austen
Sarah L. Blake
Hon. Andrew R. Bloch
Melanie M. Dunajeski
Mark A. Foster
Lynnette Gray
Alan M. Hux
Dr. Michael J. Jenuwine
Dean Jonna Kane MacDougall
Thomas A. Massey
Linda K. Meier
Richard S. Pitts
Jeffrey P. Smith
Teresa L. Todd
Inge Van der Cruysse

ICLEF

SCOTT E. KING
Executive Director

James R. Whitesell
Senior Program Director

Jeffrey A. Lawson
Program Director

WORKER'S COMPENSATION INSTITUTE

Agenda

8:30 A.M.	Registration
8:55 A.M.	**Welcome and Course Objectives** ***- Hon. Linda P. Hamilton,* Seminar Chair**
9:00 A.M.	Occupational Diseases Act. How it differs from the Worker's Compensation Act and what you need to know to successfully handle a claim *- Gary P. Goodin*
10:10 A.M.	**Break**
10:25 A.M.	Preparing for and Presenting a Case to the Full Worker's Compensation Board *- Douglas W. Meagher, Kyle L. Samons*
11:35 A.M.	Questions and Answers
11:45 A.M.	**Lunch Break (On your own)**
12:45 P.M.	Worker's Compensation Ethics Discussion *- Sharon Funcheon Murphy, Douglas W. Meagher, Kyle L. Samons*
1:15 P.M.	The Future of Worker's Compensation (topic inspired by the written work of author Rick Victor) *- Sharon Funcheon Murphy*
2:15 P.M.	**Break**
2:30 P.M.	Representing Public Entities, Municipalities, Police and Fire, as well as Public Utilities and Other Such Employers Under IC 22-3-2-5 *- John N. Shanks II*
3:30 P.M.	COVID-19 as a Worker's Compensation Claim *- Stephen E. Dever*
4:30 P.M.	**Adjournment**

November 18, 2020

WORKER'S COMPENSATION INSTITUTE

Faculty

Hon. Linda P. Hamilton - Chair
Chairman
Worker's Compensation Board of Indiana
402 West Washington Street, Room W196
Indianapolis, IN 46204
ph: (317) 232-3811
fax: (317) 233-5493
e-mail: lindahamilton1113@gmail.com

Mr. Stephen E. Dever
Hunt Suedhoff Kalamaros LLP
803 South Calhoun Street, 9th Floor
Fort Wayne, IN 46858
ph: (260) 423-1311
fax: (260) 424-5396
e-mail: sdever@hsk-law.com

Mr. Gary P. Goodin
Goodin Meyer, P.C.
3021 East 98th Street, Suite 140
Indianapolis, IN 46280
ph: (317) 204-2020
fax: (317) 204-2017
e-mail: ggoodin@goodinmeyer.com

Hon. Douglas W. Meagher
Worker's Compensation Board of Indiana
402 West Washington Street, Room W196
Indianapolis, IN 46204
ph: (317) 919-1406
e-mail: dwmeagher57@gmail.com

Ms. Sharon Funcheon Murphy
SF Murphy Law
704 Adams Street, Suite F
Carmel, IN 46032
ph: (317) 660-2424
fax: (317) 848-6197
e-mail: sfmurphylaw@gmail.com

Hon. Kyle L. Samons
Worker's Compensation Board of Indiana
402 West Washington Street, Room W196
Indianapolis, IN 46204
ph: (317) 232-3822
e-mail: kyle.samons04@gmail.com

Mr. John N. Shanks II
Shanks Law Office
349 North 500 West
Anderson, IN 46011
ph: (765) 208-1483
e-mail: jnshanks@aol.com

Hon. Linda P. Hamilton
Chair, Indiana Worker's Compensation Board, Indianapolis

Governor Mitch Daniels appointed Linda as the Chairman of the Indiana Worker's Compensation Board in August of 2005. She had served as a Single Hearing Member of the Board since 1995, following her original appointment by Governor Evan Bayh. Linda grew up in Porter County, Indiana and attended Indiana University in Bloomington, where she graduated Phi Beta Kappa and thereafter received her law degree in 1983. After graduation, Linda clerked for the Honorable Judge Robert W. Neal of the Court of Appeals of Indiana for two years before joining the Fort Wayne law firm of Helmke, Beams, Boyer and Wagner. In 1991, she resigned her partnership in the firm to resume full-time work in the public sector as the City of Fort Wayne's staff attorney and later Corporate Counsel to City Utilities. In August of 2002 Linda left her City legal career to concentrate her professional efforts on worker's compensation matters.

Stephen E Dever

Partner

Return to Attorney Directory

Stephen Dever is a partner in the Fort Wayne, Indiana office. He practices in the areas of general insurance litigation, worker's compensation, insurance coverage, first party litigation and real estate transactions. Mr. Dever received his B.S. from Indiana University-Purdue University Fort Wayne in 1989 followed by his Doctorate of Jurisprudence from Indiana University School of Law in 1995.

Practice Emphasis

- General Insurance Litigation
- Worker's Compensation
- Insurance Coverage
- First Party Litigation
- Real Estate Transactions

Professional Associations and Memberships

- Indiana State Bar Association
- Nevada State Bar Association
- Allen County Bar Association
- Claims and Litigation Management
- Defense Research Institute
- Indiana Worker's Compensation Institute

Bar Admissions

- Indiana State Bar
- Nevada State Bar
- U.S. District Court, Northern and Southern Districts of Indiana
- U.S. Court of Appeals, Seventh Circuit
- Worker's Compensation Board of Indiana

Education

- Indiana University-Purdue University Fort Wayne, B.S., 1989
- Indiana University School of Law, J.D., 1995

Additional Experience / Awards

- Mediator
- Author and Speaker

Publications

- "Fundamentals of Workers' Compensation" 2017
- "Workers' Compensation Law and Practice" 2015
- "Managing Liens and Subrogation in Auto Accident Litigation" 2012
- "Uninsured/Underinsured Motorists Insurance Update" 2009
- "Recent Development in Worker's Compensation Law" 2001 and 2005
- "Worker's Compensation in Indiana" 1988

Reported Cases

- Salomon v. Cincinnati Insurance Company, 954 F.Supp. 2d 828 (N.D. Ind. 2013)

Contact Stephen

Fort Wayne Office
803 South Calhoun, 9th Floor
P.O. Box 11489
Fort Wayne, IN 46858-1489
260-423-1311

sdever@hsk-law.com

GARY P. GOODIN is a founding principal with the law firm of Goodin Meyer, P.C. He has been practicing in the area of labor and employment defense since 1990. Mr. Goodin has assisted employers with all aspects of the employment relationship from reviewing and drafting employee handbooks, to defending employers in nearly all administrative and judicial forums, including the Worker's Compensation Board of Indiana. He has written numerous articles and speaks often to management groups and other interested parties on a wide variety of employment related topics, including worker's compensation issues in Indiana. He earned both his B.S. degree and his M.P.A. degree from the Indiana University School of Public & Environmental Affairs in Bloomington, Indiana, and his J.D. degree from the Indiana University Michael Maurer School of Law in Bloomington, Indiana.

Douglas W. Meagher
Indiana Worker's Compensation Board
402 West Washington Street, Room W196
Indianapolis, Indiana 46204

Douglas Meagher was born and raised in Crawfordsville, Indiana, and is a graduate of Crawfordsville High School. He received his Bachelor of Science and Master of Public Administration degrees from Indiana State University and his Juris Doctorate degree from the Indiana University McKinney School of Law in Indianapolis.

Mr. Meagher began his career with Indiana state government with appointment to the Governor's Fellowship Program in 1983. He served as Executive Secretary of the Indiana Worker's Compensation Board from 1989 to 1994, and as a Member of the Board from 1994 to 1999. He practiced worker's compensation defense from 1999 to 2017, and was appointed a Member of the Board again in 2017.

SHARON MURPHY is a solo practitioner in Carmel, Indiana. She primarily represents employers in workers' compensation litigation. She graduated from IU McKinney School of Law summa cum laude in 1982. Since then she has practiced law in a variety of settings (in a small Lafayette law firm, as in-house insurance counsel, as a partner in a mid-sized Indianapolis firm, and as a solo practitioner) concentrating her practice in various types of litigation. She has been active throughout her career in several Bar Associations including as a Council Member and officer of the American Bar Association Tort Trial and Insurance Practice Section, as chair of the DTCI Workers' Compensation Committee, and as a member and frequent volunteer for the Indiana and Indianapolis Bar Associations. She was a founding Fellow and past President of the College of Workers' Compensation Lawyers and is currently an emeritus member of the Board. She is also a high school English teacher, a Starfish volunteer, and a Board Member of Reach for Youth.

Kyle L. Samons
Indiana Worker's Compensation Board, Indianapolis

Kyle Samons is a Hearing Judge with the Indiana Worker's Compensation Board. He was raised in Georgetown, Indiana and graduated from Floyd Central High School in 1999, then graduated from the University of Louisville with a Bachelor's degree in History and a minor in Political Science. Kyle's law degree is from the Louis D. Brandeis School of Law at the University of Louisville.

Military Service:

Kyle's studies at the University of Louisville were broken up when he enlisted in the United States Navy in October 2001. Kyle was a Plankowner aboard USS Chafee (DDG 90) and reached the rank of Petty Officer Second Class. During his time in the Navy Kyle deployed to the Northern Arabian Gulf in support of Operation Iraqi Freedom and Operation Enduring Freedom. Following four years of service, Kyle returned home to resume his studies at the University of Louisville.

Family:

In 2004 Kyle married Rebekah 'Ball' Samons from Fort Worth, Texas. Kyle and Rebekah now live in Greenville, Indiana with their four children.

John N. Shanks II
Shanks Law Office, Anderson

John Shanks grew up in Johnson County, graduated from Center Grove High School and attended Indiana University (Air Force ROTC) in Bloomington, Indiana graduating in 1968 with a Bachelor of Arts in Sociology. He attended Indiana University School of Law in Indianapolis (a/k/a McKinney School of Law) receiving his JD in 1971.Moving forward he entered active duty in the U.S. Air Force, Judge Advocate General's Office, until being honorably discharged as a Reserve Officer (Captain) in 1978.

John was appointed Chair of the Indiana Worker's Compensation Board by Governor Robert D. Orr (1981-1988) following his service as Executive Director of the Indiana State Election Board under Governor Otis R. Bowen (1978-1980). Prior to that appointment John served the citizens of Indiana as the Hearings Commissioner for the Indiana Department of Natural Resources, Assistant Attorney General and Director of the Attorney General's Consumer Protection Division. During his terms as Chair of the Worker's Compensation Board he served on the Executive Committee and as Vice-president of the International Association of Industrial Accident Boards and Commissions (IAIABC) and founded the International Worker's Compensation Foundation and served as President (1986 -1991) and was a member of the Boards of Trustees until 1993.

In 1989, John helped form two worker's compensation related non-profit organizations: the Indiana Worker's Compensation Institute (IWCI) and a self-funded worker's compensation risk sharing pool of more than 600 public entities known as the Indiana Public Employer's Plan, Inc. (IPEP) and served as president for 17 years. John works with the Indiana Coalition Against Domestic Violence representing victims of domestic violence in protective order and dissolution of marriage cases at no cost to the victim. His general practice includes formation and management of nonprofit organizations, civil, domestic and worker's compensation litigation and criminal defense.

Table of Contents

Section One

Occupational Diseases Act..... Gary P. Goodin

Section Two

Appeal of Claims to the Full Worker's Compensation Board.....Douglas Meagher
Kyle Samons

Section Three

Worker's Compensation in 2030
Where are we Going?..... Sharon Funcheon Murphy

Section Four

Representing Public Entities, Municipalities, Police and Fire as well as Public Utilities under IC 22-3-2-5.....John N. Shanks II

PowerPoint Presentation

Slide Narrative

Section Five

Section One

Occupational Diseases Act

Gary P. Goodin
Goodin Meyer, P.C.
Indianapolis, Indiana

Section One

Occupational Diseases Act…….... Gary P. Goodin

I. INTRODUCTION

Typically, not many practitioners deal with Occupational Diseases Act cases, and since such cases are few and far between, there is little case law meat on the statutory bones. The main purpose of this presentation is to give guidance on the handling of Occupational Diseases Act cases.

The Occupational Diseases Act was first enacted in 1937. The Worker's Compensation Act provides coverage for accidents, which requires a traumatic or unexpected event. As a result, there was no coverage for workplace exposure to hazardous materials since these were not accidents. See General Printing Corporation v. Umback, 195 N.E. 281 (Ind.App. 1935), which held that lead poisoning resulting from working with paints and dyes was not an injury "by accident" and therefore, not covered under the Worker's Compensation Act.

Despite the fact that the Occupational Diseases Act has been in existence since 1937, there have not been many reported cases, not nearly as many as for the Act. Even though there may not be a plethora of case law for the Occupational Diseases Act, a great deal of the structure and Board procedures are similar between the two Acts and as a result, some Occupational Diseases Act guidance can be taken from the corresponding sections of the Worker's Compensation Act.

II. OCCUPATIONAL DISEASES ACT REQUIREMENTS

A. Occupational Disease Defined

I.C. 22-3-7-l0(a) and (b) define occupational disease as:

> (a) As used in this chapter, "occupational disease" means a disease arising out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where such diseases follow as an incident of an occupational disease as defined in this section.
>
> (b) A disease arises out of the employment only if there is apparent to the

> rational mind, upon consideration of all of the circumstances, a direct causal connection between the conditions under which the work is performed and the occupational disease, and which can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as the proximate cause, and which does not come from a hazard to which worker's would have been equally exposed outside of the employment. The disease must be incidental to the character of the business and not independent of the relation of employer and employee. The disease need not have been foreseen or expected, but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.

It is important to note that this definition states that no compensation shall be awarded when the worker would have been equally exposed outside of the employment and also excludes "ordinary diseases of life", except that it further provides that this exclusion does not apply if the disease "follows as an incident of an occupational disease". As a result, certain diseases have been excluded if the exposure existed outside the employment. In Buford v. American Tel. & Tel. Co., 881 F.2d 432 (7th Cir 1989), the Court held that the essence of an Occupational Diseases Act claim is harm resulting from exposure to dangerous conditions inherent in the workplace but not ordinarily encountered outside employment. In Star Pub. Co. v. Jackson, 58 N.E.2d 202 (Ind. App. 1944) the Court held that an occupational disease, within the meaning of the Occupational Diseases Act, was one which developed from, and had a direct causal connection to, the work conditions, and which resulted from an exposure incidental to a particular employment, and was not caused by a hazard to which workers would have been equally exposed outside employment.

In Schwitzer-Cummins Co. v Hacker, 112 N.E.2d 221 (Ind.App. 1953), the Court addressed the issue of ordinary disease of life. In Hacker, the employee alleged he contracted bronchiectasis from inhaling iron oxide while working. The Court addressed the ordinary disease of life defense. The Court stated:

> The question is not whether the workman has a disease which is more less common to others of the general public, but whether the particular conditions

> of his work were such as to cause and did cause him to acquire the disease. Hacker, at 225.
>
> In determining whether a disease suffered by a workman is one "to which the general public is exposed," consideration must be given to the circumstances and the conditions under which he is required to labor. As heretofore stated, the disease itself may be "ordinary" in the sense that it is an ailment to which many people are exposed to and suffer from, but the conditions of employment of the workmen may involve a special or inherent risk or hazard of disease to which he is exposed but to which the public is not exposed. For a disease to arise out of the employment imports that the nature and conditions of the employment are such that the contracted disease was one likely to be acquired by the workmen in that employment. Where it appears that the causative danger is inherent in or peculiar to the work performed under the then prevailing conditions which are not common to the general public outside the employment, the disease arises from the employment if it is causally connected therewith. Hacker, at 228.
>
> There is nothing in our Act which requires or implies that the work conditions must subject all the employees as a "class" to the same exposure… All members of the human family are not physically constituted alike. Some are more susceptible to a given disease than are others. Some have greater powers of resistance to disease elements of a given nature… Some are "allergic" to certain substances, conditions, or gases. It may conceded that under the conditions of work the "exposure" may be common to all the employees, whether by class or otherwise, but it does not result that all of the employees would necessarily become afflicted with the disease. If appellant means by his said "characteristic" that all employees in the same place and under identical conditions are alike "exposed" to the same hazard of disease, we find no fault therewith. But if it is meant that in order to fall within the definition of occupational disease as given in Section 6 of the Act, the disease must have a tendency to effect all the employees as a "class", we cannot subscribe thereto. Hacker, at 228.
>
> It is noted that Subd. (b) of the Act, providing the requisites necessary for a disease to be considered occupational, and to which an ordinary disease common to the public must be incidental, does not except such ordinary diseases from its provisions. Hacker, at 230.

The Hacker holding is significant in that the key issue is whether or not the disease arose out of or was caused by the occupational exposure despite additional non-occupational exposures. However, as espoused in I.C. 22-3-7-10(b), providing recovery preclusion if the employee was equally exposed outside of employment, employees must still prove that the employment exposed them to a greater extent than the general public. As with Worker's Compensation Act cases,

medical expert opinions are a key element in proving the causal element.

In May v. Ashley F. Ward, Inc., 952 N.E.2d 224 (Ind.App. 2011), the Court looked to expert medical testimony in finding that the employee's workplace exposure caused his cancer. The Court held that because the employee was exposed to activated heavy metals on a consistent basis while working for the employer and his treating physician presented expert testimony linking his workplace exposure to his cancer, he met his burden of establishing causation by showing that his cancer was the result of an occupational disease.

In Casey v. Stedman Foundry & Machine Co., 186 N.E.2d 177 (Ind.App. 1963) the Board and the Court denied employee's claim that his pulmonary emphysema and fibrosis was the result of exposure to dust and gas fumes at work. The Court relied heavily upon medical evidence suggesting that the employee's condition was a result of non-work-related emphysema.

B. Disablement Required for Recovery

I.C. 22-3-7-9(f) provides that:

> For purposes of this chapter, no compensation shall be payable for or on account of any occupational diseases unless disablement, as defined in subsection (e), occurs within two (2) years after the last day of the last exposure to the hazards of the disease ...

As a result, disablement is required for recovery under the Occupational Disease Act.

Disablement is defined in I.C. 22-3-7-9(e) as:

> …the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom the employee claims compensation or equal wages in other suitable employment, and "disability" means the state of being so incapacitated.

The Court in Zike v. Onkyo Manufacturing, Inc., 622 N.E.2d 1055 (Ind.App. 1993) addressed the issue of what constitutes disablement for purposes of the Occupational Diseases Act. In Zike, the employee was exposed to soldering fumes, which caused her to develop

hypersensitized pneumonitis. She was discharged when it was determined that she could not return to work and she received temporary total disability benefits. The employee sought a continuation of temporary total disability benefits, but the Board denied her claim on the ground that she was able to perform other types of work even though she could not return to her previous employment. The Board indicated that the employee's hypersensitivity to these exposures occurred only when she was around the offending chemicals. Once removed, she suffered no disability of any kind.

The employee appealed and the Court reversed, holding that the Board erred when it applied the standard of disability under the Worker's Compensation Act: that standard related to the capacity for work. Under the Occupational Diseases Act, the standard of "disablement" was that an employee was permanently unable to earn any wages at his or her last work or in other suitable employment. The Board's findings had focused on the employee's ability to work, rather on her ability to earn wages.

C. Time Limitations

There are two initial time limitations that must be considered when filing an occupational disease claim. I.C. 22-3-7-32(c) provides that:

> No proceedings by an employee for compensation under this chapter shall be maintained unless claim for compensation shall be filed by the employee with the worker's compensation board within two years after the date of disablement.

I.C. 22-3-7-9(f) further provides:

> For purposes of this chapter, no compensation shall be payable for or on account of any occupational diseases unless disablement, as defined in subsection (e), occurs within two (2) years after the last day of the last exposure to the hazards of the disease ...

As a result, the timely filing of an occupational disease claim requires: (1) that disablement occurs within two years of the last day of the last exposure, and (2) that the employee file a claim within two years after the date of this disablement. The time periods contained in I.C. 22-3-7-9(f)

are extended for: silica dust or coal dust (3 years), radiation (two years from the date the employee had knowledge of the condition), and either 3, 20 or 35 years in the case of asbestos. In the case of asbestos, claims involving asbestos inhalation prior to July 1, 1985, require that disablement occur within three years of the date of last exposure. If the last day of exposure was between July 1, 1985, and July 1, 1988, disablement must occur within 20 years of the last date of exposure. However, if the last day of exposure was after July 1, 1988, then the disablement must occur within 35 years of the date of last exposure.

It is important to note that is a non-claim statute and is similar to the two-year time limitations located at I.C. 22-3-3-3.

D. Employer/Carrier Liability

As one can imagine, when an employee has worked for several employers over the course of years and claims long-term exposure, issues arise as to which employer is responsible. To avoid confusion and to create more of a bright line rule, I.C. 22-3-7-33 was enacted. I.C. 22-3-7-33 states:

> An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when for any length of time, however short, he is employed in an occupation or process in which the hazard of the disease exists. The employer liable for the compensation provided for in this chapter shall be the employer in whose employment the employee was last exposed to the hazards of the occupational disease claimed upon regardless of the length of time of the last exposure. In cases involving silicosis or asbestos, the only employer liable shall be the last employer in whose employment the employee was last exposed during the period of 60 days or more to the hazard of the occupational disease. In cases involving silicosis or asbestos, an exposure during a period of less than 60 days, shall not be considered a last exposure. The insurance carrier liable shall be the carrier whose policy was in effect covering the employer liable on the last day of the exposure rendering the employer liable, in accordance with the provisions of this chapter.

The above section provides injured employees with a presumption of hazardous exposure without having to prove the extent of that exposure. The statute further creates a system by which

successive insurance carriers may resolve coverage disputes without detriment to the injured employee. It removes the difficult task of apportioning liability between successive carriers.

The issue is: whether or not the last day of exposure "rendering the employer liable" refers to the last day of the exposure which in fact caused the disease, or whether it was the actual last day of exposure. See Durham Manufacturing Co. v. Hutchins , 58 N.E.2d 444 (Ind.App. 1945). The Durham case seems to suggest that the Board may consider whether a current disablement is simply a reoccurrence of a previous injury. In Durham, the employee had contracted lead poisoning from fumes and vapors during a course of employment that expanded several years. The employee became disabled and ceased working on November 27, 1942. However, he had missed work on several occasions in both 1940 and 1941. Liberty Mutual had been the carrier up through March 1, 1942, the subsequent carrier held a policy for the period of March 1, 1942 through November 15, 1942, and Bituminous provided coverage commencing November 15, 1942. Despite the fact Bituminous was on the coverage for just over a month, the Court held it was liable for the employee's injury since it was the last carrier on the coverage. However, the court seemed to suggest another alternative. To the extent a carrier could prove exposures relating to its policy period did not have a causal relationship, then the carrier might be able to avoid liability.

The Durham court raised the question relating to the definition of the last date "rendering the employer liable" in stating that:

> Liability is not necessarily imposed upon the insurer whose policy is in effect on the last day the employee worked for the employer, nor upon the insurer who carried the risk on the last day the employee was exposed to the disease causing disablement. It is imposed upon the insurer on the risk on the last day of the exposure rendering the employer liable. The question is, therefore, what was the exposure rendering the employer liable in this case, and what was the last day of that exposure?

Durham, at 483.

A similar result was reached in Employer's Liability Insurance Company v. Merit, 75 N.E.2d 803 (Ind.App. 1947). In Merit, the employee had contracted silicosis. Lumbermans Mutual Casualty Company had been the carrier for several years until very shortly before the stipulated date of disability of October 7, 1944. Just six days prior to the date of disability, Employer's Liability Insurance Company also became a carrier of the defendant employer. The court ruled that although Employer's Liability Insurance Company had been on the coverage for a minimal amount of time, they were nonetheless liable for the employee's occupational disease. The court rejected arguments that the carrier liable should be the one who had coverage during the time period when the disease first appeared and produced temporary disablement.

E. Act Differences

Some notable differences between the Occupational Diseases Act and the Worker's Compensation Act are as follows:

1. Second Injury Fund

I.C. 22-3-3-13 of the Worker's Compensation Act provides for a second injury fund for the benefit of injured employees if appropriate. There is no such provision in the Occupational Diseases Act.

2. Procedural Safeguards

I.C. 22-3-7-16(x) provides that:

> All compensation payments named and provided for in this section, shall mean and be defined to be for only such occupational diseases and disabilities therefrom as are proved by competent evidence, of which there are or have been objective conditions or symptoms proven, not within the physical or mental control of the employee himself.

This provision of the statute is relatively unknown and not typically utilized on a regular basis. However, it does require that objective conditions must be proven, and certainly no subjective mental claims of disease would qualify. The provision should exclude certain types of

claimants such as those who fear they may have been exposed to cancer or AIDS, or certain malingerers.

3. Experts

I.C. 22-3-7-27(k) provides for the appointment of an independent industrial hygienist, industrial engineer, industrial physician or chemist to undertake investigation of the occupation, and to testify with respect to the hazards of occupational disease found to exist in the employee's occupation.

4. Mistaken Remedy

I.C. 22-3-7-27(1) essentially provides that should an employee misconceive his remedy as being a worker's compensation claim as opposed to an occupational disease claim, the Board has the power to amend the claim so as to fall under the provisions of the Occupational Disease Act, so long as it is done before "the final disposition". It should be noted that "the final disposition" requirement has been construed to mean at the conclusion of the proceedings before the Single Board Hearing Member. Mikel v. Ontario Corp., 233 N.E.2d 246 (Ind.App. 1968).

III. IMPORTANT FACTORS

A. Factors

Within the context of the aforementioned legal requirements, the following factors are seen as important in analyzing and proving an occupational disease claim.

1. That exposure to chemicals or elements actually occurs;

2. That the plaintiff actually suffers from the disease alleged;

3. That an appropriate time period has elapsed to establish a causal nexus between the exposure and the onset of the disease;

4. That a scientific basis exists relating the chemicals or elements and the disease alleged;

5. That there was an exposure to chemicals or elements in a sufficient dosage to produce the disease;

6. That the exposure occurred or was of such a nature so as to produce the complained of disease; and

7. The plaintiff can establish that he was not equally exposed to recognized alternative causes of the disease outside of the employment.

See Defense Research Institute, "Defending Chemical Exposure Cases" Volume 1985, Number 1.

1. Chemical Exposure

In a great many instances, exposure to certain materials must be admitted. For instance, in an asbestos case, mesothelioma is a rare cancerous condition of the lung. It would be quite uncommon to find the existence of this disease in an employee who was not exposed to asbestos. The same would apply to a person suffering from asbestosis.

Nonetheless, there are many other instances in which the actual exposure itself is hotly contested.

2. Disease Status

The actual existence of a recognizable disease is not always a matter upon which the parties find agreement. Unusual disorders have become common place in today's society. Some particular examples that come to mind are sick building syndrome, chemically induced immunodeficiency disorders, and dark room disease. Often times the plaintiff will have varied and bizarre symptoms which may or may not be an occupational disease.

3. Length of Exposure

Often times, in an occupational disease case, the length of time for which the injured employee was exposed to the alleged offending chemicals is a major issue. It is important to

carefully document the dates of all exposures so that an appropriate assessment can be made as to the exact length the employee was actually exposed to the offending materials.

It is important to note that there is a segment of the scientific and medical community that now believes in what is sometimes referred to as the "one hit theory". Essentially these scientific and medical experts argue that an exposure of significant intensity, for however short a period of time, could be enough to produce the chromosomal changes necessary to begin the disease process of leukemia.

4. Scientific Proof

When handling an occupational disease case, it is important to canvass all available medical literature to be certain that there are medically recognized studies which establish a link between the disease complained of and the employment related exposure. The plaintiff must be able to establish, within a reasonable degree of medical certainty, that the chemicals or elements are carcinogenic, i.e. causing cancer, or tumorigenic, i.e. having the ability to produce a tumor, or neoplasm. This is usually done via a medical expert established in the particular field at issue. For example, an oncologist for cancer cases.

In addition to the above, careful note should be made of the scientific studies that have been completed. Often times, some studies rely exclusively on mice or other animals. As compelling as the results may sound, the fact is that mice are not human and one wonders if any actual probative medical evidence can be extrapolated from these tests absent other verifiable studies on humans. There are numerous Indiana and Federal cases relating to the admissibility of scientific studies.

5. Amount of Exposure

As previously mentioned in the section on the length of exposure, the actual dosage of the

exposure is equally important. Likewise, in many types of chemicals alleged to cause cancer, detailed dose response studies have been performed. To the extent the appropriate dose response cannot be established, plaintiff's proof may fail.

6. Exposure and Disease

It should also be established that the type of disease alleged is consistent with the manner in which the exposure occurred.

7. Equal Exposure Outside Employment

In certain cases such as silicosis and asbestos, there may not be any question but that the plaintiff suffered an exposure in his employment related duties only. However, there are numerous lung disorders and cancer type claims which are subject to multiple potential causes in the everyday surrounding environment. Absent direct evidence that the origin of the disease is causally connected to a risk incidental to the employment, plaintiff's claim will likely fail.

IV. THE OCCUPATIONAL DISEASES ACT AND COVID-19

Given that we are all living through the COVID-19 pandemic, I thought I would make a brief mention of COVID-19 and its interplay between the Occupational Diseases Act and the Worker's Compensation Act. There's an excellent discussion on this issue in a later section, but given its impact on our society, and more specifically, Indiana employees, I thought I would make a brief mention of it in the context of the Occupational Diseases Act.

Occupational diseases require an exposure. Clearly, there is an exposure element with COVID-19, as that is how it is contracted. However, issues with applying the Occupational Disease Act to COVID-19 included the ordinary diseases defense found in I.C. 22-3-7-10(a) and the disablement requirement found in I.C. 22-3-7-9(f). With the extent of spread that is happening with COVID-19, an ordinary diseases defense could be argued in that the general public outside

of employment is exposed and it can be argued that the employee is equally exposed outside of employment (See I.C. 22-3-7-10(b)). An employee, possibly a healthcare worker, could argue that that there is a causal link between the employment and COVID-19 and that the employment was the proximate cause. Disablement may be another issue since many of those that contract COVID-19 may not be disabled within the meaning of the Occupational Diseases Act.

Pre Occupational Diseases Act cases, such as Wasmuth-Endicott Co. v. Karst, 133 N.E. 609 (Ind.App. 1922) and State Highway Comm. v. Smith, 175 N.E. 146 (Ind.App. 1931), both stand for the proposition that the unknowing ingestion of a germ, viruses and/or microorganisms can be an accident, and thus within the confines of the Worker's Compensation Act. In this author's opinion, this is likely how COVID-19 cases will be analyzed by the Board, as an accident under the Worker's Compensation Act.

Section Two

APPEAL OF CLAIMS TO THE FULL WORKER'S COMPENSATION BOARD

Indiana Continuing Legal Education Forum

November 18, 2020

Douglas Meagher

Kyle Samons

Section Two

Appeal of Claims to the Full Worker's Compensation Board.....Douglas Meagher
Kyle Samons

APPEAL OF CLAIMS TO THE FULL WORKER'S COMPENSATION BOARD

Appeal of disputed claims to the Full Worker's Compensation Board is the second stage of adjudication in the Indiana system. Although this stage is conducted as an appellate exercise, the Full Board is not bound by any previous determination and its decision is the final and conclusive administrative disposition of a claim. The decision then becomes the basis for much stricter review by the appellate courts.

A somewhat common misperception of Full Board appeals is that they are futile because most first stage decisions are sustained on appeal. It is historically true that the Board Members often defer to the determinations of their colleagues; however, the dynamics involved in adjudication by a seven-member panel can and frequently do alter the outcome of a claim. Described herein are the procedures and requirements for appeals in addition to some suggestion and comment about presentations to the Full Board.

I. WORKER'S COMPENSATION BOARD ADJUDICATORY POWERS

A. General Powers

The Indiana Worker's Compensation Board is composed of seven members. The Board is statutorily charged with various responsibilities for oversight and regulation of the State's worker's compensation law. The primary duty of the Board Members is adjudication of disputed claims. This work is performed by six of the seven Members in individual hearing districts throughout the State. The Chair of the Board usually does not conduct hearings on a regular basis, but it is not uncommon for the Chair to adjudicate claims as a single Board Member as circumstances may require. This adjudication by the single Board Members in their respective districts is the first stage of formal claim resolution.

The powers and duties of the Worker's Compensation Board are enumerated under Indiana Code §22-3-1-3. The powers to resolve worker's compensation claims are specifically listed in addition to the power to promulgate administrative rules necessary to perform its duties.

1. Administrative Rule Making

Indiana Code §22-3-1-3(a) states:

> The worker's compensation board may adopt rules under IC 4-22-2 to carry into effect the worker's compensation law (IC 22-3-2 through IC 22-3-6) and the worker's occupational diseases law (IC 22-3-7).

Most state government agencies have similar powers. Promulgation of administrative rules is a complex and lengthy task subject to oversight by many other agencies and authorities. This appears to be by design because administrative rules are another form of law. The Board's administrative rulemaking power is germane to this discussion because a rule discussed below is the basis for presenting Full Board appeals as appellate actions.

2. Claim Resolution

Indiana Code §22-3-1-3(b) (1-16) lists these powers and duties of the Board:

(1) To hear, determine, and review all claims for compensation under IC 22-3-2 through IC 22-3-7;
(2) To require medical service for injured employees;
(3) To approve claims for medical service or attorney's fees and the charges for nurses and hospitals;
(4) To approve agreements;
(5) To modify or change awards;
(6) To make conclusions of facts and rulings of law;
(7) To certify questions of law to the court of appeals;
(8) To approve deductions in compensation made by employers for amounts paid in excess of the amount required by law;
(9) To approve agreements between an employer and an employee or the employee's dependents for the cash payment of compensation in a lump sum, or, in the case of a person under eighteen (18) years of age, to order cash payments;
(10) To establish and maintain a list of independent medical examiners and to order physical examinations;
(11) To subpoena witnesses;

(12) To administer oaths;
(13) To apply to the circuit or superior court to enforce the attendance and testimony of witnesses and the production and examination of books, papers, and records;
(14) To create and undertake a program designed to education and provide assistance to employees and employers regarding the rights and remedies provided by IC 22-3-2 through IC 22-3-7, and to provide for informal resolution of disputes;
(15) To assess and collect, on the board's own initiative or on the motion of a party, the penalties provided for in IC 22-3-2 through IC 22-3-7; and
(16) To exercise all other powers and duties conferred upon the board by law.

These powers and duties give the board considerable control for its exercise of exclusive jurisdiction over claims arising from workplace accidents. The powers and duties are assigned to the Board collectively; however, because of rulemaking authority and exercise thereof, they are often exercised by the Board Members individually.

In addition, I.C. §22-3-4-5 sets forth the method by which claim disputes are presented to the Board for adjudication. The second states:

(a) If the employer and the injured employee or the injured employee's dependents disagree in regard to the compensation payable under IC 22-3-2 through IC 22-3-6 or, if they have reached such an agreement, which has been signed by them, filed with and approved by the worker's compensation board, and afterward disagreed as to the continuance of payments under such agreement, or as to the period for which payments shall be made, or to the amount to be paid, because of a change in condition since the making of such agreement, either party may then make an application to the board for determination of the matters in dispute.

(b) Upon the filing of such application, the board shall set the date of hearing, which shall be as early as practicable, and shall notify the employee, employer and the attorneys of record in the manner prescribed by the board of the time and place of all hearings and requests for continuances. The hearing of all claims for compensation, on account of injuries occurring within the state, shall be held in the county in which the injury occurred, (or) in any adjoining county, except where the parties consent to a hearing elsewhere. Claims assigned to an individual board member, may be heard in any county within the board member's jurisdiction.

(c) All disputes arising under IC 22-3-2 through IC 2-3-2, if not settled by the agreement of the parties interested therein, with the approval of the board, shall be determined by the board.

Accordingly, the statute provides for instigation of the Board's adjudicatory powers when the parties to a claim fail to agree upon what is due and owing to the injured worker under the Act.

B. Procedures

1. Single Hearing Member Arrangement

Common parlance in the Indiana practice is to refer to the individual Board Members (other than the Chair) as Single Hearing Members (SHM). Except in rare and extraordinary circumstances, the first stage of claim adjudication is by a SHM responsible for adjudication in a district of the State defined by the Board. This arrangement is allowed under the provisions of I.C. §22-3-4-6:

> The board *by any or all of its members* shall hear the parties at issue, their representatives and witnesses, and shall determine the dispute in a summary manner. The award shall be filed with the record of proceedings, and a copy thereof shall immediately be sent to each of the employee, employer, and attorney of record in the dispute. (italics added)

The highlighted portion of the statute is the language that allows for adjudication by a SHM. There is much that could be added here about preparation for and presentation of claims at this stage. This can also be a lengthy and complex task and is better suited to another presentation. Without unduly glossing over the work required of first stage adjudication, suffice it to say that appeal to the Full Board requires a SHM decision.

2. Time for Appeal

Indiana Code §22-3-4-7 sets a thirty-day deadline for appeal of the SHM decisions to the Full Board:

> If an application for review is made to the board within thirty (30) days from the date of the award made by less than all the members, the full board, if the first hearing was not held before the full board, shall review the evidence, or, if deemed advisable, hear the parties at issue, their representatives, and witnesses as soon as practicable and shall make an award and file the same with the finding of the facts on which it is based and send a copy thereof to each of the parties in dispute, in like manner as specified in Section 6 [IC 22-3-4-6] of this chapter.

The date of the SHM award is critical. The thirty-day period will be counted from that date; not the date of mailing or the date of receipt. The Board does not have discretion to allow late filings. The Board does not have jurisdiction to entertain an application for review of a SHM award where the application for review was not timely filed.

In *Gould Motor Co. v. Vierra*, 157 N.E.2d 204 (Ind. Ct. App. 1959) the Court of Appeals held that an untimely filing for review of SHM decision by the Full Board means the Board has no further jurisdiction over the claim. Further, that the court itself had lacked jurisdiction as a consequence of the Board's lack of jurisdiction. In this case, counsel for Gould Motor Company (Gould) untimely filed an application for review by the Full Board of an award of benefits by an SHM to Vierra. At that time the period for filing an application for review was seven days from the date of the award. Counsel for Gould alleged lack of notice as the reason for the untimely filing and argued for an exception to the seven-day filing requirement based on previous decisions allowing such exception because of inadequate notice of the SHM decision by the Board. Vierra moved to dismiss Gould's application for review; however, the Board denied his motion and sustained the SHM award. Gould appealed the award and Vierra cross-appealed the denial of his motion to dismiss.

The Court of Appeals reviewed case law pertaining to the contractual nature of the Worker's Compensation Act and first identified the obligations of injured workers to timely make claims under the Act. "The right to maintain an action for compensation is conditioned upon its exercise within the precedent statutory contractual time limitation provisions, and perishes with the failure to properly assert a claim within the time prescribed." *Gould* at 207. The court determined that Gould's "contractual obligation… to filed [the] application for review by the Full

Board within the specified time is as much as essential obligation of the contract as the obligation of the employee… to file his claim within the period prescribed by law." *Gould* at 208.

The court further determined that there was no inadequate notice of the SHM decision or other failure by the Board to perform its functions and obligations, and held:

> [T]he… Board was without jurisdiction to entertain the application … for review of the award of the hearing member, since the same was not made within the statutory seven-day period as prescribed by law. Inasmuch as the … Board was without jurisdiction to entertain the application … it was without jurisdiction to enter any award thereon as a full board. The award of the hearing member became final after the expiration of the seven-day period allowed for filing an application for review by the full board and said award now remains in full force and effect.
>
> The Full Board having improperly entertained jurisdiction of appellant's application for review, the jurisdiction of this court is likewise subject to the same infirmity, and this appeal for review must be dismissed.

Id.

Premature filing of a Full Board appeal is acceptable under the Court of Appeals decision in *Jackson v. Cigna/Ford*, 677 N.E.2d 1098 (Ind. Ct. App. 1997). In a case of first impression, the Court decided that "the purpose underlying the timeliness factor are satisfied by the premature filling of the application" for Full Board review. *Jackson* at 1101.

In the *Jackson* case, plaintiff stated his appeal of the SHM decision, on the day after the hearing and before the decision was issued, in a handwritten letter to the Board. He later failed to make a timely filing under the procedures of I.C. §22-3-4-7 after the SHM decision was issued. The Court further held that:

> If a party timely files an application for review, the statute requires the board to hold a hearing if the first hearing was not before the full board, review the evidence or hear the parties, and make an award and 'file the same with the findings of fact on which it is based.'

Jackson at 1102.

It is not clear if this implicit requirement for a *de novo* hearing applies to premature appeals or all appeals to the Full Board. Both premature appeals and *de novo* hearings by the Full Board are exceptional circumstances.

3. Full Board Procedures

Under its administrative rulemaking powers, the Board promulgated 631 IAC 1-1-15, which provides rules for the Full Board appeals:

a. Facts Upon Review

> The facts upon review by the full board will be *determined upon the evidence introduced in the original hearing*, without hearing new or additional evidence, at the discretion of the [worker's compensation] board. Any party desiring to introduce new or additional evidence shall file an affidavit setting forth therein the names and residences of the witnesses to be called to testify before the full board, the facts to which they will testify, or, if the new evidence be documentary, then a copy of the document proposed to be introduced setting forth good reason for failure to introduce such evidence at the original hearing. If such petition is granted, the opposing party shall have the right to introduce such additional evidence as many be necessary in rebuttal. (italics added)

The effect of this rule is that the Full Board acts as quasi-appellate panel in review of SHM decisions. The highlighted language of the rule establishes that the Full Board will review only the evidence considered by the SHM unless, in its discretion, a petition for submission of new evidence is allowed.

b. Additional Evidence

Though hearings before the Full Board are *de novo* procedures (discussed further below), the Board rarely allows for introduction of new, additional evidence at the appeal. Long-standing case law supports the Board's practice under this rule. Still, if new evidence (such as a stronger medical report) is obtained, there is no reason not to attempt to introduce it as part of an appeal to the Full Board.

In *Tallon v. Sexton Coal Co*., 192 N.E. 108 (Ind. Ct. App. 1938), the Court of Appeals held that admission of additional evidence in Full Board review of SHM determination is discretionary, subject to abuse of discretion review by appellate courts:

> [The Worker's Compensation Act] provides that, upon review by the full [Worker's Compensation] Board, said board shall review the evidence, or, if deemed advisable, hear the parties at issue, their representatives and witnesses. In interpreting the above-quoted provision of the law, this court has held that it is a matter within the sound discretion of the board as to whether upon the showing made it will permit the introduction of further evidence, and its action in that regard is not subject to review by this court unless the record shows an abuse of this discretion. This we think is the correct construction to be placed on the law. See *Riley v. Hunt et al*., 85 Ind. App. 647, 155 N.E. 523; *Bimel Spoke, etc., Company v. Loper*, 65 Ind. App. 479, 117 N.E. 527; *Consumer's Company v. Ceislik*, 69 Ind. App. 333, 121 N.E. 832.

Tallon at 108.

The Court of Appeals repeated its holding in the *Tallon* case in *Curry v. Roach Ind. Corp*., 23 N.E.2d 598 (Ind. Ct. App. 1939). In the *Curry* case, the injured worker sought to introduce additional evidence regarding his impairment at the Full Board level in addition to appealing denial of his claim by the SHM. The court cited to the *Tallon* decision and held "that the matter of hearing additional evidence rests largely within the discretion of the [Worker's Compensation] Board. Whether or not the refusal of the board to hear additional evidence is reversible error must depend therefore on whether or not there was an abuse of discretion…" *Curry* at 599. The court decided there was no abuse of discretion by the Board and affirmed the negative award to plaintiff.

In *B. G. Hoadley Quarries, Inc. v. Eads*, 160 N.E.2d 202 (Ind. Ct. App. 1959) the Court of Appeals determined that Full Board review is based upon evidence presented at the original hearing. In this case, a SHM awarded benefits to an injured employee and the employer appealed. The case was remanded for hearing of further evidence; however, there was a change of Board

membership and the original SHM did not participate in the hearing on remand or the Full Board appeal. The employer appealed the Full Board award to plaintiff, arguing that:

> [B]ecause the original hearing member … who had all the evidence, except the subsequent evidence of the one doctor, was no longer on the Board, and the two new members 'had had no contact with the case', that decision was rendered by a Board 'that had not heard the evidence' and consequently, the requirements of due process was not met.

Eads at 105.

The Court stated that it "experience[d] great difficulty in grasping appellant's contention that the composition of the Board that rendered the award was such as to deny it due process of law." *Id*. Further, that "we must assume, in the absence of any showing to the contrary, that the 'evidence introduced at the original hearing' was made available to the member of the… Board and that their determination was made thereon." *Id*. The Court resolved this issue by deciding that appellant did not show that the Full Board decision was based on any other evidence.

The immediate import to this decision is that Full Board review will be based upon evidence submitted to the SHM regardless of whether that SHM participates in the Full Board review. This continues to be a relevant point in contemporary operations of the Board; however, for purposes of this discussion, the primary point is that the Full Board "hears the case *de novo* and the facts upon review by the Full Board are determined upon 'the evidence introduced in the original hearing.'" *Id.*

In *Ruegamer v. Haynes Stellite Co*., 167 N.E.2d 725 (Ind. Ct. App. 1960) the Court of Appeals held that there is no requirement in the worker's compensation act that the Full Board must allow submissions of new evidence in review of SHM determination. The Court stated that:

> There is no requirement by law that upon a review of evidence by the Full Board it must hear new or additional evidence. Section [22-3-4-7] states that on review of an award made by less than all members of the Board, it shall review the evidence, or, *if deemed advisable,* hear the parties at issue, their representatives and witnesses

> * * *.' (Our emphasis.) Rule [631 IAC 1-1- 15] states that facts upon review by the Full board will be determined upon evidence introduced in the original hearing without hearing new or additional evidence at the *discretion of the Board*. The rule permits the introduction of new evidence, but such is entirely discretionary with the Board and, unless abused, that discretion is not subject to review.

Ruegamer at 729. An appeal of a Full Board decision regarding submission of new evidence at the Full Board review stage requires showing an abuse of discretion to the Court of Appeals.

The Board is generally consistent in strict application of this rule; however, the seeming harshness of the rule is mitigated by the Board's equally consistent practice of remanding cases to a SHM in circumstances where consideration of additional evidence is reasonable and appropriate.

c. Oral and Written Arguments

The administrative rule also sets requirements for oral and written argument to the Full Board. The requirements are:

> Oral argument shall not be required in cases coming before the full board on applications for review. No later than thirty (30) days prior to the date set by notice for consideration of an application by the full board, the applicant or counsel may file with the industrial board a brief of statement specifically setting forth the errors alleged for review, argument on those errors, and authorities, if any, supporting such argument. Such brief or statement shall be filed with seven (7) copies. The opposing party or counsel may file, no later than ten (10) days prior to such hearing date, any rebuttal.

Written pre-hearing briefs should always be filed. They should be as short as possible. Critical portions of the record (testimony or medical reports) should be attached and highlighted for ease of reference. Although the rule implicitly discourages oral arguments, they can be the most effect component of a Full Board appeal.

4. Forms

The Board requires use of various forms at all stages of claim action. Indiana Code §22-3-4-3(a) states:

> The board shall prepare and cause to be printed, and upon request furnish free of charge to any employer or employee, such blank forms and literature as it shall dee requisite to facility or promote the efficient administration of this chapter, IC 22-3-2 through IC 22-3-5 through IC 22-3-6.

The *Application for Review by Full Board* (State Form 1042) is available from the Board's website. The *Application* must be filed in triplicate and captioned the same as the original claim for compensation. The application number assigned to the original cause should be shown on the application for review.

C. Finality of Award/Appeal to Court of Appeals

Under the provisions of I.C. §22-3-4-8, no appeal from a SHM or Full Board award has the effect of making the award final and conclusive. This section states:

> (a) An award of the board by less than all the members as provided in Section 6 [IC 22-3-4-6] of this chapter, if not reviewed as provided in section 7 [IC 22-3-4-7] of this chapter, shall be final and conclusive.
> (b) An award by the full board shall be conclusive and binding as to all questions for fact, but either party to the dispute may, within thirty (30) days from the date of such award, appeal to the court of appeals in ordinary civil actions.

The specific references to sections 6 and 7 of the Act under subsection (a) makes decisions issued by either a SHM or the Full Board, that are not appealed, final and conclusive. Subsection (b) provides that only final and conclusive awards of the Full Board may be appealed to the Court of Appeals.

The case of *Lee v. Center Township Trustee,* 597 N.E.2d 312 (Ind. Ct. App. 1992) provides that no appeal of a SHM award will make the determination of the SHM conclusive. The Lee case involves some complicated facts regarding specification of issues for adjudication by a SHM and

the effect of a compromise settlement agreement. In summary, Plaintiff did not timely appeal to the Full Board a determination by the SHM that her condition had reached permanence and quiescence on a specific date. The issue presented to the court was whether the Board erred, as plaintiff alleged, by raising and determining the issue of permanence and quiescence *sua sponte*. The Court recognized some merits to Plaintiff's argument, but specifically addressed the applications of I.C. §22-3-4-7 and 8 and held that "Lee's failure to request review rendered the finding final and conclusive." *Lee* at 313.

Accordingly, practitioners should beware that failure to make a timely request for review by the Full Board will leave them with no further remedy. This is reinforced by the Board's lack of jurisdiction to entertain an untimely appeal.

D. Full Board Quorum/Majority

In the case of *ACLS d/b/a Nations Transportation, and Mr. and Mrs. Bob Milutinovic v. George Bujaroski*, 904 N.E.2d 1291 (Ind. Ct. App. 2009), the SHM decided several issues in Plaintiff's favor; and, Defendant appealed to the Full Board. The Full Board affirmed the decision by a tie vote of 3-3 with one Member abstaining. Citing *Allison v. Wilhite*, 17 N.E.2d 874 (1938), *Eades v. Lucas*, 23 N.E.2d 273 (1939), *Russell v. Johnson*, 46 N.E.2d 219 (1943) and *Triplett v. USX Corp.*, 893 N.E.2d 1107 (Ind. Ct. App. 2008), the Court of Appeals noted that there is no requirement that all members of the Board participate in a Full Board review. However, any action by the Full Board requires a majority vote of the Board.

In summary, the Court decided that the SHM decision was vacated when the Full Board accepted review; and, because Full Board review is *de novo*, Plaintiff had the burden of showing his entitlement to worker's compensation benefits. The Court determined that the Board's tie vote demonstrated failure to carry that burden.

II. APPEAL READINESS

A. Hearing *De Novo*

This discussions of the *de novo* nature of Full Board proceedings is presented under the heading of Appeal Readiness because there are often circumstances in which further SHM action is appropriate to resolve all issues in a claim. Petitions for submission of new evidence at the Full Board stage are often based on the correct distinction that Full Board proceedings are *de novo*. The Full Board does not normally operate in such capacity but the distinction allows considerable discretion over the disposition of claims that it review. The Board prefers to address appeals when all issues have been addressed and the claim is ripe for appeal. Therefore, when and where appropriate, the Full Board will most often remand a claim to a SHM rather than conduct a *de novo* hearing.

In situations where not all issues present in the claim have been addressed and/or additional evidence may be necessary for resolution of all issues, practitioners should stipulate accordingly at the SHM state of obviate the operation of I.C. §22-3-4-7. If the need for further action and/or evidence becomes apparent after the SHM award and no stipulation or SHM order precludes the award becoming final and conclusive, practitioners should file for review by the Full Board within the thirty-day appeal period and anticipate that that Board will hold the appeal until supplemental proceedings by the SHM have been conducted.

The cases addressing this aspect of the Board's powers recognize both the *de novo* nature or claim review and quasi-appellate role the Board has fashioned. "A review by the Full Board is on merits and is not for errors. The hearing is de novo as to all parties to the proceeding and the award of the Full Board supersedes for all purposes the award of the hearing member." *Russell v.*

Johnson, 46 N.E.2d 219, 221 (1943). Restated, this holding provides that a Full Board award is paramount and does not need to be solely a review of a SHM award for errors.

In *Burton v. Rock Road Construction Co*., 235 N.E.2d 210 (Ind. Ct. App. 1968) the Court of Appeals further defined that Full Board review is in nature of a hearing *de novo*. In *Burton*, the plaintiff appealed a decision denying compensation on three specific points:

I. There was no filing on the issue of permanent total disability which was before the Board.
II. The Board made a finding of no permanent partial impairment when the issue of impairment was not before the Board.
III. The Board acted arbitrarily and capriciously in that it made a finding that the plaintiff 'is not temporarily totally disabled on account of said accidental injuries at this time,' though no new evidence was introduced before the Full Board and plaintiff did not testify.

Burton at 212.

The Court decided that the Board's findings regarding impairment were not prejudicial or contrary to law but remanded the case to the Board with directions to enter findings on the issue of permanent total disability. In response to plaintiff's argument regarding consideration of new evidence, the Court held:

> As to Proposition III we do not agree that the Board acted arbitrarily or capriciously by finding that 'the plaintiff was not temporarily totally disabled at this time.' The appellant seems to infer that the words 'at this time' indicate that the Full Board considered new evidence not presented at the original hearing before the Hearing Member and that this cannot be done on review. It has been held that a Full Board Hearing is regarded as a hearing de novo. The Board can make its own findings and determinations.

Id.

This holding reinforces the concept of a quasi-appellate panel that has discretion to review new evidence in its own prescribed manner. This distinction was further addressed in *Eastham v. Whirlpool*, 524 N.E.2d 23 (Ind. Ct. App. 1988) in which the Court of Appeals held that Full Board review is a proceeding *de novo*, not a trial *de novo*. In appealing a negative award by a SHM,

plaintiff argued that his constitutional due process rights are denied if the Full Board is allowed to summarily reverse the factual determinations of a SHM. He argued specifically that:

> The Full [Worker's Compensation] Board has a right to delegate the constitutional requirement of a fair hearing to a single hearing officer, however, once it delegates this responsibility, the review powers of the Full [Worker's Compensation] Board are thereby limited. It cannot reverse the decision of the single hearing member unless it preserves the worker's constitutional rights.

Eastham at 26.

Plaintiff also proposed that the Full Board has two methodical options for reversing the factual determination of a SHM. He suggested that:

> First, it can grant the employee a trial de novo and hear the evidence. Secondly, it can issue a statement that it has reviewed the entire record and read all of the evidence and depositions and reaches a different factual conclusion from that of the single hearing member. If the Full [Worker's Compensation] Board fails to do one of these two things, it cannot summarily reverse a factual determination made by a single hearing member. To do otherwise would violate a worker's constitutional due process rights.

Id.

The court found no merit in plaintiff's argument and affirmed the Full Board's award, holding specifically that:

> Eastham cites no authority for his proposition that the Board's review power is limited once the responsibility to hear the evidence is delegated to a single hearing member. This is not surprising since case law provides that review by the Full Board is a *proceeding de novo* (not, as Eastham claims, a *trial de novo*). *Hayes v. Joseph E. Seagram & Co*. (1944), 222 Ind. 130, 52 N.E.2d 356, 257; *Burton v. Rock Road Const. Co.* (1968), 142 Ind. App. 458, 235 N.E.2d 210, 212 (Full Board Hearing is regarded as hearing de novo and Board can make its own findings and determinations); *B.G. Hoadley Quarries, Inc. v. Eads* (1959), 129 Ind. App. 670, 160 N.E.2d 202, 205 (Industrial Board hears case de novo, and facts upon such review by Full Board are determined upon evidence introduced in original hearing).

Id.

The *de novo* nature of Full Board proceedings has been recognized in other cases addressing the question of whether the Full Board is bound by the determination of the SHM. In *McGuire v. Universal Gear Corp*., 18 N.E.2d 474 (Ind. Ct. App. 1939), plaintiff argued that "the Full Board is acting in the capacity of an appellate tribunal and is bound to sustain the finding made by the single member." *McGuire* at 475. The court affirmed the Full Board's reversal of the SHM award to plaintiff and held that:

> [T]he statute contemplates that upon a review by the Full Board, the proceedings shall be in the nature of a hearing de novo and that the [Worker's Compensation] Board shall not be bound by the finding of a single member. Furthermore, such contention as is here made was answered by this court in the case of *Bell v. Mutual Home & Savings Ass'n*, 1938, 15 N.E.2d 738.

McGuire at 475

B. <u>Ripeness/Interlocutory Appeals</u>

The Indiana Supreme Court's decision in the case of *Cox v. Worker's Compensation Board of Indiana*, 675 N.E.2d 1053 (1996) was issued in response to a federal class action alleging that the Board's policy of not deciding claims until injuries reached quiescence deprived injured workers of property rights without due process in violation of the 14th Amendment to the United States Constitution. Described more precisely, the plaintiffs sought to change the Board's practice of not conducting Full Board reviews until all issues of a claim had been adjudicated at the SHM stage. In its decision, the Indiana Supreme Court responded to these specific questions posed by the United States District Court for the Southern District of Indiana:

> The certified question divides itself into multiple questions. Each question includes the component that the Board act "without disposing all the issues that may exist of arise between the parties." With that common predicate, the questions before us become:
>
> > 1. May the Board make an enforceable and appealable determination that temporary total disability benefits have been properly terminated?

> 2. May the Board make an enforceable and appealable determination whether certain medical care was reasonable and necessary?
> 3. May the Board make an enforceable and appealable decision as to the compensability of a claim or other limited issues?

Cox at 1055.

The Court answered specifically that an award of temporary total disability benefits resulting from a dispute over the employer's termination of such benefits is an appealable final decision at to those benefits though it does not dispose of all issues between the parties. See *Cox* at 1056. The Court also decided that the Board's determinations of what medical treatment is reasonably necessary, if incorporated into an order of compensation or direction to furnish specific treatment is an enforceable and appealable order or award of the Board. See *Cox* at 1059. Lastly, the Court ruled that the Board's determination on matters of compensability are not enforceable and appealable until such determinations are made the predicate of an award. See *Cox* at 1059.

In answering these questions the Supreme Court engaged in detailed statutory and common law analysis; mostly in the context of considering whether actions of the Full Board were enforceable and appealable by and to the Indiana Court of Appeals. The reasoning of *Cox* is, however, often applied to enforcement and appeal of SHM orders and awards to the Full Board. The pretext for such application is that the adjudicatory work of the Board is carried out by the Single Hearing Members. It is therefore rational to view an interlocutory order or award of a SHM to be that of the Full Board.

The pros and cons of such treatment is a topic of discussion until itself. The point to emphasize here is that practitioners should be careful in requesting interlocutory decisions of the Board. An early decision by the Board may set the case on a course outside the control of the parties and lead to results unanticipated by all involved. Furthermore, the Board is still reluctant to entertain Full Board reviews until all issues in the claim are ripe for such review. Single Hearing

Members are likely to encourage the parties to follow through in remaining claim administration tasks based on an interlocutory decision; the most typical example being requesting a defendant's agreement to provide appropriate medical care and benefits after an interlocutory decision regarding compensability.

C. Sufficiency of SHM Findings

Full Board review is a quasi-appellate exercise; however, because such review is a *de novo* proceedings there are not set standards of appellate review. Appellants need only to assert that the SHM order/award is contrary to law and/or not supported by the evidence. The findings of fact and conclusions of law required of the SHM are, therefore, the points on which there should be an "assignment of errors." The appellate courts have emphasized the need for clear findings of fact and conclusions of law by the Full Board so that the rationale of an order/award can be understood. This emphasis makes the Full Board's usual reliance upon a Single Hearing Member's review of the evidence and findings and conclusions and important aspect of Full Board appeals. The discretion of a *de novo* proceeding allows the Full Board opportunity to completely and succinctly explain its reasoning to the parties and, by extension, the Court of Appeals. The dual nature of Full Board review is conducted by treating the SHM findings and conclusions as the points for appeal while allowing for a range of results within the Board's discretion.

The Indiana appellate courts have expressed deference to Board determinations. In *Talas v. Correct Piping*, 416 N.E.2d 845 (1981) the Indiana Supreme Court stated:

> Our analysis … proceeds from the threshold appellate perspective that it is not the Court's prerogative to weight the evidence or judge the credibility of witnesses; in our review of the Board's findings and conclusions, we may consider only the evidence which tends to support its determination, together with any uncontradicted adverse evidence. Only when the evidence leads inalterably to a conclusion contrary to that reached by the Board will its decision be disturbed.

Talas at 26. Because of this high standard of deference, the Full Board is concerned with making appropriately clear findings of fact and conclusions of law. Effective Full Board appeals will address this concern.

The Indiana Supreme Court, in recognition of the Board's SHM/Full Board operational construct, has also emphasized the duty of the Full Board to review the findings of fact and conclusions of law made by a Single Hearing Member. In *Rork v. Szabo Foods*, 436 N.E.2d 64 (1982), the Supreme Court reversed a Full Board award of benefits to plaintiff (less than her claim of permanent total disability benefits) and the Court of Appeals' affirmation of the award because of inadequate findings of fact and conclusions of law. The court explained:

> Initially, we note that the Full [Worker's Compensation] Board did not draft its own findings of basic fact; rather, it adopted and incorporated by reference the statements denominated by the hearing officer as his "Findings of Fact and Conclusions of Law." In and of itself, that practice is neither prohibited by statute nor judicially condemned.
>
> The statute permits, as occurred here, a single member of the Board to resolve the dispute between an employer and injured employee "in a summary manner." *Id*. It is not expressly required in the statute that the hearing officer enter the findings of fact upon which the ultimate conclusion is based; instead, the hearing officer need only file "the award" and "the record of the proceedings."

Rork at 67.

The Supreme Court recognized the Board's delegation of adjudicatory authority to the SHM, but specifically identified the Full Board as having ultimate responsibility for proper claim adjudications in holding:

> It is the Full [Worker's Compensation] Board which, by statute, is required to enter the findings of fact upon which its disposition is based… It is the Full [Worker's Compensation] Board's opinion which the legislature has required; the requirement that the seven members of the Board enumerate their findings of fact is a prophylactic measure against arbitrary or hastily drawn decisions as we explained in *Perez v. United States Steel Corporation*, (1981) Ind., 426 N.E.2d 29, 32.

Id.

The court further noted that:

> There considerations warrant that the Full [Worker's Compensation] Board cautiously scrutinize statements or rationale offered by a hearing officer in the initial and summary disposition of a workmen's compensation claim. Where those statements and findings are supported by the evidence and embody the requisite specificity to satisfy the various purposes of the requirement, the Board should not hesitate to adopt and incorporate by reference the hearing officer's work.

Id at 67, 68.

The *Rork* decision reinforces the importance of comprehensive findings and conclusions by at SHM level and the Full Board's responsibility for the thoroughness of such decisions. A more recent decision of the Court of Appeals repeats the requirement that the Board must make specific findings that reveal analysis of the evidence and its determination therefrom. In *Outlaw v. Erbrich Products Co., Inc.*, 758 N.E.2d 65 (Ind. Ct. App. 2001) the Court held that:

> Findings of basic fact must reveal the Board's analysis of the evidence and its determination therefrom regarding the various specific issues of fact that bear on the particular claim. *Perez v. United States Steel Corp.*, 426 N.E.2d 29, 33 (Ind. 1981). When reviewing findings, we are mindful that findings must be tailed to the particular award, and that not all findings will necessarily be of the same character. *Starks v. Nat'l Serv-All, Inc*., 623 N.E.2d 88, 90 (Ind. Ct. App. 1994). However, the findings must be specific enough to provide the reader, whether it be the claimant, the employer, or this court, with an understanding of the Board's reasons, based on the evidence, for its findings of ultimate fact. *Perez*, 426 N.E.2d at 33.

Outlaw at 68.

The Court then explained the reason for its remand for further findings and conclusions:

> As we noted in the first appeal, this case concerns "a factual dispute [involving] complex medical sub-issues which require that the Board issue particularly detailed findings. *Outlaw*, 742 N.E.2d at 531. When issuing its additional findings, the Board failed to issue straightforward findings that explained its reasoning in deciding the medical sub-issues of this case.

Id. The Court concluded with description of why clear findings and conclusions are appropriate:

> The purpose of the Board issuing findings of fact is to create a road map so that the readers of the opinion – including this court – can clearly follow the reasoning used by the Board to reach its ultimate conclusion. When the findings of fact are

> straightforward and detailed, the Board's position is bolstered; however, when the Board's findings are vague and incomplete, it results in guesswork on the part of the readers of the decision.

Id.

III. PRESENTATION POINTS

A. Deference to the Adjudicator

Board Members are public servants entitled to appropriate deference and respect. They have an important and difficult job and the only certain result of their work is that they will displease fifty percent of the people they encounter.

B. Professional Duties

An accurate description of facts in the record is critical to the Board's understanding of the claim. Avoid distracting the Board with descriptions of facts and circumstances outside of the records

Acknowledgment of controlling law makes an effective presentation. If the law is unfavorable to the presenting party, make the necessary legal and factual distinctions.

C. Summary Argument

Oral arguments to the Full Board should be tailored to no more than ten to fifteen minutes for each party. The argument should include a short synopsis of stipulated and contested issues at the hearing before the SHM. The issue or issues need to be clearly, succinctly and quickly stated. If possible, the fewer issues presented, the easier it is to focus the Board's attention. An explanation should be given as to why the Board should make a finding different than that made by the SHM citing to the evidence in the record or case law which supports a different finding.

In general, the SHM's credibility determinations are unlikely to be overruled by the Full Board. It is better to offer some factual proof of incredibility than to simply make the allegation,

The weight given to medical or vocational evidence and testimony by the SHM may be basis of successful appeal. Relevant reports or testimony should be identified to the Board Members as part of the oral argument or pre-hearing submission.

D. Recitation of Law

Summarize applicable law, pro and con, in the oral argument. Any elaboration upon controlling law should be in pre-hearing brief. Unless the case turns on applying or distinguishing a particular case, arguments are best focused on the factual record.

E. Beware Hyperbole

The Board frequently hears the frustrations and irritations of all parties to a claim and sincerely wants ameliorate such situations. However, practitioners should beware that hyperbolic descriptions of unfairness or mistreatment, real or alleged, may backfire.

F. Transcript

The transcript needs to be ordered at the time the application for review is filed. If the appeal turns on testimony (as opposed to law or the sufficiency of medical evidence), a transcript is essential. The important parts of the transcript should be described in oral arguments and cited in the pre-hearing brief.

G. Relief Requested

State the relief requested; affirmation or reversal of the SHM (in whole or in part). Describe specifically the amount of compensation and/or medical services to be awarded or rescinded; e.g. average weekly wage, number of weeks of disability, permanent partial impairment ratings, medications, therapies, and surgical procedures. Describe any desired procedural actions; e.g. appoint an independent medical examination or remand to the SHM for acceptance of additional testimony or evidence.

IV. CONCLUSION

Appeal of a claim to the Full Worker's Compensation Board is a fluid process. Practitioners should regard the mechanics of an appeal as an appellate exercise by arguing the claimed errors of the SHM. However, practitioners should remain mindful that Full Board action or inaction is actually considered the primary adjudication of the claim. The appellate courts will view actions of the Worker's Compensation Board as actions of the Full Board regardless of whether the case under review was decided by a SHM or the Full Board acting *en banc*.

No. 93A02-0811-EX-996
Court of Appeals of Indiana

ACLS d/b/a Nations Transportation v. Bujaroski

904 N.E.2d 1291 (Ind. Ct. App. 2009)
Decided Jun 30, 2009

No. 93A02-0811-EX-996.

April 30, 2009. Rehearing Denied June 30, 2009.

Mark D. Gerth, Kightlinger Gray, LLP, Indianapolis, IN, Attorney for Appellant.

Jeffrey S. Sturm, George C. Patrick Associates, P.C., Crown Point, IN, Attorney for Appellee.

OPINION

CRONE, Judge.

Case Summary

ACLS d/b/a Nations Transportation and Mr. and Mrs. Bob Milutinovic (collectively, "Nations") appeal the determination of the Indiana Worker's Compensation Board ("the Board") that George Bujaroski was an employee of Nations and thus entitled to certain worker's compensation benefits. We remand.

Issue

1292 Nations raises three issues for our review, the dispositive issue being whether *1292 the full Board erred by purporting to affirm the decision of a single board member by a vote of less than the majority of the full Board.

Facts and Procedural History

On January 12, 2000, George Bujaroski entered into a written "Lease of Motor Vehicle Equipment" ("the Lease") with Nations, a contract interstate motor carrier. Pursuant to the contract terms, Bujaroski agreed to lease his truck to Nations, and he agreed to drive or provide a driver to perform transportation services for Nations. The agreement identified Bujaroski as an "independent contractor[.]" Appellant's App. at 46. With regard to worker's compensation coverage, the agreement stated, "LESSOR will provide the LESSEE with proof of coverage of workman's compensation insurance, and failing to do so, will allow LESSEE to secure such coverage and charge back to settlement or the escrow account, for the total cost of such coverage." *Id.* On February 10, 2000, Bujaroski was involved in a four-vehicle accident while driving for Nations pursuant to the Lease. Bujaroski died as a result of injuries he suffered in the accident.

On November 20, 2000, Bujaroski's wife and daughter filed an application of adjustment of claim with the Board, naming "ACLS d/b/a Nations Transportation" as his employer. On April 16, 2003, they filed an amended application, also naming "Mr. and Mrs. Bob Milutinovic[.]" On December 6, 2007, by stipulation of the parties, this matter was submitted to Board member Gerald Ediger for a ruling based upon written evidence

and depositions. On April 4, 2008, Ediger held that Bujaroski was an employee of Nations, that he died as a result of his work-related activity for Nations, and that Nations was obligated to pay worker's compensation death benefits.

On April 7, 2008, Nations filed an application for review by the full Board. On August 25, 2008, the full Board held a hearing on the case. On October 10, 2008, with one member abstaining, the full Board issued an order in which it purported to "affirm" and/or "adopt" Board member Ediger's prior opinion with a tie vote of three voting to affirm (including Ediger) and three voting to reverse. *Id.* at 210-11. This appeal ensued.

Discussion and Decision

Nations contends that the full Board's order is not valid because it involves a tie vote and that, pursuant to the Worker's Compensation Act, the single Board member's decision is no longer effective. Bujaroski, on the other hand, argues that it would require a majority of the full board to "overturn" the initial decision and that "[t]his did not happen and as a result the underlying decision is thereby approved." Appellee's Br. at 8.

Nations cites several cases in support of its position. In *Allison v. Wilhite*, this Court held that "it is not necessary that all of the five members participate in a hearing before the full board, as long as there is a majority of the members of the full board participating and concurring in both the finding and award." 106 Ind.App. 16, 22, 17 N.E.2d 874, 876-77 (1938). A year later, we decided *Eades v. Lucas*, 107 Ind. App. 144, 23 N.E.2d 273 (1939). In *Eades*, we referred to Sections 40-1509 to 40-1512 of the Worker's Compensation Act — which remain (with very minor changes) in today's Indiana Code at Sections 22-3-4-1-6 to 22-3-4-8.

Indiana Code Section 22-3-4-6 states as follows:

> The Board by any or all of its members shall hear the parties at issue, their representatives and witnesses, and shall determine the dispute in a summary manner. The award shall be filed with the
> 1293 record of proceedings, and a copy *1293 thereof shall immediately be sent to each of the employee, employer, and attorney of record in the dispute.

Indiana Code Section 22-3-4-7 states as follows:

> If an application for review is made to the board within thirty (30) days from the date of the award made by less than all the members, the full board, if the first hearing was not held before the full board, shall review the evidence, or, if deemed advisable, hear the parties at issue, their representatives, and witnesses as soon as practicable and shall make an award and file the same with the finding of the facts on which it is based and send a copy thereof to each of the parties in dispute, in like manner as specified in [Ind. Code § 22-3-4-6].

Indiana Code Section 22-3-4-8 states, in pertinent part, as follows:

> (a) An award of the board by less than all of the members as provided in [Ind. Code § 22-3-4-6], if not reviewed as provided in [Ind. Code § 22-3-4-7], shall be final and conclusive. With reference to these statutes, we held in *Eades:*

> From a consideration of these sections, it seems clear that any action of a hearing member is binding and conclusive only when there is no application for a [full Board] review filed. . . . If such an application is duly filed, any action of the hearing member disposing of a controversy on its merits ceases to be effective for any purpose and leaves the status of the parties unchanged. In view of the statutory provisions, all parties to the proceeding are bound to know that a new finding and award to be made by the full board is necessary; that said board neither affirms nor reverses an award made by one member, but "shall review the evidence, or, if deemed advisable, hear the parties at issue, their representatives and witnesses, and make an award and file the same with the finding of the facts on which it is based * * *" Where an application for review of an award by one member is filed, the application for compensation then stands for hearing before the full board, and is to be heard de novo.

Eades, 107 Ind.App. at 149-50, 23 N.E.2d at 276.

Similarly, in *Russell v. Johnson*, 220 Ind. 649, 655, 46 N.E.2d 219, 221 (1943), our supreme court held: "A review by the full board is on the merits and is not for errors. The hearing is *de novo* as to all parties to the proceeding and the award of the full board supersedes for all purposes the award of the hearing member."

Therefore, pursuant to Indiana's statutes and caselaw, it is clear that when the full Board accepted Nations's application for review, the single Board member's opinion was vacated.[1] The full Board's review was de novo. It was Bujaroski's burden to prove to the full Board that he was entitled to compensation under the Worker's Compensation Act. *See Triplett v. USX Corp.*, 893 N.E.2d 1107, 1116 (Ind. Ct.App. 2008), *trans. denied* (2009). Bujaroski failed to carry this burden, as demonstrated by the full Board's tie vote. Therefore, we remand to the Board for action pursuant to its options consistent with this opinion.

[1] Similarly, many years ago, cases appealed from a justice of the peace to the circuit court were tried de novo, and the effect of an appeal was to vacate and set aside the judgment of the justice. *See Baltimore O.R. Co. v. Tess*, 2 Ind.App. 507, 28 N.E. 721 (1891).

Remanded.

BRADFORD, J., and BROWN, J., concur.

64 *64

BASIS OF
SINGLE HEARING MEMBER/FULL BOARD
ADJUDICATION CONSTRUCT

- IC §22-3-4-5: Adjudication of Disagreements
- IC §22-3-4-6: "any or all of its members"
- IC §22-3-4-7: "award by less than all the members"
- 631 IAC 1-1-15: "facts upon review . . . determined upon the evidence introduced at the original hearing"
- 631 IAC 1-1-15: "errors alleged for review"
- IC §22-3-4-3(a): Forms
- IC §22-3-4-8: Finality of Award by "less than all the members"

De novo: Anew; afresh; a second time.

De novo trial: Trying a matter anew; the same as if it had not been heard before and as if no decision had been previously rendered.

Hearing de novo: Generally, a new hearing or a hearing for the second time, contemplating an entire trial in same manner in which matter was originally heard and a review of previous hearing. Trying matter anew the same as if it had not been heard before and as if no decision had been previously rendered. On hearing "de novo" court hears matter as court of original jurisdiction and not appellate jurisdiction.

Proceeding: In a general sense, the form and manner of conducting juridical business before a court or judicial officer. Regular and orderly progress in form of law, including all possible steps in an action from its commencement to the execution of judgment. Term also refers to administrative proceedings before agencies, tribunals, bureaus or the like.

Black's Law Dictionary, West Publishing Company, 1990 (case citations omitted).

Section Three

Worker's Compensation in 2030
Where are we Going?

Sharon Funcheon Murphy
SF Murphy Law
Carmel, Indiana

Section Three

Worker's Compensation in 2030
Where are we Going?..... Sharon Funcheon Murphy

WORKER'S COMPENSATION IN 2030 – WHERE ARE WE HEADED?[1]

Many changes have occurred to the Workers' Compensation legal system since its inception. Richard A. Victor[2], in his 2019 book entitled Scenarios for the 2030s: Threats and Opportunities for Workers' Compensation Systems, has summarized the most significant historical developments and opined as to the impact of them on the "grand compromise" of workers' compensation law. This paper will summarize his findings to promote thoughtful analysis of the legal system we all work within.

A. DEMOGRAPHIC FORCES THAT CHALLENGE THE WORK COMP SYSTEM

Mr. Victor has identified the aging of the Baby Boomer generation as the most significant current milestone leading to the evolution of workers' compensation in the United States. He believes the evolution of the country's demographics has resulted in higher claim rates, longer disability periods from work injuries, and a shortage of healthcare workers resulting in delay in treatment. While automation can offset some labor shortages, restrictive immigration policies have, and will continue to, worsen the shortage of labor in the United States.

Injury rates among workers have been falling for many decades. In the 1920's there were 25 work injuries for every 1 million man-hours worked in manufacturing. By 1963, that number had dropped to 13. In 1973 there were 11 injuries for every 100 full time private sector workers. By 2016 there were only 3. This decrease in the number of workplace injuries can be directly

[1] This paper is based on the book written by Richard A. Victor entitled Threats and Opportunities for Workers' Compensation Systems, (hereinafter Threats and Opportunities) with permission of the author. The book is free and available for download at http://ci36.actonsoftware.com/acton/ct/4952/s-0dc7-1912/Bct/l-06cb/l-06cb:2f3/ct1_0/1?sid=TV2%3AZJVCsipjJ

[2] Richard A. Victor has been a leader of the Workers Compensation Research Institute for three decades, and was employed by the Rand Corporation as a researcher before being asked by Sedgwick to undertake the research and writing of the book upon which this presentation is based.

attributed to safer workplaces and new technology. The decrease spans nations – it does not just exist in the United States.

However, there are two demographic trends that are expected to reverse this natural decline in injury rates. First, of these is an emerging labor shortage. The second is more restrictive immigration policies and anti-immigration rhetoric. As a result, the growth in the labor market has dropped, and is projected to continue to drop, from 2.5% (1970 to 1980) to .6% (2016 to 2030) as Baby Boomers retire. Once unemployment drops below 5%, it is commonly accepted there is the risk of a labor shortage. In those times, workers may be hired who are under-qualified.

To offset this decline, employers typically:

1. Substitute capital and technology for workers,
2. Send labor intensive operations to other countries that have more workers, and/or
3. Seek immigrant laborers.

The effect of the developing labor shortage is at least four-fold. First, the lack of workers impacts the availability of insurance personnel. One-third of employees in insurance companies and related activities will turn 65 between 2016 and 2030. Second, lower unemployment leads to higher voluntary resignations among the workforce. And third, the decrease in the number of workers results in high injury frequency and longer disability due to lax hiring standards caused by worker shortages. As a result, workers have less commitment to their job and less of the necessary skills to perform the job safely and efficiently. Finally, a shortage of health care workers could delay access and extend the duration of disability.

1. AUTOMATION AND JOB LOSS

While headlines imply that automation will offset labor shortages, it may worsen shortages as workers will require more skills to match available jobs. An example of this is the proliferation of ATM machines. When first introduced, it was thought that ATMs would eventually displace

bank tellers entirely. However, the decrease in the number of tellers from 2016-2026 was only 8%. Bank employees were, instead, assigned more challenging job tasks in addition to their original role. A large number of jobs can be partially automated, but relatively few can be totally automated.

Barriers to automation exist as well. Politically, no one wants to "eliminate" jobs due to economic and social pressures. Regulatory and technical restrictions work to inhibit automation as well. Furthermore, it is likely automation will result in new jobs that offset any job reduction. Many workers, such as the bank tellers above, will have to change their skill sets into the fields of development, installation, operation, and support.

2. RESTRICTIVE IMMIGRATION POLICIES WORSEN LABOR SHORTAGES

To understand the impact of restrictive immigration policies on the availability of workers, you must only look to the impact of BREXIT on England's migration.

> In the recovery from the Great Recession, net migration doubled from about 81,000 annually to over 170,000 in 2015. After the passage of Brexit, net-migration from the EU fell to 57,000, a drop of 67% in just 27 months. After the Brexit vote, in-migration fell by 24% and out-migration rose by 42%. This reflected location decisions by EU citizens faced with new uncertainties about work and schooling opportunities, and the quality of life as Brexit unfolded.
>
> According to the *New York Times*, since Brexit, "Hospitals are struggling to hire doctors and nurses. British universities are failing to attract foreign academics and students… the construction sector last month warned that British infrastructure face 'severe setbacks' if Britain did not train enough workers to stem a shortfall in laborers from European Union countries. About half of all construction workers in London … are foreign-born… The laborers who now come to Britain tend to be older and less skilled."[3]

[3] Threats and Opportunities, p. 41

Both anti-immigration policies and rhetoric dissuade foreign workers from coming to the US and from staying here. Since the United States is projected to have a labor shortage due to the aging population, this will only exacerbate the problem.

Mr. Victor cited the conclusions by The Health Foundation who analyzed the nursing registration trends before and after Brexit as follows:

> The huge drop in the number of EU nurses coming to work in the NHS following the referendum is a stark reminder that we must never take overseas staff for granted. We must make sure that the health service is an attractive and welcoming place to work for both international and home trained staff. With 1 in 10 nursing post[s] vacant this is one of the biggest risk [sic] facing the NHS. Uncertainty about the position of EU staff after Brexit adds to the challenge of securing enough nurses to sustain high quality care (The Health Foundation, 2018)[4]

In the United States in 2015, 17% of health care workers and 28% of physicians were foreign-born, and the number increased annually thereafter. In New York, California, Florida, Maryland, and Massachusetts 21-37% of health care workers are immigrants. (See Threats and Opportunities, Table 5.3 p. 45). Seven thousand U.S. physicians were born in the 6 countries covered by the Trump immigration ban.

B. CASE SHIFTING TO FREE CARE PROVIDED BY WORKERS' COMPENSATION

As private insurance deductibles increase, case shifting to workers' compensation will accelerate. Case shifting occurs when workers' compensation providers must pay higher rates than other providers (e.g. Medicare, Medicaid and private insurance) due to physicians finding employment causation for soft tissue conditions. Furthermore, if the Affordable Care Act is repealed, the number of uninsured will rise and case shifting will increase.

[4] Threats and Opportunities, p. 44

1. CASE SHIFTING BY WORKERS

Rising cost sharing through co-pays and deductibles motivates case shifting. When it is not clear what caused the condition and a work cause leads to free care, there is motivation to shift the treatment to workers' compensation by both the employee and the physician resulting in "free care" which is reimbursed to the treating physician at a higher rate. When an employee is first examined for an injury/condition, one of the standard questions they must answer is "was this related to or caused by work?" When work is a plausible cause or partial cause of the problem from the perspective of medical science, it is susceptible to "case shifting."

If the cause is ambiguous, unknowable, or a mix of work and non-work factors, case shifting is more likely to occur. This commonly involves soft tissue injuries (which make up approximately 40% of all claims) including non-specific back pain. Potential causes of these "injuries" include work, sports, housework, and the aging process. The Mayo Clinic advises its patients "*Back pain often develops without a cause that your doctor can identify with a test or an imaging study*."[5]

Some workers are "aware" they have or may have a claim for workers' compensation but they do not pursue it because they are afraid it could jeopardize their employment relationship. Research shows 25-40% of workers who receive indemnity benefits are afraid of being fired or laid off.[6]

Another phenomenon that impacts questionable claims is avoiding care initially due to the cost of obtaining it. In a 2016 survey by West Health Institute (University of Chicago), over 40% of Americans say they did not get medical care because of the cost when sick or injured in 2015.

[5] Threats and Opportunities p. 60, Mayo Clinic 2018
[6] Threats and Opportunities p. 62 of paper, Victor and Savych 2010

Other surveys have found 28%-29% did not seek treatment and 18% put off treatment for "very serious" or "somewhat serious" conditions. The higher the cost of care to patients, the less care they use.[7]

See Threats and Opportunities, Tables 6.1 and 6.2 on pages 65-66 that demonstrate this phenomenon. The difference is greater for conditions with more discretion in diagnosis and treatment. The effect of the Affordable Care Act (ACA) on the rate of insured people is significant. However, cost sharing (i.e. coverage that is not free) has increased for most privately insured workers, causing a growing motivation to shift claims to workers' compensation. In 2006 55% of insurance plans had deductibles; in 2016 83% of insurance plans had deductibles. In addition, the amount of the deductibles and out of pocket maximums on high deductible policies is increasing.

See Threats and Opportunities, Table 6.13 p. 75 for the characteristics of the working-aged uninsured in 2016. If the government enacts laws that increase the number of the uninsured, cost shifting is expected to rise. In addition to this phenomenon, Mr. Victor believes a driver in increasing cost shifting to workers' compensation now and into the future is (1) an awareness of work comp as "free medical" and (2) a willingness to take advantage of that possibility. He outlined the efforts of the Trump administration to weaken the ACA as follows:

1. 2018 – it cut funding for outreach during enrollment by 90%
2. 2018 – it significantly shortened the enrollment period
3. 2019 – it added additional large cuts to the program
4. 2017 – it amended tax laws eliminating the individual mandate
5. October 2017 – it eliminated payments to insurers to compensate for ACA-mandated subsidies (in anticipation of this, insurance companies raised rates by an average of 7-38%).

[7]Threats and Opportunities p. 63

2. CASE SHIFTING BY PROVIDERS

Case shifting by medical providers occurs because work comp reimbursement rates are higher than the rates of private insurance and Medicare/Medicaid. In addition, Urgent Care Centers are increasingly owned by large retail pharmacy chains or "financially-oriented" investors (rather than by physicians or hospitals). These entities are more likely to seek the higher reimbursement rates as a business tactic. Meanwhile, commercial insurers have begun to acquire large medical provider practices. They, in turn, want both the higher reimbursement rate and the shifting of care to workers' compensation. Alternative Payment Methods (APMs) which pay a fee for service with a bonus for results (i.e. quality of care goals) are viewed as lowering the urge to cost shift.

"Substantial evidence from many studies finds that providers change billing and practice patterns when reimbursement rates change."[8] Where surgeons own surgery centers, the number of surgeries performed by the surgeon-owners has been seen to increase by 14-22% as compared to their previous rates. Furthermore, when physicians are prohibited from dispensing strong opioids (which were cheaper at pharmacies), they shift to prescribing weaker pain medications that they could dispense. In addition, Medicare price reductions lead to changes in treatment by physicians to offset the shortfall in income. Threats and Opportunities, Table 7.2, p. 96 compares the average cost of knee arthroscopies under workers' compensation and commercial insurance in various states, and Indiana is shown to have one of the highest differences in cost along with Wisconsin, Illinois, and New Jersey.[9]

[8] Threats and Opportunities p. 100
[9] Threats and Opportunities p. 105

C. SOCIAL SECURITY AND WORKERS' COMPENSATION

It is forecast that in 2028 SSDI (Social Security Disability Income) will exhaust its reserves. When Congress addresses this problem, it is likely it will further investigate the overlap of workers' compensation and SSDI. Mr. Victor contends there is little evidence that work injuries have caused the rise in SSDI benefits, but he believes it is likely the legislature will investigate the overlap of work comp with SSDI anyway.

[See Threats and Opportunities, figure 8.1 p. 117] Figure 8.1 shows the depletion of the reserves of the SSDI program assuming no congressional action through 2028. This depletion is primarily attributed to the rapid growth of SSDI recipients from the 1980's to 2013 without any increase in funding. SSDI pays for benefits to disabled workers who pass several tests (Social Security Administration, 2018):

> Age test: The worker has not yet reached normal retirement age.
>
> Recent work test: The worker has been employed for a certain number of calendar quarters of recent employment covered by Social Security. For most applicants, they must have worked for 5 years out of the 10 years leading up to the onset of disability (Social Security Administration, 2018, p. 2). [n]
>
> Duration of covered work test: Anyone with at least 10 years (40 quarters) of covered employment meets this eligibility requirement. However, the minimum number of calendar quarters required for most workers depends on the worker's age at disability. For example, a worker disabled at age 50 needs 7 years (28 quarters). And a worker disabled at age 30 needs 2 years (8 quarters; see Social Security Administration, 2018, p. 2). [n]
>
> Severe disability test: The worker is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment (Social Security Administration, 2018, p. 7).
>
> - The worker is not working at the time of application (or earning less than a threshold amount).
> - The medical condition is severe. That is, the worker is significantly limited in ability to do basic work activities (e.g., lifting, standing, walking, etc.), and the disability is expected to last at least one year. No benefits are paid for shorter term disabilities or partial disability.

- The medical condition is on the SSDI list of severe impairments.
- The worker cannot do the work previously done.

The worker cannot do any other type of work, considering age, education, work experience, and skills.[10]

At the initial stage of application (Stage 1), 45% of applicants succeed, 21% are denied and do not appeal, and 33% are denied and appeal the denial. At the Reconsideration level (Stage 2) 86% of the applicants fail. At the Hearing level before an ALJ (Stage 3) 70% of applicants prevail.

Fifty percent of SSDI benefits are taxable if the household income of the recipient exceeds $25,000 for a single person or $32,000 for a married couple filing jointly. Actually, leaving Medicare once SSDI has been granted is a lengthy process in which the recipient receives Medicare for 2 years after returning to work to ensure that his/her ability to work is legitimate.

In 1984, the medical criteria for an award of benefits under SSDI was broadened to increase coverage for musculoskeletal problems and mental disorders. Previously those grounds had to match the "listings" in the statute. Disability based on musculoskeletal problems and mental disorders account for 62% of the workers who prevailed on their claims after 1984 as compared to only 32% before 1984.

	1986	2016
SSDI Recipients	4.6 million	11.8 million
SSDI Benefits paid	$16 billion	$124 billion

Mr. Victor identified the commonly accepted explanations advanced for this rapid growth in the use and cost of SSDI:

1. Demographic/economic changes

[10] Threats and Opportunities p. 118-119

2. Longer durations of SSDI cases
3. SSDI program design
4. Cost shifting from Workers' Compensation to SSDI

1. DEMOGRAPHIC/ECONOMIC CHANGES

A. Population Growth: From 1980-2016 the U.S. Labor Force grew from 107 million to 159 million. From 1986 to 2016 SSDI recipients tripled.

B. Aging Workforce: Baby boomers (those born between 1946-1964) will be 66-84 years old by 2030. 80% of the SSDI recipients are over 45, and 5% of them are under 35

C. More women are working and eligible for benefits. (To be "eligible" you must work 5 of the last 10 years)

D. Less Healthy Population: Diabetes, obesity and opioid abuse have increased. However, this is not viewed as a big factor contributing to the growth of SSDI.

E. Cyclical Application Rates: In an economic downturn, those who lose their jobs are less likely to find new employment and are more likely to apply for SSDI

F. Elimination of many lower skilled jobs: States with lower educational attainment have higher use of SSDI, and many of those jobs are going abroad.

G. Longer Duration of SSDI benefits: Since the changes in SSDI in 1984, more conditions leading to benefits are not fatal, so the length of the benefits is much longer.

H. Substantial Growth of Younger SSDI recipients

I. SSDI Benefit termination extended: The rate at which benefits are terminated once granted has dropped substantially from 16% in the early 1980's to 5% in 2015.

J. Increase in the normal Social Security retirement age: The increase in the age when Social Security is available has increased the period of time for which SSDI is the only available wage replacement benefit.

K. SSDI Benefits became increasingly attractive: As compared to wages for lower income recipients, SSDI benefits have become increasingly attractive. SSDI recipients are allowed to delay entry into Social Security Retirement Benefits, thereby maximizing those benefits which are locked in based on the date/age at which they commence.

2. DOES WORK COMP SHIFT COSTS TO SSDI?

There is a coincidence between an increase in SSDI and a decrease in workers' compensation indemnity payments from 1980-2013. However, Mr. Victor contends there is no causal connection. He supports this opinion with the following comparison:

	WORKERS' COMPENSATION	**SSDI**
What is included?	Work injuries causing disability	All disabilities
When do benefits start?	Immediately upon injury/disability	5 month waiting period (must show 1-year anticipated disability period)
Who is covered?	All ages	Those younger than retirement age
Work history?	No minimum work history	Must have worked 10 years (unless very young)
Medical coverage?	Medical coverage for injury immediately	Medicare eligible 24 months from disability
Payments made?	Pays for total or partial disability	Pays only for total disability

Since 1965, federal law limits the sum of SSDI and workers' compensation benefits to 80% of the worker's earnings on which SSDI is based. In most states this means that SSDI benefits are reduced after taking into account workers' compensation disability benefits to stay within this limit. However, in 15 states, workers' compensation benefits are offset (i.e. reduced) when SSDI is paid to stay within this 80% limit. This is called a Reverse Offset. Those states are: Alaska, California, Colorado, Florida, Louisiana, Minnesota, Montana, Nevada, New Jersey, New York, North Dakota, Ohio, Oregon, Washington, and Wisconsin.

In 2016, 480,000 SSDI recipients also got Permanent Total Disability benefits under workers' compensation, or they were claiming a right to receive those benefits. This amounts to 5% of the 2016 SSDI recipients. Two-thirds of the 5% did not have an offset as the benefits they received from both sources did not exceed the 80% cap based on their base wages. Indiana has

the lowest percentage of people getting both types of wage replacement benefits of all the states. In Indiana only 2.1% of SSDI recipients also get PTD benefits.[11]

3. POLICIES TO IMPROVE WORK COMP AND SSDI INTERACTION

Because SSDI is likely to exhaust its reserves by 2028, Congress has three choices on action that can be taken in response:

1. Reduce SSDI benefits
2. Find new sources of revenue, or
3. Kick the can down the road with accounting tricks (as they have done in the past)

Mr. Victor believes if they choose #2, workers' compensation disability benefits are a potential new source of revenue. Congress could choose to

1. Eliminate the "reverse offset" in the 15 states noted above,
2. Increase the role of the federal government in the workers' compensation system to improve the adequacy of compensation
3. Improve Social Security's ability to identify workers' compensation recipients, or
4. Require wage set-asides similar to Medicare Set Asides used currently.

D. CHANGED WC ENVIRONMENT LIMITS REFORM SUCCESS

Mr. Victor believes that workers' compensation costs may triple by 2030. In the past, legislatures addressed imbalances in the workers' compensation system with new regulations. In the 1970's, benefits were adjusted up-wards. In the 1980's the high cost of workers' compensation insurance led to the formation of state insurance funds. However, the causes of this expected

[11] Threats and Opportunities, p. 138.

increase in costs within the workers' compensation system are not readily subject to state workers' compensation reforms.

Workers' compensation reform cannot address the cost increase due to labor shortages, or the fact that the shortages lead to less skilled and/or less loyal workers. It cannot combat the continued growth of large deductibles in private insurance (motivating patients to claim workers' compensation to avoid cost). Nor can it offset the movement of commercial insurers to capitated (i.e. fee for service) rather than "value based" reimbursements.[12] The only real changes that workers' compensation reform can make are to benefit levels and duration, the scope of compensability, dispute resolution, regulating medical prices, and what constitutes medical care.

> Successful workers' compensation reform requires pragmatic, compromise-based solutions by legislators and governors. At its core, the system seeks a balance, however murkily-defined, between the needs of injured workers and the needs of these employers. Sustainable workers' compensation reform typically involves tradeoffs among competing legitimate objectives. Win-win tradeoffs are achieved by pragmatic compromises where each side achieves some objectives.
>
> Increasingly, pragmatic compromise-based solutions have been replaced by ideologically driven decision-making processes. Win-win solutions are less likely to result from ideologically driven public policy processes. Ideologically driven public policy processes tend to deny the legitimacy of the other side's objectives. Elected officials committed to an ideological approach are less likely to compromise, since it compromises their principles. We see this in the polarization of rhetoric, the growing reliance on processes that push single-party legislation, and the willingness to "fail" legislatively, rather than accept a compromise.[13]

Mr. Victor submits that to pay off the national debt would require "a doubling of all taxes and government fees at all levels of government for each of the next 50 years."[14] This includes both public debt and unfunded liabilities (e.g. Social Security, Medicare and Medicaid) For too

[12] An example of this would be if a back-pain complaint is handled under a capitated plan, the physician gets no additional compensation and may get a lower bonus under the "value based" coverage. If it is handled as work comp, the physician is paid a fee for service under work comp and his treatment is not counted against any bonus calculations. (Threats and Opportunities p. 152)

[13] Threats and Opportunities p. 152

[14] Threats and Opportunities p. 157

long taxes have been cut while social program promises were not adequately funded and maintenance of the public infrastructure has been deferred. (See Threats and Opportunities, Tables 12.2 and 12.3 p. 161) He points out that Republican Baby Boomers have consistently cut taxes and Democrat Baby Boomers have increased social services, both of which impact the tax burden on Millennials and the generations that follow. As a result, he predicts the formation of a new alliance among voters that transcends political parties and requires full disclosure by its government representatives to address the fiscal burden placed on Millennials and post Millennials by the Baby Boomers.

E. GLOBALIZATION AND PARADIGM SHIFTS IN THE 2030s

The last 1/3 of the Victor book outlines an imaginary conclusion to the financial problems that are developing including "lessons learned" and opportunities presented by new paradigms. These are couched in an imagined "looking back" from 2030 over the last ten years. During those years,

- The United States loses its competition with African nations on trade, but instead of erecting trade barriers, they turn to lowering manufacturing costs.
- A "Yellow Party" is formed made up of Millennials and Post-Millennials including both Democrats and Republicans. Their goal is to ease the financial burden imposed by Baby Boomers.
- School systems and small governmental entities are consolidated to lower costs, allegedly while improving services using half of the cost savings realized by consolidation.
- To save workers' compensation, Union and non-union systems employers join forces to standardize systems across state lines based on the premise that the diversity of state law systems results in unnecessary costs (similar to the unnecessary costs of small school systems and governmental entities).
- The holding of *Citizens United* is reversed and there is transparency in campaign financing.
- The country accepts national regulation and operation of elections.

As for changes/improvements in workers' compensation, Mr. Victor believes the system needs to be more "self-executing" to avoid attorney fees. He also advocates reducing excess fees

for medical care. However, he points out that while **Wisconsin** is lauded for having the lowest attorney involvement in workers' compensation claims and being the most self-executing, it is also criticized for unreasonably paying the highest amount for medical treatment.

Texas allows employers to opt out of providing workers' compensation entirely while remaining open to liability claims for injuries through an ERISA based plan. Data indicates "non-subscribers" (i.e. those companies who opt out of work comp) save about 50% on the cost of work injuries. Non-subscribers require an injury to be reported the day it occurs (as opposed to within 2 years). Ninety-one percent of non-subscribers require arbitration of disputes, and lost wages paid under the non-subscriber plans are taxable as income while some costs of litigation are paid by the employees.

In some states, a unionized workplace negotiates a "carve out" which could adjust choice of provider, dispute resolution, and higher benefits. **New York**, the first state to use a "carve out" plan, realized significant savings though pay-outs to employees were 44% higher than under traditional workers' compensation. This cost saving was allegedly due to union "pre-screening" of claims before employees could retain attorneys, as well as the commitment of the employer to pay all legitimate claims. The employees reportedly recognized the cost to the industry of false claims and became pro-active concerning return to work policies at the end of a claim.

In **Minnesota**, carve-outs may include providing a list of acceptable physicians and letting employees choose from the list, as well as streamlined dispute resolution.

Mr. Victor advocates what he terms "super carve-outs" negotiated between workers and employers as the only viable solution going forward. He contends that all other "interested parties" to the workers' compensation system (lawyers, insurers, agents, medical providers, claims administrators, managed care firms, drug and device manufacturers, translators, stenographers,

judges, transportation companies, etc.) should not be included in these negotiations. While he recognizes the unlikelihood that this will occur, he believes it is the only way to truly reform the workers' compensation system going forward.

SCENARIOS FOR THE 2030s:

Threats and Opportunities for Workers' Compensation Systems

RICHARD A. VICTOR

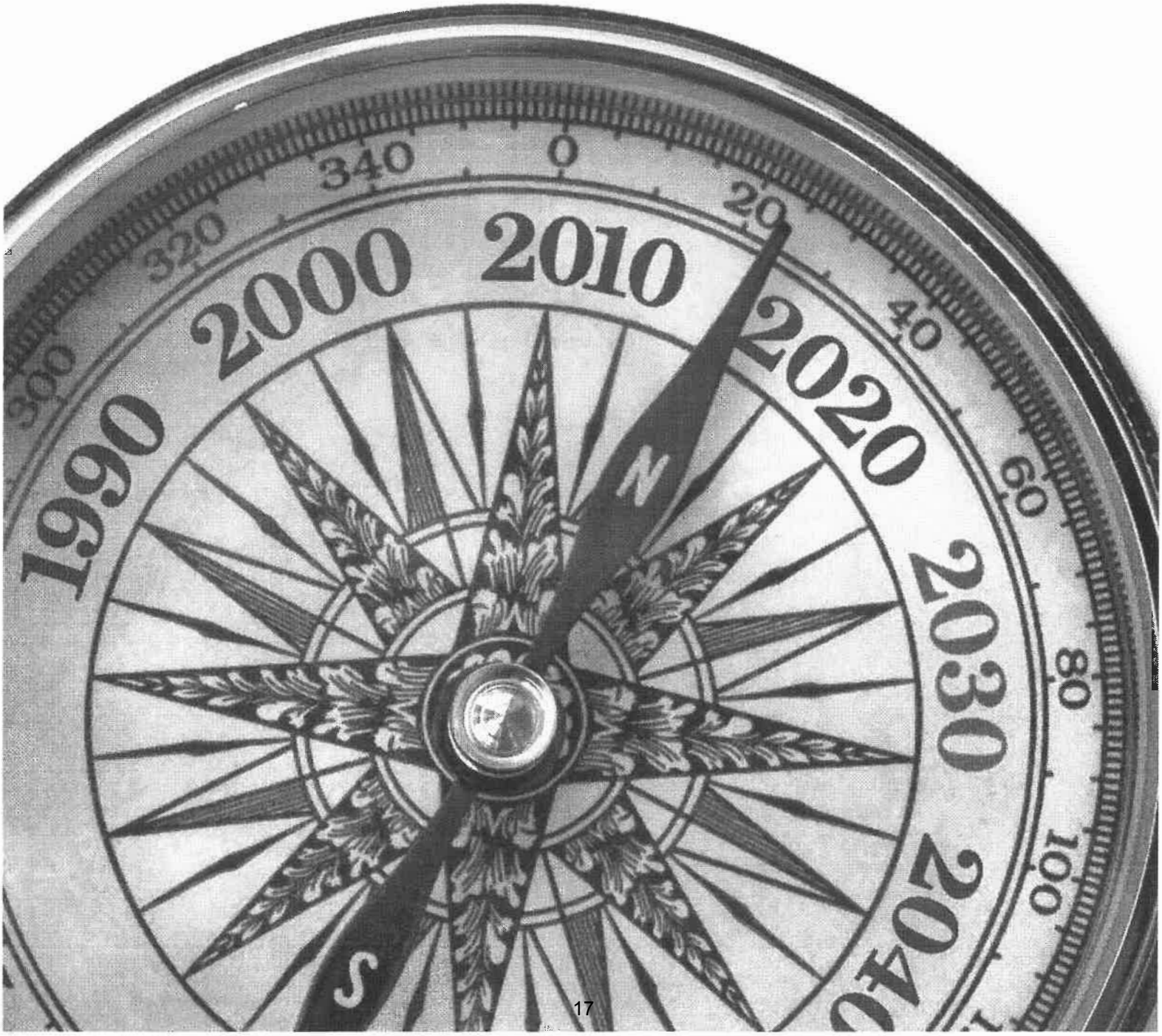

TABLE 5.3: SHARE OF U.S. CIVILIAN HEALTH CARE WORKERS WHO ARE FOREIGN-BORN, 2015

OCCUPATIONAL GROUP	ALL WORKERS	IMMIGRANT WORKERS	IMMIGRANT SHARE (%)
Total employed workers (aged 16 and older)	150,573,000	25,689,000	17.1
Health care workers (aged 16 and older)	12,395,000	2,066,000	16.7
Health care practitioners and technical occupations	8,794,000	1,364,000	15.5
Physicians and surgeons	910,000	254,000	27.9
Registered nurses	3,081,000	486,000	15.8
Therapists	786,000	79,000	10.1
Other health-diagnosing and treating practitioners	1,024,000	163,000	15.9
Health care technologists and technicians	2,992,000	382,000	12.8
Health care support	3,601,000	703,000	19.5
Nursing, psychiatric, and home health aides	2,060,000	489,000	23.8
Health care support, all others	1,541,000	213,000	13.8

Note: Migration Policy Institute tabulation of data from the U.S. Census Bureau 2015 American Community Survey (ACS).
Source: Szilvia Altorjai and Jeanne Batalova, "Immigrant Health-Care Workers in the United States," Migration Information Source, June 28, 2017, https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states.

Under the restrictive immigration policies and strong rhetoric, the labor shortages in the U.S. health care sector would worsen, delaying care and return to work for injured workers, increasing income losses for workers, and raising costs to employers.

To illustrate the impact of just one of the restrictive policies, 7,000 U.S. physicians were born in the six countries covered by the original Trump immigration ban. These doctors provide 14 million patient-visits each year. Especially affected would be patients in Michigan (1.2 million visits), Ohio (880,000 visits), Pennsylvania (700,000 visits) and West Virginia (210,000). In areas with current doctor shortages, the doctors born in these 6 countries provide 2.3 million patient visits each year.[2]

The drumbeat of anti-immigrant rhetoric, enforcement practices, and administrative delays have created substantial uncertainty (and inhospitality) for immigrants from many countries. The best and the brightest of these have many options other than the U.S. The number of overseas non-citizen applications for medical residencies in the U.S. has dropped in 2017 and 2018 (National Resident Matching Program®, 2018). "The administration's policies are having a chilling effect on the interest of medical graduates coming to the United States to train," according to Mona Signer, CEO of the National Resident Matching Program (Schwartz, and Lohr, 2018).

Both those currently working and training in the U.S. and those considering immigration for training and/or better living conditions may also be affected. For those currently training in the U.S., they wonder whether they will be allowed to return to the U.S. if they leave to visit family or attend an international professional conference. Will they be allowed to stay when their training is completed? For those considering training or relocating to the U.S., they are making a multiyear commitment

A third plan required the patient to pay a 95 percent coinsurance amount until the annual out-of-pocket maximum was met. The out-of-pocket maximum was also about $3,550 in 2016 dollars for families.

In the RAND studies, spending by patients under both of the cost-sharing plans was less than by patients with the free care plan (like workers' compensation). Almost all the spending differences resulted from patients who decided not to initiate episodes of care for certain medical problems.[7]

Compared to the free care plan, spending on care for workers in the 25 percent coinsurance plan was 20 percent lower, and the number of episodes of care was 22 percent lower. Those in the 95 percent coinsurance plan had 43 percent lower medical spending and 36 percent fewer episodes of care during the year than under the free care plan.

Brot-Goldberg et al. (2015) analyzed how expenditure changed when the employees of a single large self-insured employer were all required to change from a free care plan (no cost sharing) to HD plans.[8] The firm had more than 35,000 employees. Those employees had disproportionately higher incomes.

The change from free care to substantial cost sharing occurred between 2010 and 2013. The study used data from 4 years before the change and 3 years after. The HD plan had deductibles of $3,000 to $4,000 and $1,200 to $1,600 for family and individual plans respectively. The coinsurance rate was 10 percent for in-network care and 30 percent for out-of-network care. The annual out-of-pocket maximums were $6,000 to $7,000 and $2,400 to $2,800 for family and individual plans respectively.

The change in cost sharing led employees to reduce spending on care by an average of 13 percent during the plan-year. Most importantly, the reduction in spending that largely occurred before the deductible was met—when the cost-sharing incentives were most powerful—was 42 percent. The authors found that almost the entire reduction in spending was due to the use of less medical care.

Table 6.1 summarizes the most relevant results of the two studies. These results are used to measure the size of the pool of candidates for case shifting due to higher cost sharing.

TABLE 6.1: SUMMARY OF MOST RELEVANT RESULTS

STUDY	FROM PLAN WITH	TO PLAN WITH	EFFECT FOUND
▪ RAND (Newhouse, 1993)	Free care	25% coinsurance; $3,550 annual out-of-pocket maximum (2016$)	20% lower medical spending; 22% fewer episodes treated
▪ RAND (Newhouse, 1993)	Free care	95% coinsurance; $3,550 annual out-of-pocket maximum (2016$)	43% lower medical spending; 36% fewer episodes treated
▪ Brot-Goldberg et al. (2015)	Free care	HD plan; $3,000-$4,000; $6,000-$7,000 out-of-pocket maximum	42% lower spending before the deductible was satisfied

The estimates in these studies likely understate the size of the effect of case shifting for several reasons.

First, the effects found by both RAND and Brot-Goldberg et al. (2015) are an average across all types of medical conditions. Yet, for certain types of conditions, workers are more likely to avoid care if cost sharing rises. For example, a patient in the midst of a heart attack, or in a serious auto accident, is unlikely to avoid or defer care because of the insurance deductible. In our analysis of case shifting, we focus on what we call soft tissue conditions, many of which have an element of discretion about if, when, and how to initiate treatment. The RAND studies show that care avoidance is larger than average for medical conditions with more discretion in diagnosis and the course of treatment (Table 6.2).

TABLE 6.2: EFFECT OF COST SHARING ON PATIENT VISITS

MEDICAL CONDITION	% OF PATIENT VISITS AVOIDED DUE TO COST SHARING
Back/neck pain	-55%
Sprain	-37%
Arthritis/bursitis	-55%
Chest pain	none
Fracture	-20%
Lacerations—sutured	none
Lacerations—not sutured	-39%

Source: Newhouse, 1993, Table 5.3.

For chest pain and serious lacerations, there was no difference in use. No care is avoided due to cost sharing between the free care plan and the plans with cost sharing. For fractures, there were 20 percent fewer visits than under the free care plan—that is, 20 percent of the care was avoided due to cost sharing. For common soft tissue conditions, such as spine pain, strains, arthritis, and bursitis, there was very substantial care avoidance due to cost sharing (one-third to one half of visits that would have occurred under the free care plan).

The results for lacerations make clear how powerfully the cost sharing can influence decisions to seek medical care or not. For more serious lacerations, there was no difference between the number of medical visits for workers in the free care plan and the cost-sharing plans. However, for less serious lacerations, workers with cost-sharing plans were about 40 percent less likely to see a doctor than workers in free care plans.

Second, the employees in the Brot-Goldberg et al. (2015) study had relatively high incomes as 92 percent averaged over $100,000 each year. The RAND studies show that higher income workers are less likely than average to avoid care when cost sharing increases (Table 6.3). When faced with a 95 percent coinsurance rate, at least 26 percent of higher income people avoided care compared with 38 percent in the lower income group. In turn, the Brot-Goldberg et al. study likely understates the percentage of episodes where care was avoided due to cost sharing in a typical cohort of workers.

Who are the Uninsured?

MOST UNINSURED WORKERS ARE COVERED BY WORKERS' COMPENSATION INSURANCE

Most of the workers without health insurance are covered by workers' compensation. In 2016, 86 percent of uninsured households had at least 1 member employed. Nearly 90 percent of those workers were employed full-time (Kaiser Family Foundation, 2017, fig. 4).

HOW MANY WORKERS ARE UNINSURED?

In 2016, there were nearly 17 million uninsured workers, and nearly two-thirds worked full-time (U.S. Department of Labor, Bureau of Labor Statistics, and Census Bureau, 2019d). Before the ACA, there were 25 million uninsured workers. The ACA reduced the number of workers without health insurance by 8.2 million (Table 6.12).

TABLE 6.12: TREND IN UNINSURED WORKERS, 2006–2016 (MILLIONS)

	2006	2011	2013	2016
Total uninsured	45.2	48.6	42.0	28.1
Total working-age uninsured	36.4	41.0	35.8	23.3
Total uninsured workers aged 19 to 64	---	---	25.0	16.8

Sources: U.S. Census Bureau, 2019b to 2019g; and U.S. Department of Labor, Bureau of Labor Statistics and Census Bureau, 2019a.

WHO ARE WORKING-AGE ADULTS WITHOUT INSURANCE?

Half of adults without health insurance are employed full-time. Another 25 percent are in households where at least one other member works full-time. In nearly half, household income is under $40,000.

TABLE 6.13: CHARACTERISTICS OF WORKING-AGED UNINSURED, 2016

	% OF WORKING-AGED UNINSURED POPULATION
Age	
19 to 34	43%
35 to 54	41%
55 to 64	15%
Employment	
2+ household members work full-time	25%
1 household member works full-time	50%
Only part-time work	11%
Not working	15%
Income	
< $20,000	24%
$20,000 to $39,999	25%
$40,000 +	51%
Health Status	
Excellent/very good	62%
Good	29%
Fair/poor	10%

Source: Kaiser Family Foundation, 2017, Appendix Table B.

Forty-two percent with such bonuses said that, at most, 10 percent of their compensation was tied to these targets.

TABLE 7.1: PERCENTAGE OF PHYSICIANS WHO HAVE BONUSES TIED TO COST OR QUALITY TARGETS, 2018

SIZE OF BONUS	% OF PHYSICIANS
none	52%
< 10% of compensation	20%
10+% of compensation	28%

Source: Merritt Hawkins, 2018a, p. 45.

In a survey of its health plan members, the Catalyst for Payment Reform found that 40 percent of commercial insurance in-network payments to physicians and hospitals in 2014 were paid under APM contracts, up from 11 percent in 2013 (Catalyst for Payment Reform, 2013 and 2014). The Health Care Transformation Task Force reports that 41 percent of its members' businesses (payers and providers) used some form of APM during 2015, up from 30 percent in 2014 (Health Care Transformation Task Force, 2016).

APMs are a central feature of ACOs authorized under the Affordable Care Act (ACA). Leavitt Partners tracked over 1,000 ACOs covering 32.7 million lives—about 10 percent of the U.S. population (Muhlestein et al., 2018). Since 2016, there was a net increase of 176 ACOs (21 percent increase).

TABLE 7.2: NUMBER OF ACCOUNTABLE CARE ORGANIZATIONS, 2011–2018

AS OF FIRST QUARTER OF EACH YEAR	# OF ACOS
2011	58
2012	168
2013	440
2014	613
2015	734
2016	835
2017	923
2018	1,011

Key: ACO: accountable care organization.
Source: Muhlestein et al., 2018, Exhibit 1.

Contracts with commercial insurers accounted for 48 percent of the 1,477 ACO contracts. Medicare contracts represented 46 percent and Medicaid were 5 percent of the total. Half of the growth in Medicare contracts were shared risk contracts where the provider organization assumed both upside and downside risk (Muhlestein et al., 2018, exh. 2).

ACO penetration varies greatly by state. As of the first quarter of 2018, at least 30 percent of the population was covered by ACOs in Massachusetts, Maine, and Rhode Island. At least 20 percent was covered in Colorado, Oregon, Vermont, Iowa, Louisiana,

TABLE 12.2: FEDERAL DEBT HELD BY THE PUBLIC, 1970–2049

YEAR	DEBT (TRILLIONS)
1970	$0.3
1980	$0.7
1990	$2.4
2000	$3.4
2010	$9.0
2019	$16.6
2029	$28.7
2039	$51.7
2049	$96.8

Source: Congressional Budget Office, 2019. For 1970–2010, Table F-1; for 2019–2029, p. 2; and for 2039–2049 author's computations from Table 1-4.

UNFUNDED FEDERAL LIABILITIES

Congress enacts programs that create entitlements to future payments. These programs range from income support (e.g., Social Security) to medical insurance coverage (e.g., Medicare) to disaster insurance (e.g., crop and flood insurance), pension and health benefits for retired federal civilian and military employees, and disability benefits for veterans.

Liabilities are the costs to the taxpayers of meeting those promises made by Congress. The unfunded liabilities are the amounts by which future program expenditures exceed future dedicated program revenues. Dedicated revenues include, for example, payroll taxes for Social Security and Medicare,[1] flood insurance premiums, and federal employee contributions for retirement benefits. Revenues do not include tax revenues other than the OASDI payroll taxes. At any point in time, the total unfunded liabilities for a program are the sum of the present values of the future annual funding gaps.

By far, the largest set of unfunded liabilities come from social insurance programs like Medicare and Social Security (Table 12.3). These total $49 trillion and represent 85 percent of all federal unfunded liabilities. Retirement benefits for federal employees account for $7.7 trillion of unfunded liabilities—13 percent of the total.

TABLE 12.3: UNFUNDED LIABILITIES BY CATEGORY OF FEDERAL PROGRAM (2017 ESTIMATES OF 75-YEAR UNFUNDED LIABILITIES)

PROGRAM	UNFUNDED LIABILITIES (TRILLIONS)
Social insurance programs	$49.0
Federal employee benefits	$7.7
Environmental & disposal liabilities	$0.5
Insurance programs and loan guarantees	$0.2
Total	$57.4

Source: U.S. Department of the Treasury, 2018, pp. 57–58, 97, 106, and 109.

Section Four

Representing Public Entities, Municipalities, Police and Fire as well as Public Utilities under IC 22-3-2-5

John N. Shanks II
Shanks Law Office
Anderson, Indiana

Section Four

Representing Public Entities, Municipalities, Police and Fire as well as Public Utilities under IC 22-3-2-5……..John N. Shanks II

PowerPoint Presentation

Slide Narrative

Representing Public Entities, Municipalities, Police and Fire as well as Public Utilities under IC 22-3-2-5

PRESENTED BY JOHN N.SHANKS II

Past Chairman of Indiana Workers Compensation Board

Past President Indiana Public Employers Plan (IPEP)

IC 22-3-2-5

(a) Every employer who is bound by the compensation provisions of IC 22-3-2 through IC 22-3-6, except the state, counties, townships, cities, towns, school cities, school towns, other municipal corporations, state institutions, state boards, state commissions, banks, trust companies, and building and loan associations, shall insure the payment of compensation to the employer's employees and their dependents in the manner provided in IC 22-3-3, or procure from the worker's compensation board a certificate authorizing the employer to carry such risk without insurance. While such insurance or such certificate remains in force, the employer or those conducting the employer's business and the employer's worker's compensation insurance carrier shall be liable to any employee and the employee's dependents for personal injury or death by accident arising out of and in the course of employment only to the extent and in the manner specified in IC 22-3-2 through IC 22-3-6.

(b) The state may not purchase worker's compensation insurance. The state may establish a program of self-insurance to cover its liability under this article. The state may administer its program of self-insurance or may contract with any private agency, business firm, limited liability company, or corporation to administer any part of the program. The state department of insurance may, in the manner prescribed by IC 4-22-2, adopt the rules necessary to implement the state's program of self-insurance.

Exclusive Remedy

IC 22-3-2-6

It is very clear that the provisions of the Act are the exclusive rights and remedies of all employees subject to the Act except for remedies which might be applicable under IC 5-2-6.1 (victims of violent crimes).

CLAIMS

- PERF
- Rostered Volunteers
- COVID-19
- RTW Programs

RISK MANAGEMENT

- Budget Constraints
- Enforcing Safety Rules
- People Resources
- Political Changes

Claims – PERF

22-3-2-2. Employers and employees bound by worker's compensation law — Exceptions.

(a) Every employer and every employee, except as stated in IC 22-3-2 through IC 22-3-6, shall comply with the provisions of IC 22-3-2 through IC 22-3-6 respectively to pay and accept compensation for personal injury or death by accident arising out of and in the course of the employment, and shall be bound thereby. The burden of proof is on the employee. The proof by the employee of an element of a claim does not create a presumption in favor of the employee with regard to another element of the claim.

(b) IC 22-3-2 through IC 22-3-6 does not apply to railroad employees engaged in train service as:

(1) engineers;

(2) firemen;

(3) conductors;

(4) brakemen;

(5) flagmen;

(6) baggagemen; or

(7) foremen in charge of yard engines and helpers assigned thereto.

(c) IC 22-3-2 through IC 22-3-6 does not apply to employees of municipal corporations in Indiana who are members of:

(1) the fire department or police department of any such municipality; and

(2) a firefighters' pension fund or of a police officers' pension fund.

However, if the common council elects to purchase and procure worker's compensation insurance to insure said employees with respect to medical benefits under IC 22-3-2 through IC 22-3-6, the medical provisions of IC 22-3-2 through IC 22-3-6 apply to members of the fire department or police department of any such municipal corporation who are also members of a firefighters' pension fund or a police officers' pension fund.

Claims - PERF

- Police/Fire departments participating in PERF 77
  - Medical only coverage
  - No coverage for TTD or PPI
  - Participation may vary within department

Claims - Rostered Volunteers

IC 22-3-2-2.1 Coverage for rostered volunteers

Sec. 2.1. (a) As used in this section, "rostered volunteer" means a volunteer:

(1) whose name has been entered on a roster of volunteers for a volunteer program operated by a unit; and

(2) who has been approved by the proper authorities of the unit.

The term does not include a volunteer firefighter (as defined in IC 36-8-12-2) or an inmate assigned to a correctional facility operated by the state or a unit.

(b) As used in this section, "unit" means a county, a municipality, or a township.

(c) A rostered volunteer may be covered by the medical treatment provisions of the worker's compensation law (IC 22-3-2 through IC 22-3-6) and the worker's occupational disease law (IC 22-3-7). If compensability of an injury is an issue, the administrative procedures of IC 22-3-2 through IC 22-3-7 apply as appropriate.

(d) All expenses incurred for premiums of the insurance allowed or other charges or expenses under this section shall be paid out of the unit's general fund in the same manner as other expenses of the unit are paid.

Claims - Rostered Volunteers

- Rostered volunteers
  - Used by public entities to stretch resources
  - Not considered employee under the Act
  - "May" be covered
  - Medical only coverage
  - No coverage for TTD or PPI

Claims - COVID-19

22-3-7-10. "Occupational disease" defined — Disease arising out of employment.

(a) As used in this chapter, "occupational disease" means a disease arising out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where such diseases follow as an incident of an occupational disease as defined in this section.

(b) A disease arises out of the employment only if there is apparent to the rational mind, upon consideration of all of the circumstances, a direct causal connection between the conditions under which the work is performed and the occupational disease, and which can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as the proximate cause, and which does not come from a hazard to which workers would have been equally exposed outside of the employment. The disease must be incidental to the character of the business and not independent of the relation of employer and employee. The disease need not have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.

Claims - COVID-19

- Public Safety exposure to COVID-19
- Determining causation
  - Known exposure
  - Likelihood of exposure at work
  - Personal habits
- Negative test – no injury

Claims - RTW Programs

- Policy Management
- Leadership Support

Risk Management

Their best attribute is also their biggest weakness.

Risk Management – Resources and Budget Challenges

- Challenges:
  - Limited Workforce
  - Low Budget
  - Lack of Technology
  - Limited Training
  - Limited Personal Protective Equipment
  - Limited Safety Equipment

Solutions to Resources and Budget Challenges

- Solutions:
  - Providing resources to Safety Committees
  - Access to safety grant funds for added personal protective equipment, training and safety equipment
  - Providing multiple delivery options for all levels of technology
  - Provide in person and online training

Risk Management – Political Changes

- Administration may change every 4 years
  - May affect safety culture
  - Priorities may change
- Leadership Style
  - Establish and maintain safety culture

Risk Management – Enforcement

- Ability to enforce safety rules
- Affirmative Defenses
- Relationship Management
- Creative Solutions

Slide #1 (Opening Slide)

Representing Public Entities, Municipalities, Police and Fire, as well as Public Utilities and other Such Employers Under IC 22-3-2-5

John N. Shanks II

Slide #2 IC 22-3-2-5 sets the stage for public entities which includes the state and local governments, schools, banks, trust companies and building and loan associations All other employers must obtain worker's compensation insurance pursuant to IC 22-3-3 or obtain a self-insurance certificate from the board. The state may not purchase worker's compensation insurance pursuant to IC 22-3-2-5 (b). However, it may administrate its self-insurance program or contract it out to a third-party but the Indiana Department of Insurance may adopt administrative rules necessary to implement the state's program. .

Slide #3 The foundation of the Worker's Compensation Act is IC 22-3-2-6 known as the "Exclusive Remedy" provision. It is very clear that the provisions of the Act are the exclusive rights and remedies of all employees subject to the Act except for remedies which might be applicable under IC 5-2-6.1 (victims of violent crimes).

There are two parts to representing public entities: Claims **(Slide #4)** and Risk Management **(Slide #5)**

(Slide #6) A fundamental issue of representing public entities is claims. IC 22-3-2-2 (a) which some refer to as the "Mandatory Compliance" provision, requires employers and employees, respectively "*to pay and accept compensation for personal injury or death by accident arising out of and in the course of the employment, and* ***shall be bound thereby***". The exceptions to this statute are railroad employees "engaged in train service", and members of municipal police and fire departments which are members of Public Employees Retirement Fund (a/k/a "PERF").

(Slide # 7) PERF: Under IC 22-3-2-2(c), IC 22-2-2 through IC 22-3-6 doesn't apply to police and firefighters who are members of a pension fund (PERF), however, the common council may elect to purchase worker's compensation insurance with respect to medical benefits for those in the pension plan and those who are not. If the municipality purchases worker's

compensation insurance, these benefits will be exclusive and those otherwise provided by IC 36-8-4-5 do not apply.

Slide # 8 & Slide # 9 ROSTERED VOLUNTEERS: Volunteers are an intricate part of every county, municipal and township government and IC 22-3-2-2.1 addresses this issue. It requires an entity to maintain a roster of its volunteers so someone can't just claim to be a "volunteer" so they may be covered for medical expenses if injured.

Volunteer firefighters are not covered by this section of the code nor are "inmates" assigned to a correctional facility operated by the state or other unit. However, volunteer firefighters are covered under a special provision of the Indiana code. IC 38-8-12-10.3 provides that if a volunteer firefighter responds to an emergency call while working for a private employer, that firefighter is considered an "employee" of the governmental unit he or she is serving while on that emergency call, for purposes of worker's compensation benefits.

There is another class of volunteers which are covered under the Act, they are known as "school to work students". Under IC 22-3-2-2.5 students participating in "on-the-job-training" under the federal School to Work Act are entitled to medical benefits, permeant partial impairment, death and burial benefits (payable to dependents or parents).

(Slide #10) Claims – Covid-19

We are in the most unique times in American history. We all wear masks and practice social distancing but this virus continues to infect thousands of Americans. What if a public employee contracts this virus and has medical bills and can't work? Well IC 22-3-7-10, also known as the Occupational Disease Act, may apply. The problem is proof!

The act is specific in that it must be proven that there is a "*direct causal connection between the conditions under which the work is performed and the occupational disease.*"

(Slide #11) Public safety exposure to the virus is part of the determination of causation. Determining facts are: known exposure, likelihood of exposure at work and, very important, personal habits. The employee's life style can weigh heavily on this issue. What if there was a negative test and no injury, well no case.

(Slide #12) Return to Work Programs

During by term as Chair of the Worker's Compensation Board, one of the frequent topics I addressed was return to work programs. Does the employer have a program which focuses on returning injured employees back to work? Some of the options are light duty, and flex time schedule to allow for resting and medical treatment. Many employers don't recognize the cost of an employee not being able to work. It is often necessary to temporarily fill that employee's position with another employee who may be without the same level and quality of experience n that position. The sooner an employer can return an employee back to work the cheaper it is for the employer, not just in temporary disability benefits but in the overall quality of the employer's mission..

I believe it is important for there to be leadership support for an injured employee on temporary total disability. There are simple things that can help return an injured employee back to work. Many injured employees suffer emotional damage not just physical damage. They have feelings of guilt for being injured and unable to work. "What did I do wrong?" The simple things to which I am referring are "get well" cards, friendly telephone calls from a supervisor or other leadership and contact from other employees. If the injured employee regains a feeling of being "wanted" the sooner he or she may return, physically and emotionally.

It's challenging to have a consistent RTW policy across all departments without an HR Department or Safety Director. In the absence of these positions, RTW policies are left up to individual departments. This makes it challenging to accept change and RTW policies. Special consideration would be required due to union contracts within Police, Fire and sometimes Sanitation departments, which involves approval from elected officials.

(Slide #13) Risk Management. (Attitude)

The old saying is true, *"An ounce of prevention is worth a pound of cure"*. Its challenging for public entities to focus on their own internal safety because their primary focus is providing civilian safety. Our biggest challenge is refocusing their attention internally to first provide safety for their employees so they can affectively provide civilian safety. One trend we

found while looking at claims data from October 2017 to October 2020 is the amount of Slip, Trip and Fall injuries that were reported. This is our highest incident type which accounts for over 17% of our reported claims. Public entities are responsible for snow removal on streets and sidewalks in public areas to reduce civilian injuries. This places public entity workers first to respond to hazardous environments. Resources are also limited for public entities meaning they often do not have adequate footwear, slip resistant boots, etc.

(**Slide #14) Resources and Budget Challenges**.

Limited workforce.
Low budget.
Lack of Technology
Limited Training
Limited Personal Protective Equipment
Limited Safety Equipment

(Slide #15) Solutions

Providing Resources to Safety Committees
Access to Safety Grant funds
Providing multiple delivery options for all levels of technology.
Provide in person and online training.

(Slide #16) Political Changes

Administrative changes

Safety Culture: Morale can shift for employees when leadership changes. Some public entities experience a complete department change when a new leader is placed. This may create fear, disruption and/or animosity for employees who stay. Key to maintaining a safe workplace environment hinges on "leadership style"

Leadership style: Sustainable leadership is by example. Since I was a Boy Scout I have believed in this slogan, "leadership by example". If you are a "leader" and you don't follow the rules, no one under you will either. Just like we hear on TV, no one is above the "law". Without leadership by example enforcement of safety rules is impossible.

(Slide #17) Enforcement.

Ability to enforce safety rules

Most public entities allow each department head to provide their own safety training, safety rules and enforcement. This practice creates challenges on how to consistently manage enforcement. This can also create a challenge to establish and defend affirmative defenses.

Affirmative defenses

Relationship Management

Relationship Management: When enforcing a safety rule, it is important to stay politically neutral because of the complexity of relationship management. Many of the workers in public entities are family members, friends, neighbors, classmates, etc.

Creative Solutions

Solution: A solution that we find to be useful is to bring all department leaders together to collaborate and establish one cohesive guideline to follow. Most public entities need special guidance in this area.

Section Five

COVID-19 as a Workers' Compensation Claim

Stephen E. Dever
Hunt Suedhoff Kalamaros LLP
Fort Wayne, Indiana

Section Five

COVID-19 as a Workers' Compensation Claim…….. Stephen E. Dever

Introduction

We are less than a year from the first diagnosed case of COVID 19 in Indiana. Yet the COVID 19 Pandemic has had an unprecedented impact on our lives. We have shut down (partially). We have reopened (mostly). We have learned to social distance and wear masks. The COVID 19 virus has infiltrated the work places of Indiana employees. And, due to our current understanding of how the virus is spread, some employees appear more likely to be exposed to the virus than others.

It follows that COVID 19 infections are and will be the subject of numerous claims for workers compensation and/or occupational disease benefits. There have been 4,240 First Reports of Injury filed with the Indiana Workers Compensation Board (as of the completion of this article) alleging work place injury or exposure. This leads to the question of how does COVID 19 fit into the Workers' Compensation Act and/or the Occupational Disease Act? Is it a work injury? Is it an occupational disease? Is it an every day disease of life? This article focuses on Indiana court decisions that have addressed disease claims filed under the Indiana Workers Compensation Act as opposed the Occupational Disease Act and their applicability to what we know about COVID 19.

What is COVID 19

COVID 19 is an infectious disease caused by a newly discovered coronavirus. COVID 19 is one of many viruses with the large family of coronaviruses. Historically, coronaviruses caused mild to moderate upper respiratory illnesses like the common cold. However, three new coronaviruses have developed over the last 20 years that have caused widespread illness and death. Those three viruses are the Middle East Respiratory Syndrome (MERS), the Severe

Acute Respiratory Syndrome (SARS) and now COVID 19 (SARS-CoV-2). *(www.niaid-nig.gov)*

COVID 19 is thought to spread from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land on the mouths and noses of nearby persons and can be inhaled into the lungs. Therefore, close proximity to an infected person appears to have a significant impact on the spread of the disease. *(www.cdc.gov)*

Distinguishing Workers' Compensation Diseases from Occupational Disease

We all understand that a workers' compensation claim focuses on injury or personal injury, whereas an occupational disease claim focuses on… well… disease. Does the very presence of the Occupational Disease Act mean a disease or illness cannot fall with the Workers' Compensation Act? The short answer is no. Diseases can and have been found to fall within the Workers' Compensation Act.

The Workers Compensation Act applies to "…personal injury or death by accident arising out of and in the course of employment, …" I.C. 22-3-2-2(a). "Injury" and "Personal Injury" are defined by the Workers' Compensation Act to mean "…only injury by accident arising out of and in the course of employment and do not include a disease in any form except as it results from an injury." I.C. 22-3-6-1(e) (emphasis added.). Disease is excluded from the Workers Compensation Act except when it results from an injury. Thus, a disease can arise under the Workers' Compensation Act if it meets the requirement of "resulting from an injury". Of course, we also know that to be compensable an injury must be caused by an accident. *I.C. 22-*

3-2-2(a). Therefore, we see that for a disease to be compensable under the Indiana Workers' Compensation Act the disease must result from an injury caused by an accident.

An occupational disease has neither of these requirements. Pursuant to I.C. 22-3-7-10, an Occupational Disease means:

> Sec. 10. (a) As used in this chapter, "occupational disease" means a disease arising out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where such diseases follow as an incident of an occupational disease as defined in this section.
>
> (b) A disease arises out of the employment only if there is apparent to the rational mind, upon consideration of all of the circumstances, a direct causal connection between the conditions under which the work is performed and the occupational disease, and which can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as the proximate cause, and which does not come from a hazard to which workers would have been equally exposed outside of the employment. The disease must be incidental to the character of the business and not independent of the relation of employer and employee. The disease need not have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.

From this definition we can see that an occupational disease does not require an "accident" it requires an "exposure". Further, clearly no injury is required for an occupational disease to be compensable. The distinction, therefore, resulting from injury by accident versus an exposure, appears to be the key to differentiating an occupational disease from a workers' compensation disease. To understand this distinction, we turn to the courts.

Pre-Occupational Disease Act Cases.

The Indiana Workers Compensation Act was originally enacted in 1915. The Occupational Disease Act did not come along until 1937. Not surprisingly, in the interim, the Indiana courts

addresses some disease claim filed under the Workers' Compensation Act and rendered some interesting decisions that shape the distinction between a workers' compensation disease and an occupational disease.

In *Wasmuth-Endicott Co. v. Karst, 77 Ind.App. 279, 133 N.E. 609 (1922)*, Karst worked for Wasmuth-Endicott in its cabinet factory. Wasmuth-Endicott furnished its employees, while at work, drinking water from a well in its factory through pipes. This water was pumped by means of a steam engine and flowed constantly during working hours. Without Wasmuth-Endicott's knowledge, the water from this well became contaminated by seepage from a toilet in the factory. Karst, having drank the water, became infected with typhoid germs, developed typhoid fever, and was confined to his bed for several weeks. The Industrial Board found that Karst received a personal injury by accident arising out of and in the course of his employment.

Wasmuth-Endicott appealed the decision of the Industrial Board. Was there an accident? The Indiana Court of Appeals applied the definition of an accident. "An accident is any unlooked-for mishap or untoward event not expected or designed." Applying this definition to the facts disclosed by the evidence the court found,

> "it is clear that the entering of typhoid germs into appellee's intestines, by reason of drinking the polluted water furnished him by appellant for that purpose, while in its employ may rightfully be termed an "accident." Dove v. Alpena, etc., Co., 198 Mich. 132, 164 N. W. 253; Vennen v. New Dells, etc., Co., 161 Wis. 370, 154 N. W. 640, L. R. A. 1916A, 273, Ann. Cas. 1918B. 293; Monson v. Battelle, 102 Kan. 208, 170 Pac. 801.

The court continued, however, noting that the mere fact that an accident happens to an employee will not authorize the payment of compensation, unless it results in personal injury which causes disability to work. The court had this to say about "personal injury"

> "In common speech the word 'injury,' as applied to a personal injury to a human being, includes whatever lesion or change in any part of the system produces

> harm or pain or a lessened facility of the natural use of any bodily activity or capability." In re Burns, 218 Mass. 8, 105 N. E. 601, Ann Cas. 1916A, 787.

The court then found when applying the facts to this definition that it is not difficult to determine an injury resulted from the accident in question. The court stated:

> It is well known that typhoid fever is due to a specific micro-organism, known as the typhoid bacillus, taken into the intestines. Here the bacillus sets up a catarrhal inflammation of the mucus membrane of the intestines, causing ulcers and fever. When this occurs the individual evidently sustains an injury. The typhoid bacillus, when taken into the intestines, does not always create a catarrhal inflammation. If it does not, no fever follows, and no injury is sustained. In the instant case, however, such an inflammation occurred with resulting fever, which constituted an injury within the meaning of the Workmen's Compensation Act.

You might be thinking at this point that the court just eviscerated the Act's restriction that personal injury does not include "disease in any form" effectively providing that personal injury includes disease of any form. The court was mindful of that criticism and attempted to provide an explanation:

> It has been suggested that, if compensation be awarded on account of disability to work arising from a disease contracted by an employee under the circumstances of the instant case, it will result in a violation of that part of said section 76, quoted above, in which the meaning of the words "injury" and "personal injury," as used in the Workmen's Compensation Act, is expressly limited, and from which "disease in any form, except as it shall result from injury," is expressly excluded, and, through a form of judicial legislation, render all employers, operating under said act, liable for compensation thereunder on account of disability to work, resulting from diseases generally, contracted by their servants while engaged in the discharge of the duties for which they *611 are employed. We are clearly of the opinion, however, that no such result will follow. It will be observed that in the instant case we have clearly indicated the accident and the resulting injury, which caused the fever and consequent disability. Therefore, it cannot be said that the decision in this case is not in harmony with the limitation of said section 76, with reference to awarding compensation for disability resulting from disease. It is obvious that in any given case involving disability so resulting the inquiry must always be, Did the disease result from an injury by accident, arising out of and in the course of the employment? If it did not, by the express provision of the statute, no compensation can be awarded. The injury, however, need not be produced by violence, as our statute, unlike those of some other states does not so provide. It suffices in that regard, whatever the accident may have been, if it produces a

> lesion or change in any part of the system which injuriously affects any bodily activity or capability. Where this occurs, and disease follows, causing disability, the right to compensation is not affected by the limitation contained in said section 76. But it must be borne in mind that the injury must be by accident arising out of and in the course of the employment. This limitation alone will have the effect of preventing a recovery of compensation for disability resulting from diseases generally, as it is clear that a disease contracted by an employee through such usual intercourse with his fellow workmen as is common among men, and not because of any unusual circumstance connected with his employment, cannot be said to be an accident within the meaning of the Workmen's Compensation Act. This is in harmony with the general rule, denying compensation for injuries arising from risks common to the general public. Union Sanitary Mfg. Co. v. Davis (1916) 64 Ind. App. 227, 115 N. E. 676; In re Harraden (1917) 66 Ind. App. 298, 118 N. E. 142; Central, etc., Co. v. Ind. Com., 291 Ill. 256, 126 N. E. 144, 13 A. L. R. 967; Cunningham v. Donovan, 93 Conn. 313, 105 Atl. 622; Re Donahue, 226 Mass. 595, 116 N. E. 226, L. R. A. 1918A, 215; Kunze v. Detroit, etc., Co. (Mich.) 158 N. W. 851, L. R. A. 1917A, 252; Re McNicol, 215 Mass. 497, 102 N. E. 697, L. R. A. 1916A, 306; Larke v. John Hancock, etc., Co., 90 Conn. 303, 97 Atl. 320, L. R. A. 1916E, 584.

One can see in this quoted language some early precursors of the Occupational Disease Act. There is discussion of what is in essence the exclusion of ordinary diseases of life. Nevertheless, it is clear the court found in Karst's contraction of Typhoid an accident and an injury from which the disease resulted. The court's definition of injury which includes "a change in any part of the system which produces harm or pain" is very broad indeed. The court's only real limitation to the loose definition is the requirement that it be proven the injury was caused by accident arising out of and in the course of employment. Which is really no limitation at all on the definition of injury as arising out of and in the course of are simply other factors in the analysis of compensability under the Act.

A similar result is found in *State Highway Comm. v. Smith, 93 Ind.App. 83, 175 N.E. 146 (1931)*, where the court relied upon *Karst* to find that an employee who became sick with gastroenteritis, which lead to the development of cardiac arthritis resulting in death, as a result of drinking polluted water furnished by a water boy in the employ of the employer and which

had been obtained from a tile ditch was injury by accident arising out of and in the course of employment.

The court's decisions in *Karst* and *Smith* can be contrasted by two other pre-Occupational Disease Act decisions. In *Brewer v. Veedersburg Paver Co. 92 Ind.App. 547, 177 N.E. 74 (1934)*, Brewer worked for 14 years in the operation of the brick yard and kiln at Veedersburg facility. In his duties he was constantly exposed to dust vapor and gas. He reported, on April 14, 1930 (a Monday), that he became suffocated and sick from the vapors and gas. Nevertheless, he worked through the rest of that day and the rest of the week. On Friday he called his doctor and was given a shot of morphine. He received a second shot of morphine on Saturday. He never returned to work again. His testimony at hearing included that the smoke and gas were bad on April 14. The smoke and gas were blue. But he also testified the smoke and gas were just about as bad as on other days. Brewer's doctor determined he was suffering from bronchitis. Brewer was found by the Industrial Board not to have sustained an injury by accident. The Court of Appeals affirmed saying:

> Applying the principles announced heretofore to the facts of this case, we do not believe that the appellant's sickness is compensable under our law. He had worked for appellee under conditions similar to the conditions testified to for almost a year and, had worked in appellee's brickyard twelve or fourteen years. The smoke and gas were visible to his sight on previous days as well as on the day of his injury. He knew that they must enter his lungs and that they made others sick. There is no evidence that this smoke and gas were thrown into the room where the appellant worked in any unexpected manner or that either smoke or gas entered his body in any unexpected or unlooked for manner, or in any greatly unusual quantity. The very nature of the work being done in the brick factory necessarily and not accidentally caused the air to become smoke and gas laden and to enter the appellant's body in the course of natural processes. The evidence fully sustains the finding and order of the Industrial Board.

The court, in essence, held that because the dust, vapor and gas were normal conditions within the brick yard and Brewer could see and knew he was breathing the smoke and gas in the air at his place of employment his injury was not unexpected, thus, not an accident.

The *Brewer* court relied upon a similar result in *Moore v. Service Motor Truck Co. 80 Ind. App. 668, 142 N. E. 19 (1924)*, where it was held that an accident within the meaning of the Workmen's Compensation Act did not to include sickness caused by accumulation in the claimant's stomach and bowels of emery and metallic dust thrown off from a grinding and buffing machine at which the employee worked; the dust impregnated the air so that it passed into his mouth and was swallowed, where the employee knew that the dust was passing into his stomach and bowels and making him sick and that it made other employees sick.

The distinction between on the one hand *Karst* and *Smith* and on the other hand *Brewer* and *Moore* appears to be in what the courts considered at that time to be an accident. In *Karst* and *Smith* the employees' unknowing consumption of contaminated water was an accident. However, in *Brewer* and *Moore* the employees' breathing in of air laden with dusts, fumes and gases which had been know to make others ill was not an accident.

As an aside, the court in *Brewer*, in its decision, noted that some states had adopted an occupational disease act. Therefore, in looking to other states for guidance one needed to ensure that the ct of the other states was similar to Indiana's Act i.e. no occupational disease act.

Post Occupational Disease Act Cases

Even after the enactment of the Occupational Disease Act, *Karst* and *Smith, supra* remained relevant decisions in the analysis of Workers' Compensation disease claims.

The case of *Allen v. Public Service Co. of Indiana 122 Ind.App. 421, 104 N.E.2d 756 (1952*), in which the Court relied upon *Karst* and *Smith*, hits very close to home when discussing communicable diseases such as COVID 19. Therein, Allen was a maintenance man for an electric utility. Allen was assigned to work with another employee. Their duties of maintaining electric poles and lines required them to "climb the same poles together, to drink from the same water container, handle the same tools and to work each day all day together as 'buddies'". Unbeknownst to Allen, his workmate was afflicted with a highly contagious condition. Allen became afflicted with the same condition and filed a civil suit. At issue was whether the suit was precluded by the exclusive remedy provision of the Workers' Compensation Act.

Relying on *Karst* and *Smith supra*, the court held that Allen's claim was governed by the Indiana Workers Compensation Act, the court stated:

> Here, under the allegations of the complaint, the appellant was required to drink from the same water container as Hanger and handle the same tools. The facts are somewhat analogous to those in the last two cited cases (*Karst* and *Smith*). We believe such cases and the reasoning upon which they are based require the conclusion that the injury was by accident and the pleaded case comes within the provisions of the Workmen's Compensation Act. (emphasis added.)

Notably the court did not find the condition was an occupational disease. Nor did the court speak in terms of "exposure". The court specifically concluded injury by accident.

More recently in *Harris v. United Water Services, Inc., 946 N.E.2d 35 (Ind.Ct.App. 2011),* while employed at United Water's waste-water treatment plant, Harris developed a bacterial

infection, acid reflux, an ulcer, and gastric cancer. Harris attributed these conditions to exposures at United Water. Harris testified that there was a specific incident on December 15, 2005 when he was splashed in the face with waste-water and ingested the waste-water. However, while Harris thought the December 15, 2005 incident was a major factor contributing to his illness, he also testified that he was always exposed to bacteria and could have contracted it at any time. Harris made it clear that he was splashed multiple times during each shift, that he often lacked protective gear, and that he felt that the company provided inadequate facilities for cleaning up.

At issue was whether Harris had timely filed his Application. This issue implicated sub-issues of whether Harris' claim was an occupational disease claim versus a workers' compensation claim and if a workers' compensation claim, was it a repetitive trauma claim. The key for our purposes is the following language from the Court of Appeals:

> 'Injury' and 'personal injury' mean only injury by accident arising out of and in the course of the employment and do not include a disease in any form except as it results from the injury." Ind.Code § 22–3–6–1(e). In Duvall, we stated that "trauma is synonymous with injury," and that a trauma is a "wound, especially one produced by sudden physical injury." 621 N.E.2d at 1126 (emphasis in original). Thus, a disease that is caused by an accident is considered an injury rather than an occupational disease.

We all remember *Duvall v. ICI Americas, Inc, 621 N.E.2d 1122 (Ind.Ct.App. 1993)* as the case that distinguished carpel tunnel syndrome as a repetitive trauma injury rather than an occupational disease. The court in *Duvall* noted that a disease is an occupational disease when it results from "exposure occasioned by the nature of the employment." I.C. § 23–3–7–10(b). The *Duvall* court explained that the term "exposure" indicates a passive relationship between the worker and his work environment rather than an event or occurrence, or series of occurrences, which constitute injury under the Worker's Compensation Act. The court found that Duvall's carpal tunnel syndrome did not result from exposure to workplace conditions at

ICI but resulted from the hand and wrist mechanics associated with Duvall's work on ICI's production line. Her carpal tunnel syndrome did not result from where she worked but from the work she did.

Injury By Accident

If it was not clear before *Harris*, it is clear after *Harris* that the presence of the Occupational Disease Act does not preclude a disease or illness from falling within the Workers Compensation Act. If a disease or illness is caused by an injury by accident then the disease falls within the Workers' Compensation Act. An accident is any unlooked-for mishap or untoward event not expected or designed. In *Karst* and *Smith* the simple unknowing ingestion of a "microorganism", germ or virus, was held to be accident. In *Karst* the attachment of the microorganism to the intestinal wall causing inflammation leading to the disease and symptoms was injury. The *Karst* court noted that in some cases the microorganism attaches and in some cases it does not. In the later incident the microorganism simply passes through the body and no injury occurs.

Thus, the case law presents an argument that an employee's contraction of Covid 19 falls within the Workers Compensation Act. Covid 19 is caused by a virus, a microorganism. Covid 19 is contracted by the ingestion of the Covid 19 virus. Covid 19 is believed to be transmitted by a non-infected person breathing in or swallowing the virus after the virus has been transmitted to the air by the cough or sneeze of another person. If the virus attaches, creating, in essence, an inflammation and symptoms there is injury. If the virus passes through the body without attachment there is not injury. Thus, the contraction of Covid 19 is injury by accident. The

Workers Compensation Act is, then, applicable. Our next inquiry, as explained the court in *Karst* is whether that injury by accident arose out of and in the course of employment.

Arising Out Of And In The Course of Employment

Regardless of whether a Covid 19 claim is asserted under the Workers' Compensation Act or the Occupational Disease Act, the condition must "arise out of and in the course of employment". This is a much tougher argument when dealing with Covid 19 or other Covid viruses. The virus is believed to be spread by human interaction. An infected person coughs or sneezes spreading the virus into the air via respiratory droplets. Those infected respiratory droplets then land on or about the mouth and nose of a non-infected person or are inhaled by the non-infected person from the air. Once introduced into the body the microorganism either attaches and causes infection/injury or passes through the body. Through this means of transmission, Covid 19 contracted in many places. Certainly, Covid 19 can be passed at work. But it can also be passed at home, at school, at the grocery, at the gas station, or any other numerous essential places of life where people are gathered. Thus, proof that the disease was caused by an accident in the course of employment is difficult.

The *Karst* and the *Smith* cases presented relatively easy cases of arising out of and in the course of employment. Mr. Karst was diagnosed with typhoid. Mr. Karst was able to show the water at work was contaminated with typhoid due to a leaking toilet. Similarly, Mr. Smith was able to tie his disease to contaminated water provided by the water boy. The identification of the source of the disease as being work related was relatively easy in these cases. As noted, it is not so easy to narrow the exposure of Covid 19 to a work exposure because there is such a multitude of potential exposure location.

Let's look at the situation of an office of 20 employees. Suddenly 6 of those employees develop symptoms of Covid 19, are tested, and all test positive. The statistical argument can be made that some of those employees likely became infected at work. However, the Covid 19 virus did not magically appear at that office. It had to be transmitted into the office some way. Based upon the known science of Covid 19, it did not enter through the water pipes. More likely than not, one or more of those employees contracted the condition outside the employment and shared it with the other employees. It currently appears virtually impossible to determine who contracted Covid 19 outside the employment versus who contracted it within the employment. How, then do we determine who has a compensable claim versus who does not?

The office environment mentioned above can be contrasted with emergency and medical personal who are regularly exposed to people who are known to have Covid 19. Thus, our more likely than not causation analysis would appear to swing such that it would seem medical workers directly exposed to Covid 19 patients would have a much stronger argument of arising out of and in the course of employment.

Some states have addressed the arising out of and in the course of conundrum with a presumption. Below is a chart from *workerscompensation.com* of those states that have established or have pending presumptions regarding Covid 19 and the nature of the presumptions.

State	EO or Legislation	Employees Covered	Applicability of Presumption	Bases for Rebuttal
Alaska	**SB241** was signed into law by Gov. Michael Dunleavy on April 9.	Firefighters, emergency medical technicians, paramedics, peace officers, health care providers receive coverage.	The employee must be exposed to COVID-19 in the course of employment and receive a: 1) COVID-19 diagnosis by a physician; 2) presumptive positive COVID-19 test result; or 3) laboratory-confirmed COVID-19 diagnosis.	None. SB241 makes the presumption "conclusive" when a covered employee contracts the virus in the course of employment.
Arkansas	**Executive Order 20-35** issued on June 15 from Gov. Asa Hutchinson.	The EO covers employees required to perform work that involves exposure to COVID-19 "within the normal course and scope of the employee's job performance."	COVID-19 is considered an "occupational disease" for covered employees.	Employees asserting an occupational disease for COVID-19 exposure must prove a causal connection between employment and the disease.
California	Gov. Gavin Newsom issued **Executive Order N-62-20** on May 6. (Also, several bills are being considered in the state legislature.)	The EO refers only to "employees" but cross-references a March 19 EO that allowed only "operations of critical infrastructure sectors" to remain open. Thus, it would be these "critical" employees who would be covered.	Any employee who contracts COVID-19 will be presumed to have caught it in the course of employment if: 1) the employee tested positive for or was diagnosed with COVID-19 within 14 days after the employee went to work at the employee's place of employment at the employer's direction; 2) the work was performed on or after March 19; 3) the employee didn't work at home; and 4) the diagnosis was from a state-licensed doctor.	The presumption may be controverted "by other evidence."
Illinois	**HB2455** was enacted June 5.	Firefighters, police officers, front-line	For covered employees, a confirmed positive lab test	The presumption may be rebutted by

		workers, and 23 other categories of employees a previous EO deemed "essential" receive coverage.	for COVID-19 or COVID-19 antibodies or a confirmed diagnosis from a licensed medical professional will support a rebuttable presumption that the employee contracted the virus while in service.	evidence that includes the following: 1) the employee was working from home, on leave, or some combination thereof; 2) the employer was "engaging in and applying to the fullest extent possible" workplace sanitation, social distancing, and health and safety practices based on updated guidance from the Centers for Disease Control or the state health department; or 3) the employee was exposed to COVID-19 by an alternate source.

Kentucky	Gov. Andy Beshear implemented **Executive Order 2020-277** on April 9.	The presumption applies to health care workers, first responders, corrections officers, military, activated National Guard, domestic violence shelter workers, child advocacy workers, rape crisis center staff, Department of Community Based Services Workers, grocery workers, postal service workers, and child care workers.	Under the presumption, the removal of eligible employees from work by a physician is presumed to be due to occupational exposure to COVID-19.	The EO doesn't specifically create bases for rebuttal but notes that there must be a "causal connection" between the work involved and COVID-19 that can be seen to have "followed as a natural incident to the work as a result of the exposure occasioned by the nature of the employment."
Louisiana	Proposed **SB475** is under consideration.	The law would apply to "essential" employees, who are defined as people working in public safety, government, disaster response, health care, or private business deemed "necessary or critical for response to the COVID-19 pandemic."	Under the presumption, every covered employee who is "disabled because of the contraction of the disease, COVID-19, or the dependent of an essential worker whose death is caused by COVID-19," would be entitled to workers' compensation.	The essential worker must have been disabled from working or died as the result of COVID-19.
Massachusetts	Legislation proposed in **HB4749** is being considered.	Emergency medical technicians, emergency room and urgent care medical personnel, and emergency room and urgent care non-medical staff are covered.	When an employee is diagnosed with COVID-19, the presumption would apply when: 1) the employee was performing her regular duties at the time of contracting	As proposed, the bill doesn't create explicit grounds for rebuttal.

			COVID-19; 2) the claim comes within the provisions of state workers' compensation law; and 3) sufficient notice has been given.	
Michigan	**Executive Order 2020-128** went into effect on June 18.	The order applies to "COVID-19-response employees" whose jobs require them to have "regular or prolonged contact with COVID-19 in the course of their employment."	A COVID-19-response employee who is confirmed as COVID-19 positive on or after March 18 "shall be presumed to have suffered a 'personal injury'" under state workers' compensation law.	The presumption is "subject to rebuttal by specific facts to the contrary."
Minnesota	On April 7, the state enacted **a bill**.	The legislation covers: 1) licensed peace offices; 2) health care workers; 3) correctional officers or security counselors; 4) child care providers; and 5) firefighters, paramedics, and emergency medical technicians.	Covered employees are presumed to have contracted a workers' compensation occupational disease if they become ill with COVID-19.	The employer may rebut the presumption by proving that the employee's employment was not a direct cause of the disease. To do so, the employer must provide by a preponderance of the evidence that the employee was not exposed to COVID-19 while performing her job duties.
Missouri	An **emergency rule** went into effect on April 22.	Under the rule, first responders, which are defined as law enforcement officers, firefighters, or emergency	Any first responder who contracts or is quarantined for COVID-19 is presumed to have an occupational disease	The presumption does not apply when "clear and convincing evidence" shows

		medical technicians receive coverage.	arising out of and in the course of their employment.	that the first responder did not actually have COVID-19 or contracted or was quarantined for COVID-19 resulting from exposure that was not related to employment.
New Hampshire	**Emergency Order #36** became effective on April 24.	The rule applies to first responders, which covers "emergency response" and "public safety" workers under state law.	The order ensures workers' compensation coverage for first responders exposed to COVID-19 and creates a presumption that the exposure and infection were occupationally related.	For the presumption to apply, the first responder must have tested positive for COVID-19 and the case must have been reported to the state's Department of Health and Human Services.
New Mexico	On April 23, **Executive Order 2020-025** was issued.	The order applies to "certain agency employees and eligible volunteers" who provide direct assistance or care to people infected with COVID-19.	Under the order, employees who contract COVID-19 through their employment receive service credit to obtain compensation, medial care, and "other benefits necessitated" by the illness.	For the presumption to apply, the employee or volunteer must contract COVID-19 within two weeks of providing direct assistance or care to COVID-19 patients or within two weeks of working in any capacity inside a facility that provides direct assistance, care, or

				housing to COVID-19 patients.
New Jersey	A senate bill and an **assembly** bill are under consideration.	"Essential" employees would receive coverage and this would include heath care and public safety workers.	The presumption "shall only apply to essential employees who perform functions pertaining to those roles and involving interactions with the public."	The presumption would be rebutted by a preponderance of evidence showing that the worker was not exposed to the disease.
New York	Senate bill **S8117A** is in committee.	The bill would cover "certain police, parole and probation officers and other emergency responders."	COVID-19-related health impairments would be presumed to have been incurred in the "performance and discharge of duty."	The presumption would apply "unless the contrary be proven by competent evidence."
North Carolina	**HB1057** has been under consideration since early May.	First responders, health care workers, and "essential service workers" would be included in the presumption. "Essential service workers" refers to employees "required to work during a pandemic for a business declared essential by executive order of the Governor or by order of a local governmental authority."	The bill would establish that "a pandemic infection contracted by a covered person shall be presumed to be due to exposure in the course of the covered person's employment."	For rebuttal, the employer would need "clear and convincing evidence." Though not explicit from the text, the evidence would be of another source of infection.

North Dakota	Gov. Doug Burgum issued **Executive**	The EO applies to first responders and health	For eligibility to apply: 1) the worker must be	The EO's language doesn't seem to go

	Order 2020-12 on March 25.	care providers; an April 16 amendment extended coverage to funeral directors and funeral home workers.	subject to quarantine resulting from a work-related exposure; and 2) the worker must experience lost wages and not be eligible for lost wage benefits from another source.	as far as creating a presumption because eligibility only kicks in if a worker "can demonstrate that the infection resulted from a work-related exposure." Thus, the burden remains with the employee rather than the employer.
Ohio	The Buckeye State's house of representatives passed HB606, which is now under consideration in the senate.	The coverage would apply to employees working in "governmental functions" or "public duties." This includes police, fire, emergency medical, ambulance, and rescue services. It also refers to the provision of pubic education, the free public library system, and judicial and legislative functions.	The presumption would apply when the employee becomes infected with COVID-19 as the result of the performance or nonperformance of a governmental function or public duty.	The employer could rebut the case with evidence that the infection was from another source.
Pennsylvania	HB2396 is under consideration in the Keystone State.	The law would apply to people "employed by a life-sustaining business or occupation." The definition includes 14 categories of workers, ranging from first responders to retail workers.	"Life-sustaining" workers who are required to work and contract, have symptoms, or are otherwise exposed to an infectious disease would be presumed to have encountered the disease at work.	No explicit basis for rebuttal is listed in the proposed bill.
South Carolina	Proposed	The proposed bill covers	The presumption would be	

	legislation has emerged in the state's house of representatives.	first responders, health care providers, and correctional officers.	that the diagnosis of COVID-19 "arose from and in the course and scope" of employment as a first responder, health care provider, or correctional officer.	

As you can see, the presumptions are varied. All presumptions limit the workers to whom the presumptions apply. Generally, the presumptions apply to emergency and medical personnel. Although in some cases other types of employment are applicable. The majority of the presumptions seem to implicate the respective state's Occupational Disease Act by either specifically rendering the condition an occupation disease or calling it an occupational exposure. Although, some presumptions speak in terms of "occupationally related" or "in the course of employment". Most presumptions do allow for rebuttal of the presumption.

At this time, Indiana does not have a presumption on the issue of arising out of employment. Nor do we yet have case authority on the issue. Nevertheless, one would expect the burden of proof to result in cases generally following these presumptions. Emergency and medical personnel will generally be better able to prove causation than office or factory personnel. Even then some medical and emergency personnel will not be able to carry their burden of proof or their case will be rebutted. Similarly, some non-medical or non-emergency personal will be able to carry their burden of proof despite the obstacles. Ultimately, though, we must wait for that first Covid 19 case taken to decision to see what guidance our Board and Courts will provide on these issues.

Conclusion

Covid 19 is currently a novel virus but non-the-less one of a family of viruses that has been around for years. Nevertheless, case law supports the argument that the contraction of Covid 19 can be considered an injury caused by an accident and, therefore, falling within the ambit of the Indiana Workers' Compensation Act (and not necessarily falling with the Indiana Occupational Disease Act). However, an employee with Covid 19 must still prove that his/her Covid 19 condition arose out of an in the course of the employment. And, while in Indiana the burden of proof is the same for all, due to the lack of any presumption. The nature of employment for some employees will, presumably, make reaching that burden of proof easier than for other employees.