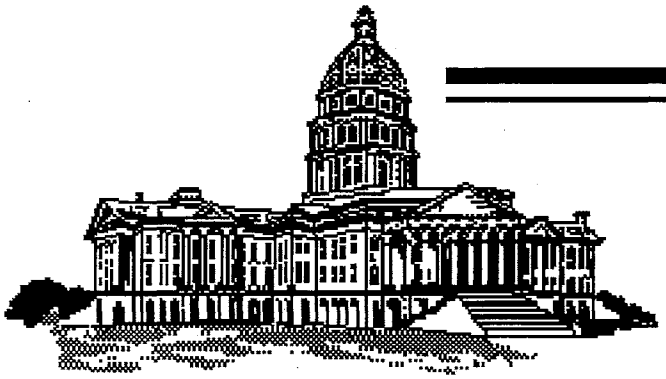

PERFORMANCE AUDIT REPORT

Examining Increases in Expenditures from the State Workers' Compensation Fund

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
November 1992

93-31

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

EXAMINING INCREASES IN THE EXPENDITURES FROM THE STATE WORKERS' COMPENSATION FUND

OBTAINING AUDIT INFORMATION

This audit was conducted by Murlene Priest, Rick Riggs and Tom Vittitow, Auditors, of the Division's staff. If you need any additional information about the audit's findings, please contact Ms. Priest at the Division's offices.

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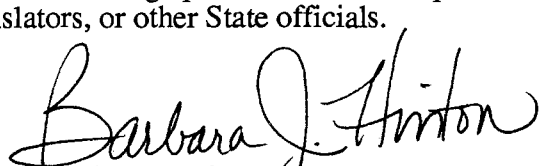
Why have expenditures from the Workers' Compensation Fund increased in recent years? The Workers' Compensation Fund, formerly known as the Second Injury Fund, was established in 1945 to encourage employers to hire veterans who were disabled during World War II, or to hire people who were disabled in a previous industrial accident. The Fund pays claims that would otherwise be paid by individual employers or insurance companies, and is funded by assessments from all workers' compensation insurers. Over the years, coverage of the Fund has been broadened by legislative and judicial actions. Between fiscal years 1983 and 1992, expenditures from the Fund more than quadrupled, from $8 million to nearly $33 million. The Fund's expenditures increased primarily because more claims were opened than closed each year, creating an ever-growing pool of active claims for which expenses are being incurred. In addition, medical costs have risen dramatically over the years.

New claims increased in part because of an increase in industrial accidents, and in part because of the continued impact of legislation and court interpretations that have allowed more and more workers' accident-related disabilities to be filed against the Fund. Kansas currently has one of the most liberal second-injury funds of all the states we contacted. Limiting the Fund's coverage would not reduce workers' compensation costs. It would simply shift those costs from the Fund back to the insurance companies and employers. Other states have implemented a number of alternatives to control total costs in their second-injury funds and in workers' compensation in general. Unfortunately, Kansas does not now have the basic management information needed to identify the types and causes of injuries that are most common and most expensive, and thus, most in need of controlling.

Is the Workers' Compensation Fund being administered efficiently? Administrative costs for operating the Workers' Compensation Fund have decreased as a percentage of total costs over the past few years, and administrative costs per active claim have dropped as well. In terms of cost per claim, the Fund was being operated more efficiently in 1992 than it was in 1985. Cost efficiencies appear to have been brought about because the number of claims against the Fund have increased dramatically, but the number of staff handling those claims has not increased significantly. Also, the Insurance Department has made some efforts to control administrative costs for attorney fees. Even so, the Department could improve the administration of the Fund if it had better information about claims.

The report makes a series of recommendations for improving the operation of the Fund. We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials.



Barbara J. Hinton
Legislative Post Auditor

Examining Increases in the Expenditures from The State Workers' Compensation Fund

The Kansas Insurance Department administers the State Workers' Compensation Fund. The Fund was originally designed to encourage employers to hire handicapped workers by relieving those employers of liability for workers' compensation claims in certain cases where the handicapped employee's injury or death could be attributed to, or made worse by, the employee's pre-existing handicap. Originally the Fund was responsible only for second injuries that resulted in total permanent disability. Over time, the Fund's coverage has been expanded by Legislative enactments and by judicial interpretations to cover more types of injuries and handicaps.

The Fund is supported primarily by annual assessments against insurance companies that write workers' compensation insurance. Between fiscal years 1983 and 1992, expenditures from the the Worker's Compensation Fund increased from $8 million to about $32.5 million, an increase of about 300 percent. For fiscal year 1993, the Insurance Department estimates expenditures could be as much as $46 million.

Legislative concerns have been raised about why the Fund's expenditures have increased so significantly in recent years. The Legislative Post Audit Committee authorized a performance audit to answer the following questions about the Workers' Compensation Fund:

1. **Why have expenditures from the Workers' Compensation Fund increased in recent years?**

2. **Is the Workers' Compensation Fund being administered efficiently?**

To answer these questions, we reviewed legislative changes over the years affecting the Fund, and compared increases in the number of claims filed against the Workers' Compensation Fund between fiscal years 1983 and 1992 to increases in the number of industrial accidents reported in Kansas during the same time period. We also analyzed industry, injury, and expenditure information the Insurance Department and the Department of Human Resources' Division of Workers' Compensation provided about claims closed by the Fund during fiscal years 1989 and 1992. In addition, we interviewed officials from the Insurance Department and the Division to determine their opinions about why expenditures have increased.

We reviewed previous audits by Legislative Post Audit and others to determine what recommendations had been made about operations of the Fund. We examined trends in the Fund's administrative costs for fiscal years 1985 through 1992 to determine whether the Fund was spending more (or less) on a per-claim basis than it had in the past. We also contacted a sample of other states to determine what cost-containment measures they were using and whether it appeared Kansas could use similar cost-control measures.

A Variety of Groups Have Examined Workers' Compensation Issues In 1992

At least four groups have examined workers' compensation issues during 1992. All four groups are made up of representatives of business, labor, medicine, law, and government. Following are summaries of the groups reviewing workers' compensation issues during calendar year 1992:

Special Committee on Workers' Compensation. This Kansas legislative committee was charged as follows: "Until November 4, 1992, compile, collect, and assimilate information on specific issues within the topic of workers compensation and, thereafter, develop recommendations deemed appropriate."

State Insurance Commissioner's Workers' Compensation Task Force. The Insurance Commissioner's group studied the following topics: education and information, alternative dispute resolution, fraud and abuse, the workers' compensation plan, statutory or institution impediments to fair and equitable treatment, and workplace safety. The task force was scheduled to complete its work by December 1992.

Governor's Workers' Compensation Task Force. The Governor's group had no formal charge, but looked generally at the spiraling cost of workers' compensation in Kansas. It was scheduled to complete its work by December 1992.

Blue Ribbon Panel on Workers' Compensation. This national group, operating under the auspices of the National Council of State Legislatures, examined five issues: the delivery of medical services, permanent partial disability, administration of the system, economic insurance issues, and occupational health and safety. The Panel's report was issued July 1992.

In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office, except that we did not verify the accuracy of all computerized data analyzed during the audit. We did determine whether other agencies had audited or checked the data. In those cases where data were not audited or we had some reason to question the reliability of information used, we noted those limitations in this report.

Between fiscal years 1983 and 1992, expenditures from the Fund more than quadrupled, from $8 million to $32.5 million. We found that the Fund's expenditures increased primarily because of the cumulative effect of large increases in new claims filed against it. New claims increased in part because of an increase in industrial accidents, and in part because of the continued impact of legislation and court interpretations that have allowed more and more workers' accident-related disabilities to be filed against the Fund. Increases in medical costs and compensation for lost wages accounted for part of the 10-year increase in expenditures as well. Kansas now has one of the most liberal second injury funds of all the states we contacted. Other states have implemented a number of alternatives to control total costs in their second injury funds and in workers' compensation in general. Unfortunately, Kansas does not now have the basic management information needed to identify the types and causes of injuries that are most common and most expensive, and thus, most in need of controlling.

Although administrative costs have increased significantly over time, it appears that the Fund is operating more efficiently in 1992 than it was in 1985, and that Fund officials are attempting to control administrative costs. In any event, administration is a very small part of the Fund's total expenditures.

These and related findings are discussed in more detail following a brief overview of the Workers' Compensation Fund.

Overview of the Workers' Compensation Fund

Most employers in Kansas are required by law to provide some form of workers' compensation coverage for their employees. This coverage may be in the form of an insurance policy, a self-funded plan, or a group-funded pool. If an employee has a work-related injury, he or she can file a claim with the employer's workers' compensation insurer. This claim may include a request for compensation for lost wages, payment of medical expenses, vocational rehabilitation, or other costs. If the employee had a "pre-existing" condition that contributed to the injury or made the injury worse, all or part of the claim may be paid by the Workers' Compensation Fund, previously known as the Second Injury Fund.

The Second Injury Fund Was Created in 1945 Primarily To Cover Disabled Veterans, But Coverage Has Expanded Over the Years

In the aftermath of World War II, the Second Injury Fund was established to encourage employers to hire veterans who were disabled during the war, or to hire people who were disabled in a previous industrial accident. A person had to have previously lost an eye, arm, leg, foot, or hand to qualify as a handicapped individual eligible for benefits from the Fund.

The Fund relieved employers of workers' compensation liability if these individuals became totally and permanently disabled as a result of a subsequent work-related accident. From 1945 to 1960, the Fund operated within this very narrow definition and had few claims filed against it.

In 1961, the Legislature changed the Fund's coverage to include nearly all individuals with pre-existing conditions or previous injuries. Legislation passed that year no longer required an individual to be totally and permanently disabled to qualify for benefits from the Fund. In addition, the qualifying handicap no longer had to result from the loss of a body part. Instead, the Legislature introduced a list of 16 pre-existing conditions or "handicaps" a person could have to be eligible for benefits from the Fund. Included in the list were conditions such as epilepsy, diabetes, arthritis, cardiac disease, and a 16th category titled "physical deformity."

The box on the next page has a complete list of these qualifying conditions. A judicial decision in 1970 defined the 16th category—physical deformity—to include all prior back injuries or conditions.

Laws Requiring Employers To Prove Knowledge of a Previous Condition Have Changed Over the Years

Until 1974, to be eligible to make a claim against the Fund, employers had to file a form with the Division of Workers' Compensation to prove prior knowledge of an employee's pre-existing condition. In 1974, the Legislature removed the requirement, put it back in the law in 1977, and then took it out again in 1979. Since 1979, employers may file the form to prove prior knowledge of an employee's pre-existing condition, but the form is no longer required. If no form is filed, the employer must prove knowledge of the pre-existing condition at the time the employee was hired, or prove that the employee misrepresented that he or she had no handicap at the time of employment.

Pre-existing Conditions That Make Individuals Eligible To File Claims Against the Workers' Compensation Fund

From 1945 to 1961, the Legislature limited benefit eligibility to people who had lost a body part in a previous industrial accident or during military service. If these individuals later had a work-related accident that could be tied to their pre-existing condition, then the Fund would pay all or part of their workers' compensation claim. In 1961, the Legislature expanded the eligibility list to include a number of chronic illnesses and previous injuries. Below are the illnesses or injuries included in the 1961 law.

- Epilepsy
- Diabetes
- Cardiac disease
- Arthritis
- Amputated foot, leg, arm, or hand
- Loss of sight in one or both eyes, or partial loss of vision greater than 75 percent in both eyes
- Disability resulting from poliomyelitis
- Cerebral palsy
- Multiple sclerosis
- Parkinson's disease
- Cerebral vascular accident or stroke
- Tuberculosis
- Silicosis or asbestosis
- Psychoneurotic or mental disease or disorder
- Any physical deformity or abnormality

In 1974, the Legislature added a 17th category to the list of eligible pre-existing conditions. The 17th category could cover any chronic physical condition because of the breadth of its definition: "Any other physical impairment, disorder or disease, physical or mental, which is established as constituting a handicap in obtaining or in retaining employment."

As part of this expanded coverage, the Legislature required the Fund to pay claims for injuries caused by pre-existing conditions, as well as injuries that were made worse by a pre-existing condition. This means the pre-existing injury or condition may or may not have actually caused the current work-related injury. The following example will help illustrate this point: An employer hires a man who previously lost one eye. If the employee has a subsequent work-related accident that is caused by his limited eyesight, the Fund would be liable for the entire claim. If the employee had a subsequent accident that was not caused by his limited eyesight, the Fund would be liable only if the injury occurred to his good eye. In that case, the level of disability would be greater than if the injury had occurred to someone else with two good eyes. If the subsequent accident affected anything other than the employee's good eye, the employer's workers' compensation insurer would be liable.

The Legislature made the last major change affecting the Fund's coverage in 1974. Before 1974, only claims involving a work-related injury to an individual with one of the 16 pre-existing conditions could be paid by the Fund. In 1974, legislation was passed making the Fund liable for a 17th category of pre-existing condition called "any other impairment." The law also was changed to allow the Fund to pay claims involving insolvent employers and to reimburse insurance companies for workers' compensation insurance payments they make that they are later found not to be liable for.

In recognition of the Fund's newly expanded role, its name was changed from the Second Injury Fund to the Workers' Compensation Fund. At the same time, administration of the Fund was transferred from the Department of Human Resources to the Kansas Insurance Department. At the same time funding for the program was changed to include assessments on insurance companies, as well as some funding from the State General Fund.

Since 1974, benefit levels have been increased and new benefits such as vocational rehabilitation have been created, but the basic qualifications to get benefits from the Fund have remained essentially the same.

Although the Department of Human Resources Initially Handles All Workers' Compensation Claims, the Insurance Department Is Reponsible for Administering and Defending the Fund

Most functions of the workers' compensation system in Kansas are handled by the Department of Human Resources' Division of Workers' Compensation. The Division records all accident reports, and offers assistance to involved parties. When necessary, administrative law judges employed by the Division will hear evidence about a claim to determine whether the claimants are entitled to workers' compensation benefits, and who is responsible for paying those benefits. The various processes are outlined in the chart on the following page.

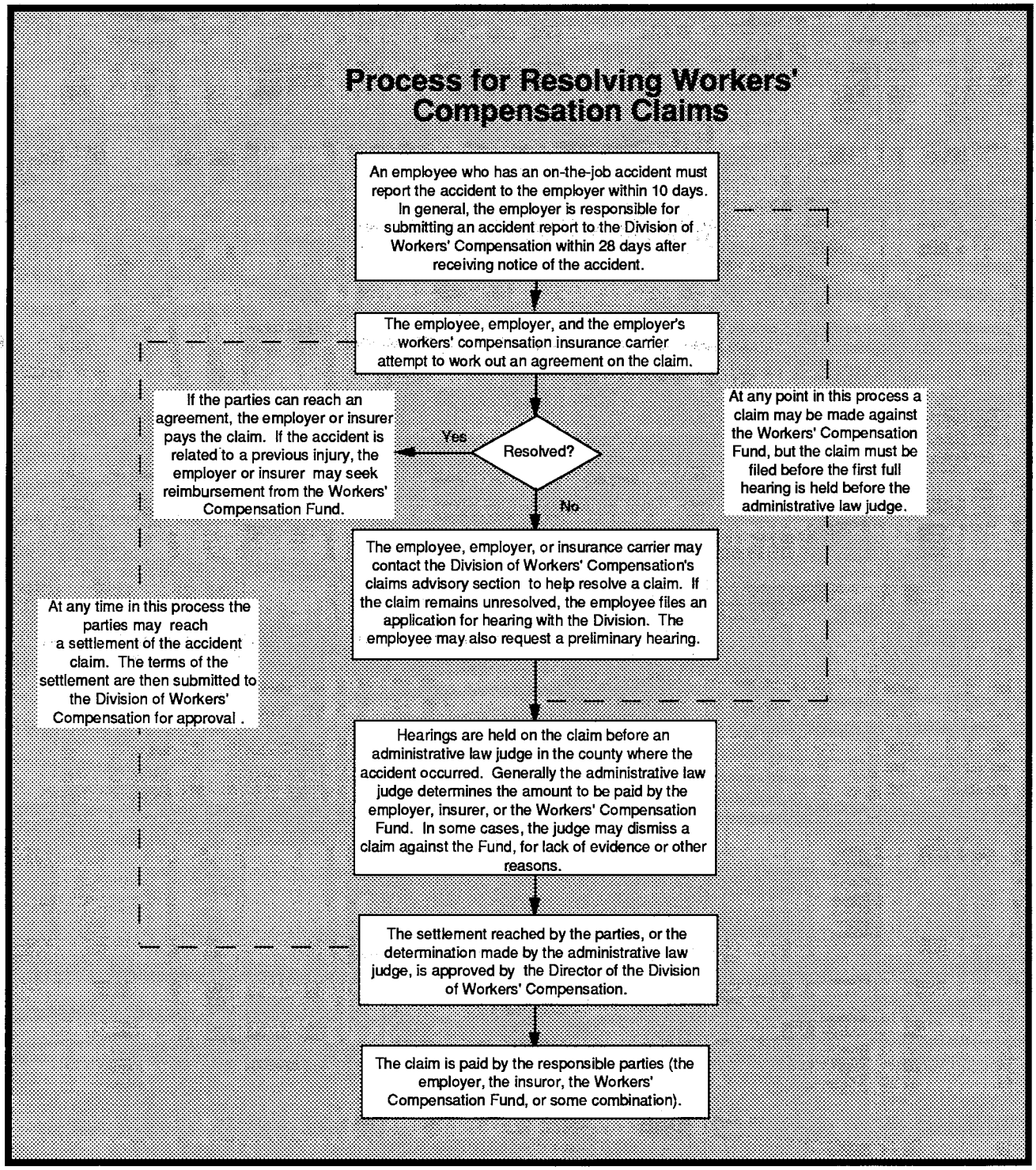
If at some point during a claim's resolution any one of the parties to the case (the employer, employee, or insurer) alleges the Fund is liable for the claim, the administrative law judge may then decide whether the Fund is liable for a portion or all of the claim. The Insurance Department is charged with defending the Workers' Compensation Fund so that only legitimate and reasonable claims are paid. Defense of the Fund generally includes contracting with attorneys to handle cases against the Fund, and deciding at key points whether to proceed with the defense of a case or enter into a settlement agreement with the claimant. Some claims against the Fund may be dismissed for lack of evidence, or for technical issues, such as not notifying the Fund before the first full hearing on the claim.

The Insurance Department also sets the assessments to be paid by insurance companies to finance the Fund's operations. In 1992, the Insurance Department had about seven people assigned to administer the Fund.

The Workers' Compensation Fund Generally Is Financed Through Assessments Against Insurance Companies

In Kansas, the majority of workers' compensation insurance is written by private companies. These companies are required to pay an assessment into the Workers' Compensation Fund each year, at a rate set by the Insurance Commissioner. The overall amount to be collected is based on projected expenditures from the Fund for the next fiscal year. The assessment for each insurance company is based on that company's previous year's workers' compensation insurance claim losses.

Assessments also are paid by employers who have chosen to self-insure and by group-funded pools. For example, the State of Kansas has a self-funded workers' compensation plan for State employees, and pays its assessment to the Workers' Compensation Fund based on losses from the State plan.



Claims against the Fund may include payments for medical care, vocational rehabilitation, or compensation for lost wages (for as long as 415 weeks for a permanent disability). Payments may be made on a one-time or monthly basis. If the parties are liable for future medical costs, the claim and the payments may go on indefinitely. Depending on the circumstances, Fund payments may be made to the employee, employer, or the insurance company.

Since 1982, the Legislature appropriated a maximum of $4 million annually from the State General Fund for the Workers' Compensation Fund. Beginning in fiscal year 1992, the Legislature continued to provide about $4 million to the Fund for operations at the beginning of each fiscal year, but required the Fund to repay the State contribution during the second quarter of each fiscal year.

Over the Past 10 Years, Expenditures from the Fund More Than Quadrupled, from $8 Million to $32.5 Million

The table below shows expenditures from the Fund for fiscal years 1983 and 1992 in the major categories of expenditures: compensation paid for lost wages, payment of medical expenses, fees paid to attorneys under contract with the Insurance Department for defending the Fund, court costs, vocational rehabilitation, and other operating expenses. Appendix A provides this detail for each year during the 10-year period.

As the table shows, by far the largest amounts paid from the Fund have been for compensation, medical expenses, and attorney fees. Although they do not make up the largest category of expenditures, medical expenses have increased the fastest over the 10-year period and accounted for about one-fourth of the total increase.

Expenditures from the Workers' Compensation Fund
Fiscal Years 1983 and 1992 (a)

Category of Expenditure	Fiscal Year 1983	Fiscal Year 1992	% change
Compensation for lost wages	$ 6,412,463	$ 21,568,628	236.4%
Payment of medical expenses	557,825	6,507,739	1,066.6
Fees paid to attorneys hired to defend the Fund	1,028,320	3,579,981	248.1
Court reporting fees	57,894	209,709	262.2
Vocational Rehabilitation	0	402,155	n/a
Operating Expenses (b)	0	244,406	n/a
Total	**$ 8,056,502**	**$ 32,512,618**	**303.6%**

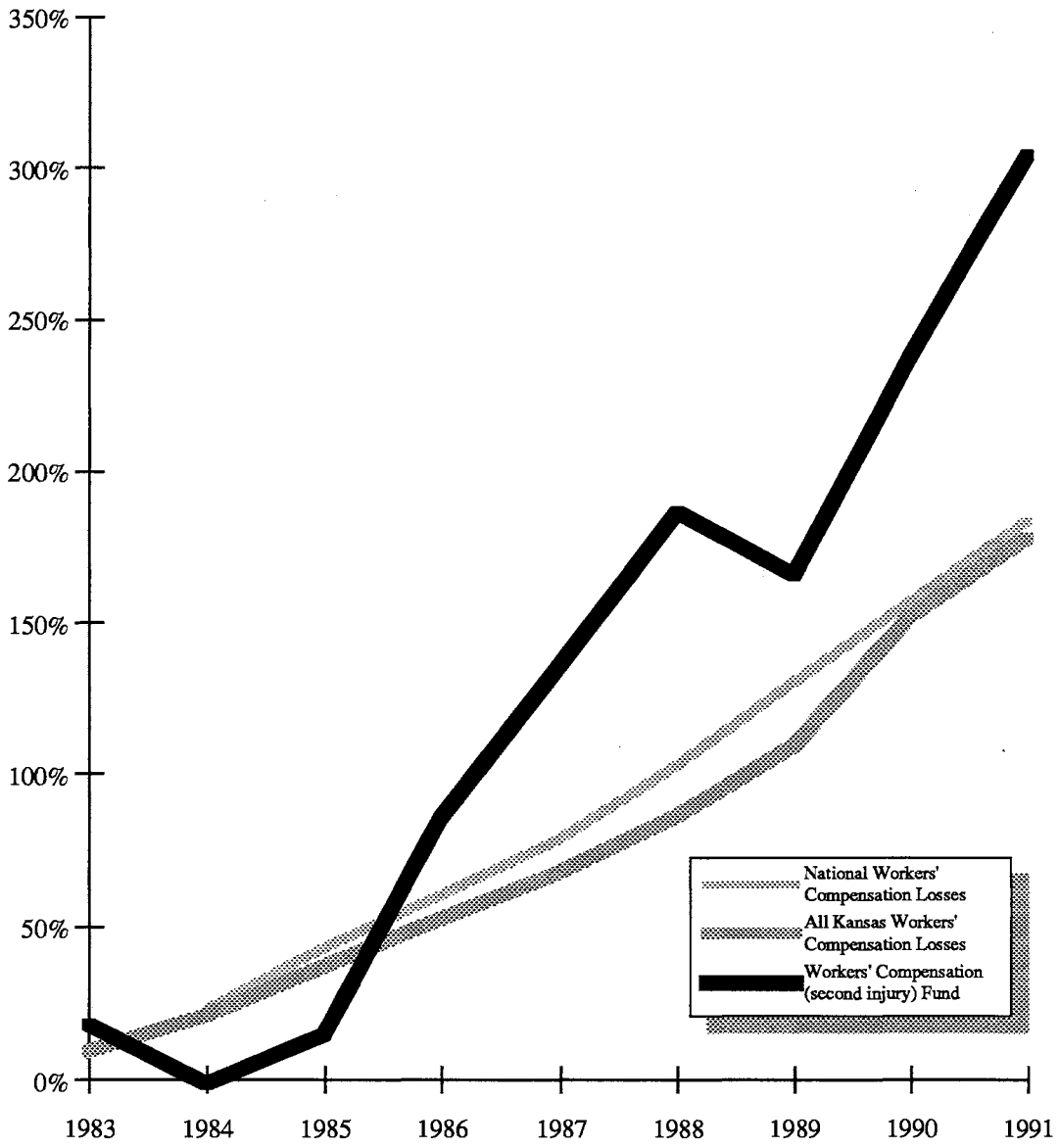
(a) In 1983 and 1991, the Insurance Department underestimate the expenditures from the Fund, and ran out of money. It carried these expenditures into the following fiscal years. For comparability purposes, we allocated the expenditures to the years in which they actually occurred.

(b) Operating expenses includes the salary and general expenditures for the Workers' Compensation Fund staff and expenses which are paid from the Workers' Compensation Fund. Before 1985, these expenses were included in the general expenses for the entire Insurance Department and were not paid from the Workers' Compensation Fund.

The remainder of this audit focuses on the reasons for these huge increases in expenditures from the Workers' Compensation Fund.

Cumulative Increases in Workers' Compensation Expenditures

Comparison of National and Kansas Workers' Compensation Losses to Claims Paid from the Kansas Workers' Compensation Fund



The graph above shows that from 1983 through 1991, expenditures for claims paid by the Kansas Workers' Compensation Fund increased at a faster rate than expenditures for all other workers' compensation claims in Kansas and nationwide. By 1991, annual expenditures from the Kansas Workers' Compensation Fund had increased 304 percent, while all Workers' Compensation in Kansas and nationally increased 178 percent and 183 percent, respectively. (Figures for national and State workers' compensation losses are reported by calendar year; Fund expenditures are reported by State fiscal year. For comparison purposes, Fund expenditures are represented here as if they too were reported by calendar year.)

Why Have Expenditures from the Workers' Compensation Fund Increased in Recent Years?

The driving force behind the Fund's increase in expenditures has been the cumulative effect of a large influx of new claims filed against it. The number of active cases more than tripled between 1983 and 1992. New claims increased in part because of an increase in industrial accidents, and in part because of the continued impact of legislative enactments and court interpretations that have broadened the Fund's coverage. Increases in medical costs and compensation for lost wages accounted for some of the dramatic growth in expenditures as well.

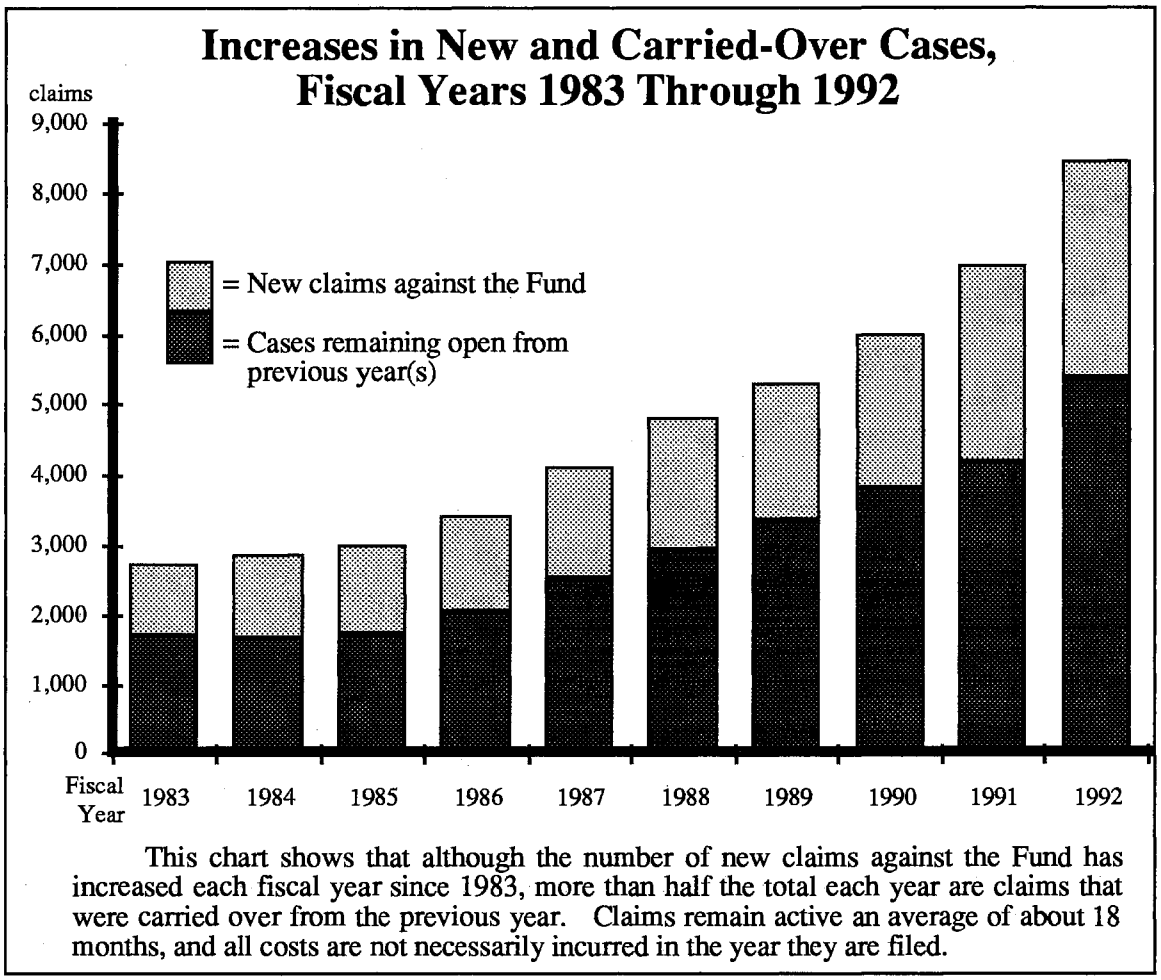
Kansas currently has one of the more liberal second-injury funds. Many states have implemented a number of alternatives to control total costs in their second-injury funds and, more importantly, in workers' compensation in general. Without some type of cost-control measures, expenditures from the Workers' Compensation Fund will continue to increase dramatically. But Kansas does not now have basic management information it would need to identify specific types or causes of injuries that could be controlled. These and related findings are discussed in the sections that follow.

Expenditures Have Increased Primarily Because of the Cumulative Effect of Large Increases In New Claims Against the Fund

We found that between fiscal years 1983 and 1992, the total number of new claims filed against the Fund tripled—from 1,018 to 3,081—as did the total number of active cases handled by the Fund. Active cases, which include new claims filed during the year and claims filed in previous years that were still active, rose from 2,713 cases to 8,449 cases. These figures are illustrated in the chart on the following page.

As the chart shows, the number of cases carried over from previous years has increased dramatically as well. This is the result of more new cases being filed than being closed each year. According to officials in the Insurance Department and our own analyses, new cases are open an average of about 18 months. However, some cases may be "active" for years. Cases stay active many years for a number of reasons. For example, claimants may receive compensation for up to eight years. Similarly, some claimants may receive medical benefits for their lifetime. Other cases may take a long period to be resolved after being filed against the Fund.

Department officials told us they review these open cases periodically to ensure that they are legitimate, and close those that appear unlikely to have any future payment activity. Within the time available for this audit, we were not able to verify this review process.



This chart shows that although the number of new claims against the Fund has increased each fiscal year since 1983, more than half the total each year are claims that were carried over from the previous year. Claims remain active an average of about 18 months, and all costs are not necessarily incurred in the year they are filed.

With so many active claims—new claims and claims carried forward from year to year—the Fund now has a much larger pool of claims for which expenditures must be made. However, not all claims will result in expenditures every year, and some may result in little if any expenditures from the Fund.

New Claims Against the Fund Have Increased For a Number of Reasons

Between 1983 and 1992, the number of new claims filed against the Fund rose from 1,018 to 3,081, an increase of about 200 percent. We identified a number of reasons why new claims have increased so dramatically.

The number of industrial accidents has increased over the past decade. Industrial accidents and occupational diseases reported to the Division of Workers' Compensation increased by 71 percent between 1983 and 1992. Although this information was not available just for claims against the Fund, all things being equal we would expect there to be a corresponding increase in new claims against the Fund.

Legislative changes and judicial interpretations that have made more and more people eligible to make claims against the Fund continue to impact the Fund. As discussed in the Overview, the 1974 Legislature added a 17th pre-existing condition to the law, making more injured workers eligible for potential benefits from the Fund. That 17th pre-existing condition states, "Any other physical impairment, disorder, or disease, physical or mental, which is established as constituting a handicap in obtaining or in retaining employment." The broad nature of this condition has created a doorway of opportunity for people with all types of physical and mental conditions to seek benefits from the Fund.

According to literature we reviewed, only minor conditions would not qualify as a disabling condition under this broad definition of physical disability. Almost any chronic physical or mental impairment could be considered a disability. Examples of conditions some courts have determined to be disabling include stress, alcoholism, low vision, serious speech impairments, and learning disabilities. If a work-related injury could be caused by any of these conditions, or if the conditions could make the injury more severe, the Fund could be required to pay all or part of the injury claim.

Judicial decisions have further broadened the statutory provisions making people eligible to file a claim against the Fund. Several judicial rulings during the 1980s and early 1990s have increased access to the Fund and increased benefits for some types of injuries. For example, in the early 1980s, the courts ruled that an employer needed to have prior knowledge of an injured worker's pre-existing condition, as well as a "mental reservation" about hiring the handicapped employee in order to make the Fund liable for work-related injuries. In 1987 and 1988, the Kansas Court of Appeals and Supreme Court ruled (in Denton v. Sunflower Electric Cooperative) that employers had to prove prior knowledge of the pre-existing condition but no longer needed "mental reservations" about the condition in order to hold the Fund liable for work-related injuries. This decision has made it easier for claims to be filed against the Fund.

Other possible reasons include a system that is claimant-oriented, potential incentives for employers to shift some claims to the Fund, and possibly fraudulent claims. Some workers' compensation officials in Kansas also told us they thought the legal system was too claimant-oriented. Officials in the Insurance Department and the Kansas Self-Insurance Fund indicated that some administrative law judges and district court judges liberally interpret the statutes governing workers' compensation. In their opinion, the judges' interpretations allow claimants to get workers' compensation benefits when none were due, or allow claimants to receive greater benefits than they were entitled to. One workers' compensation official provided specific examples of three such cases. Those examples appear in the box on the following page.

We noted that economic conditions of the past several years may have created an incentive for employers and their workers' compensation insurance plans to "control" their rising claims costs by shifting some claims to the Fund. An employer's annual workers' compensation premiums are based on his or her claims during previous years.

Some Administrative Law Judge Decisions Seemed Excessively Claimant-Oriented

A workers' compensation official provided us with some examples of cases in which the rulings of the administrative law judges seemed to favor the claimant at the expense of the legitimate interests of the employer and insurer. In some cases, the actions of the claimant appeared potentially fraudulent as well.

A MIDDLE-AGED WORKER developed bunions over the course of many years. Her job required walking as part of her usual duties and upon the advice of her attorney she filed a compensation claim after having the bunions removed. The administrative law judge found the worker to be entitled to workers' compensation benefits because walking aggravated the bunions. Workers' compensation benefits paid the claimant's medical bills, and she was referred for vocational rehabilitation. The claimant's attorney argued that she would not be able to return to work because she could not walk long distances. Two doctors said the claimant was permanently disabled and should find other work as a result of not being able to walk. Through the vocational rehabilitation provider, the claimant was trained and placed in another job that could be performed at comparable pay. At this point, a settlement hearing was held, the claimant received $19,000 as full and final settlement for her permanent disability, and the case was closed. Subsequently, the claimant obtained a full release from her doctor, and six weeks later demanded and got her old job back. (Because she left her old job as the result of a disability, her employer was forced to take her back.)

A YOUNG WORKER suffered a back injury and received medical care and disability compensation. After an extended period of working with the claimant, as required by law, the vocational rehabilitation counselor determined that the claimant could not return to his old job, and no other suitable work was available given the claimant's medical restrictions. At the suggestion of the claimant's attorney, a compromise settlement was reached, which resulted in the claimant receiving a lump-sum payment. A week later, the claimant returned to his workplace with a signed release from his treating physician, who earlier had stated that the claimant would never be able to work again. As in the previous case, the employer had no choice but to return the claimant to his old job. Within 25 minutes, the worker claimed another injury. The employer denied this new claim on the grounds that no additional injury had occurred; however, the administrative law judge in a preliminary hearing ordered the employer to pay temporary total disability and medical costs until the attending physician released the claimant for work again. Currently, nearly two years after the alleged second injury, the claimant remains off work and drawing full benefits.

AN OLDER WORKER applied for early retirement and listed his medical condition as the reason. After applying for retirement, the employee decided to file workers' compensation claims and hired an attorney. The attorney filed claims for three separate conditions: a back condition that a doctor later diagnosed as cervical neuralgia (back pain), hearing loss, and carpal tunnel syndrome. There was no evidence of an accident, but the facts seemed to point to the aging process as the underlying cause of the worker's condition. The claims were denied by the employer, but a preliminary hearing resulted in an order to provide medical care and temporary total disability until such time as the patient recovered from all three conditions. To date, the claimant has received almost $19,000 in disability payments, and medical providers have been paid more than $27,000, under terms of the preliminary order. The employer has not yet had an opportunity to provide evidence on whether this worker's three injury claims should be compensable under workers' compensation law. Division of Workers' Compensation officials said that at preliminary hearings the employer or insurer is often not allowed to present evidence or testimony because of time constraints. If, at the final hearing, the administrative law judge finds that the employer or insurer paid costs that should not have been paid, those costs are reimbursed by the Workers' Compensation Fund.

If the employer or the insurer is able to shift a claim to the Fund, the insurer avoids paying the claim, and the employer avoids increased premiums because of the claims' cost.

Finally, according to the Kansas Industrial Council of the Kansas Chamber of Commerce and Industry, it is impossible to determine how prevalent workers' compensation fraud is in Kansas. The system may allow abuse to occur because there is no

incentive to discourage fraud. Currently, if a fraudulent claim is believed, benefits can be awarded. This may happen because employers may not be allowed to present evidence or testimony at a preliminary hearing when the initial awards are given to the claimant. If the fraud is found out, recourse is through the civil court system, but this action is rarely pursued and the individual is allowed to keep his or her workers' compensation benefits. An insurer who pays a claim that is later determined to be fraudulent may then seek reimbursement from the Workers' Compensation Fund. The profiles cited on the previous page include some potentially fraudulent workers' compensation claims.

Increases in Medical Costs and Compensation for Lost Wages Also Contributed to the Large Increase in Expenditures From the Fund

Between fiscal years 1983 and 1992, the average expenditure per active claim rose from $2,970 to $3,848, a 29.6 percent increase. The following table breaks out expenditures on a per-active-claim basis for fiscal years 1983 and 1992.

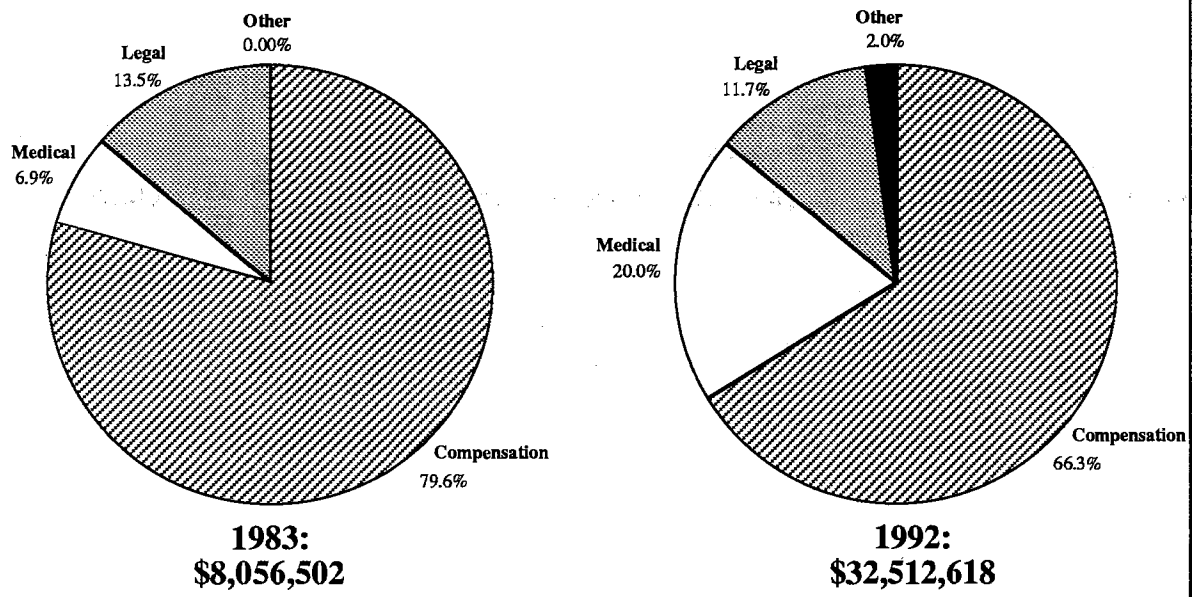
Average Expenditure per Active Claim Against the Workers' Compensation Fund

Expenditure category	Fiscal Year 1983	Fiscal Year 1992	% Change
Compensation for lost wages	$2,364	$2,553	8.0%
Payment of medical expenses	206	770	274.6
Fees paid to attorneys hired to defend the Fund	379	424	11.8
Court costs	21	25	16.3
Vocational Rehabilitation	0	47	n/a
Operating Expenses	0	29	n/a
Total	**$2,970**	**$3,848**	**29.6%**

Medical costs have had the largest impact on the rise in average expenditures per active claim since fiscal year 1983. As the chart shows, average expenditures per active claim for medical costs over the past decade nearly quadrupled, and accounted for $564 of the $878 increase. This increase is considerably higher than the 88.3 percent medical inflation rate for the period.

The chart on the following page also shows that medical costs now account for nearly 20 percent of the average cost of a claim, compared with only about seven percent in 1983. In contrast, compensation for lost wages has been shrinking as a percentage of total claims payments. In 1983, compensation represented almost 80 percent of the average claim; by 1992, it accounted for only about 66 percent. As medical costs continue to rise nationwide, a greater and greater portion of the moneys spent from the Workers' Compensation Fund are likely to be for such costs.

Changes in Total Workers' Compensation Fund
Categories of Expenditures
1983 and 1992



1983:
$8,056,502

1992:
$32,512,618

This chart shows that medical costs, which represented 6.9 percent of total Workers' Compensation Fund expenditures in 1983, increased to 20 percent of the total by 1992. Compensation and legal costs grew at a slower rate and consequently constituted smaller portions of the overall total in 1992. Other costs (vocational rehabilitation and administration) were not paid from the Fund in 1983.

Compensation for lost wages made up the largest share of the average expenditures per claim, but that amount has increased by only eight percent over the past 10 years. As the table shows, the average increase in compensation accounted for nearly $200 of the $878 increase in average expenditures per-active-claim.

Over the past 10-year period, compensation expenditures have increased by only eight percent and have not kept pace with the 40.9 percent increase in inflation for the period. Although maximum compensation benefits and average weekly wages increased during the period, these increases have not resulted in significant changes in compensation benefits on a per-claim basis.

Judicial interpretations combined with the new vocational rehabilitation benefit may cause compensation to increase now and in the future. (Vocational rehabilitation is described in the left-hand box on the next page.) For example, the Kansas Supreme Court ruled in Stephenson v Sugar Creek Packing that a new section of a 1987 law specifically limiting benefits for claims involving repetitive-use injuries like carpal tunnel syndrome was unconstitutional. The court said repetitive-use and similar injuries resulting from a single incident could not be treated differently. In another case (Hughes v. Inland Container Corporation), a Supreme Court ruling gave claimants a potential for receiving higher awards in all cases where permanent disability is an issue. These two cases are described in the right-hand box on the next page.

Although other expenditures have not increased significantly, vocational rehabilitation costs are likely to do so in the future. Neither attorney fees nor court costs have risen significantly on a per-claim basis. From 1988 to 1992, vocational rehabilitation expenditures increased from zero to $47 per claim and totaled more than $400,000 in 1992. Officials have indicated this benefit is likely to cause even greater expenditure increases in the future.

Vocational Rehabilitation Benefits Can Increase the Amount of Kansas Workers' Compensation Claims

In 1987, the Kansas Legislature defined when and how vocational rehabilitation benefits were to be provided to injured workers. The new law mandated vocational rehabilitation benefits for a claimant after 90 days of continuous disability. Some claimants may not need, nor want, vocational rehabilitation, but workers' compensation would have to provide those services unless the claimant gives up his or her rights to them through a settlement agreement.

An individual may receive a variety of benefits, such as a vocational assessment, vocational training or tuition, mileage, temporary total disability compensation, and medical benefits. This training period may last up to 18 months and according to some officials averages about a year. According to Kansas law, vocational rehabilitation may increase the maximum workers' compensation disability period for some types of injuries by six months. After this training period, the claimant may or may not get a job, may not want a job, or may not want to work in the area for which he or she has been retrained. The claimant can then claim disability based on inability to perform work in the open market even though he or she may be able to earn comparable wages in a new field. As a result, increased use of vocational rehabilitation may not decrease compensation benefits paid.

An additional problem with this mandated benefit is that it can be used as a bargaining chip to increase the dollar amount of lump-sum settlements. An individual may ask for additional compensation for vocational rehabilitation benefits to be included in a lump-sum settlement. Kansas workers' compensation officials indicate claimants may use lump-sum awards in any way they want and sometimes vocational rehabilitation is used as an argument to increase the final dollar amount of a settlement.

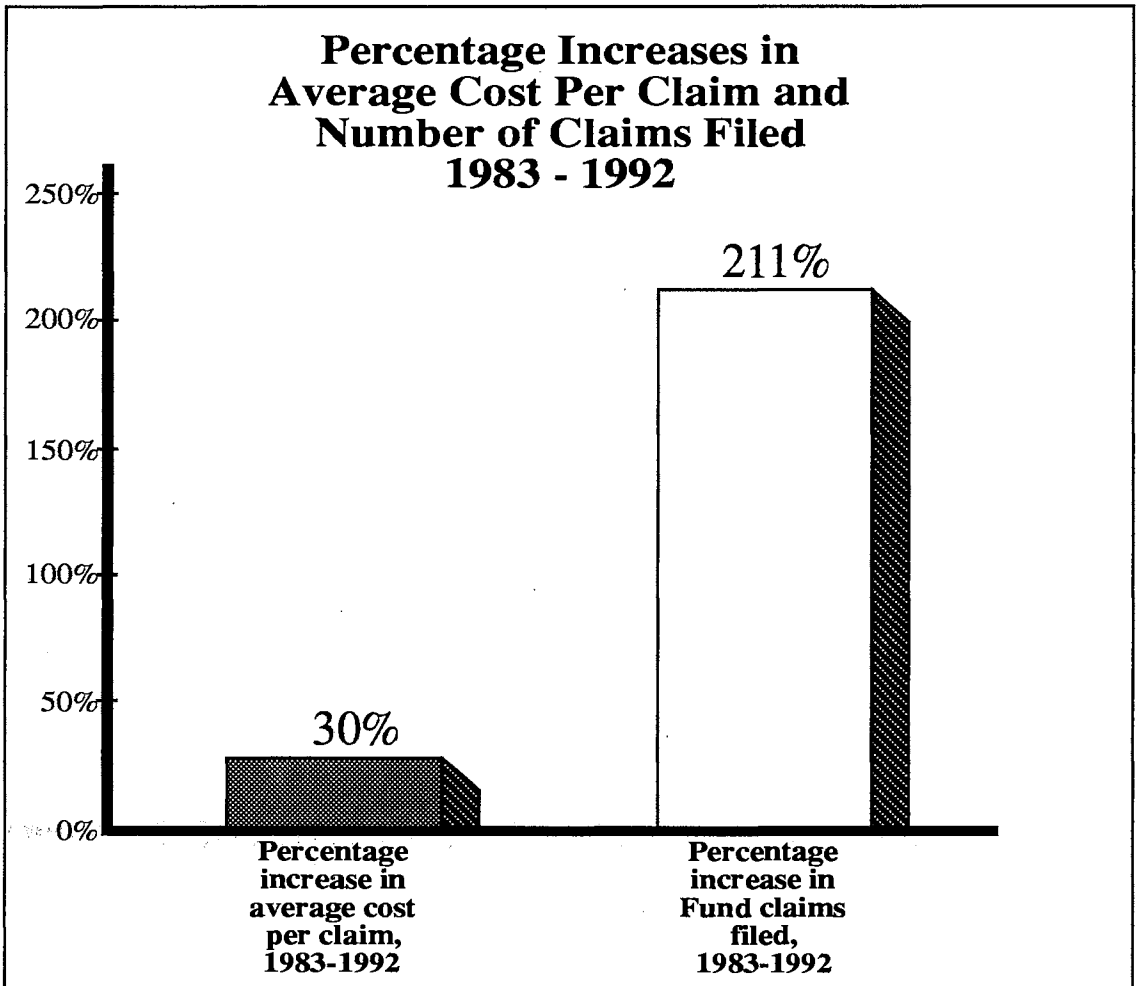
Judicial Decisions Have Increased Claimant Access to Fund Benefits

Our review of workers' compensation case law identified several recent judicial decisions that have affected workers' compensation and the Workers' Compensation Fund. Both of the decisions have increased benefits that may be paid to injured workers.

Hughes v Inland Container Corporation. In 1990, the Kansas Supreme Court upheld a district court decision that both reduction in a claimant's ability to perform work in the open market and the claimant's ability to earn comparable wages must be considered in determining the extent of permanent partial disability. This decision required the court to look at how many jobs, in the open market, the claimant could perform after his or her injury, as well as how the claimant's current wage compared with pre-injury wages.

The decision established the two-pronged test for determining extent of permanent disability. Before this decision, the court simply looked at whether the claimant could earn comparable wages. Given the two-pronged test, claimants have a potential for receiving higher awards in all cases where permanent disability is an issue.

Stephenson v Sugar Creek Packing. In 1987, the Kansas Legislature amended K.S.A.44-510(d) by adding a new section. The new section applied specifically to conditions, like carpal tunnel syndrome, that resulted from repetitive use. The new section of the law treated benefits for those conditions different from benefits for other types of arm injuries by setting a specific maximum benefit level. The Kansas Supreme Court ruled that the new statutory provision was unconstitutional because it created a distinction in benefits between two similar types of injuries. Declaring the distinction between benefits for repetitive use injuries and other arm injuries unconstitutional makes higher awards possible for repetitive use injuries.



Between 1983 and 1992, the average cost for a claim against the Workers' Compenstion Fund increased from $2,970 to $3,848, an increase of 29.6 percent. During the same period, the number of claims increased from 2,713 in Fiscal Year 1983 to 8,449 in Fiscal Year 1992, an increase of about 211 percent.

Compared With Six Other States We Contacted, Kansas Currently Has One of the Most Liberal and Inclusive Second-Injury Funds

During this audit, we contacted second-injury fund officials in Arizona, Missouri, Nebraska, Ohio, Oklahoma, and South Dakota to determine how their second-injury funds compared with Kansas' Workers' Compensation Fund. We asked them what kinds of claims were paid from their second-injury funds, trends officials had noted in fund claims or awards, and cost-containment measures they employed to hold down fund costs.

We found it is easier to file a claim against the Workers' Compensation Fund in Kansas than it is to file claims against second-injury funds in some other states. Also, it

is easier to qualify for benefits from Kansas' Fund, and those benefits generally are more liberal in Kansas than for the second-injury funds in other states. Each area is described below.

It is easier to file a second-injury fund claim in Kansas than in some other states. In Kansas, the employer, insurance company, or injured worker can involve the Workers' Compensation Fund in a claim. In other words, any party to the claim can cause the Fund to incur legal costs, regardless of the merits of the claim. There is no disincentive to involve the Fund. In other states, access to the second-injury fund is more limited. For example,

- In Nebraska, the claimant must convince a workers' compensation judge that the second-injury fund should be brought into the case. Further, state law requires the judge to conserve the assets of the Fund. In Kansas, a judge's approval is not required to bring the Fund into a case, nor is the judge required to guard the Fund's assets.

- In Oklahoma only after a claim has been found to be legitimate and compensable can the insurance company involved with the claim apply to the Fund for reimbursement of some costs. In Kansas, the Fund can be brought into the case before the claim is determined to be valid.

- In South Dakota, the claim must be found to be legitimate, compensable, and approved by the Department of Labor before the employer or insurer can file a claim with their Subsequent Injury Fund. As with Oklahoma, requiring settlement of the claim before the Fund is involved protects the Fund from claims that are without merit.

It is easier to qualify for second-injury fund benefits in Kansas than in some other states. The conditions, injuries, or illnesses eligible for compensation under the Kansas Fund are more numerous than in some other states we contacted. As noted earlier in this report, Kansas law lists 16 pre-existing conditions plus a 17th category for "any other impairment." Taken together, these 17 conditions cover just about any physical or mental condition with a potential to reduce a person's employability. Other states have much stricter limits on eligible conditions or impairments. For example:

- In Arizona, claimants with any of 25 pre-existing conditions are eligible for benefits from the second-injury fund, but all 25 are specific injuries or handicaps, such as blindness, tuberculosis, diabetes, and the like. Unlike Kansas, there is no "any other impairment" category.

- To qualify for benefits from the Oklahoma second-injury fund, the second injury must result in at least a 40 percent disability to the body as a whole. Kansas' fund sets no minimum degree of disability for a second injury.

Benefits are more liberal for the second-injury fund in Kansas than in some other states. The Kansas Workers' Compensation Fund pays benefits for partial or total disabilities that are either temporary or permanent. Benefits can start as soon as one day after the disability occurs, and can last as long as 415 weeks—almost eight years—for some types of permanent disabilities. As noted earlier, the Kansas program originally required individuals to be totally and permanently disabled in order to receive benefits from the Fund. This provision was broadened in 1961 to include temporary and partial disabilities. Further, the Kansas Fund pays benefits to workers whose employers are uninsured or insolvent. Other states' funds pay fewer benefits. For example:

- Oklahoma's second-injury fund pays only compensation for lost wages, and does not pick up the tab for workers whose employers are insolvent.

- Neither the Arizona nor Oklahoma funds pay medical bills for injured workers (medical bills are paid by the private insurer).

- Other states' funds pay benefits for shorter periods; for example, several states' funds only pay benefits after the first 104 weeks, as compared to first-day benefits for some injuries in Kansas.

Appendix B provides additional information about second-injury funds throughout the United States.

Without Some Steps to Limit the Number of Claims Being Filed Against the Fund or to Control Costs, Expenditures From the Fund Will Rise Dramatically

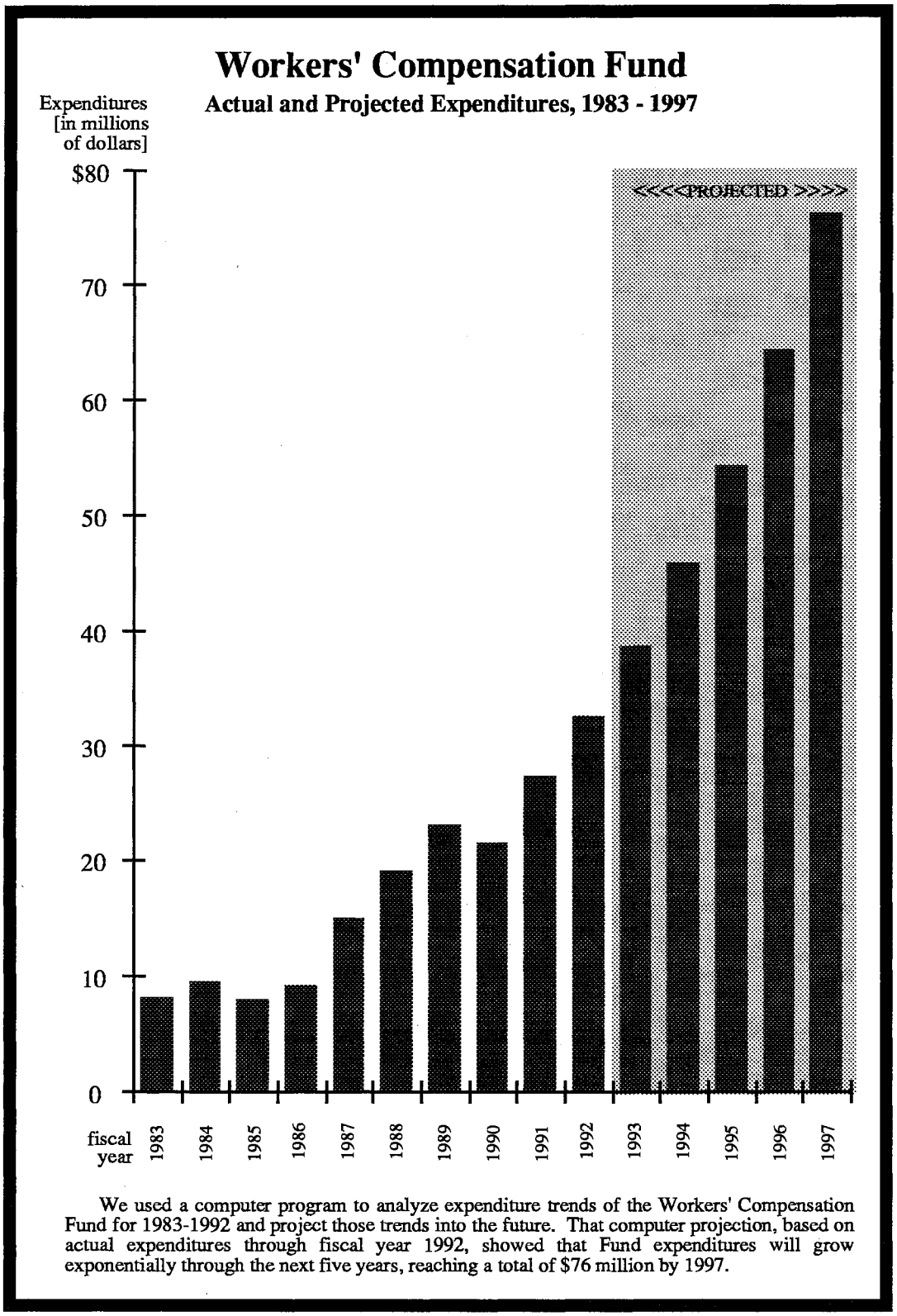
For fiscal years 1983 through 1992, the Fund has experienced an average increase in expenditures of about 19 percent annually. Based on the Insurance Department's expenditure estimates in its fiscal year 1994 budget documents and our own computer projections, we estimate the Fund's expenditures will increase to as much as $83 million in fiscal year 1997 unless something is done to curtail those expenditures.

The Department has estimated the Fund's expenditures will increase 42 percent during fiscal year 1993, to a total of $46.2 million. The Department also provided an estimate of future liabilities for the State Financial Report which indicated the Fund's expenditures would total $132.3 million over the next 30 months.

We used expenditure information for 1983 through 1992 to project the Fund's future expenditures, based on its past expenditure history. The results of our projections are shown in the chart on the following page.

As the chart shows, if the Fund's expenditures continue to rise at an average annual rate of 19 percent, those expenditures will be about $54 million in fiscal year 1995, and will rise to about $76 million in 1997. If, however, the Department's estimate for fiscal year 1993 is correct and expenditures rise 42 percent this year, our computer projections

indicate that expenditures for 1995 will total about $58 million, and will rise to more than $83 million in 1997.



We used a computer program to analyze expenditure trends of the Workers' Compensation Fund for 1983-1992 and project those trends into the future. That computer projection, based on actual expenditures through fiscal year 1992, showed that Fund expenditures will grow exponentially through the next five years, reaching a total of $76 million by 1997.

Besides Having More Restrictive Requirements for Their Funds, Some States Also Have Instituted Cost-Control Programs

We contacted workers' compensation officials in Idaho, Oregon, Washington, and Wisconsin, four states that were reputed to have effective workers' compensation cost-control programs. These states have instituted a variety of practices that could be considered to help control Kansas' spiraling Workers' Compensation Fund expenditures. The following are examples from each state we contacted:

- In Idaho, all injuries eligible for compensation from the second-injury fund must be physical; behavioral conditions such as alcoholism, mental illness, drug abuse and the like are not covered by the second-injury fund.

- Oregon has instituted a system of primary care physicians and managed care. It also has standardized its disability rating system, which means that doctors and workers' compensation officials now use the same criteria to assess a worker's degree of disability. This practice, in turn, has eliminated much of the litigation associated with disability claims.

- Washington has developed an extensive system of reimbursement schedules, which has reportedly saved more than $90 million since 1985.

- Wisconsin does not allow the use of discovery in workers' compensation cases. In other words, attorneys are not allowed to take depositions or use interrogatories when preparing for workers' compensation cases. This restriction has had the effect of significantly reducing the amount of litigation in workers' compensation cases, which in turn reduces the fund's costs.

The boxes on the next two pages describe the programs in Oregon and Washington and their comprehensive cost control measures in more detail.

In Kansas, Basic Information That Will Be Needed To Help Determine How Best to Control Costs— Or to Determine the Effectiveness of any Cost-Control Measures That Are Implemented—Is Not Available In a Useable Form

A key to knowing how to control costs is to be able to identify where those costs are being incurred. For example, basic information about which industries or employers file the most claims, what types of injuries occur most frequently and are most costly, what are the most frequent causes of injuries, and how have these factors changed over time would be essential to making an informed decision about how to limit the number of claims being filed, or how to control cost increases.

We found that neither the Insurance Department nor the Division of Workers' Compensation had complete information about workers' compensation claims that

involve the Fund. The Workers' Compensation Division maintains computerized information about the employer, the accident and injuries sustained, the attorneys involved in the case, and the like, but the Division does not have expenditure information. The Insurance Department generally only keeps computerized information about expenditures for closed cases from the Fund, by claim, but little about the background or nature of the claim.

We hoped to analyze claim information for each fiscal year—1988 to 1992— to track trends and changes in a number of areas. However, in an attempt to merge these two databases we ran into some serious problems. For example, supposedly common information on both systems—such as names and docket numbers—often did not match. We also found that some claimants had filed several claims at a time, and although these cases often were settled together, the Insurance Department and the Department of Workers' Compensation recorded the settlement information on one case. We eventually matched all closed claims for 1992 and about 70 percent of claims closed in 1989. It took us weeks to sort out these problems so that we could review and compare basic

Oregon Has Taken a Comprehensive Approach to Containing Workers' Compensation Costs

Benefits from the Oregon second injury fund are paid through the state's Preferred Worker Program. Employers hiring a Preferred Worker (a worker with a previous injury or pre-existing condition who has enrolled in the Program) are exempt from paying premiums and premium assessments on that worker for three years from the hire date. The Fund then reimburses all claim costs for that worker within the three-year period. Other return-to-work incentives include paying for as much as $25,000 in worksite modifications, a wage subsidy of 50 percent for as long as six months, and necessary employee purchases such as new work clothes or tools. Officials told us that the emphasis of the program is not on saving money; however, reduced compensation costs have resulted from returning workers to work earlier.

The Program's procedures discourage high litigation costs. Most workers' compensation claims are heard by the state Workers' Compensation Board, but Fund claims are specifically exempted from the Board's jurisdiction. According to Oregon law, claim and benefit decisions related to the Fund are made by staff of the Preferred Worker Program. In the event of a dispute, the Director makes a final decision that is not subject to further review (other than through a civil suit). Because the decision of the Director is final, the Fund does not have to bear the costs of defending the Program in court proceedings. (In the one civil suit filed since 1985, the Fund settled for $2,000.)

Beyond the savings associated with the Preferred Worker Program, the Oregon workers' compensation program has adopted other cost-control measures:

- Officials told us that the factor that has been most effective in controlling claim costs has been the use of primary care physicians and managed care.
- A major cost savings of the managed care system has been achieved through elimination of the use of herbalists, faith healers, and other non-traditional health-care providers, and limitations on the use of chiropractic services.
- Employees and insurers can now settle a claim by compromise. Formerly, even if the employee and insurer might have preferred to reach a lump-sum compromise settlement that would have been more satisfactory than continued benefit payments, they were not allowed to do so. Such lump-sum settlements are generally less costly than continuing compensation payments.
- Oregon has standardized its disability rating system. Formerly, doctors, the Insurance Department, and the Worker's Compensation Board all used their own criteria to rate the degree of disability caused by a given injury. Now, everyone uses a standardized system that minimizes inconsistent findings of disability, and eliminates much of the litigation formerly associated with disability determinations.

Washington State's Efforts To Control Workers' Compensation Costs Required Good Information

Private insurance companies do not write workers' compensation insurance in Washington; all such insurance is provided either by the state, or by approximately 360 self-insured employers. The program pays reasonable accommodation expenses to the employer of a previously injured worker for workstation modification. Washington officials told us that the measures associated with the second injury fund are designed to encourage employers to hire or retain disabled workers; as in Oregon, cost control is incidental.

Washington has taken a number of measures to control workers' compensation costs in general. Officials told us that the first step in getting a handle on costs was getting good data. Before 1986, Washington's computer data was not organized in such a way that it was useful for analysis, and officials had to spend considerable resources to develop information that would aid in their decisionmaking. The state contracted with private vendors for consulting and technical services in development of some of its cost management strategies. Officials found that most of the state's uncontrolled charges were in hospitals, and so concentrated much of their early efforts there. Below are some cost-containment strategies Washington used.

- One of the steps the state took was to develop a diagnostic-related group payment system (commonly known as DRGs). Developing the system required a great deal of data on the time and procedures needed to treat particular conditions. Development of good information for the payment system took two years.
- Officials started doing hospital bill audits, which resulted in significant savings.
- Because Washington hospitals are required to report their costs to the state health department, workers' compensation officials had access to good data on actual hospital costs; officials used this information to develop payment systems that covered the cost of procedures without paying excessive hospital overhead charges. For example, research showed that a portion of hospitals' charges went to offset bad debts by other patients. The state reimbursement schedule does not pay that bad-debt allowance.
- Washington's workers' compensation program will pay only for conservative, medically necessary procedures.
- Officials reimburse hospital outpatient procedures and the same procedures performed in a non-hospital setting equally. Procedures requiring hospitalization require previous authorization.

Washington has had a fee schedule for doctors since 1986. Injured workers are allowed to use their own doctor. Washington does not use primary care physicians under contract to the state as a way to control costs because, officials said, doctors generally make poor gatekeepers. Instead, the state controls costs through fee schedules, and by requiring prior approval for some procedures.

As a result of these measures, Washington has reportedly saved $92.8 million since 1985 in workers' compensation costs. Officials said that the most important requirement of their system is sufficient data on which to set reimbursement rates and fee schedules. (Kansas' use of private insurers means that the necessary claims data is largely in private hands.) Officials also pointed out that if hospital and other medical cost information is not reported to the State, then another vital piece of information is missing.

information about Workers' Compensation Fund claims. Thus, it would be impractical for either agency to try to merge the data in its current form on a routine basis.

To check the accuracy of the computer-based information we matched-up, we selected a sample of 30 claims closed in 1992, and compared the computerized information with information in the case file. The data generally appeared to be reliable, although we did find some apparent miscodings in the information recorded by the Division of Workers' Compensation.

Although we ultimately were able to obtain descriptive information about closed claims from the available data, much of that information was coded so broadly that it was meaningless. We had hoped through our computer match-up to be able to provide specific information as to the nature of the pre-existing condition involved in the injury, which types of injuries were the most frequent and costly, what caused them, and in which industries they occurred. Such information could help the Legislature and the agencies decide which areas to target for certain cost-control or workplace safety measures, and in which areas the Fund's involvement could be made more restrictive.

What we found, however, was that claims information was coded so generally that it often was not useful for management-information purposes. Information about pre-existing conditions was available for some of the closed cases, but was generally not specific enough to generate usable management information. Similarly, one of the most common causes of injuries for cases closed in fiscal year 1992 was "no explanation." Some of the most common injuries were coded simply as "multiple injuries," "upper extremities, multiple," and "no explanation." Information we were able to provide is summarized below. Appendix C also presents additional summary information.

- **About two-thirds of the claims closed in 1992 were in the manufacturing, services, and retail trade industries.** Those three industries accounted for about 66 percent of total claims. Major manufacturing employers included Boeing, Cessna, and Goodyear. In the services and retail industries, there were no big individual employers. The major kinds of service industry employers included nursing homes and hospitals. Major retail employers generally were restaurants and grocery stores.

  With the exception of the manufacturing industry, the percentage of closed claims among these industries generally did not change much between fiscal year 1989 and 1992. In other words, these figures seemed to point to a general increase in claims from all industries over the four-year period.

- **"Multiple injuries" and back injuries were by far the most common injuries among cases closed in 1992, and were among the costliest of injuries.** According to officials in the Division of Workers' Compensation, "multiple injuries" could include any injury involving more than one body part such as hand and wrist or leg and ankle. These two categories accounted for nearly two-thirds of all injuries. Other common injuries were to workers' "upper extremities" and knees.

  On average over the life of the claim, each claim for "multiple injuries" or back injuries cost nearly $17,000. For the 619 claims for back injuries that were closed in fiscal year 1992, a total of $10 million had been paid out over the years. For the 690 claims for "multiple injuries" closed that year, about $11 million had been paid out. The average cost for back injury claims rose by 11 percent between fiscal years 1989 and 1992; the average for "multiple injury" claims rose by 36 percent during that four-year period.

- **Half the injuries for claims closed in fiscal year 1992 were caused by lifting objects, "no explanation," and falling on the same level.** The most frequently cited cause was lifting objects, which contributed to about one-fourth of workers' injuries. Repeated motions, such as those related to carpal tunnel syndrome, caused about six percent of the injuries.

  Injuries caused by lifting objects were also among the most expensive; over the life of the claim, they cost an average of nearly $16,000. (This fact would be expected because so many of these claims would be for back injuries.) The closed claims that had the largest average per-claim cost increase between fiscal years 1989 and 1992 were cited as having "multiple causes" (the cost of these claims had grown from an average of $3,385 in 1989 to $13,572 in 1992).

We identified several potential reasons why the information was recorded the way it was. First, the Division of Workers' Compensation developed its computer system to help process claims, not for management information purposes. Second, the information submitted to the Division may not contain complete information about the injuries or their causes. Third, it may be difficult to accurately summarize all the information about some work-related accidents because of the nature of the accident or disability. There may be other reasons as well.

Division of Workers' Compensation officials acknowledged the limited usefulness of these data and the problems associated with them. Those officials indicated they are planning to institute a data management program to improve the quality of the data

It Is Not Clear What Effect the Americans With Disabilities Act Will Have on the Workers' Compensation Fund

Public Law 101-336, commonly known as the Americans With Disabilities Act of 1990, establishes a comprehensive law against discrimination of disabled persons. This law covers employment, public services and accommodations, telecommunications, and state and local government services; however, it is not significantly different from the Rehabilitation Act of 1973. The one major difference is that the Americans With Disabilities Act contains a variety of enforcement avenues available to remedy discrimination. The 1990 Act took effect July 26, 1992, for employers with 25 or more employees, and will take effect July 26, 1994, for employers with 15 or more employees.

In employment situations, the law prohibits discrimination, but does not mandate hiring handicapped individuals who are not able to perform the requirements of a specific job or who do not have the required skill, experience, or education for the job. If a handicapped individual is hired, the employer is required to make reasonable workplace provisions for the individual. The employer must not discriminate in pay, advancement, fringe benefits, or discharge between handicapped and non-handicapped individuals. In essence, the compensation and fringe benefit package the employer provides must treat all employees equally.

Workers' compensation is a part of the fringe benefit package. It is not yet clear whether this act will have a positive or negative effect on the Workers' Compensation Fund. Some literature we reviewed suggested that employers will have to make greater use of state second injury funds, as well as pre-existing clauses in their health insurance coverage, in order to keep insurance costs down. Other writers believe disabled workers do not add to injury claims and even may have better than average work-related safety records.

Officials with the Workers' Compensation Fund told us they did not think the Act would have a significant effect on the Workers' Compensation Fund, nor would it eliminate the need for the Fund.

collected on workers' compensation claims in Kansas, to monitor the accuracy of the data going into the system, and eventually to produce meaningful summary reports.

The State's Self-Insurance Fund maintains computer information about State employees' workers' compensation claims that provides the kind of management information needed for decision-making purposes. As noted in the overview section of this report, workers' compensation claims for State of Kansas employees are paid from the State Self-Insurance Fund. Officials of that Fund, which is administered by the Department of Administration, have developed a data management system that provides information on such things as types of accidents by agency or time period, costs, and so forth. Officials use reports generated by the system to manage litigation costs, set State agency assessment rates, and track the status of claims. The Department also has used vocational rehabilitation cost data to help develop a managed-care program for vocational rehabilitation benefits for State employees.

This kind of management information, collected Statewide on all workers' compensation claims, would be useful to the Division of Workers' Compensation, the Insurance Department, and the Legislature.

Is the Workers' Compensation Fund Being Administered Efficiently?

Administrative costs for operating the Workers' Compensation Fund have decreased as a percentage of total costs over the past few years, and administrative costs per active claim have dropped as well. In terms of cost per claim, the Fund was being operated more efficiently in 1992 than it was in 1985. Cost efficiencies appear to have been brought about because the number of claims against the Fund have increased dramatically, but the number of staff handling those claims has not increased as much. Also, the Insurance Department has made some efforts to control administrative costs for attorney fees. Even so, the Department could improve the administration of the Fund if it had better information about claims. These findings will be discussed in detail in the sections that follow.

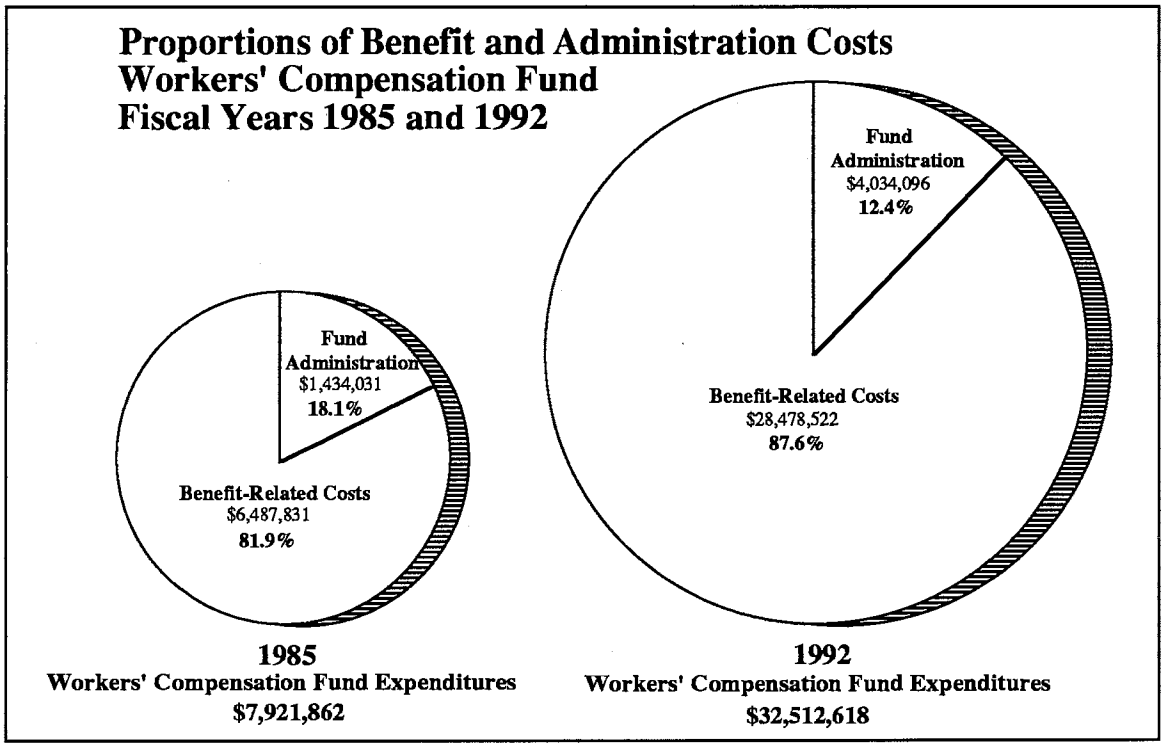
Administrative Costs As a Percent of Total Fund Expenditures Have Decreased in Recent Years

When we set out to examine the efficiency of the Fund's administration, we tried to gather information from other states about staffing and administrative costs for their second-injury funds. However, the other states we contacted operated very differently from Kansas. For example, some states had as few as 31 new claims against their second-injury funds in a year, whereas Kansas had more than 3,000 new claims during 1992. Also, there was a lot of variation in ways claims were handled in other states. Therefore, it did not appear that comparing Kansas with other states would be meaningful.

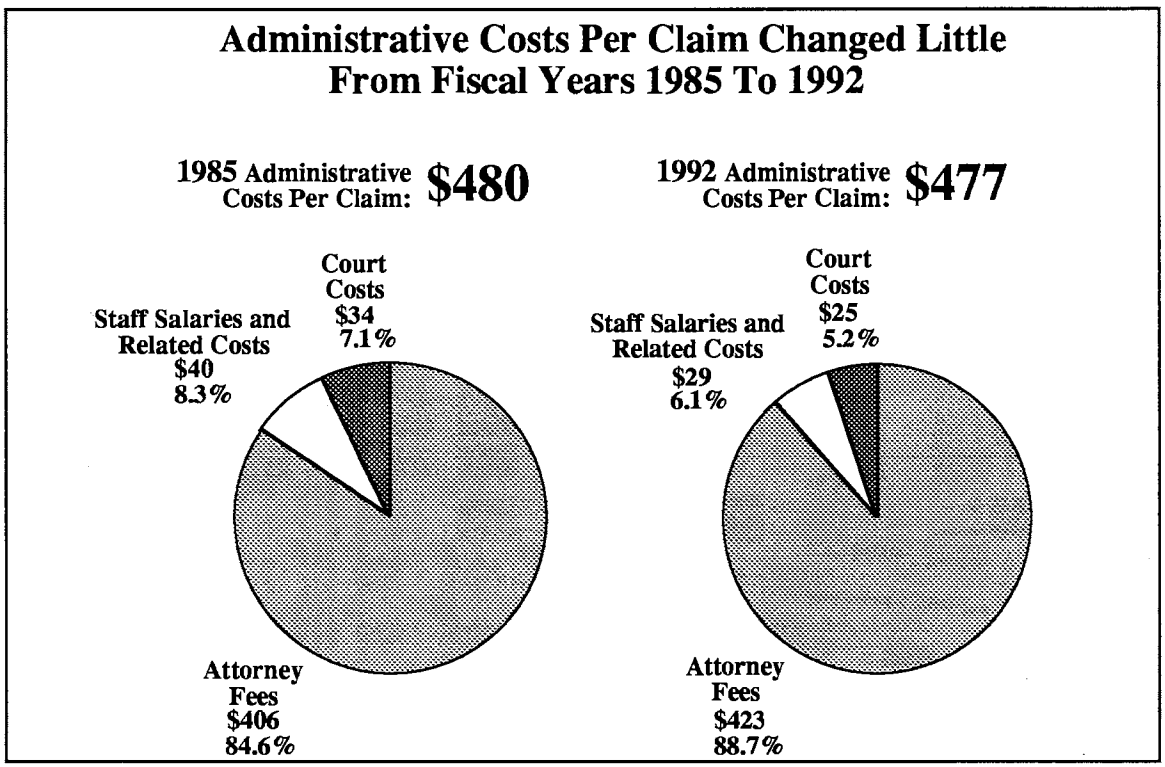
As an alternative, we compared the administrative costs of Kansas' Workers' Compensation Fund over time to determine whether the Fund was operating more or less efficiently now than in the past. We looked at three measures of efficiency—the percent of total expenditures for administrative costs, the change in average administrative costs per active claim, and the number of claims per Fund employee.

During 1992, about 12 percent of the Fund's expenditures were for administrative costs, compared with slightly more than 18 percent in 1985. We defined administrative costs as those costs that were not benefit related. Our definition included costs the Insurance Department pays to administer the Fund such as the salaries for employees who operate the Fund at the Insurance Department, fees for attorneys hired by the Insurance Department to defend the Fund against claims, court costs, special witness fees, and the like. The figure at the top of the next page shows total Fund expenditures in 1985 and 1992 and the portion that was paid for Fund administration and benefit costs in those years.

As the figure shows, total Fund expenditures in 1992 were more than four times greater than they were in 1985, but the portion spent for Fund administration was a significantly smaller piece of the pie.



Average administrative costs per active claim are essentially unchanged. On a per-active-claim basis, average administrative costs were about $480 in 1985 and about $477 in 1992. The figure below shows the breakdown of administrative expenditures for an average active claim in 1985 and 1992.



The Insurance Department Appears To Have Complied With Previous Audit Recommendations

As part of this audit we reviewed performance audits by the Legislative Division of Post Audit for 1978 through 1992 and financial audits for 1988 through 1992 that included comments or recommendations about the Workers' Compensation Fund.

Two performance audits specifically addressed the Fund. In 1978, an audit of the Insurance Department addressed some of the concerns cited in this report, as well as recommending that the Department "advertise" the Fund's purpose and existence to ensure that Kansas employers are aware of the Fund.

In 1988, the Legal Services for State Agencies audit reviewed whether State agencies were spending more to contract for attorneys than they would if they hired attorneys to work for the agency full-time. The audit recommended each agency review its legal needs and determine the most economical way of meeting those needs.

Since that audit, the Department has periodically calculated the cost of hiring legal staff and compared it to the cost of contracting for services, but has found the cost of hiring sufficient staff would most likely exceed the cost of contracting for services. Our analysis of costs for hiring legal staff generally supported the Department's findings.

The financial audit for 1989 made several recommendations, including one that the Department develop a formalized claims processing system and develop a method for monitoring future Fund liability.

The Department appears to have complied with all recommendations.

As the bottom figure shows, fees the Insurance Department pays for attorneys who defend the Fund represented the lion's share of administrative costs per claim in both years. In 1985, attorney fees accounted for more than 84 percent of the total; by 1992, those fees accounted for more than 88 percent of administrative costs.

The increase in attorney costs for an average claim was most likely caused by a 20 percent increase in the hourly rate paid to attorneys who handle claims on behalf of the Fund. On December 31, 1985, the amount the Insurance Department paid attorneys for the Fund increased from $50 per hour to $60 per hour. If the number of hours billed per case remained the same in both years, we would expect to see approximately a 20 percent increase in attorney costs per claim. Because the increase in attorney costs was only about four percent from 1985 to 1992, it appears that there was either a reduction in the average number of hours billed per case, or a reduction in travel or other expenses charged by the attorneys.

Two other components of administrative costs were court costs (primarily fees paid for special witnesses and court reporters), and staff salaries and related costs for the staff the Insurance Department employs to administer the Fund. Each of these components accounted for only about five to eight percent of administrative costs in each year.

Insurance Department staff are handling more claims per employee than in the past. Between fiscal years 1985 and 1992, the number of active claims handled by Insurance Department employees nearly tripled, from 2,986 to 8,449 active claims. During that same time period, the number of employees who administered the Fund increased from 4.1 full-time equivalent positions to 7.0 positions. This means that in 1992, the Fund employees handled about 1,207 claims per employee, compared with about 728 during fiscal year 1985.

The Insurance Department Has Taken Some Steps To Control the Fund's Attorney Costs

Officials told us they have occasionally conducted audits of charges submitted by private Fund attorneys as part of their efforts to control Fund administration costs. Fund officials provided us with a copy of their report to the Commissioner of Insurance describing their most recent such audit in February 1989. The report summarized the major problems officials found, and made recommendations for action. The problems noted generally fell into three areas: travel-related issues, excessive or unnecessary charges, and other billing or reimbursement issues. The following are examples of those problem findings and recommendations.

- **Travel:** Insurance Department staff noted instances of unverifiable travel to Topeka to visit with Fund officials, billing of time by Fund attorneys for travel which was not authorized or pre-approved by Fund staff, and travel related to more than one claim being billed to both.

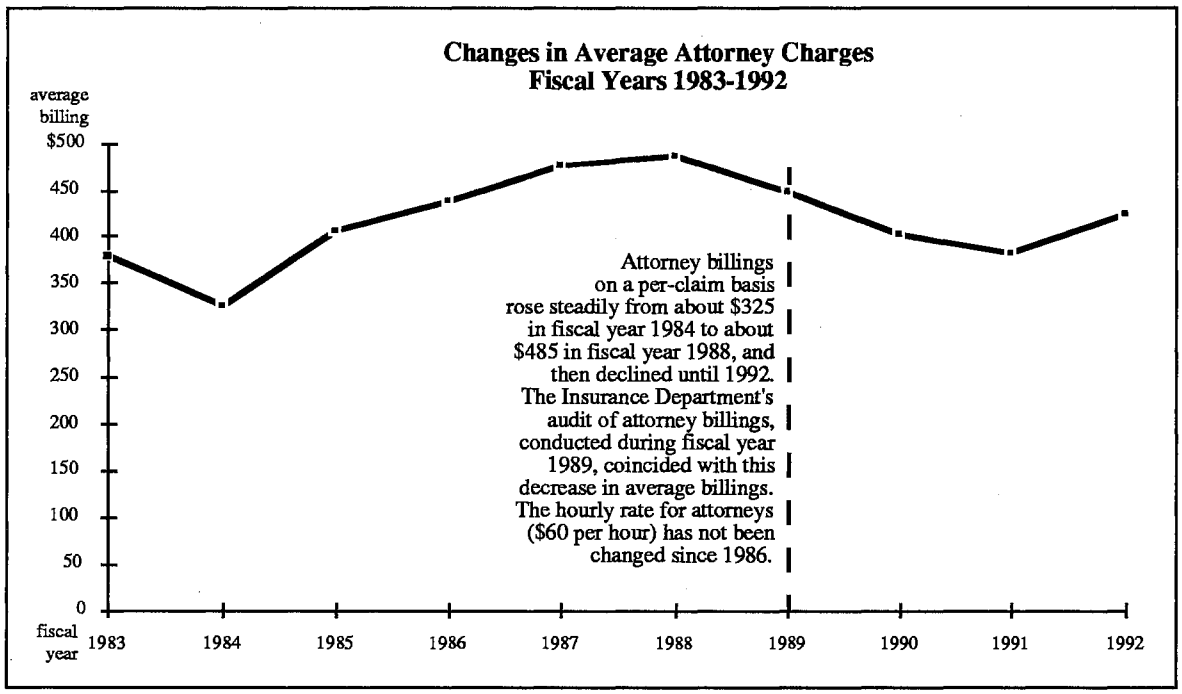
- **Excessive or unnecessary charges:** Staff found instances in which attorneys had sent unnecessary correspondence, such as acknowledgment of receipt of a file, and then billed the Fund for preparation of that correspondence. They also cited excessive charges—such as being billed for 10 hours to draft a submission letter—and being billed for travel to a city in which another Fund attorney was already located.

- **Other billing problems:** Attorneys were submitting requests for reimbursement of travel and miscellaneous expenses that lacked receipts, were overly vague, or not timely (as much as a year after the service was rendered).

Insurance Department officials also indicated that during the audit of attorney billings they discovered that about 10 attorneys billed the Fund for the time needed to prepare the billings. Officials estimated that this charge totaled between $20,000 to $30,000 per year, or about one percent of attorney fees paid from the Fund. Additionally, they found that some larger fees were being billed and paid without previous written approval, as required by Department procedures.

To remedy these problems, Fund officials sent a letter to all Fund attorneys stating that only reasonable charges would be paid for services rendered and explaining when travel would need to be pre-approved, what kinds of correspondence should be discontinued, and the like.

Although we did not review attorney billings in detail to verify that improvements have been made, we found that since this review of attorney billings was conducted in early 1989, attorney fees, which had previously been rising, leveled off and even began to decline somewhat, as shown in the following graph.



As the graph shows, attorney costs for an average claim increased from $325 in 1984 to $486 in 1988 (a 28 percent increase). Starting in 1989, those costs fell each year until 1992, when expenditures began to increase again.

Department officials told us that they have taken some additional actions to improve the efficiency of the Fund, such as cross-training some employees, and automating some procedures, although they could provide no figures on specific cost savings achieved.

The Insurance Department Needs More Complete Information About Claims To Provide a Better Basis for Assigning Attorneys to Cases

To involve the Fund in a workers' compensation claim, an employer, insurer, or injured worker files an "impleading" notice with the Commissioner of Insurance. That notice lists very few details about the claim, and rarely, if ever, lists the real reason for involving the Fund. Insurance Department staff then assign a private attorney under contract with the Department to investigate the claim and prepare to defend the Fund.

The problem we saw with the current system was that the Department generally does not have enough information to make an appropriate attorney assignment that takes into account the attorney's area of expertise. For example, the Department contracts with 11 attorneys in Wichita to handle claims against the Fund. If one of those attorneys had expertise with particular types of injuries, such as back injury claims or carpal tunnel

syndrome, Department staff could take that expertise into account in assigning the case. Similarly, if Department officials had more information about the particulars of the claim they might be in a better position to provide initial direction to the assigned attorney.

Assigning attorneys based on area of expertise could potentially provide cost savings to the Fund because an attorney with experience in a particular type of claim may be more likely to win the case. Also the attorney may end up billing for fewer hours because his or her familiarity with particular types of injury cases could reduce the amount of research that would have to be done to handle the case.

Officials at the Insurance Department told us that one possible solution to this problem would be to amend State law to require "impleading by particularity." In other words, the notice sent to the Commissioner of Insurance would be required to contain more specific and complete information about the claim. For example, the law could require the notices to contain specific information about the nature of the accident, its cause, the resulting injuries, and exactly why the Fund was being involved. Although this type of information is available from the Division of Workers' Compensation, Insurance Department officials said they do not use that information because they do not have enough staff to research the 250 new claims they receive each month. Department officials said that requiring such information on the impleading notice would allow them to make more knowledgeable attorney assignments with no increase in cost to the Department.

The Division of Workers' Compensation May Be Incurring Unnecessary Costs for Filing Forms Associated with the Workers' Compensation Fund

In their response to the draft report, the Division brought up a concern about the forms filed by employers to prove they knew about employees' pre-existing conditions. As mentioned in the overview section of this report, at various times the Legislature has required that employers file a form with the Division of Workers' Compensation to show that an employee had a pre-existing condition that would qualify for Fund benefits should that employee become injured on the job. Since 1979, use of that form has been optional. In other words, an employer currently has the choice of either filing the form to show knowledge of an employee's pre-existing condition, or later proving knowledge of the condition by other means.

The Division of Workers' Compensation receives more than 100,000 such forms each year. When we looked at the 2,076 claims against the Fund that were closed during 1992, we found that about 40 percent had no form on file. In those cases where one was on file, the form seldom provided useful information about the nature of the previous injury or pre-existing condition. Within the scope of this audit, we were not able to

ascertain the annual cost the Division of Workers' Compensation incurs in filing and storing these forms. Nonetheless, if the forms are not useful in determining the liability of the Workers' Compensation Fund, any cost associated with them may represent inefficiency that could be eliminated.

Conclusion

Over the years, coverage of the Workers' Compensation Fund has been broadened from its original intent of encouraging the employment of war veterans and a narrowly-defined group of handicapped workers. With this expansion in coverage have come enormous increases in the number of claims and expenditures by the Fund.

Essentially, the Fund serves as insurance for insurance companies and self-funded or group-funded employers. These companies pay premiums in the form of annual assessments, and are able to pool the risk of employees who have pre-existing injuries or disabilities being injured on the job. In essence, these companies and employers are able to shift claims to the Fund they otherwise would have to pay directly. Insurance companies and employers that are able to shift a significant portion of their claims to the Fund benefit the most, while those companies that use it less benefit less. The reason: assessments are based on their workers' compensation claims experience, and claims paid by the Fund do not count toward that experience.

Although Kansas has one of the most liberal second injury funds we examined, limiting the Fund's coverage would not save money for the State because, in recent years, the $4 million annual General Fund contribution to the Fund has been repaid. Limiting the Fund's coverage would simply shift the liability for workers' compensation claims away from the Fund and back to the insurance companies or the employers themselves.

Although the Insurance Department and the Division of Worker's Compensation can do some things to control administrative costs and to provide better information about compensation claims, ultimately, if real cost savings are going to be realized, the Legislature will need to enact reforms of workers' compensation laws in general to control costs, increase workplace safety, and eliminate frivolous or fraudulent claims. We will be conducting an audit of workers' compensation in general in Kansas, and will address these issues in that report.

Recommendations

1. To provide the types of information the Legislature needs to make informed decisions about workers' compensation, the Insurance Department and the Division of Workers' Compensation should work together to develop a database that provides accurate and sufficiently detailed information about workers' compensation claims. In designing this system, the agencies should decide what information is needed for decision-making purposes, and should review what other states and Kansas' Self-Insurance Fund have done to collect, record, and summarize this information.

2. To further control attorney costs for the Workers' Compensation Fund the Insurance Department should seek a change to State law or regulations that would require "impleading by particularity." Impleading by particularity means that the person filing the claim against the Fund would have to provide specific information about the nature of the accident, its cause, the resulting injuries, and exactly why the Fund was being involved.

3. The more insurance companies and employers are able to shift their workers' compensation claims to the Fund, the less they have to pay in assessments to finance the Fund. To address this situation, the Legislature should consider revising the mechanism for setting assessment rates so that assessments are more closely tied to insurance companies' and employers' actual use of the Fund.

4. The Division of Workers' Compensation should determine whether the forms employers file on employees' pre-existing conditions serve a purpose in the current Workers' Compensation environment in Kansas. If Division officials find that this filing procedure does not serve a purpose, they should seek to have that provision removed from State law.

APPENDIX A

Workers' Compensation Fund Sources and Uses of Funds and Claims Opened and Closed For Fiscal Years 1983 to 1992

Between 1983 and 1992 expenditures from the Workers' Compensation Fund increased from about $8 million to about $32.5 million. Funding sources for the Workers' Compensation Fund increased from $6.1 million to $34.1 million during the same period. The first page of this appendix shows the Workers' Compensation Fund sources and uses of funds for fiscal years 1983 through 1992. Between 1983 and 1992 active claims for the Fund increased from 2,713 to 8,449. The second page of this appendix shows, for fiscal years 1983 through 1992, the number of claims carried forward from the year before, the number of new claims, the number of claims closed, and the number of claims open at the end of the year.

Workers' Compensation Fund
Sources and Uses of Funds
Fiscal Years 1983 to 1992

Sources and Uses of Funds	Adjusted (a) FY1983	Adjusted (a) FY1984	FY 1985	FY 1986	Adjusted (a) FY 1987	Adjusted (a) FY 1988	FY 1989	FY 1990	Adjusted (a) FY 1991	Adjusted (a) FY 1992
Sources of Funds:										
Previous Year Balance	$2,803	($1,989,441)	$164,207	$4,259,466	$908,156	($3,211,420)	$9,125	$3,767,063	$3,758,997	($2,210,907)
Cancelled Warrants	$0	$0	$0	$14,430	$9,486	$3,242	$8,916	$2,486	$22,563	$20,393
Assessments	$3,298,785	$7,311,026	$7,850,888	$1,644,420	$6,542,599	$17,983,751	$22,595,122	$17,137,820	$17,030,546	$35,961,471
State General Fund	$2,642,346	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$3,930,000	$0
Non-Dependent Deaths (b)	$72,000	$262,050	$148,000	$122,250	$153,000	$136,131	$92,500	$55,500	$129,500	$166,500
Miscellaneous	$51,127	$51,718	$18,233	$63,530	$127,847	$92,052	$147,188	$177,766	$94,490	$162,906
Total Funds Available	$6,067,061	$9,635,353	$12,181,328	$10,104,096	$11,741,088	$19,003,756	$26,852,851	$25,140,635	$24,966,096	$34,100,363
Uses of Funds:										
Disability Compensation	$6,412,463	$7,145,008	$5,493,930	$6,328,251	$10,838,368	$13,274,267	$16,606,747	$14,260,105	$18,950,904	$21,568,628
Medical Expenses	$557,825	$1,305,314	$993,901	$1,105,749	$1,865,068	$3,036,206	$3,727,061	$4,257,531	$4,949,876	$6,507,739
Attorney Fees	$1,028,320	$926,574	$1,211,694	$1,497,818	$1,953,605	$2,330,799	$2,356,858	$2,402,730	$2,645,923	$3,579,981
Court Costs	$57,894	$79,250	$102,818	$124,217	$159,986	$199,156	$210,661	$193,769	$225,342	$209,709
Vocational Rehabilitation	$0	$0	$0	$0	$0	$0	$7,046	$49,752	$166,450	$402,155
Non-Dependent Refunds (b)	$0	$15,000	$0	$18,500	$7,493	$50	$9,587	$9,457	$0	$0
Operating Expenses (c)	$0	$0	$119,519	$121,405	$127,988	$154,153	$167,828	$208,294	$238,508	$244,406
Total Funds Used	$8,056,502	$9,471,146	$7,921,862	$9,195,940	$14,952,508	$18,994,631	$23,085,788	$21,381,638	$27,177,003	$32,512,618
Ending Balance	($1,989,441)	$164,207	$4,259,466	$908,156	($3,211,420)	$9,125	$3,767,063	$3,758,997	($2,210,907)	$1,587,745

(a) In 1983, 1987, and 1991, the Insurance Department underestimated the expenditures from the Fund, and ran out of money. It carried these expenditures into the following fiscal years. For comparability purposes, we allocated the expenditures to the years in which they actually occurred.

(b) An employer must pay an amount specified by law to the Workers' Compensation Fund when a work-related injury results in the worker's death and there are no eligible dependents entitled to compensation. In 1982, that amount was changed from $5,000 to $18,500.

(c) Operating expenses includes the salary and general expenditures for the Workers' Compensation Fund staff and expenses which are paid from the Workers' Compensation Fund. Before 1985, these expenses were included in the general expenses for the entire Insurance Department and were not paid from the Workers' Compensation Fund.

Workers' Compensation Fund
Fund Claims Opened and Closed
Fiscal Years 1983 to 1992

Type Cases	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Claims Carried Over	1,695	1,659	1,726	2,027	2,503	2,936	3,343	3,804	4,174	5,368
New Claims:										
No Dependent Deaths (a)	62	43	25	24	11	7	10	18	15	9
Insolvent Employer (b)	29	43	25	47	44	66	61	71	95	86
Reimbursement (c)	9	11	6	7	13	11	9	2	21	9
Second Injury	918	1,097	1,204	1,327	1,535	1,778	1,853	2,090	2,641	2,977
Total New Claims	1,018	1,194	1,260	1,405	1,603	1,862	1,933	2,181	2,772	3,081
Active Claims (d)	2,713	2,853	2,986	3,432	4,106	4,798	5,276	5,985	6,946	8,449
Closed Claims:										
No Dependent Deaths (a)	12	13	10	17	44	8	4	21	10	4
Insolvent Employer (b)	42	26	43	34	43	38	46	58	50	67
Reimbursement (c)	29	11	8	9	10	9	7	8	16	14
Second Injury	971	1,077	898	869	1,073	1,400	1,415	1,724	1,502	1,993
Total Closed Claims	1,054	1,127	959	929	1,170	1,455	1,472	1,811	1,578	2,078
Claims Carried Forward	1,659	1,726	2,027	2,503	2,936	3,343	3,804	4,174	5,368	6,371

(a) An employer must pay an amount specified by law to the Workers' Compensation Fund when a work-related injury results in the death of the worker and there are no dependents entitled to compensation.

(b) The Workers' Compensation Fund is responsible for paying workers' compensation claims when the employer can not pay the claim because of insolvency, the employer can not be located, or the employer has no insurance to pay the claim.

(c) The Workers' Compensation Fund is responsible for reimbursing employers or insurance companies for workers' compensation payments in excess of what the worker was legally entitled to.

(d) Active claims are the total number of claims open during the year and include claims carried forward from the previous years and new claims opened.

APPENDIX B

Table of Second Injury Fund Provisions Nationwide

The table on the following pages shows, for the second injury fund in each state, the injuries covered, the benefits payable by the employer and by the fund, the funding source, and any special provisions that apply to each fund. The information is as of January 1, 1992. We verified the information in the course of our contacts with a sample of states; the information was generally accurate, although some changes had occurred during the 1992 legislative sessions.

CHART XIII — SECOND-INJURY FUNDS — January 1, 1992

JURISDICTION	INJURIES COVERED	PAYABLE BY EMPLOYER	PAYABLE BY FUND	SOURCE OF FUND	SPECIAL PROVISIONS
ALABAMA	Second injury which conbined with prior permanent partial disability results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent total disability.	$100 in death cases	Employer must have knowledge of prior disabling injury affecting employability.
ALASKA	Second injury which added to pre-existing permanent physical impairment results in substantially greater disability than from second injury alone.	Disability caused by second injury up to 104 weeks.	Compensation in excess of 104 weeks.	Up to 6% of compensation payable to fund; percentage varies from 0% to 6% depending on fund balance. $10,000 in no-dependency death cases; civil penalties.	"Physical impairment" as listed or would support an award of 200 weeks or more.
AMERICAN SAMOA	Second injury which combined with prior permanent impairment results in death or compensable disability greater than from second injury alone.	Benefits for first 104 weeks.	Benefits beyond first 104 weeks.	$1,000 in no-dependency death cases, plus fines and penalties.	Employer must have prior knowledge of disability.
ARIZONA	Second injury which added to a pre-existing work-related disability or a pre-existing physical impairment not industrially related (25 types of handicaps as listed by statute) results in disability for work.	Disability caused by second injury.	Employer and special fund are equally liable for remaining difference between compensation payable for second injury and compensation for combined disability.	1.5% of all premiums and costs of self insurance. Commission may allocate up to .5% of yearly premiums to special fund to keep fund actuarially sound.	Employer must have knowledge of non-industrial physical impairment. Payments are also made from the fund for vocational rehabilitation, claims against non-insured employers, insolvent carriers, supportive medical care.
ARKANSAS	Second injury which added to previous permanent partial disability or impairment results in additional disability or impairment greater than from second injury alone.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent disability.	$500 in no dependency death cases to be paid to the Permanent Total Disability and Death Fund. A portion of premium tax allocated to the Second Injury Fund and Death and Permanent Total Disability Trust Fund.	Employer liable for combined disability of both injuries in same employment.
CALIFORNIA	Second permanent partial injury which added to pre-existing permanent partial disability results in 70 percent or more permanent disability. Second injury must account for 35 percent.*	Disability caused by second injury.	Difference between compensation payable for second injury and permanent disability.	Legislative appropriations and $50,000 in each no-dependency death case or unpaid balance.	Payments are made by State Compensation Insurance Fund.
COLORADO	Second injury which added to pre-existing permanent partial disability results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent total disability.	$15,000 in no-dependency or partial-dependency cases, and tax of 4/10 of 1% of premiums received by insurance carriers and equivalent charge on self-insurers.	If employee obtains employment while receiving compensation from second-injury fund, fund compensates at rate of 1/2 of employee's average weekly wage loss during employment.
CONNECTICUT	Second injury or disease which added to pre-existing injury, disease, or congenital causes results in permanent disability greater than from second injury alone.	Benefits for first 104 weeks, less compensation payable for prior disability.	Benefits beyond first 104 weeks, less compensation payable for prior disability.*	Tax equal to 5% of compensation paid by carriers and self-insurers during preceding calendar year plus fines.	Tax imposed each time fund balance is reduced to $1,000,000.
DELAWARE	Second injury or disease which added to existing permanent injury from any cause results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent disability.	Tax of 2% of premiums received by insurance carriers and equivalent charge on self-insurers.	Payments suspended when fund reaches $750,000 and resumed when below $250,000.
DISTRICT OF COLUMBIA	Second injury or disease which added to pre-existing injury, disease, or congenital causes results in permanent disability greater than from second injury alone.	Disability caused by second injury for first 104 weeks and first $1,000 medical expenses.	Difference between compensation payable for second injury and permanent disability.	$5,000 in no-dependency death cases or unpaid awards. Pro-rata assessments upon carriers and self-insurers based on paid losses. Fines and penalties.	
FLORIDA	Second injury or disease which merges with previous permanent physical impairment and results in substantially greater disability than from the second injury alone.		Fund reimburses employer for 60% of impairment benefits, 60% of wage-loss benefits during first 5 years after maximum medical improvements and 75% thereafter, PT benefits after 175 weeks, 75% of death benefits and funeral expenses, and 50% of first $10,000 in temporary disability and medical benefits and 100% beyond $10,000.	Prorata annual assessment upon net premiums of insurers and self-insurers.	Assessment must equal sum of immediate past 3 years' disbursements. If injured employee has been unemployed due to injury for 2 consecutive years and is subsequently hired, the new employer will be reimbursed from the fund for 50% of the employee's wages for up to 6 months.
GEORGIA	Second injury or disease which merges with prior permanent physical impairment and results in greater disability than from second injury alone.	Disability caused by second injury for first 104 weeks.	Employer reimbursed for 50% of medical and rehabilitation expenses in excess of $5,000 up to $10,000, and 100% of medical and rehabilitation expenses in excess of $10,000, plus income benefits beyond 104 weeks.	Assessments on carriers and self-insurers proportionate to 175% of disbursements from fund to annual compensation benefits paid, less net assets in fund. In no-dependency death cases, 1/2 of benefits payable or $10,000, whichever is less.	Employer must have prior knowledge of impairment. Assessments may be reduced or suspended when no funds are needed.
GUAM	Second injury which combined with a previous disability causes permanent disability.	Disability caused by second injury.	Difference between compensation payable for second injury and compensable disability.	State fund (appropriation).	
HAWAII	Second injury which added to pre-existing disabilities results in greater permanent disability, permanent total disability, or death.	Disability benefits for first 104 weeks.	Benefits beyond first 104 weeks.	$8,775 in no-dependency death cases; and unpaid balance of compensation due in permanent total and permanent partial disability cases, if no dependents; special assessment on insurers and self-insurers.	Premium tax suspended when balance exceeds $200,000, resumed when below $100,000.
IDAHO	Second injury which combined with prior permanent physical impairment results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent disability.	Amount equal to 5% of all benefits except temporary disability income benefits and accrued medical benefits and $10,000 in no-dependency death cases.	When fund exceeds $2,000,000, excise may be reduced to 4% and suspended when fund exceeds $2,500,000.
ILLINOIS	Second injury involving loss or loss of use of major members or eye which added to pre-existing loss of member results in permanent total disability.	Disability caused by second injury.*	Difference between compensation payable for second injury and permanent total disability.	Semi-yearly employer payment of .125% of compensation payments.	When fund reaches $500,000 amount payable into fund reduced by 1/2. When fund reaches $600,000, payments cease. When fund reduced to $400,000, payment of 1/2 amount required. When fund is reduced to $300,000, payment of full amount shall be resumed.
INDIANA	Second injury involving loss or loss of use of hand, arm, foot, leg, or eye which added to pre-existing loss or loss of use of member results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent total disability.	1% of compensation paid by insurers and self-insurers during preceding calendar year.	Payment suspended when fund reaches $400,000.

Calif. *Second injury must account for 35% unless prior disability involved a major member and second injury was to opposite and corresponding member and accounts for at least 5%. No benefits payable for subsequent unrelated noncompensable injury.

Conn. *Fund also pays accident and health insurance coverage for injured employees when employer moves out of state or goes out of business.

Ill. *Employer is liable in full if second injury is permanent and total without relation to prior injury.

CHART XIII ☐ SECOND-INJURY FUNDS ☐ January 1, 1992 (continued)

JURISDICTION	INJURIES COVERED	PAYABLE BY EMPLOYER	PAYABLE BY FUND	SOURCE OF FUND	SPECIAL PROVISIONS
IOWA	Second injury involving loss or loss of use of member or eye which added to pre-existing loss of use of member results in permanent disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent disability, less value of previous loss of member or organ.	$4,000 in dependent death cases; $15,000 in no-dependent death cases; any contributions by the United States; payments due but not paid to non-resident alien dependents; and sums recovered from third parties.	Payments to the fund are suspended when fund reaches $1,000,000, resumed when below $500,000.
KANSAS	Second injury related to 17 types of handicap as listed in statute–any physical or mental impairment.	Difference between fund payment and maximum award.	Compensation to the extent pre-existing handicap contributed to second injury.	$18,500 from employer in no-dependency death cases, and pro-rata annual assessment upon carriers and self-insurers based on losses.	Legislature oversees adequacy of workers' compensation fund, administered by Insurance Commissioner. Employer must prove knowledge of prior disability.*
KENTUCKY	Second injury or disease which added to prior disability or condition results in permanent disability greater than from second injury alone.	Disability caused by second injury.	Difference between compensation payable for second injury and greater disability, less amount paid for prior injury.	16.9% on all policies and an additional tax of 47% on premiums for policies issued to coal companies.	
LOUISIANA	Second injury which combined with prior permanent partial disability results in disability greater than from second injury alone, or in death.*	Total disability benefits for first 104 weeks; in death cases, first 175 weeks; 50% of medical benefits which exceed $5,000 but are less than $10,000, and 100% thereafter.	Employer reimbursed for balance of benefits.	2.0% premium tax on carriers and self-insurers, minimum $10.	Assessments reduced at discretion of the Board within 30 days written notice before assessment is due.
MAINE	Second injury caused by accident, disease, or congenital condition, which added to pre-existing impairment results in permanent total disability.	Disability caused by second injury.	Fund reimburses employer for compensation payments not attributable to the second injury.	In no-dependency death cases, 100 x SAWW and civil penalties of up to $10,000 assessed against employers who fail to insure.	Duplicate payments from Second Injury Fund and Employment Rehabilitation Fund prohibited.
MARYLAND	Second injury which combined with a pre-existing permanent impairment due to accident, disease, or cogenital condition results in a greater combined disability constituting a hindrance to employment.	Disability caused by second injury.	If permanent disability exceeds 50% of the body as a whole, employee is entitled to additional compensation for the full disability from the "Subsequent Injury Fund." Prior injury and second injury must each be compensable for at least 125 weeks.	6% of compensation on all awards and settlement agreements until 6/30/91.	
MASSACHUSETTS	Second injury which added to pre-existing physical impairment results in substantially greater disability or death. Pre-existing disability must support 25% earnings loss or 90 weeks of benefits.	Benefits for first 104 weeks.	Employer reimbursed for 75% of benefits after first 104 weeks.	$500 in no-dependency death cases, and additional $500 in every death case; unpaid balance of scheduled awards.	Pro-rata assessment based on losses paid during preceding year by carriers and self-insureds.
MICHIGAN	Second injury involving loss of member or eye, which added to pre-existing loss of member results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent total disability. Benefits for employee with more than one job but for whom injury occurred on job which represented less than 80% AWW. For workers certified "vocationally handicapped," fund pays benefits after 52 weeks.	Assessments on carriers and self-insurers proportionate to 175% of disbursements from fund to annual compensation benefits paid.	Fund is credited with any balance in excess of $200,000.*
MINNESOTA	Second injury that results in substantially greater disability than would have resulted from second injury alone.	Disability caused by second injury.	Employer reimbursed for disability after 52 weeks, medical after $2,000. If second injury results in permanent partial disability, fund pays wage replacement benefits beyond deductible.	$25,000 in no-dependency death cases, 31% of compensation for current indemnity payments, which finances all fund obligations; assessment based on various factors for injuries occurring after 1/1/84; certain penalties.	Commissioner determines assessment base and rate dependent on fund's financial position and increasing up to 12% annually.
MISSISSIPPI	Second injury involving loss or loss of use of member or eye, which added to pre-existing loss or loss of use of member or eye results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent disability.	$500 in no-dependency death cases; $300 in dependency cases. Commission may transfer up to $200,000 from Administrative Expense Fund.	Payments suspended when fund reaches $350,000 and resumed when fund reduced to $150,000.
MISSOURI	Second injury resulting in permanent partial disability which compounds either a greater pemanent partial or a permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and compounded disability.	Surcharge on all workers' compensation premiums not to exceed 3% of premiums, paid by all insureds and self-insurers.	Surcharge suspended when fund reaches $24,000,000 and resumed when fund is reduced to $12,000,000.
MONTANA	Second injury which combined with prior permanent physical impairment results in death or disability.	Insurer liable for payment of benefits for first 104 weeks.	Employer reimbursed after first 104 weeks.	$1000 paid by employers, insurers, or accident fund in every death case. Carriers and self-insurers assessed 5% of losses paid in preceding year.	Department must certify worker as vocationally handicapped.
NEBRASKA	Second injury which combined with pre-existing disability causes substantially greater disability. Pre-existing disability must support 25% earnings loss or 90 weeks of benefits.[1]	Disability caused by second injury.	Difference between compensation payable for second injury and the total resulting disability.	1% premium tax on carriers or self-insurers ($25 minimum) payable to Workers' Compensation Court.	Payments suspended when fund reaches $400,000. Assessment (1%) when fund reduced to $200,000.
NEVADA	Second injury which combined with any previous permanent physical disability causes substantially greater disability.*		Compensation allocated between insurer and fund.	Subsequent Injury Fund in state treasury.**	Compensable claim considered "excess loss" in calculation of employers' experience rating. Employer must prove knowledge of prior inpairment.
NEW HAMPSHIRE	Second injury which combined with any pre-existing disability results in greater disability.[1]	Benefits for first 104 weeks.	Employer reimbursed after first 104 weeks, and for 50% of anything over $10,000 during first 104 weeks.	Assessment against carriers and self-insurers proportional to total benefits paid by all carriers.	Employer who undertakes job modifications to retain injured worker is reimbursed 50% of the cost of modification from the fund, not to exceed $5,000 per employer/year.
NEW JERSEY	Second injury resulting in permanent partial disability which added to pre-existing partial disability, compensable or not, results in permanent total disability.	Disability caused by compensable injury.	Difference between compensation payable for second injury and permanent total disability.	Annual surcharge on policyholders and self-insured employers of pro-rata percentage of 150% of payments estimated to be paid from fund during forthcoming year. Annual surcharge paid quarterly.	When fund balance exceeds $1,250,000, up to $50,000 per year may be applied toward administration costs of Division.

[1]In death cases it must be established that either the injury or the death would not have occurred except for such pre-existing permanent physical impairment. "Permanent physical impairment" means any permanent condition due to previous accident, disease, or congenital condition which is likely to be a hindrance to employment.

Kan. *Employer may file description of prior impairment to create presumption of prior knowledge.

La. **"Permanent partial disability" means any permanent condition due to injury, disease, or congenital causes which is likely to be a hindrance to employment. Certain scheduled conditions are presumed to be permanent partial disability if employer had prior knowledge.

Mich. *Compensation to certified vocationally handicapped persons payable from fund after 52 weeks.

Minn. *If injury, disability or death would not have occurred but for the preexisting impairment, the fund pays all benefits (except for a cardiac condition, impairment of at least 10% of the whole man, or as prescribed by rule).

Nev. *Pre-existing disability must support a rating of 12% or more of the whole man based on A.M.A. guides, which is likely to be a hindrance to employment.
**Fund is composed of assessments, penalties, bonds, securities, and all other property collected by administrator, Division of Industrial Insurance Regulation.

CHART XIII ☐ SECOND-INJURY FUNDS ☐ January 1, 1992 (continued)

JURISDICTION	INJURIES COVERED	PAYABLE BY EMPLOYER	PAYABLE BY FUND	SOURCE OF FUND	SPECIAL PROVISIONS
NEW MEXICO	Second injury which added to pre-existing disability results in permanent disability greater than from second injury alone; or, second injury resulting in death.	Liability apportioned by Workers' Compensation Administration determination.	Liability apportioned by Workers' Compensation Administration determination.	$1,000 in no-dependency death cases. Employer or insurer pays quarterly assessment up to 3% of compensation paid during quarter, exclusive of attorney's fees.	Employers and insurers have 2 year statute of limitations, from date of notice or knowledge of claim, for claims against the fund.
NEW YORK	Second injury where employee had a pre-existing physical impairment or where employee incurred a subsequent compensable injury or occupational disease at work.	Benefits for first 104 weeks.	Employer reimbursed after first 104 weeks. Fund also pays any additional benefits due to an employee who was working in concurrent employments when injured.	Assessment against carriers and self-insurers proportional to compensation payments made by all carriers.	Employer or insurer pays awards and medical expenses, but is reimbursed from special disability fund for benefits after first 104 weeks.
NORTH CAROLINA	Second injury involving loss of member or eye which added to pre-existing injury results in permanent total disability, provided the original and increased disability were each 20% of the entire member.*	Disability caused by second injury.	Difference between compensation payable for second injury and permanent total disability.	Assessments against employer or insurer for each permanent partial disability, up to $50 for a minor member and $200 for a major member (currently $25 and $100, respectively).	
NORTH DAKOTA	Second injury or aggravation of any previous injury or condition which results in further disability.	Disability caused by second injury.	Percent attributable to aggravation or second injury.	Benefit Fund.	Compensation in excess of amount chargeable to second injury is charged to general fund. Prior registration into the fund is not required or accepted.
OHIO	Second injury which aggravates pre-existing disease or condition (25 types of handicaps as listed by statute), resulting in death, temporary or permanent total disability, and disability compensable under a special schedule.*	Disability attributable to injury or occupational disease sustained in employment.	Amount of disability or proportion of cost of death award determined by Industrial Commission to be attributable to employee's pre-existing disability.	Reserve set aside out of statutory surplus funds.	In the case of a self-insuring employer, excess payments are made from the surplus fund, though self-insuring employers may opt not to participate in the handicap reimbursement fund. By rule of Commission in the case of State Fund employer, compensation in excess of amount chargeable to second injury is charged to surplus fund.
OKLAHOMA	Second injury to "physically impaired person"* which causes injury to the body as a whole, or to a major member combined with disability to body as a whole. Must exceed 17% to body as a whole.	Disability caused by latest injury.	Difference between compensation payable for prior injuries and compensation for combined injuries.	3% of permanent disability losses by carriers, state fund, and self-insurers, and 3% of awards for permanent disability by injured worker.	Permanent total awards are payable by the fund for five years or until 65, whichever is longer.
OREGON	Any new compensable injury sustained by an injured worker within 3 years from the hire date as a Preferred Worker through the reemployment Assistance Reserve.	None	Employers hiring a Preferred Worker are exempt from paying premiums & premium assessments on the worker for 3 years from hire date. Reserve reimburses all claim costs incurred by the worker for any new compensable injury within the 3-year period. Other return-to-work incentives include worksite modification up to $25,000, wage subsidy of 50% up to 6 months, and necessary purchases for obtained employment.	Worker pays 4.25 cents per day and employer pays 2.25 cents per day into Reserve.	Reimbursement from Reserve subject to funds available. Decisions regarding eligibility and extent of assistance not reviewable. Settlement of claim requires Department approval if reimbursement involved.
PENNSYLVANIA	Second injury involving loss or loss of use which added to pre-existing loss or loss of use of member results in permanent total disability.*	Scheduled benefits as a result of second injury.	Remaining compensation due for total disability.	Assessment against carriers and self-insurers proportional to compensation payments.	Payments are made directly by the Department.
PUERTO RICO	Second injury which aggravates or augments any former disability.		Job injury not caused by work accident is compensated in addition to second injury. Compensation for prior job injury is deducted from compensation payable for total disability, except where combined injury results in permanent total disability, which is compensated as such.	Insurance premiums.	The difference between expenditures by the Industrial Commission and the Manager of the State Insurance Fund and their maximum budget allotment are placed in the Reserve Fund for catastrophes except for medical expense surpluses; maximum $1 million.
RHODE ISLAND	Second injury which merges with pre-existing work-related disability resulting in greater disability or death.	Benefits for first 26 weeks.*	Employer reimbursed after first 26 weeks.*	2-3/4% tax on gross premiums collected from insurers and comparable tax on self-insurers, plus $750 in no-dependency death cases; also certain penalties.	Employer must prove knowledge of prior injury unless employee failed to disclose. Tax may be reduced when fund reaches $5 million. Any partially incapacitated employee who returns to work for at least 13 weeks at a rate less than his pre-injury AWW, is entitled to a lump sum after 13 weeks, and weekly benefits thereafter to a sum equal to the difference between current and pre-injury AWW.
SOUTH CAROLINA	Second injury which added to any previous permanent physical impairment results in substantially greater disability or death.	Disability caused by second injury for first 78 weeks' compensation and medical care.	Employer reimbursed for all benefits after 78 weeks, plus 50% of medical payments over $3000 during first 78 weeks.	Pro-rata assessments on carriers and self-insurers based on losses paid. In no-dependency deaths, unpaid benefits to fund.	Employer must prove prior knowledge of impairment or that worker was unaware of impairment.* Any claim against the Fund must be filed with the Fund prior to payment of 78 weeks of benefits.
SOUTH DAKOTA	Second injury which combined with any pre-existing disability, results in additional permanent partial or total disability or death.	Disability caused by second injury.	Difference between compensation payable for second injury and compensation for combined injuries.	Carriers and self-insurers assessed 1% of losses paid during preceding year and $500 in no-dependency death cases.	Payments suspended at $200,000, and resumed at $100,000. Any claim against the Fund must be filed with the Division of Insurance within 2 years of the subsequent injury.
TENNESSEE	Second injury involving loss or loss of use of member or eye, which added to pre-existing loss or loss of use of member results in permanent total disability.*	Disability caused by second injury.	Benefits in excess of 100% total disability to body as a whole.	50% of revenues from the 4% premium tax on insurers and self-insurers.	
TEXAS	Subsequent compensable injury combined with the effects of a previous injury entitles employee to life- time income benefits.	Benefits which would accrue if only the subsequent and not the previous injury had occurred.	Balance of lifetime income benefits due.	Maximum $150,424* payable into fund in each no-dependency death case.	The Workers' Compensation Commission has right of subrogation to recover claims and attorney's fees paid from Second Injury Funds.
UTAH	Second injury which combined with a previous permanent incapacity due to accident, disease, or congenital condition results in permanent total disability.	Employer pays first 6 years of PT unless there is a 10% pre-existing condition, then employer pays first $20,000 of medical benefits and first 3 years of PT.	50% of medical expenses in excess of $20,000 and permanent total disability compensation after initial 3 year period.	Up to 7.25% tax on insurers and self-insurers.	If employee is permanently and totally disabled, employer or insurance carrier credited for all prior payments of temporary total, temporary partial and permanent partial disability compensation.

N.C. *Epilepsy is considered a prior permanent disability.

Ohio *Does not apply to compensation for temporary partial or percentage of permanent partial disability.

Okla. *"Physically impaired person" is one who, by accident, disease, birth, military action, or any other cause, has suffered the loss of sight of one eye, the loss by amputation of the whole or a part of, or loss of use of, a major member of his body.

Pa. *Benefits under the Subsequent Injury provision are only payable with respect to subsequent loss or loss of use of one hand, one arm, one foot, one leg or one eye.

R.I. *For claims filed after 9/1/90. Employer reimbursed after first 52 weeks for injuries between 5/18/85 and 8/31/90; and before 5/18/85, after 104 weeks.

S.C. *"Permanent physical impairment" means any permanent condition due to injury, disease, or congenital causes which is likely to be a hindrance to employment. Certain scheduled conditions are presumed to be permanent physical impairment if employer had prior knowledge.

Tenn. *Also covers death or disablement resulting from injuries of an epileptic seizure occurring on or after 7/1/85.

Texas *360 times maximum weekly benefit.

CHART XIII☐ SECOND-INJURY FUNDS☐ January 1, 1992(continued)

JURISDICTION	INJURIES COVERED	PAYABLE BY EMPLOYER	PAYABLE BY FUND	SOURCE OF FUND	SPECIAL PROVISIONS
VERMONT	Second injury involving loss of use of member or eye which added to previous disability results in permanent total disability.	Disability caused by second injury.	Difference between compensation payable for second injury and permanent total disability.	$500 in no-dependency death cases.	Payments suspended until sufficient funds become available.
VIRGIN ISLANDS	Second injury which combined with prior impairment results in death or compensable disability greater than from second injury alone.	None. Employer's experience rating affected by disability payments after 104 weeks.	All benefits	Premiums paid by employers by classification and experience, plus fines, penalties, and interest.	Employer must have prior knowledge of disability.
VIRGINIA	Second injury involving 20% loss or loss of use of member or eye which added to pre-existing disability of 20% or more results in total or partial disability.	Disability caused by second injury.	Employer reimbursed for compensation after all other compensation has expired plus up to $7,500 each for medical and vocational rehabilitation expenses.	1/4% premium tax on carriers and self-insurers.	Payments suspended at $250,000, and resumed at $125,000.
WASHINGTON	Second injury or disease which added to pre-existing injury or disease results in permanent total disability or death.	Disability caused by second injury.	Difference between charge assessed against employer at time of second injury and total pension reserve.	Transfer of not more than cost from accident fund to second injury account. Self-insurers pay proportional to claims against self-insurers.	Preferred workers* have all benefits for claims arising within 3 years of new employment paid Second Injury Fund.
WEST VIRGINIA	Second injury which combined with a definitely ascertainable physical impairment caused by prior injury results in permanent total disability.	Disability caused by second injury.	Remainder of the compensation that would be due for permanent total disability.	Self-insureds in deep shaft mining pay 22% of the manual rate; all other self-insureds pay 17%.	Self-insured employer who has elected not to pay into the fund liable for full compensation of permanent total disability from combined effect of a previous injury and a second injury.
WISCONSIN	Second injury with permanent disability for 200 weeks or more with a pre-existing disability of an equal degree or greater.	Disability caused by second injury.	Disability caused by lesser of 2 injuries. If the combined disabilities result in permanent total disability, fund pays the difference between compensation payable for second injury and permanent total disability.	$5,000 in death cases, $7,000 for loss of a hand, arm, foot, leg, or eye. 100% of death benefit in no-dependency death cases.	
WYOMING	Not applicable				
LONGSHORE ACT	Second injury resulting in permanent partial disability which added to pre-existing injury results in permanent total disability.	Disability caused by second injury for first 104 weeks.	Balance of compensation after 104 weeks.	$5,000 in no-dependency death cases or unpaid awards. Pro-rata assessments based on losses paid. Fines and penalties.	
ALBERTA	No specific statutory provision*				
BRITISH COLUMBIA	All enhanced disabilities by reason of a pre-existing disease, condition or disability.	No	Yes	Accident Fund	
MANITOBA	Cost relief fund includes pre-existing conditions, occupational diseases with exposure outside Manitoba, loss of earnings from an employment other than worker's employer and some increase in benefits due to recurrences or age or apprenticeship of worker.	No	Yes	Accident Fund	
NEW BRUNSWICK	Second injury coupled with other prior injuries or disabilities.	No	Yes	Reserve Fund	
NEWFOUNDLAND	All enhanced disabilities because of similar or other disabilities.	No	Difference between compensation payable for second injury and final result of disablement.	Reserve Fund	
NOVA SCOTIA	Injury that aggravates, activates, or accelerates a disease or disability existing prior to the injury; or injury that results in injury or disease caused partly by employment and partly by other causes.	No	Disability attributable to second injury.	Accident Fund	Board has authority to establish second injury fund.
NORTHWEST TERRITORIES	All disabilities due to pre-existing disease, condition or disability.	No	Difference between second injury and total cost.	Accident Fund	
ONTARIO	All enhanced disabilities due to pre-existing diseases, condition, or disability.	No	Difference between second injury and total cost.	Accident Fund	Not restricted to permanent disability cases.
PRINCE EDWARD ISLAND	No specific statutory provision				
QUEBEC	In the case of a worker already handicapped when his employment injury appears, the Commission may impute all or part of the cost of the benefits to the employers of all the units.			Commission has authority to establish second injury fund.	
SASKATCHEWAN	All enhanced disabilities due to preexisting disease, condition, or disability.	No	Difference between second injury and total cost.	Injury Fund	
YUKON TERRITORY	All enhanced disabilities because of similar or other disabilities.	No	Yes	Compensation Reserve Fund for enhanced disabilities. Assessment on employers' annual payroll.	
CANADIAN MERCHANT SEAMEN'S ACT	No specific statutory provision				

Wash. *Defined as workers who must change jobs due to effect of an industrial injury or illness.

Alta. *Board has established reserve funds to cover enhanced disability or aggravation of previous condition.

APPENDIX C

Additional Information on Selected Types of Injuries and Their Causes

The tables on the following two pages provide additional information on the most common types of injuries, the most expensive types of injuries on a per-claim basis, and the injuries exhibiting the biggest increase in average costs between 1989 and 1992. Similar information is presented for the causes of those injuries.

The data came from our review of Workers' Compensation Fund claims closed in 1989 and in 1992. The 1992 data contain all claims closed in that year; the 1989 data contains about 70 percent of the claims closed in that year.

Selected Injury Information for 1989 and 1992 Closed Cases

	Number in Our 1989 Sample (a)	Percent of Total	Number in Our 1992 Sample	Percent of Total	1989 Average Cost	1992 Average Cost	Percentage Cost Increase
Top Five Injuries as a Percentage of the 1992 Total:							
MULTIPLE INJURIES	112	10.80%	690	33.24%	$12,256	$16,626	36%
BACK INJURIES	302	29.12%	619	29.82%	$15,113	$16,772	11%
MULTIPLE UPPER EXTREMITIES	14	1.35%	150	7.23%	$6,875	$10,154	48%
NO EXPLANATION	306	29.51%	127	6.12%	$15,071	$16,344	8%
KNEE	44	4.24%	121	5.83%	$10,159	$10,974	8%
Top 10 Most Expensive Injuries (based on 1992 average cost):							
CIRC. SYSTEM[STROKE]	0	0.00%	5	0.24%	$0	$28,811	--
EYES	4	0.39%	2	0.10%	$12,061	$21,063	75%
MISCELLANEOUS	3	0.29%	5	0.24%	$15,365	$18,855	23%
BODY PARTS not elsewhere classified	100	9.64%	12	0.58%	$14,964	$17,851	19%
BACK INJURIES	302	29.12%	619	29.82%	$15,113	$16,772	11%
MULTIPLE INJURIES	112	10.80%	690	33.24%	$12,256	$16,626	36%
NO EXPLANATION	306	29.51%	127	6.12%	$15,071	$16,344	8%
HIPS	5	0.48%	9	0.43%	$4,743	$15,117	219%
NECK	5	0.48%	8	0.39%	$14,006	$14,763	5%
SHOULDER	35	3.38%	75	3.61%	$11,852	$14,435	22%
Top Seven Percentage Increases in Average Cost, 1989-1992:							
HIPS	5	0.48%	9	0.43%	$4,743	$15,117	219%
FOREARM	4	0.39%	12	0.58%	$1,983	$6,014	203%
ABDOMEN	4	0.39%	12	0.58%	$2,538	$6,894	172%
THUMB	3	0.29%	6	0.29%	$3,729	$8,863	138%
ELBOW	5	0.48%	7	0.34%	$5,442	$10,068	85%
EYES	4	0.39%	2	0.10%	$12,061	$21,063	75%
TRUNK/BUTTOCKS	4	0.39%	14	0.67%	$8,356	$14,120	69%

(a) Our 1989 sample consisted of about 70 percent of all 1989 closed claims; the 1992 group contained all claims closed in that year.

Selected Cause Information for 1989 and 1992 Closed Cases

	Number in Our 1989 Sample (a)	Percent of Total	Number in Our 1992 Sample	Percent of Total	1989 Average Cost	1992 Average Cost	Percentage Cost Increase
Top Five Causes as a Percentage of the 1992 Total:							
LIFTING OBJECTS	236	22.76%	512	24.66%	$13,768	$15,576	13%
NO EXPLANATION	370	35.68%	322	15.51%	$14,786	$16,562	12%
FALL, SAME LEVEL	92	8.87%	203	9.78%	$14,243	$13,718	-4%
BODILY REACTION	102	9.84%	129	6.21%	$12,809	$15,270	19%
REPEATED MOTION	25	2.41%	117	5.64%	$12,912	$10,728	-17%
Top 10 Most Expensive Causes (based on 1992 average cost):							
MOTOR VEHICLE (non-collision)	4	0.39%	6	0.29%	$12,039	$24,679	105%
FALL, LOWER LEVEL	33	3.18%	78	3.76%	$11,010	$18,264	66%
FALL, ONTO/AGAINST	9	0.87%	29	1.40%	$20,875	$17,537	-16%
NO EXPLANATION	370	35.68%	322	15.51%	$14,786	$16,562	12%
WIELDING, THROWING, HOLDING, or CARRYING	7	0.68%	44	2.12%	$4,520	$16,446	264%
PUSHING/PULLING	34	3.28%	98	4.72%	$8,631	$15,993	85%
STRUCK/STEPPED ON	14	1.35%	61	2.94%	$17,809	$15,712	-12%
FALL ON STAIRS	11	1.06%	20	0.96%	$10,344	$15,618	51%
LIFTING OBJECTS	236	22.76%	512	24.66%	$13,768	$15,576	13%
BODILY REACTION	102	9.84%	129	6.21%	$12,809	$15,270	19%
Top Four Percentage Increases in Average Cost, 1989-1992:							
MULTIPLE CAUSES	2	0.19%	83	4.00%	$3,385	$13,572	301%
WIELDING, THROWING, HOLDING, or CARRYING	7	0.68%	44	2.12%	$4,520	$16,446	264%
NOISE EXPOSURE	2	0.19%	4	0.19%	$3,211	$7,584	136%
MOTOR VEHICLE (non-collision)	4	0.39%	6	0.29%	$12,039	$24,679	105%

(a) Our 1989 sample consisted of about 70 percent of all 1989 closed claims; the 1992 group contained all claims closed in that year.

Appendix D

Agency Responses

On November 12, we provided copies of the draft audit report to the Kansas Insurance Department and the Department of Human Resources. The agencies' written responses are included as this Appendix. In response to comments made by the two agencies we made a number of changes to improve the accuracy and clarity of the audit report.

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

RON TODD
Commissioner

November 18, 1992

Ms. Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
Merchants Bank Tower
800 S.W. Jackson, Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

We appreciate having the opportunity to review the draft copy of your performance audit report, Examining Increases in the Expenditures from the State Workers' Compensation Fund. Before addressing your recommendations, we would like to make some general comments concerning the report.

In the first few pages of the report in which you present the background of the Workers' Compensation Fund it might benefit your readers to know that in 1974 when the responsibilities of the Fund were expanded and it was transferred to the Insurance Department all payments were ultimately funded from the state general fund. It was not until 1982 when Fund expenditures began to rapidly increase that the legislature capped the state general fund's contribution to $4 million per year. In recent years, as you indicated in your report, the Workers' Compensation Fund has had to repay the $4 million annual entitlement to the general fund, meaning that for the present time all claim payments and related expenditures are being funded entirely from assessments on insurance companies and self-insurers which, of course, means Kansas employers are bearing the cost.

With regard to your discussion on page 9 concerning the cumulative effect of large increases in new claims against the Workers' Compensation Fund, we would like to more clearly explain our procedures for closing inactive files. Once a year, we send a listing to all attorneys appointed to defend the Workers' Compensation Fund indicating the active claims they have been assigned. We ask them to compare their records against ours and advise us of any files they have closed. When we receive either our listing back or a letter from the attorney indicating which files have been closed we then adjust our records accordingly. Although the time constraints of this audit did not allow you to

thoroughly review this process, we would be glad to verify our procedures with you at your convenience.

We would also like to bring to your attention an inaccurate statement appearing on page 15 of the report pertaining to vocational rehabilitation. Your report incorrectly states, "The amount of time an individual receives vocational rehabilitation is not counted as part of the 415 week maximum disability period so an individual may extend their benefits by as much as 18 months." We recommend that you change this sentence to read, "The amount of time an individual receives temporary total or temporary partial disability payments paid by virtue of vocational rehabilitation is not deducted in the calculation of permanent disability compensation under K.S.A. 44-510d (scheduled injuries), up to a maximum of 26 weeks."

Additionally, we wish to clarify a comment appearing on page 28 of the report in the section pertaining to previous audit recommendations. In this section you mention that the financial audits for 1988 through 1992 made several recommendations for the Insurance Department, all of which appeared to have been complied with. Although this remark is technically true we believe it might be misleading. While the financial auditors did make four recommendations for FY 1989, to our knowledge those are the only recommendations made for our department during the past ten years. Since we pride ourselves on the strong internal controls and accounting procedures we maintain, we do not want readers of the report to think that financial audit recommendations are routinely made for our department.

Throughout the report and in your recommendation number 1, you suggest that the Insurance Department and the Division of Workers' Compensation work together to develop a database that would provide the legislature with the types of information needed to make well informed decisions about workers' compensation. While we would be more than willing to establish any type of data base the legislature sees fit, we wish to remind you that claims involving the Workers' Compensation Fund represent an extremely small number of the total workers' compensation claims filed in Kansas. If your goal is to provide the legislature with information it needs to control overall workers' compensation costs in Kansas, we believe that is a function of the workers' compensation system as a whole and not limited to the Workers' Compensation Fund.

In your recommendation 2.b., you suggest the Insurance Department review all cases to determine whether attorney fees could be recouped under K.S.A. 44-566(a)(f), and pursue those cases where it

would be cost effective to do so. This recommendation was apparently based on discussions that you had with our office, as noted on page 31, in which you understood that we do not exercise our right to recover attorney fees in cases where there is no Fund liability. This latter situation is true only if the respondent dismisses the Workers' Compensation Fund when it becomes obvious there is no Fund liability. In those situations where this is not the case, the Workers' Compensation Fund does file a motion requesting the administrative law judge to order payment of the Fund's attorney fees. Although we currently attempt to recoup attorney fees as you recommend, our motion is seldom granted. Incidentally, in your discussion of this subject on page 31 the term, "potential claimants", should be changed to "respondents".

In your final recommendation you state the Insurance Department should modify the basis for making its annual assessment to finance the Workers' Compensation Fund by assessing insurance companies and self-insurers according to their actual usage of their Fund. As you discussed on page 5 of the report the annual assessment for each company and self-insurer is presently based on their previous year's workers' compensation insurance claim losses as required by K.S.A. 44-566a. Consequently, before we can change the basis for the assessment, the legislature will need to amend The Workers' Compensation Act. Please note, however, that we do not support this recommendation since it would effectively penalize employers who hire previously injured or handicapped employees which would, of course, defeat the purpose of the Workers' Compensation Fund.

Again, thank you for allowing us to respond to the draft copy of your report.

Please be assured the legislature will have our complete cooperation in reviewing this matter further and in implementing any administrative enhancements.

Very truly yours,

Ron Todd
Commissioner of Insurance

RT:rkn

Kansas Department of Human Resources

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November 18, 1992

Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Suite 1200
Topeka, KS 66612-2212

Re: Performance Audit: Examining Increases in the Expenditures from the State Workers Compensation Fund

Dear Ms. Hinton:

We have reviewed the above captioned draft report and find a few points that need mentioning.

Two incorrect statements as to provisions of the law occur on page 15 in the left boxed-in area. In the second paragraph there appears the following sentence:

> "The amount of time an individual receives vocational rehabilitation is not counted as part of the 415 week maximum disability period, so an individual may extend their benefits by as much as 18 months."

In all general disability cases (415 week cases) the period of vocational rehabilitation is a part of and not in addition to the 415 weeks.

In that same paragraph there appears the sentence:

> "The claimant can then claim disability based on inability to perform the previous job even though he or she may be able to earn comparable wages in a new field."

The sentence incorrectly states the law. The claim an injured worker would make under

current law is for "inability to perform work in the open labor market", not for "inability to perform the previous job".

An erroneous statement appears on page 12 in the boxed-in area in the third of the three anecdotes. In the third story there is the statement that, "There was no evidence of an accident..."

Our position is simply, if there had been no evidence of an accident, compensation benefits would not have been awarded. Possibly the respondent felt the claim was questionable. Perception of claimant and respondent bias in the system depends on individual commentators and what part of the workers compensation system is under discussion.

There is one area of Second Injury Fund law that was not mentioned in the report but probably deserves comment. In order for an employer to make a claim for a "Second Injury", the employer must prove one of the following bases:

1) The employer filed, prior to the second injury, a form notifying the Director of Workers Compensation that the employer had hired or retained a handicapped employee, or;

2) The employer had knowledge of the pre-existing condition at the time of the hiring or retaining a handicapped employee in their employ, or;

3) The employee, in connection with obtaining employment, made material misrepresentations that the employee had no pre-existing handicap.

It may be useful to know:

1) What percentage of second injury claims against the Fund were based on each of the three catagories.

2) If the percentage of claims against the Fund on the second basis is a significant percentage perhaps the filing required for the first basis is superfluous and should be discontinued. If a showing on the second basis will suffice, the law is causing a needless cost to employers, insurance carriers and the workers compensation director's office in the prepartion, filing and receiving of some 100,000 such filings per year.

Thank you for the opportunity for comment.

Sincerely,

George Gomez
Workers Compensation Director