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Second Injury Funds: Maximizing Your Recovery Results

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Workers compensation claims management has entered a new era. Rapid technological advances in computer software enable claims managers to track information, people, and statistics, and to learn from them as never before. This development provides an unparalleled opportunity for cost savings at a time when costs are rapidly escalating. Sophisticated computer claims-management systems allow claims managers to unbundle, measure, and reengineer various services, targeting the most efficient solution at the lowest cost. The same openness to change that has already been witnessed in other areas of the workers compensation industry needs to be carried over to the second-injury-fund recovery process.

Unfortunately, the management of second-injury-fund recovery has often been the forgotten stepchild throughout this period of change. A lack of focus

and prioritization has resulted in the retention of cumbersome and marginally effective recovery methods, and the consequence is clear: Dollars that rightfully belong to employers and insurers are being left on the table.

Building the Right Solution

A world-class model for second-injury-fund recovery requires that the best ideas and unique tools of two very different disciplines be incorporated. A factory-like process is necessary to handle the second-injury-fund claims that are straightforward and routine, yet the process must also incorporate a *knowledge-management* system that has many of the attributes of a law firm, but with the propensity for administrative resolution rather than litigation.[1] *Knowledge management* refers to the technology used to gather, analyze, and organize information, documents, and human expertise. Use of knowledge management enables standardization of the recovery process and recognition of economies of scale. The process must focus on eliminating error and waste as well as on using the technology to support efficiency. Employees who would thrive using this process must be recruited, trained, and retained. A knowledge-management model must employ a structured problem-solving approach and make targeted use of outstanding vendor partners. It must capture, codify, and share knowledge, using expert databases, settlement tracking, and legal research on common issues. Through education, feedback, and performance evaluation, it can also help to change the behavior of individual claims representatives.

Building the right solution starts with asking the right questions. How can employers and insurers obtain the maximum reduction in the *total cost* of claims? Looking at *total cost* shifts the emphasis from cost of recovery alone or just recovered dollars to the net effect on incurred costs, looking at indemnity, medical, allocated loss adjustment expenses (ALAE), and unallocated loss adjustment expenses (ULAE) as a whole. This difference is sometimes subtle, but enforces an emphasis on integrating the recovery process into an underlying claims-resolution program, while seeking to maximize total cost reduction. This discussion will offer an overview of the concept of the second injury fund, will focus on the potential benefits that a reengineered process can have on total cost, and will discuss the key attributes that contribute to success in a reengineered process.

What are Second Injury Funds?

A second injury fund is a mechanism that historically has been intended to encourage the hiring of impaired workers by reducing financial risk for

employers. It is based on the theory that people with certain underlying conditions are prone to suffer additional injuries. For example, an employee with prior back surgery, heart disease, or carpal tunnel syndrome may pose a greater risk for an additional injury than an employee who has no such condition. An employer might be wary of hiring an employee under those circumstances.

Second injury funds are state-administered funding mechanisms enabled by legislation within each states' workers compensation laws and supported by employer assessments proportionate to losses. While most, but not all, states have some type of second injury fund, material recoveries are available in only about 20 to 25 states. In the broadest sense, the terms of the legislation state that an insurer or self-insured employer is entitled to reimbursement of benefits paid either when the employee's industrial or "second" injury is caused in part by a preexisting impairment or when the resulting disability is extended by the preexisting impairment. In many states, the employer must be able to present evidence demonstrating awareness and knowledge of the prior impairment. Recoveries generally apply to long-term claims and usually do not reimburse the entire cost of the claim. An insurer or self-insured employer obtains the right to reimbursement for the remaining life of the claim after an initial waiting period.

Value Is Being Lost

Because qualified claims are generally long-term in nature, the per-claim value can average as much as $100,000 in some jurisdictions. Consequently, failure to identify each and every opportunity to collect can be costly. Every employer is paying into the system, but the insurance purchased by the assessment all too often goes unused. Employers and insurers frequently fail to realize how much they are leaving behind, because they rarely subject the recovery process to independent scrutiny. "We have it covered" is a common response by claims professionals to an inquiry on this matter.

Only actual file examination will tell the real story, but based on our experience reviewing tens of thousands of claims, it is clear that the opportunities for slippage in current systems exist. Typically, this oversight can represent a loss of 20 percent or more. It is equally clear that losses will continue to occur unless systemic change is instituted. This slippage may occur whether the process is part of a bundled claims service or an unbundled service. We advocate that the first step to addressing this unrealized opportunity needs to be unbundling the service from the day-to-day claims administration process, either by selecting an expert outsourced

vendor or by building dedicated internal recovery resources. Yet, as we will discuss, merely unbundling it is not enough.

Reengineering Works

As previously stated, any "best practices" recovery process needs to incorporate both the features of a factory-service model and a knowledge-management/law-firm model. Software should be used to achieve a continued focus on reducing waste and time in the recovery production cycle. In addition, this software can be used to capture and manage knowledge related to difficult claims, fully leveraging information gleaned from each transaction.

Examples of Success

When software programs are deployed, a dedicated and disciplined process brought to bear, and knowledge managed, dramatic results can occur. For example, prior to outsourcing its New York second-injury-fund function in 1997, one major workers compensation insurer was collecting approximately $600,000 per year in reimbursement. In August of 1997, a complete audit of this insurer's workers compensation files was conducted, and by the end of 1997, more than $700,000 in additional backlogged reimbursement potential had been identified and requested. The insurer subsequently outsourced all second-injury-fund claim identification, investigation, and resolution. Within a year, recoveries increased from $600,000 to $2.2 million. Currently, the insurer's recoveries remain steady between $9 and $10 million annually, with total recoveries since 1997 exceeding $40 million.

The proactive audit features of a knowledge-management system will consistently result in locating money not previously identified. Experienced recovery specialists are often able to find and reconstruct valuable files that have been misplaced or prematurely destroyed. In one instance, a vendor collected more than $3 million for one insurer alone through these efforts. In a Florida case, a vendor was able to uncover an abandoned claim and found a way to resurrect employer knowledge, yielding $1.2 million in reimbursement. Most recently, a self-insured employer admitted, "We thought we had it covered." Shortly after taking the initiative to retain the services of a focused second-injury-fund vendor, the employer received a check for approximately $500,000, calling it "found money." The money was obtained because knowledge garnered from one case was used in a series of other cases to obtain recovery previously not thought possible.

Many successful recoveries can be attributed to a dedicated service aggressively pursuing claims that a nondedicated service would abandon. For example, in one situation an adjuster discouraged an outsourced recovery service from pursuing a file because he had been unable to obtain evidence of employer knowledge of the prior impairment as required by statute. Yet, at $300,000, the claim had a high exposure potential for a second-injury-fund case. The recovery expert was able to obtain evidence of employer knowledge, and successful recovery was achieved. In another instance, the claimant had undergone a prior surgery, but the insurer could not provide any evidence of this surgery that predated the second injury. The claim was denied by the fund. When recovery experts took over the claim, they relentlessly pursued a magnetic resonance imaging (MRI) test taken right after the second surgery. Since they were able to obtain films but no report, they had the MRI films read and, in this manner, were able to establish that the employee had in fact had a laminectomy prior to the second injury. On this basis, the fund accepted the case, which had an initial reimbursement value of approximately $70,000 and a present value of $177,000, based on the life of the claim.

Why Second-Injury-Fund Recoveries Get Left on the Table

Typically, potential beneficiaries do not spend the time or money to improve their second-injury-fund recovery process because they fail to project the full monetary potential of recovery dollars that would more than justify such expenses.

The process of second-injury-fund recovery involves three functions: identification and investigation; negotiation and/or litigation; and reimbursement. At a typical insurer or claims administration service, these functions are performed by at least three different sets of people, often with different priorities and workloads. Inevitably, there is slippage as the claim travels from function to function and is subjected to varying skill levels. When recovery is not a dedicated process, neither the discipline of a factory-like approach nor the discipline of a knowledge-management/law-firm model can be fully enabled. Some of the major reasons why second-injury-fund recoveries get left behind are lack of focus, invalid assumptions, and failure to conduct regular audits.

Lack of Focus, Specialization, and Experience

The job of identifying and investigating second-injury-fund claims has traditionally fallen to claims adjusters, who are often overloaded. They tend

to address the emergency on their desks first and second-injury-fund reimbursement if and when they can get to it. In the process, valuable time is lost. Statutes-of-limitations and filing deadlines are missed; important protective documents are not filed; and critical medical and employment records are lost with the passage of time.

Many potential claim recoveries are overlooked due to lack of training or specialization. Second-injury-fund statutes vary widely by jurisdiction with each having subtleties that require an in-depth knowledge of the system. Critical judicial decisions or changes in the law can alter the roadmap overnight and require a vigilance that cannot be expected of an employee whose main job function has nothing to do with second injury funds. Knowing how to characterize a claim in a manner that succeeds with an individual fund, as well as dedicating the time that is necessary to make it work, can produce recovery on a claim that would otherwise be turned down. Finally, assembling a claim in a professional and organized manner makes it easier and quicker for the fund to agree to honor the claim and for the insurer or employer to be reimbursed.

In the negotiation/litigation function, insurers and employers often rely on defense counsel to make decisions and push claims through the system. Again, the recovery task is corollary to the attorney's primary function, and not likely to get the attention and skill it deserves. Defense counsel often does not know the full value of the claim or have enough direct experience to recognize the potential that can be expected from negotiation. In addition, conflicting interests often stymie progress. For example, a claimant will generally stick to a story that he never had any problems with his back before his work injury in the belief that this will help his claim for benefits. Because of the lack of specialization and focus, the claims become muddied and information is withheld.

The third step — recovery — is often given too little priority despite the fact that it is the reason for the first two steps. The process of tracking the actual receipt of settlements or judgments requires time and dedication and is best done on a systemwide basis rather than by an individual adjuster. Obtaining the reimbursement of ongoing benefits when a settlement or judgment provides for them is even more important. If the case is not in active litigation, this aspect can often be overlooked, and statutes-of-limitations deadlines can be missed.

Invalid Assumptions

There seems to be more misinformation passed around about second

injury funds than just about any other aspect of workers compensation. Some of it is based on history and some on assumptions that are just plain inaccurate.

For example, in one jurisdiction, there was a time when the fund resisted processing claims and a backlog grew, resulting in a delay of several years from the time of filing to the time of adjustment. The notion that the fund would not pay claims prevented many insurers and employers from filing claims in a timely manner to preserve their rights. Furthermore, insurers and employers often relinquished the right to work with the fund to do what it was required by law to do: process and pay qualified claims. Even after the backlog was resolved and claims processing back on track, the rumor persisted, and years of recovery opportunities were lost for many potential beneficiaries.

Without a specialized skill set, the employee charged with identifying and processing claims will often fail to "think outside the box" and to challenge the fund on the notion of what constitutes a qualifying claim. A fund may create its own internal rules about what it requires, but that does not mean that these rules will be upheld when challenged in litigation. Assuming that a fund is always right in interpreting the statute is giving away money.

Insurers and employers also often underestimate what they are losing. We estimate that a well-run, traditional bundled approach to second-injury-fund recovery may capture only 80 percent of potential opportunities. Out of the 80 percent that is captured, 10 percent to 15 percent of these claims typically have not been processed properly or in a timely manner. Let's do the math: That means that at least 20 in 100 files may be missed and another 8 to 12 may not be fully collectable (10 percent to 15 percent of the 80 captured files). At an average of as much as $100,000 per file in some jurisdictions, the loss on these 100 files can represent a potential of up to $1 million in unrecognized recovery and $800,000 to $1.2 million that may not be fully collectible due to improper handling. Lost or delayed recovery always leads to increased total cost.

Failure to Conduct Regular Audits

Even though a claim may not show evidence of a prior impairment when it is first opened, or at the moment when a second-injury-fund checklist is applied, it does not mean that the claim will never qualify for recovery. Such evidence often comes to light only during a later independent medical examination (IME) or a subsequent investigation. But by that time, the

focus is no longer on second-injury-fund claims, and the opportunity can be missed. By regularly auditing both new and old claims for recovery potential, an insurer can capture dollars that would otherwise be lost. Nondedicated in-house resources rarely have the time or expertise to conduct dedicated audits for this purpose.

Measuring Your Success

One of the results of lack of focus is that insurers and employers generally do not know how successful they are at capturing available money. Generally, no internal standards exist, and no effort is made to find out average recovery statistics.

Each year, an estimated $800 million is paid out on second-injury-fund claims, with an estimated $100 million added annually in new claims. In addition, we estimate that there is a "clean up" potential of $1 billion nationally, most of which resides in key jurisdictions such as Alaska, Georgia, Louisiana, Massachusetts, Nevada, New Hampshire, New York, South Carolina, and Washington D.C.

Given this potential, it is worth your while to conduct an internal recovery audit. A quick test of 150 files should determine whether you are maximizing your recovery potential from every file. Some outsourced services will offer an initial recovery assessment at little or no cost.

Recovery opportunities and statutes for each jurisdiction vary significantly. Our experience shows that in some jurisdictions and specific years of recovery, the average recovery per million dollars of losses could range from 5 percent to 7 percent. Opportunity exists, and systems can be implemented to maximize and capitalize on this opportunity.

How to Increase Your Success

As a risk manager or claims manager, ask the following questions of those in charge of recovery:

- Has the recovery potential been evaluated and recovery goals established?

- Is the recovery operation bundled or unbundled? If it is bundled, does the necessary expertise exist? Are the necessary staff, systems, and disciplines in place to achieve success?

- Is there a proactive audit function that backs up identification by

claims personnel? Does the identification process combine both knowledge management and human expertise?

- Is there a specialized production unit responsible for and rewarded for managing the whole process to success? Are the producers rewarded for the tasks they can accomplish that will drive success?

- Does the system give you the information you need to measure success? Is expected recovery measured? Is actual recovery measured? Is the future value of the recovery of the tail of a long-term claim measured?

- Are the right systems in place? Is there a quality-control audit system? A knowledge-management system? A litigation-management system? A collection-and-reimbursement system?

- How and when is the recovery opportunity used to resolve claims?

Increasing Your Success by Utilizing an Unbundled Service for Your Recovery

One of the most important questions you face is whether your second-injury-fund recovery process should be bundled or unbundled. You will need to decide whether you will develop or retain a dedicated unit that focuses exclusively on second-injury-fund recoveries, or whether you will accept a bundled service as part of your claims administration. The distinction between bundled services and unbundled services is critical, and your decision might hinge on your claim volume and the recovery potential. If your claim volume and average cost per claim is low, a bundled service may suffice. On the other hand, you may want to consider having an expert vendor as a referral asset for the bundled process. Before making a decision, the recovery potential should be assessed.

It is tempting to view bundled servicing units as more cost effective because the associated expense can be spread out among existing resources. In reality, the systemic problems associated with a bundled recovery process can lead to a much greater total cost.

The prerequisite for success is a focused, proactive, process-engineered system that approaches recovery with dedication, efficiency, and expertise. Unfortunately, many insurers and self-insured employers are unwilling or

unable to make the financial and management commitment to develop such a highly specialized, dedicated unit.

There are many advantages to using the unbundled approach. Highly trained lawyers/claims professionals can mine all opportunities. Focused producers have statute-of-limitations diaries and ensure that notice is complete and accurate. They are also trained investigative specialists who work with medical experts to produce a complete opinion. Claims are assembled into a petition in which all data are present to achieve immediate resolution. The process should create a better than 85 percent success rate at the first resolution attempt. Negotiators know all the issues, practices, and procedures and have access to a national database to apply to special cases. Producers are measured not only by the quality of their work but also by early resolution. Each action step is taken at the earliest possible time. A bonus to resolution of the second-injury-fund claim is that it often leads to the early resolution of the underlying claim. Using such an unbundled approach results in a significantly higher net rate of recovery and lower total cost.

Cooperate With Your Service

Finally, once a dedicated recovery service is selected or developed, providing the servicing unit with all relevant claim information in a timely manner will maximize success. Train claims adjusters to recognize the criteria for second-injury-fund recovery and to bring these cases to the attention of the service provider as early as possible. Employers also need to make sure their hiring process includes the development of information that will sustain a claim without violating the Americans with Disabilities Act (ADA) requirements. Physicians who conduct IMEs and investigators who conduct interviews must be directed to ask the right questions. The process is a cooperative one, and everyone involved in the claim process should be responsible for maximizing the results.

Maximize the Opportunities

Experience shows that reengineering the recovery process to include the best practices we've discussed will provide an impressive return on investment (ROI). Generally, at least a 30 percent ROI can be expected, and often the ROI can yield as much as 100 percent or greater. If working with a servicing vendor, you may also be able to mitigate the marginal risk of increased cost by obtaining a contingent fee agreement, either on a contingency of what is collected or on a gain-sharing basis. In light of these

probabilities, what would you suggest your claims manager do? Avoid any further cost or reengineer for success?

Second injury funds are there for the purpose of reimbursing eligible insurers and employers. Employers that don't ask for this money won't get it, but they will continue to finance the fund regardless, paying for others to get paid. Your reimbursement is not guaranteed until it is awarded or negotiated and collected in a timely manner. If your quick audit showed that you are not maximizing your opportunities, reengineering may be in order. Flexible thinking and focusing on total cost savings can get you every dollar that is rightly yours.

Endnotes

1. Mendelson, Simon, and Ellen Shumway, "Working Both Sides of the House," *Best's Review* (July 2003).

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