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focus REPORT

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Proposals to Change Workers' Compensation

Following a significant overhaul in the late 1980s and further revisions enacted in 2001, the Texas Legislature is poised to revisit the issue of workers' compensation during the 79th regular legislative session. Employers say return-to-work rates by injured employees are too low, workers say the system denies them the benefits they deserve, and doctors say it is simply too costly to take on workers' compensation patients. The one thing they all agree on is that the workers' compensation system needs to be changed.

Current proposals focus mainly on changes in three areas: regulatory structure, health care delivery system, and rates reduction. Both the Sunset Advisory Commission and SB 5 by Staples, which incorporates the recommendations of the Senate Select Interim Committee on Workers' Compensation, would eliminate the Texas Workers' Compensation Commission (TWCC), although the former would transfer its duties to the Texas Department of Insurance (TDI) and the latter would create a stand-alone agency with a single commissioner. Other plans for systemic change include the development of a network system of health care providers designed to resemble group health insurance networks. The Senate select interim committee also examined the issue of escalating rates for workers' compensation insurance.

This report examines the leading proposals before the 79th Texas Legislature that are designed to change the workers' compensation system.

Workers' compensation in depth

Workers' compensation is a no-fault, state-supervised system established under the Workers' Compensation Act (Labor Code, Title 5, subtitle A) to pay the medical expenses of employees who are injured on the job and to compensate them for lost earnings. Employers who carry workers' compensation insurance get protection from unlimited legal liability for employees' on-the-job injuries, and workers receive timely compensation without having to sue their employers.

Protection for employees. Eligible employees who seek benefits following an on-the-job injury have certain rights and obligations under the Workers' Compensation Act. In order to file a claim, an employee must report a work-related injury or illness to the employer within 30 days of the incident, or within 30 days of learning that the health problem is related to work. Also, within one year, the employee must file a notice with TWCC that contains general information about the injury and claim, including a description of the circumstances surrounding the injury or illness, lost salary and wages, and the name of the treating doctor.

Under the current system, an injured employee who wishes to file a claim must select a primary care provider (also known as a "treating doctor") from TWCC's Approved Doctors' List (ADL). Once the worker has chosen a treating doctor, however, changing doctors requires approval from the commission. Health care providers are prohibited from billing an injured employee directly for medical care related to an on-the-job injury, and injured employees are not required to pay copayments or deductibles in order to receive medical care. Under an approved claim, medical benefits include all treatment deemed reasonable and necessary by the patient's doctor and the insurance carrier. Injured workers also may be eligible for income benefits (see *Income benefits under Texas' workers' compensation system*, page 4).

The family of an employee whose compensable injury resulted in death is eligible for burial and death benefits through the workers' compensation system. The death benefit equals 75 percent of the worker's salary and is payable to a dependent spouse or child up to certain time restrictions. The family of a worker who is killed on the job retains the right to sue the employer if the death was the result of gross negligence.

While the system is designed to protect and compensate injured employees regardless of their personal negligence, in a few instances workers' compensation insurance would not cover an employee's injury. These include cases when an employee was injured while in a state of intoxication, during horseplay, or participating in a voluntary recreational, social, or athletic activity that was not part of the employee's duties. Also not covered are injuries caused by an employee's willful attempt to harm himself or another employee, injuries caused for personal reasons by a non-employee, or injuries caused by acts of God, such as hurricanes or earthquakes.

Protection for employers. Just as the system compensates workers for injuries regardless of negligence, it protects employers from lawsuits over employer negligence. While participation is optional in Texas, employers have a significant incentive to carry workers' compensation insurance because only those who participate may invoke common-law defenses against charges of negligence by an injured employee (see *Common-law defenses and workers' compensation*, page 5). The liability of employers without workers' compensation insurance also is not limited by the statutory caps on compensation payments that protect insured employers.

Employers who want to carry workers' compensation insurance have several options, including:

- purchasing an individual policy from a commercial insurance carrier licensed to write workers'compensation insurance in the state of Texas or from the insurer of last resort;
- purchasing, with TDI's approval, a group policy with other employers in a similar line of business;
- becoming, with TWCC's approval, a certified self-insured employer; or
- self-insuring, with TDI's approval, as a group together with other employers in a similar line of business.

According to TDI, more than 200 insurance carriers, which translate into about 80 insurance groups, currently write workers' compensation policies in Texas. The four largest workers' compensation insurance groups account for about 50 percent of the direct written premium in Texas. Texas Mutual Insurance Company, the state's insurer of last resort and the state's largest writer of competitive policies, alone accounts for over 25 percent of the workers' compensation premium in Texas. Established by the 72nd Legislature in 1991 and initially funded with bonds issued by the Texas Public Finance Authority, Texas Mutual (formerly known as the Texas Workers' Compensation Insurance Fund) was converted into a domestic mutual insurance company in 2001 by the 77th Legislature, which protected its assets from appropriation by the state.

Under Texas law, employers are not required to hold open an employee's job after an injury occurs, although many are subject to the federal Family Medical Leave Act, which requires employers of a certain size to provide leave for up to 12 weeks because of certain debilitating, serious

A brief history of workers' compensation in Texas

Texas workers' compensation statutes first were enacted in 1913 and have been amended many times since. The most recent overhaul of the system occurred during the second called session of the 71st Legislature in 1989. That legislation created TWCC to replace the former Industrial Accident Board; prohibited the use of compromised settlement agreements; and established the current administrative income and medical dispute resolution and ombudsman programs, which eliminated many appeals to district courts; established the Approved Doctor List (ADL); and changed the way certain types of income benefits are calculated (e.g., permanent partial benefits), breaking with the distinction between loss of use and loss of earning capacity. Prior to this legislation, Texas law assigned values for injuries to each part of the body. For example, loss of total sight in one eye was worth 100 weeks of income benefits, whereas total loss of a thumb was worth only 60 weeks.

At that time, in response to concerns about cases with dubious merit and lawyers representing injured workers for high fees, lawmakers acted to remove much of the dispute resolution process from courts to the agency. The current dispute resolution process is a legacy of this legislation. Because injured workers were losing opportunities to take their cases to court, lawmakers built within TWCC a dispute resolution process with many layers of appeals and review.

In 2001, the 77th Legislature enacted HB 2600 by Brimer to address high medical costs and insurance premiums in the workers' compensation system. To curb rising medical costs due to overutilization, the legislation gave TWCC additional authority to review and sanction doctors on the ADL, required doctors to register and receive workers' compensation training to be on the ADL, and authorized the state to conduct a feasibility study on the possibility of establishing regional networks of physicians, and if feasible, begin implementing regional networks. While a TWCC workgroup – the Health Network Advisory Committee (HNAC) – did study the feasibility of networks, the initiative never was implemented. The advisory committee published a feasibility study in which it evaluated many aspects of networks, representing the views of both employers and labor that were members of the committee. The committee's network recommendation was different, however, from current proposals (see *Networks of doctors for medical care*, page 14) in that it would have made network participation voluntary for the employee.

HB 2600 also required the agency to adopt the reimbursement methodology used by the federal Centers for Medicare and Medicaid Services and to address pharmaceutical dispensing. In response, TWCC adopted a rule that requires generic substitution, unless a brand specifically is requested by the physician. In addition, the legislation simplified the medical dispute process by requiring a review of medical necessity by an Independent Review Organization (IRO) instead of TWCC. IROs are TDI-certified third-party panels of health care providers that are qualified to review cases and ascertain the veracity of a treating doctor's assertion that a procedure was medically necessary.

The legislation also changed the system for workers and employers. It specified that injured workers with multiple jobs must have their income benefits calculated on all their wages, not only on wages from the job that resulted in the injury, and prohibited liability waivers for employees who work for employers that do not carry workers' compensation insurance. It also promoted "return-to-work" in the system and required insurers to provide return-to-work coordination services to employers.

health conditions. However, many companies also have established programs that permit employees to return to work when they are medically able. Return-to-work programs, established in-house, usually involve light-duty or modified work for the injured employee. They permit companies to take advantage of employees' experience and reduce the amount of productivity lost while an employee is recovering from an injury. An employee who refuses a bona fide offer to return to work with modifications following a doctor's approval may face a termination or reduction in income benefits.

Income benefits under Texas' workers' compensation system

In addition to medical benefits, injured workers also may be eligible for income benefits to replace lost wages. Income benefits are broken into four categories by TWCC:

Temporary Income Benefits (TIBs) are paid during a period of temporary disability (i.e., time away from work) while the worker is recovering from an on-the-job injury. TIBs are paid at a rate equal to 70 percent of the difference between a worker's average weekly wage prior to the injury and the worker's average weekly wage after the injury. They are available to workers whose illness or injury causes more than seven days of missed work. TIBs end when the patient reaches maximum medical improvement (a date assigned by a doctor signifying that the worker is not expected to significantly recover any further), when the patient's income returns to the pre-injury level, or when the worker reaches statutory maximum medical improvement (104 weeks from the date that benefits begin to accrue).

Impairment Income Benefits (IIBs), which equal 70 percent of the worker's average weekly wage, are available if the worker has a permanent impairment. An injured worker becomes eligible for impairment income benefits the day after reaching maximum medical improvement. Benefits end after the worker has received three weeks of payments for each percentage point of impairment rating, a numerical representation of how much of the worker's body is injured or impaired. Impairment ratings are assigned by the injured worker's treating doctor, TWCC's designated doctor, or in some cases, the insurance carrier's doctor using the American Medical Association's Guides to the Evaluation of Permanent Impairment, fourth edition. For example, an impairment rating of 6 percent would translate into 18 weeks of benefits. Impairment income benefits also may be offered as a lump-sum payment.

Supplemental Income Benefits (SIBs) are available if the worker's injury meets a stricter standard. To be eligible, the injured worker must have an impairment rating of 15 percent or greater. In addition, the worker either must not have returned to work or must be earning less than 80 percent of the pre-injury average weekly wage upon returning to work. The worker's disability also must be a direct result of the work-related injury and not some other cause, and the worker must not have taken a lump sum payment of impairment income benefits and must make a "good faith effort" to return to work. Supplemental income benefits equal 80 percent of the difference between 80 percent of the worker's average weekly wage and the weekly wage after the injury. Injured workers are eligible for supplemental income benefits the day impairment income benefits expire and must qualify on a quarterly basis. With the exception of Lifetime Income Benefits (LIBs) and regardless of whether the injured worker has returned to work, by statute all income benefits expire 401 weeks after the date of the injury.

Lifetime income benefits equal 75 percent of the worker's average weekly wage, with a 3 percent increase each year. Workers are eligible if their injury or illness resulted in total and permanent loss of sight in both eyes; loss or complete paralysis of both feet, both hands, or one hand and one foot; a traumatic brain injury that resulted in incurable insanity or imbecility; or third-degree burns over a significant portion of the body. Lifetime income benefits continue until the death of the employee.

Employers with substantially higher workers' compensation claims than others in their industry may be designated "hazardous employers" by TWCC. State law requires that public hazardous employers hire a TWCC-approved consultant to develop and implement an accident inspection plan. Six to nine months after the plan's implementation, TWCC inspects the workplace to ensure that the employer has taken corrective action. A company on the list of hazardous employers remains there for 12 months. However, as a result of a lawsuit several years ago that determined that the federal Occupational Safety and Health Administration (OSHA) pre-empts TWCC's hazardous employer program, private employers are not required to implement a plan or undergo inspections.

Employer participation. Texas is the only state that effectively allows any private-sector employer the right to purchase or not purchase workers' compensation coverage. Many employers do not participate in the state workers' compensation system. Private employers that choose not to carry workers' compensation insurance, termed "nonsubscribers," are required to disclose this fact to

their employees. While some nonsubscribers may have an alternative occupational benefits program and some form of alternative liability insurance, nonsubscribers do not have any liability protection under the Workers' Compensation Act because these employers are not subject to it. Those companies may choose to purchase an alternative liability policy rather than workers' compensation insurance because it reduces the financial risk of "going bare" and may be more affordable than a traditional workers' compensation policy.

Large companies, however, may obtain protection under the Workers' Compensation Act even if they do not purchase a workers' compensation insurance policy. Such companies may self-insure if they would be responsible for a total unmodified workers' compensation insurance premium of at least $500,000 in Texas or $10 million nationally. Self-insurers also must show sufficient financial strength and liquidity to ensure the prompt and full payment of all workers' compensation claims. Once those terms have been satisfied, TWCC certifies the company's status as self-insured.

The state of Texas insures itself to provide compensation for state employees by assuming the cost of paying any benefits to its injured workers. The state's workers' compensation program primarily is managed by the State Office of Risk Management (SORM), but the University of Texas System, the Texas A&M University System and the Texas Department of Transportation (TXDOT) also have their own self-insured workers' compensation programs. Political subdivisions, such as cities, counties, and school districts, are required by law either to self-insure or to obtain workers' compensation coverage from an insurer.

Federal workers' compensation laws preempt the state statute for certain occupations, including maritime workers, railroad workers, and federal employees. Other groups are excluded from the Texas workers' compensation law, including domestic workers and farm and ranch workers. Their employers may carry workers' compensation insurance, but even if employers do not, they still are permitted to raise common-law defenses. As part of a revision of the workers' compensation laws in 1985, Texas included all migrant workers in the workers' compensation system.

The only companies for which workers' compensation insurance is required are building and construction contractors working on public projects. A governmental entity that enters into a building or construction contract must require that the contractor provide coverage for each employee working on the public project.

Common-law defenses and workers' compensation

Texas Labor Code sec. 406.033 prohibits employers from using common-law defenses in cases involving an injured employee if the company does not carry workers' compensation insurance. Common-law defenses generally refer to assumption of risk, contributory negligence, or the "fellow servant" rule, three arguments used frequently in workers' compensation cases prior to the establishment of workers' compensation laws.

An assumption-of-risk argument holds that the injured employee knew and accepted in advance that the work environment was risky and might result in injury. A contributory negligence argument holds that the injured employee's own negligence, not the work environment created by the employer, contributed to the injury. Finally, the fellow servant rule holds that a fellow employee, not the employer, caused the injury to the employee, and that the injured employee instead should bring a cause of action against the fellow employee.

TWCC regulates the system. TWCC is the state agency that oversees much of the workers' compensation system. The agency maintains the list of approved doctors who can treat workers' compensation injuries, sets the rates for medical care reimbursement, and manages the income and medical dispute resolution process for employers, patients, providers, and insurance carriers.

Approved Doctor List (ADL). The ADL exists to ensure that any worker with a work-related injury who needs medical care sees a doctor who is willing to accept workers' compensation patients, has received some basic training on workers' compensation rules and requirements, and understands how the provider may be reimbursed for the medical care rendered to a workers' compensation patient. Prior to HB 2600 in 2001, any doctor licensed to practice in Texas automatically was on this list, but HB 2600 changed the ADL requirements to require that doctors register to

be on the list and receive certain training in order to treat injured workers. There are about 17,000 doctors and other approved health care providers on the TWCC list. Although that number reflects all doctors that can treat workers' compensation patients, not all do so frequently.

State law requires TWCC to order a medical examination to evaluate an impairment caused by the compensable injury or to determine whether maximum medical improvement – the point when further treatment is not expected to result in additional clinical improvement – has been attained. If a doctor wishes to not only treat injured employees, but also assign impairment ratings, then the doctor must receive additional impairment rating training and testing.

Medical fee guidelines. TWCC establishes medical fee guidelines, which set the rates that insurers pay for medical benefits related to treatment for a compensable injury. By statute, these fee guidelines must follow the reimbursement methodology and billing requirements of the federal Medicare system. The commission does not assign values to specific current procedural terminology (CPT) codes – codes assigned to medical procedures for billing purposes – but rather establishes the workers' compensation conversion factor to compensate for the administrative and other differences between treating workers' compensation patients and Medicare patients. This conversion factor essentially acts as a a multiplier to the rates set by Medicare. The current fee guideline pays providers 125 percent of the reimbursement rates for specific services set by Medicare. TWCC currently is in the process of adopting or developing other fee guidelines for ambulatory surgical centers and outpatient/inpatient hospitalization.

Dispute resolution. Conflicts arise in the determination of indemnity, including disputes about liability, compensability, wages, and disability, and in the award of medical benefits, primarily related to fee disputes and the medical necessity of certain procedures. TWCC administers dispute resolution processes for both indemnity and medical disputes (see Fig. 1, page 7).

Premium rate setting in workers' compensation. While TWCC administers the workers' compensation system, TDI regulates the solvency and premium rates of insurance carriers. TWCC certifies individual self-insurers, and TDI approves group self-insurers.

Premium rates for workers' compensation carriers are a file-and-use system. TDI establishes classification relativities – numbers that convey the relative risk for injury in one profession over another. Insurers then file with TDI a deviation from the relativities set by TDI. This deviation represents the amount the company will deviate from the relativity for each classification to determine the rate per $100 of payroll. That rate then is multiplied by the payroll to determine the premium. Any insurance company that has a schedule-rating plan, which states both the criteria the company will use to determine the amount of debit or credit applied to each policyholder's premium and the maximum or minimum of debits and credits, must file it with TDI. Many companies file a schedule rating plan with a maximum debit/credit of 40 percent. However, the insurer of last resort has a schedule rating plan with a maximum debit/credit of 75 percent to account for the higher risk.

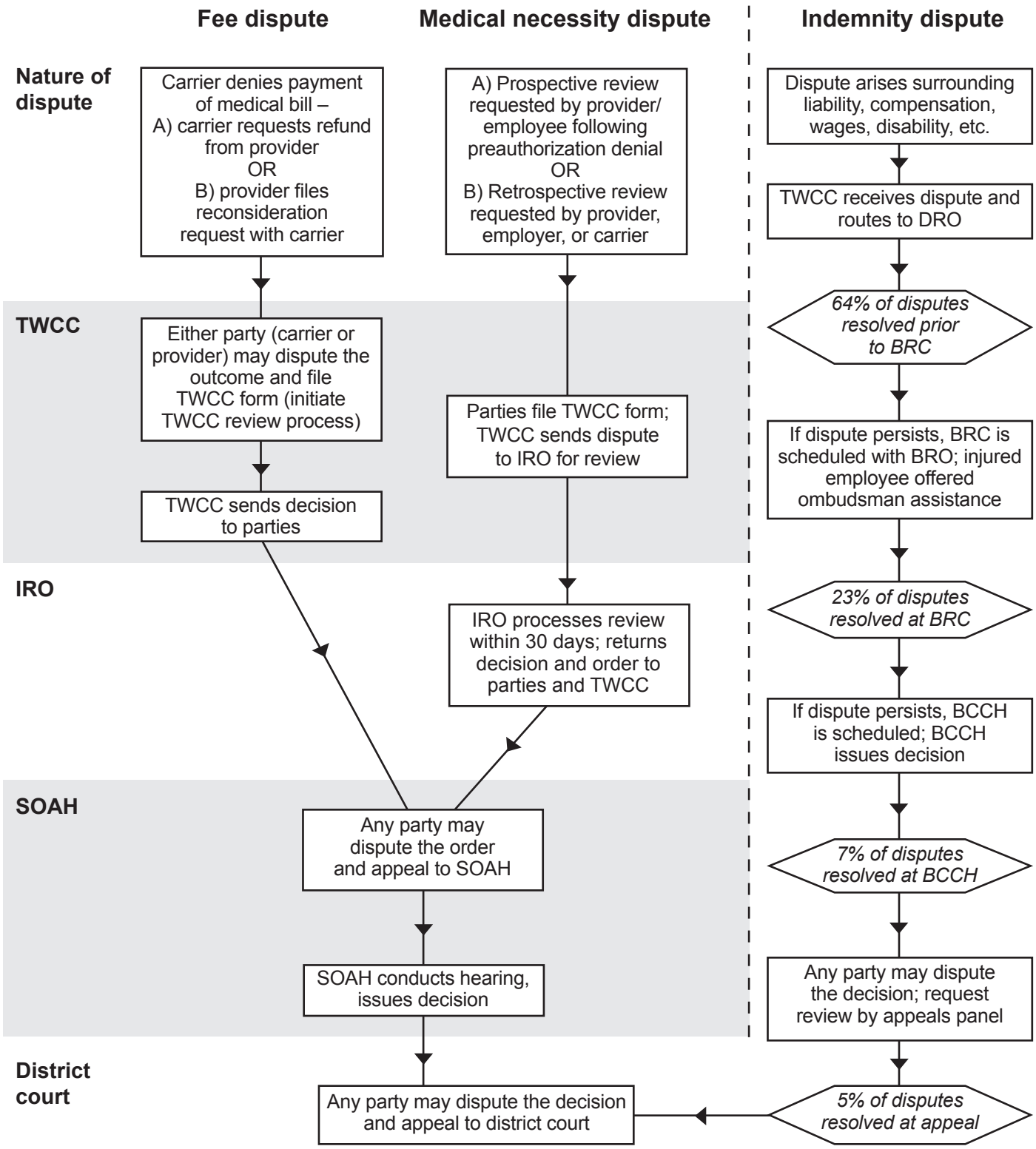
Premium amounts in Texas swung wildly during the 1990s as the industry's rate-setting system changed from a tightly controlled rate schedule to the one that exists today. Some stakeholders say that lower rates at the end of the 1990s reflected intense market competition among carriers in the state and favorable economic conditions. According to insurers, the recent rise in premiums stems from unfavorable market conditions in the early 2000s, and they expect rates to flatten or fall given the improving economic outlook.

Issues prompting calls for change

A convergence of factors has caused workers' compensation to become a pressing issue for the 79th Legislature. Advocates for changing the system cite several primary problems: low return-to-work rates, physicians leaving the system, insufficient participation by employers, under-compensation of injured employees, insufficient regulation by the state agency for workers' compensation, and rising premium rates.

Return-to-work rates. Higher-than-average medical costs in Texas have not translated into better care, according to advocates for changing the system. In 2001, the Research and Oversight Council on Workers' Compensation (ROC), the state agency responsible for conducting objective research on the operational effectiveness of the system, studied Texas' return-to-work rates and found that, compared to other states, injured workers were off work longer and fewer had returned to work within two years. These findings

Figure 1: Dispute resolution processes in the workers' compensation system



Source: TWCC

IRO - Independent Review Organization
SOAH - State Office of Administrative Hearings
TWCC - Texas Workers' Compensation Commission

BCCH - Benefit Contested Case Hearing
BRC - Benefit Review Conference
BRO - Benefit Review Officer
DRO - Dispute Resolution Officer

later were corroborated in a December 2003 study by the Workers' Compensation Research Institute (WCRI), a non-profit research group located in Cambridge, Massachusetts.

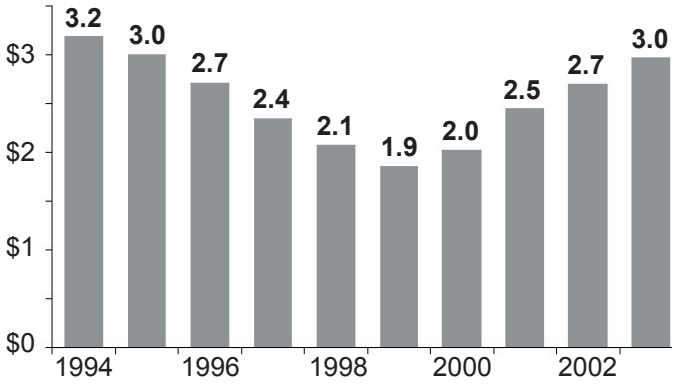
Because longer time off work means higher insurance premiums, and because costs of filling an injured worker's position can be expensive or result in decreased efficiency, employers are interested in improving Texas' return-to-work rates through more appropriate medical care. Texas workers similarly are interested because, on average, approximately one-third were not working almost two years after their injury and 15 percent had never gone back to work. In addition, a higher percentage of injured Texas workers who participated in return-to-work indicated that they take home less pay after the injury than workers in other states.

Physicians leaving the system. Doctors' groups say the current system is driving physicians away from treating patients with workers' compensation claims. According to the Texas Medical Association, the number of doctors who will treat workers' compensation patients has declined by 50 percent over the last two years. They say that high administrative burden, reimbursement rates that are insufficient to cover the amount of paperwork, and the frequency of retrospective reviews for medical necessity all are factors that have contributed to the decline.

Insufficient regulation. Many observers are dissatisfied with the leadership and oversight provided by TWCC over the workers' compensation system. The Sunset Advisory Commission found that TWCC lacked strategic direction, a finding echoed by other stakeholders who have complained that the agency's commissioners are ineffective and lack accountability. They cite the amount of time it takes to resolve complaints and an inability to implement measures to stem rising costs of medical care in the system as two areas where agency leadership has failed. Stakeholders who oppose the abolition of TWCC have concerns about folding such a key function into TDI without direct appointment of a commissioner for workers' compensation.

Insufficient participation. Many Texas workers are not covered by the workers' compensation system because their employers either self-insure or opt out. According to a 2004 study by the TDI Workers' Compensation Research Group (formerly known as the ROC), 38 percent of year-round employers in the state currently do not carry workers' compensation coverage, and they employ about 24 percent of the Texas workforce. Companies without coverage tend to be smaller employers that are less likely to have the resources to cover a workers' compensation suit. However, of those without coverage, more than half say they pay some or all medical expenses for an injured worker and some income benefits.

Figure 2: Average premium per $100 of payroll by policy year, 1994-2003



Source: Texas Department of Insurance, ROC

System under-compensates injured employees. An employee who is injured on the job in Texas will receive 70 percent of wages as an income benefit, with a maximum amount pegged to the state average weekly wage. The 70 percent rate is supposed to be compensation for after-tax income, since workers' compensation benefits are not subject to federal income taxes. Some stakeholders say that the 70 percent rate should be raised because many lower-income employees pay less than 30 percent in federal income taxes and therefore are being under-compensated by the workers' compensation system. At the same time, other stakeholders say that statutorily capping the income benefit at the state average weekly wage makes it too low for workers who earn more than the average weekly wage.

Figure 3: Distribution of total payments in Texas' workers' compensation system

Hospitalization and surgery	48.0 %
Physical medicine	21.0%
Office visits	11.0%
Diagnostic tests	8.0%
Pharmaceuticals	3.5%
Other	8.5%

Source: ROC, Striking the Balance*, 2001*

Rising premiums. According to TDI, premiums for workers' compensation insurance have risen by almost 60 percent over the last four years, from a low of $1.87 per $100 of payroll in 1999 to $2.98 in 2003 (see Fig. 2, page 8). The 2004 Workers' Compensation Research Institute (WCRI) report put medical costs per claim in Texas among the highest of the 12 states studied and reported growth of cost per claim at double-digit rates for the third consecutive year. According to preliminary research by the WCRI, medical cost growth in Texas may have dropped to about 5 percent in the most recent time period analyzed. A clearer picture of Texas' costs relative to other states will be available in February when WCRI publishes its 2005 report. According to a 2001 ROC study, *Striking the Balance*, Texas' medical costs per claim in 2000 were 20 percent higher than the next highest state. Both the ROC and WCRI studies found that Texas' high medical costs were primarily the result of an overutilization of medical services (both in the amount and length of medical treatment provided to injured workers) rather than the price of these services. A decrease in the growth of medical costs could be due to an increase in the number of claim denials by insurance carriers and an increase in denial rates for medical bills.

Advocates for changing the system say that higher premiums are driven by medical costs, which in turn are inflated by high rates of utilization – the number and frequency of services an injured worker receives. According to the ROC study, almost half of total payments in the Texas workers' compensation system were made for hospitalization or surgery (see Fig. 3, page 8), and about 20 percent were for physical medicine, which includes chiropractic manipulations, therapeutic exercise, and other treatments. Of nine states studied, Texas had either the highest or second highest utilization rates for surgery, injections, physical medicine, office visits, and diagnostic testing services. Recent findings by the TDI Workers' Compensation Research Group indicate that the utilization of many of the services identified in the ROC studies as cost drivers has not declined in recent years. In fact, the utilization of certain services, such as physical medicine, has continued to increase on a per claim basis despite the increasing number of medical bill denials by insurance carriers.

Advocates for change say that curbing utilization would reduce the medical cost per claim. Insurers say that they expect costs per claim to flatten and fall, accompanied by a reduction in premiums, as the statutory changes from HB 2600 work their way through the system – specifically those relating to regulation of doctors, generic drug preference, and income benefit provisions.

Proposals to change the workers' compensation system

Overview of proposals. One proposal to change the workers' compensation system appears in the Sunset Advisory Commission's decision report, published in September 2004. SB 5 by Staples, filed on January 13, 2005, reflects recommendations made by the Senate Select Interim Committee on Workers' Compensation. The primary tenets of both proposals include changing the regulatory structure and redesigning the system along the lines of a group health

Other resources for injured workers

In addition to the workers' compensation system, federal programs, including Social Security and Medicare, assist disabled workers. Workers' compensation pays for medical care beginning at the date of injury, temporary disability benefits after a waiting period of seven days, and permanent partial and total disability benefits to workers who have long-lasting disabilities from injuries on the job. Social Security and Medicare, by contrast, pay benefits to workers with long-term disabilities from any cause, but only when the disability results in the inability to work. Social Security benefits begin after a five-month waiting period, and Medicare coverage begins 29 months after the onset of work incapacity.

According to the National Academy of Social Insurance's Steering Committee on Workers' Compensation, a group composed of employers, labor, academics, and others, about 70 percent of private-sector employees have sick leave or short-term disability coverage, which pays a full salary for a few weeks. The remaining 30 percent have no income protection for illness or injury other than workers' compensation. Approximately 25 percent of workers retain long-term disability protection, which pays a portion of the worker's salary and is purchased by either the employee or the employer.

Workers' compensation changes in other states

Workers' compensation systems vary greatly from state to state. Texas is the only state that does not require employers to carry workers' compensation insurance, although some states have exemptions for certain industries or for small employers. Two comparable states, California and Florida, have significantly changed their workers' compensation systems within the last year.

Florida's workers' compensation system once was one of the most expensive in the country, with high costs per claim and high premium rates. In 2003, the state enacted a law that increased physician reimbursement and decreased hospital fees, tightened the criteria for permanent total disability designation, adjusted certain income benefits, limited mental disability claims, limited all benefits for subsequent injuries, increased the maximum number of chiropractic visits, reduced pharmaceutical reimbursement rates, eliminated hourly lawyers' fees for most cases, eliminated construction industry exemptions, and created a new subplan for small employers.

Some elements of Florida's system are unique from the perspective of proposals to change the system in Texas. Florida had mandatory networks of physicians, which required patients to see a physician within the workers' compensation carrier's group of doctors, but repealed the statute in 2000. While Florida was an employer-choice state before the new law, meaning that the employer picked the doctor but not from within a network, stakeholders say that Florida's network statute was rife with problems from the start: it was mandatory, required employers to have their networks certified by the state, had very detailed network requirements, and was administratively onerous. Because employers failed to fulfill the administrative requirements, the state was unable to keep track of compliance, and the legislature eventually repealed the statute.

Faced with similar industry characteristics, numerous significant cost drivers, and rapid growth in costs, California enacted changes to its workers' compensation system in April 2004. Two key changes included deregulating insurance rates and requiring that injured workers select doctors from a pool of doctors approved by employers and insurers. The law also tightened eligibility for permanent disability payments, capped payments for temporary disability, and permitted injured workers to seek immediate medical attention paid for by the employer. Labor and attorneys' groups criticized the law for lacking rate regulation and for not giving injured workers enough choice in choosing a doctor.

model. Other proposals include a mandatory rate reduction and address the issue of workers' compensation in the construction industry.

Regulatory structure. The most significant change proposed by the Sunset Commission is to abolish TWCC and transfer its duties to TDI and the Texas Workforce Commission (TWC). The proposal would establish a new office of employee assistance, administratively attached to TDI, to provide legal representation to workers during the dispute resolution process at TDI, in addition to the existing ombudsman program, and modify the medical and income dispute resolution processes. It would align the method for determining the state average weekly wage (which serves as the basis for the statutory cap on weekly income benefits) with the rates used by the TWC in determining unemployment benefits and reduce from four weeks to two the amount of time a worker must be off work before recouping income benefits. Return-to-work programs would be encouraged under this proposal, possibly by requiring carriers to offer premium discounts to employers that offer such programs. The Senate plan also would abolish TWCC, but would create a stand-alone agency headed by a single commissioner. It also would establish a return-to-work pilot program for small businesses to encourage them to bring injured employees back into the workforce under modified duty.

Networks for medical care. Group health insurance would be the model for the delivery of health care through the workers' compensation system under the Sunset Commission's proposal and SB 5. The primary organizational change would be the establishment of networks of health care providers, similar to those used by Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) (see *The difference between HMOs and PPOs in Texas*, page 15). For doctors in the networks, medical reimbursement rates could be negotiated, although some fee schedule likely would remain for doctors in areas not served by a network. Neither proposal addresses

directly the issue of chiropractic care, although it is possible that fewer chiropractors would participate in a network than under the current system because chiropractors generally are not primary care providers under group health. Other proposals include stricter limits on chiropractic care to bring utilization rates for that type of care in line with those for primary care physicians.

Rates reduction. While business leaders have focused primarily on return-to-work rates as their biggest issue, an underlying problem is high workers' compensation insurance rates. As with most insurance regulation, the goal for consumers – employers in this case – is to enact new regulations that will cause rates to fall or to require an accompanying rate reduction. Lawmakers did not include a mandatory rate rollback for homeowners' insurance or medical malpractice insurance during the 78th Legislature (although TDI was authorized to review rates in the case of homeowners' insurance). However, lawmakers could include a mandatory rate rollback as part of a comprehensive workers' compensation package. SB 5 does not include a mandatory rate rollback, but would authorize the insurance commissioner to review rates and report the effect of changes in the system going forward.

Regulatory structure. As outlined by the Sunset report, the commission's recommendation would abolish TWCC and transfer to TDI the Accident Prevention Services Program and the functions of the Medical Quality Review Panel, the advisory panel created by HB 2600 to evaluate doctors on the ADL. The medical and income dispute resolution processes also would be transferred. The Workers' Compensation Research Group would remain at TDI. The proposal would transfer workplace safety functions from TWCC to TWC, including the Occupational Safety and Health Consultation Program. The proposal would create the Office of Employee Assistance and link it administratively to TDI. This office would provide legal representation to injured workers and advocate for labor in the TDI rulemaking process. Some TWCC functions would be abolished under this proposal because, supporters say, they would be inconsistent with the new approach to workers' compensation. These would include the ADL, the Hazardous Employer Program, and the Medical Advisory Committee, which administers medical policies, fee guidelines, and utilization guidelines.

The Senate plan also would abolish TWCC, but would transfer its duties to a new stand-alone agency to be named the Texas Department of Workers' Compensation, which would be headed by a single commissioner.

Supporters of abolishing TWCC say that the agency has a long history of failing adequately to manage the workers' compensation system. While TDI is an agency with a single leader, supporters say TWCC's structure thwarts effective policy-making because too many people are involved in each decision. Because workers' compensation would be similar to group health insurance coverage under the Sunset proposal, and because TDI has the most experience with group health, supporters say TDI should manage the new system.

Opponents of the plan say that workers' compensation is not an insurance product like property or health insurance. It is a way to manage the relationship between employers and injured workers without involving the courts. Without a dedicated, stand-alone agency, workers will not have adequate influence in the rules governing the system, they say, and would be treated unfairly without legal recourse. A better approach, say opponents, would be to take the elements that work at TDI – a single commissioner, streamlined review processes, and an office that represents individuals – and apply them to TWCC.

Commissioners. Under current law, TWCC has a six-member commissioner panel appointed by the governor and confirmed by the Senate. Some stakeholders favor replacing the panel with a single commissioner. The current panel contains three employer representatives and three employee representatives, which critics say causes the commission to deadlock on important issues. Others say that the six-member panel is the only fair way to ensure that the agency is not biased toward either group. The Senate proposal would have a single commissioner head a new agency. The commissioner would be appointed by the governor and confirmed by the Senate. To be eligible for the position, a person would be required to have 10 years' experience as an executive in business or government or as a practicing attorney or certified public accountant (CPA), with at least five years of that experience in the field of insurance. Appointed associates or deputy commisioners also would be required to have five years' executive, attorney, or CPA experience, two years of which would be required in insurance.

Supporters of appointing a single commissioner say that it has worked well in other agencies. They say the move from multiple commissioners to one makes the appointee more accountable and establishes a closer relationship with the governor. Other agencies represent many constituencies with a single commissioner, which has not led to biased

governance, they say. Supporters point to the State Board of Insurance, whose three-member panel was replaced by a single commissioner in 1993, as a positive example of such a change.

Opponents say that because the workers' compensation system mediates between employers and workers outside the court system, special care is required to guard against bias, which can be accomplished only through joint leadership by both stakeholder groups. Labor, in particular, is concerned that a system led by a single appointed commissioner would treat unfairly injured employees for whom the workers' compensation system is the sole remedy. Instead of moving to a single commissioner, opponents recommend returning to a three-commissioner panel, which existed in the past under the Industrial Accident Board (the predecessor agency to TWCC). They say the smaller panel would be more agile in decision making, yet able to represent fairly the diverse interests within the system. It also would resemble TWC's structure, which has three members representing employers, labor, and the public in matters of unemployment insurance and benefits.

Those who oppose requiring specific types and amount of experience for commissioners say such a policy would be biased toward business and insurers because people in those industries are more likely to possess the required experience. Workers' representatives would have a better opportunity at becoming commissioner without inflexible qualifications.

Under the Sunset proposal to dissolve TWCC, the issue of commissioners would be moot. The workers' compensation system would operate under TDI's single commissioner, who has the authority to establish advisory boards. Supporters of this proposal say that it actually would represent labor's interests better because it would set up a new Office of Employee Assistance, led by a single appointed director, that would provide legal representation to injured employees. Opponents of this plan say that workers would have no voice within TDI as there would be no institutional representation of their interests.

Enhance independent review authority within medical dispute resolution. The Sunset recommendation would change the medical dispute resolution process by giving more weight to decisions made by an independent review organization (IRO) – a third-party panel of doctors certified by TDI. Under the current system, both parties may appeal IRO decisions of medical necessity to the State Office of Administrative Hearings (SOAH). A SOAH decision then may be appealed to district court. Under the proposal, the insurance carrier would have no appeal of the IRO decision, and workers could appeal only to district court.

Some observers favor streamlining the medical dispute process by removing SOAH, arguing that the medical dispute resolution process takes too long. Medical decisions have an impact on patient care: for preauthorization disputes, the patient often must wait months before obtaining care or, if a patient's claim generated multiple denials, the patient's care may be halted by the physician until reimbursement is secured. Matters of medical necessity in workers' compensation should be treated as they are under group health, supporters say, where insurers do not have the option to go to SOAH. Some insurance carriers favor keeping SOAH in the process because, they argue, they should have an appeal process for IRO decisions.

Streamline income dispute resolution. The income benefit dispute process currently involves four possible steps: informal resolution through a benefit review conference (akin to mediation), a more formal contested case hearing, an appeals panel review of the contested case hearing decision, and an appeal to district court. The Sunset proposal would require a system of mandatory informal resolution between the injured worker and the insurance carrier.

Supporters of this proposal say that TWCC often gets involved too early in the process under the current system. Instead of trying to sort it out amongst themselves, workers and carriers use the benefit review conference as a way to convey information to one another, which could be done without the involvement of a state agency.

Although employees generally support streamlining the dispute resolution processes, they are concerned that requiring workers to meet with an insurance carrier without the benefit of a structured mediation process would be unfair. Insurance carriers have access to legal counsel from the start because they have in-house legal departments, while workers do not receive the benefit of even an ombudsman until they have entered the dispute resolution system. Requiring workers to meet with insurers before they enter the formal dispute resolution process could place them at a disadvantage, say these employee advocates.

Alternative dispute resolution. Not addressed by either the Sunset proposal or SB 5, alternative dispute resolution – a way to resolve medical necessity disputes for low cost

medical services without using an IRO – became an option when the 78th Legislature enacted HB 3168 by Giddings in 2003. The law authorized TWCC to create, by rule, an alternative dispute resolution process for medical services that cost less than the review of medical necessity by an IRO ($650 or $460, depending on the specialty of the reviewer). However, in finding that TWCC's rule – which did not include the same appeals mechanism for alternative dispute decisions as it does with IRO decisions, namely SOAH and then district court – violated an insurers' right to due process, a Travis County district court halted its implementation.

Supporters of a lower-cost alternative to the IRO say that physicians and pharmacists need an easier way to recover small claims. A prescription that costs $75 is not worth pursuing under the dispute resolution process because the cost of an IRO review would be far greater. Small claims add up for practitioners, supporters say, and any proposal for change should include an alternate solution for pursuing small claims.

Another proposal, offered by advocates for practitioners, would allow physicians to bundle disputed claims so that as a group they represent a significant enough amount of money to make using an IRO cost effective. Insurers say that an alternative dispute resolution process would be preferable to bundling by ensuring that each dispute was handled individually. However, they also say that there should be a way to appeal decisions made by the alternative dispute resolution process so that due process is not compromised.

New Office of Employee Assistance. The Sunset proposal would establish an Office of Employee Assistance, attached administratively to TDI. It would represent throughout the complaint resolution process individuals who could not afford legal counsel, serve as an ombudsman to perform case management functions, and speak for employees and the public in policy making. Other agencies have similar though more limited arrangements, such as the Office of Public Utility Counsel (OPUC) and the Office of Public Insurance Counsel (OPIC), which represent the interests of consumers in public utility and insurance matters, respectively.

Supporters say the new office better would represent employees. Under the current system, injured workers have access only to an ombudsman, who can help a worker navigate the system but cannot offer legal advice or advocate for the worker. Injured workers who cannot afford a lawyer often go without under the current system. Even though the proposed transfer of duties from TWCC to TDI would involve the loss of institutional representation by workers at the commissioner level, the new office would be their voice in policy making, supporters say. Because the office would be involved with individual workers' cases every day, it would serve better as a policy advocate than would a commissioner.

Some stakeholders do not wish to see the return of lawyers into the system and are opposed to the state paying for legal representation. Changes to the system since the late 1980s largely have focused on ensuring that money is spent on benefits and not on lawyers. Critics say that even a move by the state to pay lawyers to represent low-income injured workers would be a step in the wrong direction. Also, it is unprecedented for the state to pay plaintiff's legal fees. It would be more appropriate, they say, for ombudsmen to represent workers and for the system to be more accessible to workers without legal counsel.

Other stakeholders question the new office's legitimacy as a public policy advocate for workers' interests. They say that public interest offices such as OPUC and OPIC represent consumers in rate setting and other matters in which the public's financial interests are at stake. The difference for workers' compensation is that employees' rights are at stake. Because employees trade their right to civil recourse in exchange for access to no-fault income and medical benefits in the workers' compensation system, the need for adequate representation in the rule-making and policy-setting mechanism for that system is of vital importance. An office fashioned after a consumer advocacy office would be insufficient to represent employee interests, they say.

Income benefits. Both the Sunset proposal and SB 5 would create a new method for determining the state average weekly wage (SAWW) that serves as the basis for capping income benefits. Under current law, the maximum income benefit is capped at the state average weekly wage – $537 for fiscal 2004 and $539 for fiscal 2005 (Labor Code § 408.047). Prior to 2003, the SAWW was based on the average weekly wage of manufacturing production workers as determined by TWC. During the last session, lawmakers realized that due to a change in the industrial classification coding system (SIC codes to NICS codes), the average weekly wage for manufacturing workers increased significantly and that this change potentially would increase the cost of the system. In response, lawmakers set the SAWW in statute for the next biennium and resolved to create an alternative method for determining the SAWW during TWCC's Sunset review. The

Proposals for change in the construction industry

Although not related directly to the workers' compensation system, the construction industry's workers' compensation issues often are linked to the system as a whole. A House select interim committee has studied the separate matter of workers' compensation issues related to the construction industry.

The construction industry has unique workers' compensation issues because the relationship between employer and employee is not as clear as in other industries. The workers' compensation system is the sole remedy for employees of a company that carries a policy. Therefore, an injured employee may obtain benefits from the workers' compensation system only and may not sue the employer for additional damages.

In the construction industry, a building owner may hire a general contractor, who in turn may hire a host of subcontractors. An injury on the job site is covered by the immediate employer's workers' compensation policy, but the employee is free to sue other employers on the site because he does not work for them. In an attempt to protect themselves against such suits, companies routinely require subcontractors to sign indemnification clauses to their contracts, but this does not prevent injured employees from suing contractors who were not their direct employers. In January 2004, however, a court of appeals in Houston ruled in *Etie v. Walsh & Albert Company* (135 SW.3d 764), that an injured employee could not sue another employer on the job site because the plaintiff was in fact an employee of the defendant because of the way the contract was structured. This case applies only in the 14th Court of Appeals, but signifies a significant departure from how the law formerly was interpreted.

One proposal for change would ban indemnification clauses in all construction contracts and make workers' compensation the sole remedy for injured employees. Supporters say this would be a fair trade for employers and employees: employers would be responsible only for their direct employees, and injured employees would have access to the workers' compensation system for medical and income benefits. They also say that it would preserve the injured employee's right to sue other companies on the job site for negligence, just not the owner or contracting entity. For example, if an employee of the carpenter were injured because of something the plumber did, then the carpenter's employee could sue the plumber but not the owner of the property.

Some stakeholders oppose this proposal because, by preserving workers' rights to sue other subcontractors on the job site, it would not go far enough in making workers' compensation the sole remedy. At the same time, workers' representatives oppose the proposal because workers would lose the right to sue other groups on the job site without gaining additional benefits. Some observers say that changes made during the 78th Legislature currently are fixing the problem. HB 4 by Nixon permits defendants to name responsible third parties who may be found at fault and allocated a portion of responsibility. In construction cases, the owner of the property might be named, but allocated a very small portion of responsibility, or none at all.

Sunset commission has recommended that TWC determine the SAWW by using the average weekly wage of all workers covered by unemployment insurance.

Because the maximum income benefit is capped statutorily, it inadequately compensates many workers, according to supporters of changing the way income benefits are calculated. Because the statute does not change along with the state economy or inflation, the figure set in statute often lags behind the actual state average weekly wage. TWC calculates the average weekly wage for each fiscal year based on the previous calendar year's data and uses it as the basis for maximum and minimum unemployment benefits. For 2004, the average weekly wage is $705.02, which the Sunset proposal would use as a base for workers' compensation. It also would change the modifier for temporary income benefits from 100 percent to 130 percent to better reflect workers' wages but would not change the 70 percent modifier for imparment income benefits.

Some stakeholders say that the calculation of income benefits should be changed further than what is proposed. They say that the system for calculating an injured employee's Impairment Income Benefits (IIBs) is unfair

because it focuses on the percent of a worker's body that is injured, not on the worker's inability to work. Texas calculates IIB's by multiplying the percentage of impairment by a time modifier. For example, an injured arm might have a 9 percent impairment, which when multiplied by the time modifier might translate into 18 weeks of benefits. This is unfair, critics say, because it inadequately compensates an employee whose injured arm is essential to the job and takes more than 18 weeks to heal, but overcompensates a worker whose job might be performed adequately without that arm.

Return-to-work programs. Although many of the changes proposed in the Sunset plan are designed to address return-to-work rates, the plan does not address the issue of programs that can benefit injured workers who may be able to return to their jobs on light or modified duty. Some stakeholders propose encouraging employers to create return-to-work programs by requiring carriers to offer discounts to employers that offer them. Carriers say that they already offer discounts to employers that have return-to-work programs and that they should not be required to discount any single employer's rate unless that specific employer's risk profile warrants it. According to TDI, however, no carrier actually offers a discount, but companies with return-to-work programs indirectly may have lower premiums because they generally have a better loss experience.

SB 5 would create a pilot program that would reimburse small employers for the cost of workplace modifications to accomodate an injured employee's return to modified or light duty work. The bill would create a fund from administrative penalties collected by the state that would be used to reimburse up to $2,500 per worker. Expenses eligible for reimbursement would include physical modifications to the worksite, special equipment or furniture, and other costs incurred in accomodating the employee's restrictions.

Supporters of the pilot program say that it directly would encourage earlier return to work for employees whose injuries require some modification of the worksite. Without a program like this, employers might not see the benefit in bringing back an employee with an up-front cost.

Abolished programs. According to the Sunset proposal, some programs currently administered by TWCC would be abolished for being inconsistent with the new approach to workers' compensation. Among these is the Hazardous Employer Program, which identifies employers with substantially higher workers' compensation claims than others in their industry. Since *Robinson v. TWCC* (934 S.W.2d 149 (Tex. Ct. App. 1996)), prohibits TWCC from inspecting private employers and SORM, the University of Texas, Texas A&M University, and the Texas Department of Transportation cover state agencies, the program is limited primarily to municipalities and other political subdivisions.

Advocates for safer workplaces say that instead of abolishing the program, Texas should find ways to identify and improve hazardous workplaces. One proposal would be to set up a state office of occupational health and safety, similar to the federal OSHA. To better identify workplace hazards, it would have investigative power and the authority to levy fines for non-compliance with safety standards. Twenty-two states, including California, have state occupational-safety plans. If Texas developed such a plan, it would have greater latitude in inspecting and enforcing safety standards, which supporters say better would address the prevention side of workers' compensation.

Networks of doctors for medical care. Group health insurance would be the model for the delivery of health care through the workers' compensation system under the Sunset Commission's proposal and SB 5. The primary organizational change would be the establishment of networks of health care providers, similar to those used by HMOs and PPOs (see *The difference between HMOs and PPOs in Texas*, page 15). For doctors in the networks, rates could be negotiated, although some fee schedule likely would remain for doctors in areas not served by a network. Neither proposal addresses directly the issue of chiropractic care, although it is possible that fewer chiropractors would participate in a network than under the current system. Other proposals include stricter limits on chiropractic care.

Closed networks. The Sunset proposal and SB 5 recommendations include requiring that primary care physicians order all services, limiting retrospective reviews of medical necessity, applying prompt payment rules, and encouraging choice among providers within the network structure. The key to the policy change involving networks is that it would change the system from employee-choice to employer-choice, a significant shift in Texas' workers' compensation system. Because it is unlikely that employees would have the choice of a physician outside the network, the final model likely will be a system of closed networks. Within the framework of a discussion about networks, there are a number of considerations that stakeholders say lawmakers should consider, including adequacy and prompt pay.

The difference between HMOs and PPOs in Texas

Proposals that seek to fashion workers compensation along the lines of group health leave some observers wondering which group health model the new system might follow. Two managed care models of group health insurance now dominate the industry: health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs, which became widespread in the 1970s, control costs by limiting utilization. Members are required to select a primary care physician, who serves as the "gate-keeper" for access to specialty medical care. In addition, preauthorization requirements limit utilization of expensive procedures. HMOs limit financial risk by paying for services under a capitated – or per person – rate, although critics say that capitation also encourages underutilization because it limits physicians' compensation.

PPOs emerged as a more flexible option to the restrictions imposed by HMOs. Under the PPO system, patients are not required to see an in-network physician, although they pay less if they do, nor are they required to see a primary care physician for all specialist referrals. Preauthorization also is required for fewer procedures under a PPO. Physicians within a PPO network are paid negotiated rates, usually a discounted rate. The HMO model has become more flexible since PPOs entered the market, while PPOs have adopted some of the rigidity of HMOs as the cost of medical care continues to rise.

In Texas, each type of group health insurance operates under separate statutory authority. Insurance Code chapters 20A and 843 pertain to HMOs, while PPOs operate under Insurance Code article 3.70-3C. While each statute contains provisions specific to the insurance arrangement it governs, many provisions apply to both models, including prompt payment requirements, solvency standards, and need for a certificate of authority.

Two statutory areas diverge slightly because of the difference between open and closed networks. Statutes pertaining to HMOs include more specific network requirements than the statutes for PPOs because HMO patients cannot go outside of the network for treatment unless they pay for it themselves. The requirements for PPOs are less stringent because patients in a PPO can go outside of the network for treatment, although their co-payments and cost sharing may be higher. For the same reasons, the HMO statute includes quality assurance requirements under which TDI monitors HMO networks to ensure that patients receive quality health care. These differences would be a consideration in writing a new, networked, workers' compensation statute.

In addition to the statutes relating directly to the insurance arrangement, regulations for HMOs and PPOs require the use of utilization review, which is designed to control and limit medical expenses through such measures as precertification for admission to a health care facility and continuous analysis of a patient's need for care. Included in the laws governing utilization review are timelines and appeal processes that keep the insurer, physician, and patient moving toward a fair, medically accurate decision when utilization reviews are required. As in workers' compensation system, HMOs often employ independent review organizations to issue prospective opinions, but in workers' compensation they also are used retrospectively. Unlike workers' compensation, the decision by an IRO is binding and final.

Adequacy. The key consideration when evaluating a network proposal would be the adequacy of the network, according to some stakeholders. They say that it is important to ensure that any network has a sufficient number of primary care physicians and specialists, such as occupational health specialists and orthopedic surgeons, who treat the types of injuries usually seen in workers' compensation cases, and that patients could see network doctors close to their homes or places of work. Under the Sunset proposal, the adequacy of a network would be determined by TDI at the time of certification or review.

Supporters of TDI's making the decision about adequacy say that this most closely resembles what happens in a group health system, in which an insurer establishes a network of physicians based on the adequacy standards set by TDI. For example, each policy must have a ratio of obstetricians within the network commensurate with the number of women of child-bearing age covered by the plan. Not all services offered by the plan must be available in-network, and the plan must have out-of-network care options.

Some stakeholders say that the decisions about adequacy of networks and certification should not be left up to TDI. Those decisions are vital to a worker's ability to access medical care and should be overseen by an independent organization or a body such as TWCC that has employee representatives.

Non-network care. Networks are not available everywhere in Texas, as some parts of the state are too sparsely populated to support them. In those areas, under a network proposal, workers' compensation carriers would have to pay providers under an arrangement similar to the one that exists today. Because the Sunset proposal would abolish TWCC's Approved Doctor List, some stakeholders say there should be another way to determine who could treat workers' compensation patients outside of the established networks.

Fees. In group health, insurers assemble networks by negotiating discounted rates with physicians in return for a group of patients. Supporters of the network proposal say that the same thing would occur for workers' compensation within networks and that the state would have a non-network fee schedule similar to the one currently in use. The non-network fee schedule would be set by TDI and would be more flexible than the current one pegged to the Medicare reimbursement rate, they say.

Doctors would like the non-network rate to be significantly higher than the 125 percent of Medicare in use today. They say the current rates do not adequately reimburse them for the administrative hassle of dealing with workers' compensation claims. In addition, some doctors have proposed that the non-network rate be the floor for network negotiations, with rates rising from there. Opponents of setting non-network rates as the base say that it would be inappropriate for the state to set a floor for private negotiations between a physician and an insurer and that the calculation would best be determined by market forces.

Any willing provider. An issue in group health among networks and physicians who have not negotiated to become part of a network is the matter of who may join. Doctors have promoted the idea of "any willing provider," meaning that any physician who will work under the terms and rates set by the network should be able to treat patients in the network, whether or not that provider was approached by the insurer to join.

Carriers say that permitting any willing provider to treat patients would undermine their ability to ensure that patients receive appropriate care. Insurers look at many factors when evaluating whether or not to permit a provider to join the network, a decision process that they say is an essential element of their competitiveness.

Prompt pay. The relationship between providers and insurers within group health networks is governed by a set of statutes, known loosely as "prompt pay." It sets timelines and processes for billing, payment, and dispute resolution, among other provisions. One of the key elements of prompt pay is a fairly rigid and tight timeline for payment of services by the insurer.

The issue in workers' compensation relates to compensability and the 60 days from the date the insurance carrier receives written notice of the injury that the insurer has to investigate a claim and determine whether or not the injury is compensable under the workers' compensation system. By contrast, in group health an insurer can determine whether or not the patient is covered even before services are rendered. Stakeholders say that one way to solve this problem in workers' compensation would be to adopt the system used in California, under which the workers' compensation insurer is liable for the first $10,000 of treatment until compensability is determined. If the case then is determined not to be a workers' compensation claim, the insurer seeks reimbursement from the group health insurer or patient.

Evaluation. One of the requirements of HB 2600 was the development of "report cards" to evaluate the quality of health care under a network plan. Alhough networks never were implemented as a result of that legislation because the agency never completed action on rulemaking, stakeholders say that any new network plan should employ report cards or another evaluation tool. SB 5 would require the new agency overseeing workers' compensation to issue annual report cards comparing networks, though it would leave the information to be included up to the agency. According to a ROC report, *Health Care Network Report Cards*, 19 states (including Texas) have HMO or PPO report cards to provide consumers clear and objective information about the performance of participating plans.

The TWCC Health Network Advisory Committee that convened to study the feasibility of networks in 2002 established 11 criteria for the evaluation of network plans in workers' compensation:

1. employee access to care;
2. coordination of care and return to work;
3. communication among system participants;
4. return-to-work outcomes;
5. health-related outcomes;
6. employee, health care provider, employer, and insurance carrier satisfaction;
7. disability and reinjury prevention;
8. appropriate clinical care;
9. health care costs;
10. health care utilization; and
11. statistical outcomes of medical dispute resolution provided by IROs.

According to the committee, the information on the report card should be tailored to specific populations and distributed to patients, employers, carriers, and policy makers so that the effectiveness of specific networks could be evaluated over time.

Access to networks for small employers. Because networks are designed to reduce costs and improve treatment outcomes, which should translate into reduced workers' compensation premiums, some stakeholders are concerned carriers may offer network access only to large employers because their business is more valuable. Small employers have experienced similar discrimination in group health where it has been difficult for them to obtain affordable health coverage for their employees.

Ownership of the network. Property and casualty companies offer workers' compensation insurance, while health insurance companies offer group health plans, and current law prohibits health insurers from writing workers' compensation policies. While property and casualty companies are not prohibited from offering health insurance, very few do. Proposed changes to the workers' compensation system would amend the law to permit health insurance companies to offer workers' compensation policies, although the initial level of interest is unlikely to be great because the two lines are very dissimilar. It is more likely that property and casualty companies will lease existing networks of providers from health insurers.

Some workers' representatives say that the state should require leasing of networks by group health insurers to workers' compensation carriers to maintain a degree of separation between the payer and the physician. Other stakeholders feel this would be unnecessary because the dispute resolution process within networks is capable of resolving conflicts between physicians and payers.

Chiropractic care. The role of chiropractors as primary care doctors in the workers' compensation system is controversial to some stakeholders who say that chiropractors drive overutilization and costs in the system. They say that one of the benefits of a network system is that chiropractors likely will be treated as specialists, as they are in group health, which will curb their rates of utilization. Supporters of limiting chiropractors' role in the system say that they should not be primary care providers because they cannot perform surgery or prescribe, which makes them poor substitutes for primary care physicians.

Other stakeholders say that the debate about chiropractors is a red herring and that other specialties are much greater cost drivers in the workers' compensation system. According to the WCRI, chiropractic care accounts for less than 10 percent of medical payments, while hospital stays add up to 30 percent. While a patient might see a chiropractor more often, the total cost of chiropractic care is lower, stakeholders say. In addition, chiropractors perform a group of services, such as in-house radiology and physical therapy, that other specialties likely would refer out. As a result, a single chiropractic visit might be more expensive but include more services that the insurer would have to pay for separately under another specialist's care.

Workers' representatives say that injured employees should not be limited in choosing a doctor. In fact, very few choose a chiropractor as a primary care provider, but that option should be available. Blaming the industry's woes on chiropractors is a way to force the change from employee-choice to employer-choice, they say.

Evidence-based medicine. One of the changes in April 2004 in California's workers' compensation system was the mandatory use of "evidence-based medicine" for guiding the medical treatment of injured workers. SB 5 would require the use of evidence-based medical guidelines. This term refers to sets of guidelines that recommend certain treatment patterns based on the clinical outcomes observed during studies of different practices, similar to provisions in Texas' Medicaid and community mental health programs that require physicians to follow evidence-based protocols in treating patients. California named a particular treatment guideline in its statute – the American College of Occupational and Environmental Medicine – and authorized

the California Workers' Compensation Agency director to add to this guideline or substitute it. The statute also linked its definition of what constitutes "reasonable and necessary" medical care to this guideline. Some stakeholders say that Texas should include a similar provision in any change the state makes. Others say insurance carriers should be allowed to decide whether to implement guidelines for care.

Rates reduction. Texas is unique among states in that it does not require carriers to file their rates but instead uses a system of relativities. Some stakeholders say that the way rates are set in Texas should be more transparent, while others argue that rates are too high and should be rolled back.

According to some stakeholders, rates in Texas have been rising because insurers have reduced the discounts they offer to employers by as much as 25 percent and in some cases have even eliminated them. Because the adjustment was in the amount of discounts, they have not been required to report those changes to TDI, and their filed rates have remained the same. As a result, some stakeholders say that insurers should be required to disclose to TDI the type and amount of discounts and premiums they are charging that make the actual premium deviate from the filed rates.

The structure of the rate-setting system in Texas would make it very difficult to mandate a rate roll-back, although some stakeholders would like to include one in any change of the system. They say insurers have a history of not passing savings along to customers and that the state should ensure that employers get some of the benefit from any new legislation. The difficulty arises because insurers have significant leeway in deviating from the filed rates to the actual premiums they charge. One way to implement a rate rollback or to ensure that the deviation from filed rates is not as significant a factor would be to tighten the band within which insurers can set their premiums. Supporters of this idea point to the system in Georgia, which allows insurers to set their rates over or under 25 percent of the filed rate but requires that insurers' policies, when taken together, average no more than 5 percent greater or less than the filed rate.

SB 5 would not include a mandatory rate rollback, but it would require the Insurance Commissioner to review insurance rates and determine the effect of changes in the system on the market. If the commissioner determined that the rates did not reflect savings anticipated in SB 5, the bill would require the commissioner to recommend legislative or other changes that would help the commission better regulate rates. The bill also would authorize the commission to impose sanctions against a company that filed rates that were disapproved by the commission. Under current law, sanctions only are authorized if a company has a pattern of overcharging.

– by Kelli Soika

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